HE ARORANGI WHAKAMUA

Reducing the uptake of tobacco
In Ngāti Hauiti Rangatahi

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A thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Philosophy
at Massey University, Wellington Campus,
New Zealand.
2003

ABSTRACT

Tobacco is the leading cause of preventable death in New Zealand and is known to cause various types of cancers, heart disease and respiratory illnesses such as emphysema. As well as harm to smokers, tobacco products cause harm to non-smokers by exposure to tobacco smoke. Smoking is a major issue for Māori in terms of health, equity, economic status and cultural identity as smoking rates, for both adults and youth, are about double the New Zealand European rate.

The author of this thesis and tribal leaders of Ngāti Hauiti believe a comprehensive Māori tobacco intervention strategy, based on traditional values, using current iwi development principles and incorporating contemporary evidence may impact in significant ways on the attitude to smoking in Ngāti Hauiti rangatahi and whānau. In the longer term, the prevalence and social costs of tobacco use can be reduced most effectively and substantially through the adoption of whānau-centred policies aimed at preventing tamariki and rangatahi from initiating tobacco use.

The objectives of this research programme were to collect and analyse data on the historical, social, economic and cultural context of smoking for Ngāti Hauiti tamariki, rangatahi and whānau. The data, combined with information about the context for the intervention and substantial reviews of the literature, would be used to develop a comprehensive framework for the progress of tobacco control research and intervention activities within Ngāti Hauiti.

The study has produced a tobacco uptake intervention strategy using five separate data sources, two of which are original to this thesis: the analysis of Ngāti Hauiti as the

intervention context; and defining of the social constructions of tobacco uptake from a whānau perspective. A Tobacco Uptake Intervention Strategy has been outlined incorporating the contexts for the intervention, the whānau constructions around tobacco uptake, Ngāti Hauiti research principles, and best practice evidence.

The study concludes that Māori health promotion principles were consistent with iwi development principles, therefore aligning the tobacco control intervention with a wider whānau hapū iwi development role was seen as advantageous to both goals; the context for the intervention is clearly able to be identified as a distinctive community setting with a range of strengths that will enable effective implementation of the tobacco control intervention; and, it is clear from qualitative data and evidence that a comprehensive approach that targets multiple sites and multiple levels, and uses complementary components from each intervention approach studied may result in positive changes in tobacco smoking attitudes and behaviours.

ACKNOWLEDGEMENTS

My heartfelt thanks to members of my iwi, Ngāti Hauiti, for supporting and encouraging this research. Without your support this doctorate would not have been possible.

Thank you to all the whānau who agreed to korero with Raihania and me. I hope your stories will enable us as whānau and hapū of Ngāti Hauiti to work with your goals and aspirations towards an auahi kore future.

I would like to express my appreciation and gratitude to the Health Research Council. Your financial support has made it possible for me as the principal researcher to focus my energies on this thesis and complete the conceptual phase of an auahi kore intervention strategy for Ngāti Hauiti. Your ongoing support of the implementation phase of this PhD allowed the iwi to take the next step and implement a public health programme that may significantly improve the health of whānau and hapū of Ngāti Hauiti.

Thank you to Chris Cunningham and Philippa Howden Chapman for academic supervision. Chris, you were always positive, you provided a broader Māori research perspective and your practical support of the project in a variety of ways was invaluable. Thanks, Philippa, for your review of the thesis, your comments and questions helped me to go a bit deeper and to review issues I might have taken for granted.

Thanks to friends and colleagues for taking the time to review specific chapters, I appreciate the time you all took out of your busy schedules. Thank you Bridget Robson, Louise Signal,

Utiku Potaka, Anaru Waa, Shane Bradbrook, Robin Kearns, and Kevin Dewe. Your feedback made the final document that more robust.

I would like to make special mention of George Thompson, who completed his PhD on Tobacco Policy this year. George, you were always a bit of an inspiration, your dedication to the task was remarkable and you were always encouraging of my work.

Thanks to my whānau. In particular my partner Awhina, who provided sound wisdom and support throughout the last four years. To my sister Maureen, who completed her doctorate in 2002. Thank you for leading the way. Thanks to Hana for taking the time to proof read my thesis. To my other children, thanks for being there and being proud of me.

Finally, I would like to dedicate this thesis to my Mum and Dad who both died of lung cancer after many years of smoking.

MAORI/ENGLISH GLOSSARY OF WORDS

Aroha	love
Auahi kore	smoke free
Hapū	sub-tribe
Hauora	lifebreath, health
Hauititanga	Ngāti Hauiti understanding of tikanga
Hui	meeting or gathering
Iwi	tribe
Kai	food
Kainga	house
Kaimahi / kaiāwhina	worker- support worker
Kaitiaki	guardian
Kanohi ki te kanohi	face to face
Kapa haka	form of modern Māori cultural group performance
Karakia	prayer or incantation
Kaumātua	elderly men
Kaupapa	groundwork, topic or subject
Koha	present or gift
Kohanga	nest
Kuia	elderly women
Koroua	elderly man
Kura	school
Mana whenua	having rights over this land
Mana	prestige, authority
Māori	native people of Aotearoa New Zealand
Mauri	Life force or principle
Māoritanga	Māori culture and beliefs

Marae	Māori gathering place
Marae atea	place in front of the meeting house
Mōteatea	lament
Mirimiri	massage
Noa	free from restriction
Pa	stockade or fortified place
Pātere	song
Pakeke	adults
Rangatahi	teenagers or younger people
Rangatira	chief
Reo	language
Rohe	district
Rongoa	traditional medicine
Rūnanga	iwi governing body
Takiwā	district
Tamariki	children
Tangihanga	funeral
Taonga	precious or valuable item
Tapu	Sacred
Tautoko	support
Tauparapara	incantation
Tika	right or correct
Tikanga	protocols and practices
Tino rangatiratanga	sovereignty
Tūpuna	ancestors
Waiata	song
Wānanga	learning education
Whakapapa	genealogy
Whānau	family
Whānaungatanga	making of a family
Wharepuni	place for meeting and sleeping
Wharekai	place for food preparation and eating
Whenua	land

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INTRODUCTION

Background

The Ministry of Health's 5-year plan for tobacco control identified smoking as "a major issue for Māori in terms of health, equity, economic status and cultural identity" (Ministry of Health, 2002a). While smoking has declined among Māori adults (i.e. from 56% in 1981 to 46% in 1996; Laugesan & Swinburn, 2000), Māori smoking rates remain relatively high at over double the European rate (Ministry of Health, 2002a). Similarly, the smoking rate among 14–15-year-old Māori is double the European rate (Ministry of Health, 2002a). The particularly high smoking rate amongst young Māori women students has been identified in a number of studies (Reeder, Williams, McGee, & Glascow, 1999). A study of alcohol and drug use by Ngāti Hauiti rangatahi (Tauwhare 1999) identified a youth prevalence rate of smoking in this population above the national average.

Tobacco is the leading cause of preventable death in New Zealand (Ministry of Health, 1999a). Not only can smoking cause various types of cancers, as well as heart disease and respiratory illnesses such as emphysema, it can also cause serious complications for people with other medical conditions, such as diabetes (*A Tobacco Control Research Strategy: Draft Document*, 2002). As well as being harmful to smokers, tobacco products cause harm to non-smokers by exposure to tobacco smoke. It is estimated that 347 people die each year in New Zealand as a result of exposure to second-hand tobacco smoke (Woodward & Laugesan, 2001).

In terms of smoking-related illness in tamariki and rangatahi, tobacco use is likely to be a major reason for the higher Māori rates of respiratory infections, for chronic otitis media with effusion (glue ear), and for the relatively high hospitalisation rate for asthma among Māori (Ministry of Health, 1999b). It has been estimated that 33 Māori children die each year from sudden infant death syndrome (SIDS) as a result of exposure to smoking by adults (Ministry of Health, 1999b). Smoking may also play a role in the higher rates of meningococcal disease among Māori, given that a New Zealand study found the number of smokers in a household was a significant risk factor for meningococcal disease in children (Baker, McNicholas, & Garrett, 2000).

For all New Zealand, smoking remains the highest risk factor in avoidable mortality and disability and is therefore responsive to primary prevention (Ministry of Health, 1999b). Tribal leaders of Ngāti Hauiti believe a comprehensive Māori tobacco intervention strategy, based on traditional values, using current iwi development principles, and incorporating contemporary evidence might have significant impact on the attitude to smoking in Ngāti Hauiti rangatahi and whānau.

In the longer term the prevalence and social costs of tobacco use can be reduced most effectively and substantially through the adoption of whānau-centred policies aimed at preventing tamariki and rangatahi from initiating tobacco use.

Research Goal

The ultimate goal of the research project is to reduce the uptake of tobacco smoking in the tamariki/rangatahi population of Ngāti Hauiti. This would be achieved in several phases.

Phase one, the doctoral research, will develop the comprehensive conceptual framework that will guide the implementation of a tobacco-intervention strategy for Ngāti Hauiti.

Phase two, the intervention research (yet to be undertaken), would use these principles and strategies in ongoing tobacco intervention programme; in particular the development, design, pilot testing and evaluation of the tobacco-control intervention programme.

Phase three is the putting into operation and delivery of the tobacco-control programme.

The tobacco-control research with Ngāti Hauiti is a long-term research programme, focusing on the Māori-centric mechanisms for reducing uptake. The doctoral research will provide the iwi with a three-tier framework for advancing tobacco control work. First, it will provide an overarching set of principles that will drive all tobacco control research in the iwi; second, it will provide a subset of Māori health promotion principles that will drive development of the intervention itself; and finally it will provide a set of strategies that will form the basis of the Tobacco Intervention Programme.

Theoretical Framework

This research is undertaken using qualitative methods, and within the broader construct of qualitative research the paradigm used is largely a social constructivist approach in the generation of local knowledge. A social constructivist perspective is used as the study seeks to establish context and meaning surrounding tobacco smoking.

The study explores the relationship between two paradigm positions – that of kaupapa Māori research and social constructivism – and concludes that while the accommodation between the two poses some tensions, there are some important similarities, and further debate is required within Māoridom to determine the effectiveness of social constructivism as a paradigm for advancing Māori health research goals. The approach to this research project can currently be described as Māori-centred, with a local approach to social constructivism.

I am a Māori researcher carrying out research with whānau and hapū in my iwi, with the endorsement and leadership of kaumātua in the iwi. It is my intention that this research will benefit whānau, hapū and iwi development. The study operates not only from a Hauititanga perspective, as understood by some tribal members, but also seeks to explore the meanings of this for the wider Hauiti whānau and hapū. This research seeks to generate solutions to issues located in a culturally specific context.

Research Process

The objectives were to: gather data on the historical, social, economic and cultural context of smoking for Ngāti Hauiti tamariki/rangatahi; analyse the data in an attempt to understand the issues more fully; then, using this information combined with information from key informants, iwi leaders, and substantial reviews of the literature, develop a comprehensive

framework for progressing tobacco-control research and intervention activities within Ngāti Hauiti.

Five different types of qualitative interviews took place during this study: whānau interviews based on hapū affiliation; rangatahi hui facilitated by rangatahi auahi kore kaimahi; school-based interviews in small groups; opportunistic interviewing; and key informant interviews. However, the same interview guide was used in all situations with additional questions added for key informant interviews. The qualitative interview data presented in the thesis are largely from whanau interviews as this was the most comprehensive data source gathered and provided the richest insights; however, some data from other types of qualitative interviews have been used to highlight particular issues.

The whānau interviews were conducted with a cohort of Ngāti Hauiti tamariki/rangatahi. The primary focus was youth; however, these young people were viewed within the context of their whānau, hapū and iwi, and the historical, social, economic and cultural contexts of smoking were analysed.

A discussion guide was formulated to focus the interviews. This guide was based on a set of open-ended questions aimed at encouraging discussion and understanding of the following issues: smoking history of whānau; the context of uptake of tobacco; attitudes to tobacco smoking in the whānau; perceived influences; self-perception as a smoker; whānau knowledge of effects of smoking; concepts of addiction; possible reasons why some rangatahi do not smoke; awareness of broader issues of smoking and Māori; options at a whānau-, hapū- and iwi-level for reducing uptake. These themes were chosen after examining the literature on youth and smoking.

The data were analysed using inductive analysis, i.e., the patterns, themes, and categories of analysis come from the data rather than being imposed on them before data collection and analysis. In constructivist analysis, categories are developed and articulated by the participants, and consensus is sought on meaning and interpretation.

In addition to the above data collection, several other methods were used to develop the comprehensive intervention framework. The Tobacco Control Research and Intervention Principles were arrived at by:

- analysing what was understood to be the research paradigm that would drive the doctoral research;
- debating this with peers and other iwi members;
- analysing the theories behind existing tobacco control programmes aimed at youth prevention; and,
- deciding what had the best fit with the context of the intervention and the needs of the key participants in the programme.

The Tobacco Control Research and Intervention Principles are intended to be the drivers for the long-term tobacco control research programme for Ngāti Hauiti. The Principles are specific to this programme and do not necessarily reflect the research principles that would be used by the iwi to carry out other iwi-based research.

In addition to the above research principles, it was necessary to determine a core set of health promotion principles that would guide the development of the intervention framework.

To achieve this, a meta-analysis of three Māori health promotion models – Whānau Ora (Gifford, 1999), Kia Uruuru Mai A Hauora (Ratima, 2001), and Te Pae Mahutonga (Durie) – was carried out and a common set of principles necessary for Māori wellbeing was identified from the frameworks discussed.

Finally, analysis of the evidence from national and international strategies for reducing tobacco uptake in youth, with particular focus on effectiveness of strategies for reducing Māori youth uptake, provided the basis from which the tobacco intervention framework was developed. Other data were analysed for the final set of strategies and included whānau interviews, iwi policies, and data collected on the historical, cultural and social context for the intervention. These data were compared and contrasted and a robust framework was developed to advance iwi tobacco intervention activities.

All information gathered during this research remains the property of Ngāti Hauiti whānau and hapū; however, permission will be sought from the iwi participants and governance to publish the final research report.

Thesis Organisation

The thesis is organised in five stages:

- stage one: the introduction;
- stage two: the research paradigm discussion and methodology chapters;
- stage three: the background data collection and analysis, which include information on Māori youth and smoking, evidence from international health promotion theory, meta-analysis of indigenous health promotion theory, and evidence of effectiveness of tobacco prevention approaches;
- stage four: original data including exploration of Ngāti Hauiti as contexts for the intervention and analysis of the whānau qualitative interviews; and,
- stage five: the synthesis of all data sources and a comprehensive tobacco intervention strategy for Ngāti Hauiti.

Chapter One introduces the reader to the subject of Māori youth smoking. It briefly outlines the extent of the problem and the health impacts, and places these within a specific research context; i.e., the tribal area of Ngāti Hauiti. Current gaps in our understanding and knowledge of Māori youth smoking are discussed and the particular research question, method and methodology in this study are presented. The chapter concludes with an outline of the following chapters and how these are organised throughout the thesis.

Chapter Two, the theoretical framework for the study, provides an opportunity to discuss the assumptions and values underpinning this research and contributes to the discussion on Kaupapa Māori research.

Chapter Three, the methodology, places the researcher in the research study and discusses the methods used in the doctoral research.

Chapter Four, Māori youth and smoking, builds on information presented in the introduction, provides the reader both with more detail on the broader study population and with background information about the problem of Māori youth and smoking.

Chapter Five, theoretical approaches to preventing tobacco uptake, presents multiple theories that are used throughout the world to prevent tobacco uptake. The Ottawa Charter is used as the framework for discussion of various theoretical approaches.

Chapter Six, Māori models of health and health promotion, provides a discussion of three contemporary approaches to Māori health promotion and the meta-analysis of these will further inform the theoretical framework for intervention.

Chapter Seven, Māori tobacco control activities, reviews the evidence of effectiveness of reducing Māori youth uptake and starts with a brief overview of tobacco control activities in New Zealand from the mid 1900s to 2002. Initiatives aimed at Māori and focused on prevention or reduction of uptake will be discussed under the Ottawa Charter framework. The chapter will also review the evidence of the effectiveness of prevention programmes in general, and with specific reference to evaluation studies undertaken in Aotearoa.

Chapter Eight, Ngāti Hauiti, the context of the study, brings the reader's focus to the specific tribal area in which the study is being carried out. This chapter presents a profile of this community, with particular reference to tribal development and the opportunities provided by this environment to prevent tobacco uptake in its youth population.

Chapter Nine, the whānau meaning of smoking, analyses the qualitative interviews, presents information from the interviews with rangatahi and whānau and describes what has been learned about the context of smoking from a whānau, cultural and wider social context. This information is analysed with a view to further informing the intervention framework.

Chapter Ten, Synthesis of the data, brings together data from all the previous chapters and discusses these under the following headings: the research principles that will drive the long-term Tobacco Intervention Strategy for Ngāti Hauiti; Māori Health Promotion principles that will underpin the intervention programme; the strengths and weaknesses of the intervention context; the results from the qualitative interviews: what whānau say about tobacco use and rangatahi; and what the evidence suggests for effective tobacco control prevention interventions.

Chapter Eleven presents the findings: The tobacco Uptake Intervention Strategy For Ngāti Hauiti. This chapter also contains an epilogue that describes the intervention research that will take place with the community of Ngāti Hauiti as a result of this PhD study.

The Contribution of the Research Programme

The value of this research can be considered in both academic and applied research terms. In academic terms, the research presents the first comprehensive attempt by an iwi to formulate a theoretical and evidence-based framework to reduce the uptake of nicotine in its youth population. The Ngāti Hauiti Tobacco Intervention Strategy is the main product of this research. The framework has the potential to contribute to national tobacco control strategies and frameworks and may also be generalisable to other iwi contexts. The research also contributes to further development of Māori specific research, and in particular will guide the intervention research that will be carried out by the iwi over the next 5 years. The framework has the potential to contribute both to a common understanding between academics as to what constitutes an iwi development approach to tobacco control and to indigenous tobacco control theoretical development.

In applying this research, Ngāti Hauiti will conceptualise an intervention approach based on theory and empirical research results delivered in this PhD research. Critical to this objective will be the development of an approach to transport the intervention indicated in this research to the specific cultural setting, which is Ngāti Hauiti. The ongoing research will also:

- develop and standardise the intervention;
- develop the programme protocol;
- define intervention components;
- produce the programme manual;
- develop outcome measures; and,
- pilot and review feasibility of the intervention.

The application of this research will contribute to improved outcomes for rangatahi Māori by:

- reducing smoking uptake through effective intervention;
- providing an opportunity for rangatahi to gain skills and knowledge through involvement in the intervention development research;
- contributing to whānau, hapū and iwi development;
- addressing an important Māori health-outcome priority area;
- putting research with rangatahi into practice for rangatahi; and,
- providing an experienced Ngāti Hauiti health researcher with the opportunity to mentor her younger whanaunga.

CHAPTER TWO
THEORETICAL FRAMEWORK FOR THE STUDY

Interpretive Paradigms: Aligning Social Constructivism with Kaupapa Māori Research

This chapter discusses the assumptions and values underpinning this research and attempts to add to the discussion on definitions of kaupapa Māori research.

This research is undertaken using qualitative methods, and within the broader construct of qualitative research the paradigm approach is most closely aligned to social constructivism. However, aspects of critical theory and a Māori worldview have also influenced the approach.

A Māori worldview is difficult to define as there is no single definition; yet this is an area of considerable interest to Māori academics (Royal, T. 2003).

Social constructivism inquiry aims to produce reconstructed understandings from the point of view of the interacting individual (or institutional context), and researchers operating in this type of tradition are concerned with questions of knowing and being. While there are many different approaches operating within the one paradigm, Guba and Lincoln presented a useful definition of constructivism as adopting a relativist ontology, a transactional epistemology, and a hermeneutic, dialectical methodology (Guba, 1990).

Critical theory, like constructivism, operates from multiple theoretical standpoints. However, critical theory as described in this thesis tends to align critical theory with a particular race analysis as proposed by Māori researchers such as Smith, Cram, and Kiro. My understanding of how critical theory is presented in this particular approach is that as researchers they seek to bring about transformations in the social order, producing knowledge that is historical and structural. This knowledge is judged by its ability to produce praxis or action.

I have chosen to use aspects of both paradigms for a number of reasons. First, I am a practitioner, that is a researcher, and in this sense a pragmatist when it comes to using a range of methodological approaches. Firestone (1990) explained this paradigm-praxis dialectic as the need to reconcile the issues of collecting data in a recalcitrant world and to use whatever is the most appropriate methodological paradigm for a particular situation.

Second, as a Māori researcher and someone actively involved in iwi development, I have used aspects of critical theory, in the analytical phase, as this paradigm enables the exploration of issues of racism, sexism, colonisation, imperialism, and power as a coercive act. However, believing critical theory did not fit well with my knowledge of my context, I was reluctant to use it as the single paradigm underpinning the wider research project.

Third, the subject and nature of the research lends itself well to using a social constructivist framework for the following reasons:

- it was important to suspend any judgement about the situation and to focus on increasing my understanding of the context of Māori youth uptake of nicotine;
- as I was working in this research with adolescents who are often in a state of change and transition, I needed to be open to change and new ways of identifying self and other;
- whānau (whom we interviewed) held diverse opinions about their identity as Māori (and ultimately the solutions that could be generated), and flexibly in the design of the intervention was required.

Social constructivism provided for all these contingencies. It allowed me, as the researcher, to know what more (if anything) there was to know, to gain meanings from the situations,

and to acquire insight into the shared language of youth (i.e., the shared practices, rituals, traditions and forms of life).

Gergen (1999) described social constructivism as a methodological paradigm that provides the opportunity to reflect on one's own premises, to listen to alternative framings, and to grapple with comparative outcomes from multiple standpoints. There are similarities between this approach and critical theory. For example, the personal and institutional racism debate requires us to view situations through a different lens from that of the predominant mode of thinking about a particular situation; in that way it challenges us to think about our assumptions and to listen to a particular viewpoint.

I believe there can be an accommodation between paradigms, particularly post-positivist paradigms such as critical theory and constructivism. For example, constructivist scholars increasingly using discourse analysis to explore emancipatory goals that have traditionally been the realm of critical theorists. Not all would agree with this approach: as previously mentioned, Firestone (1990) argued that the need to accommodate the issues of praxis demands some compromises, whereas Skrtic (1990) argued that compromise or accommodation between paradigms is impossible:

> *The adoption of a paradigm literally permeates every act even tangentially associated with inquiry, such that any consideration even remotely attached to enquiry processes demands rethinking to bring decisions into line with the world view embodied in the paradigm itself.* (p. 81)

The rest of this chapter explores the accommodation between critical theory and constructivism and then discusses how these paradigms, and this research in particular, fit with Kaupapa Māori research principles. The reason for not starting with Kaupapa Māori research in the paradigm discussion is twofold. First, the articulation of a Māori inquiry paradigm is still developmental (Ratima, 2001) and requires Māori researchers in all fields to continue debating the fit or otherwise of Kaupapa Māori paradigms with existing paradigms (including reviewing the relevance of Western knowledge). Second, Kaupapa Māori research has been strongly positioned, by some Māori researchers, in relation to critical theory (Smith, 1999) and therefore the discussion about critical theory and its fit within constructivism needed to happen first.

A logical starting point in the accommodation debate is an examination of the similarities and differences between the ontology, epistemology and methodology of critical theory and social constructivism. The levels at which we can draw on these two traditions will also be discussed.

Ontology

Ontology is the nature of such things as reality, knowing, and being (Cram, 1995). Cram described a continuum of reality from realist positions where the world is made up of "objectively defined facts", to relativist positions where there is acknowledgment of multiple realities.

The ontological position of social constructivism can be interpreted from a variety of perspectives. Skirtic (1990) stated:

> *reality is a social, and therefore multiple , construction; that there is no single tangible , fragmentable reality on which science can converge; that reality exists rather as a set of holistic and meaning-bounded constructions that are both intra and interpersonally conflictual and dialectic in nature.* (p. 77)

Denzin and Lincoln (2000) agreed with this view and discussed the idea of individuals inventing concepts and models to make sense of the world and our experiences in it. They described this inventing as an ongoing process of testing and modifying in the light of new experiences. They also highlighted the importance of the historical and socio-cultural dimension to this construction.

Not all constructivists would agree with this description. Potter, cited in Denzin & Lincoln (2000), went so far as to state that social constructivism is not an ontological doctrine at all and thus takes no position on what sorts of things exist and what their status is. His primary concern was with how a descriptive utterance is socially made to appear stable, factual, neutral, and independent of the speaker. Troyer, cited in Best (1989), used this approach to describe the "claims making" surrounding the tobacco problem. He exposed the various positions and claims that are made by both the tobacco industry and the anti-smoking lobby

groups in a way that challenges some of these "factual and neutral claims". At the same time, he examined the consequences of these claims for smokers, e.g., increased stigmatisation and segregation of smokers, and the classification of smoking as a "lower class habit". Another example of this approach is given in an article on how social constructivism can be used in social work practice. Franklin (1995) focused on stories the clients told, the meaning of the problem within a client's social networks, and, like Troyer, exposed the socio-political processes involved in labelling a problem a problem.

This exposing of the socio-political processes and assumptions, and the importance placed on the historical and sociocultural dimension of any situation proposed by Denzin and Lincoln, is similar to the critical theory viewpoint where social, political, cultural, economic, ethnic, and gender issues are exposed in the examination of any particular social issue. However, not all commentators see similarities between critical theory and social constructivist ontology.

Skrtic described the ontological viewpoint of critical theorists as realist. That is, the researcher can expose and articulate immutable natural laws (for both the social and the natural world) and these are expressed as generalizations, usually in the form of cause and effect (Skrtic, 1990). This view of realism, often described as naïve realism, is associated more with a positivist approach, which Denzin and Lincoln (2000) described as no longer applicable in the contemporary research world. Furthermore, they proposed an ontological position of critical and historical realism and various forms of relativism as being more appropriate. This position is more in line with the ontological accommodation I see between social constructivism and critical theory. The key difference I see is that critical theory tends to locate the foundations of truth in specific historic, economic, racial and social infrastructures of oppression, injustice, and marginalisation, and take a positioned approach to achieve social change, whereas social constructivists tend to evaluate these positions critically; for some constructivists the goal of emancipation is yet another social construction.

I believe it is possible to reconcile the positions of critical and historical realism and various forms of relativism. I would propose that exploring a range of views and keeping an open mind to various constructions in the collection of data are important, while at the same time

using a critical approach to data analysis and explanation is important in achieving iwi development goals.

Epistomology

The relationship between the knower and what can be known is referred to as epistemology. In social constructivism it is claimed that these two positions are fused, with the enquirer and the inquired both being intrinsically involved in the research process. Findings are literally the creation of the process of interaction between the two (Guba, 1990).

Guba continued:

> *the interactivity between researcher and researched be recognized and utilized in the teaching and learning process between the two; and that the values that inhere in the research process be explicated and explored as part of the initial and final research process and products.* (p. 78)

I would agree with the principles espoused here, but in reality there are numerous barriers to participants participating in the manner described above, especially the whānau group who were the prime participants in this study. Some of these barriers are more closely aligned to a critical theory viewpoint where educational, economic and class barriers impact on the ability to participate in what at times is seen as a "privileged, academic, middle-class occupation".

Some researchers see the research goals of constructivism and critical theory as being different: constructivists create findings out of the depiction of participants' viewpoints in the research process, while the role of the critical theorists in relation to participants is to emancipate (Denzin & Lincoln, 2000; Lather, 1991). However, critical theory is often described in other texts (Denzin & Lincoln, 2000; Firestone, 1990; Guba, 1990) as being closely aligned to social constructivist epistemology, in that both are defined as values based and hence subjectivist, and researchers working from both paradigms engage in an interactive manner with the participants. Because of this value-mediated stance, Denzin and Lincoln (2000) saw a fusion between the ontological position and the epistemological position for both critical theory and constructivists paradigms.

I would argue against the view- stating the values underpinning research make research subjectivist. All research is subjectivist in that all researchers hold values; the difference between what is seen as objectivist research from a quantitative viewpoint and subjectivist qualitative research is in the transparent declaration of the researcher's value base. Critical theorists and social constructivists both use what is considered objectivist methods to expose claims and positions inherent in particular social situations.

Firestone (1990) described how values might enter into and influence the course of inquiry:

- values influence decisions about what to study, how to study it, and what interpretations to make of the resulting data;
- inquiry is influenced by the paradigm selected to guide the investigation into the problem;
- inquiry is value bound by the choice of theory and methods chosen to collect, analyze and interpret data;
- inquiry is influenced by the multiple value and belief system inherent in the context into which the inquiry is taken; and,
- inquiry is either value resonant or value dissonant with the nature of the problem to be studied, e.g., problem, paradigm, method, and context must exhibit value resonance.

This set of values is congruent with a range of paradigm positions including kaupapa Māori research, critical theory and social constructivism.

Methodology

While Cram (1995) defined methodology as "the process of inquiry that determines the method(s) used", Denzin et al. (2000) described it as "how we gain knowledge about the world".

Social constructivist methodology is hermeneutical and dialectical: 'hermeneutic' refers to depicting individual constructions as close to the research participants understanding of their viewpoint as possible; 'dialectic' consists of comparing and contrasting existing individual constructions (conflict as well as consensus) so that each respondent must confront the

constructions of others and come to terms with them (Firestone, 1990). According to Firestone (1990) and Skrtic (1990), the methodology of social constructivism aims to:

- produce informed and sophisticated constructions;
- keep channels of communication open so that information and sophistication can be continuously improved;
- reconstruct the world in the mind of constructors; and,
- generate one (or a few) constructions about which there is substantial consensus.

Social constructivism discerns meaning implicit in human activity and uses the researcher as an instrument in understanding this meaning. The research inquiry occurs in natural contexts, and methods should be designed to capture realities holistically. Methods are typically qualitative (although not exclusively) and theory must arise from the data.

At the methodological level, critical theorists operate in many of the same ways as social constructivists, i.e., they take a dialogic approach. However, the end goal in some critical theory research is more directly purposeful and prescribed. For some critical theorists the end goal is transformation, and the dialogic approach is used to raise consciousness and energize and facilitate transformation around a common point of view (Friere, 1973; Hooks, 1994; Lather, 1991). By comparison, while social constructivists view social emancipation as an intrinsically desirable endpoint, it tends to be driven from a participant rather than a "transformative intellectual" viewpoint (Denzin & Lincoln, 2000).

I believe there can be accommodation between these two points. In the same way as some critical theorists have resisted the idea that a researcher has the power to transform or emancipate another and prefer to work on participants' understandings of the world and the way it is shaped so that they may transform it, some constructivists see research directly as a means of exposing the assumptions (through revealing certain claims) and the implications of these assumptions. Both perspectives take the critical analysis approach as a means of influencing our understanding about existing social situations.

How then do both these viewpoints – social constructivism and critical theory – align with Kaupapa Māori research?

Kaupapa Māori Research – Ontology

A separate Māori knowledge and its definition in a contemporary context are like all knowledge, dynamic and not necessarily easily defined. However, Māori researchers, academics, writers, social commentators and activists are endeavouring to do just that, to reclaim and restate a distinctive Māori worldview. Henry et al. (2001) described a situation where Māori intellectuals "in resistance to the colonial heritage and hegemony of New Zealand's colonial past" are at the forefront of developing Māori knowledge and a "Kaupapa Māori paradigm" in particular. The Tertiary Education Commission recently decided that there is no adequate or agreed current definition of kaupapa Māori research, only a Māori approach to research (oral discussion with TEC member, 2003).

Some Māori academics describe traditional Māori knowledge as sophisticated, highly complex, highly valued, highly organised and distinctive, and exclusive to Māori (Cunningham, 1998; Ratima, 2001; Smith, 1999). This traditional knowledge base was centred on notions of connection and interdependence, on the personal and the collective, and on the relationship between man and the environment (both physical and spiritual) (Cunningham, 1998; Ratima, 2001).

At the same time as traditional knowledge is being researched and defined, contemporary writing and praxis is generating new Māori knowledge. Contemporary Māori knowledge is identified as holistic and recognises links between historical, cultural, spiritual, social, economic and political factors (Cunningham, 1998; Durie, 1996; Ratima, 2001; Royal, 1992).

Smith (1999) linked the contemporary claiming of distinctive Māori knowledge to Māori activism:

> *The reassertion of Māori aspirations and cultural practice which came about through Te Kohanga Reo, The Waitangi Tribunal and other forms of Māori activism has demonstrated a will by Māori people to make explicit claims about the validity and legitimacy of Māori knowledge.* (p. 172)

This activism, and more specifically the reclaiming of a distinct Māori knowledge, arises from an understanding of the undermining of Māori knowledge, the substitution of Western values, beliefs and customs, and the role of colonial domination in the erosion of the Māori knowledge base. Kiro (2001) saw kaupapa Māori theory development as a "politicising agent for conscientisation and emancipation" and the process of "deconstruction and reconstruction of explanations of the human condition" as a necessary component of conscientisation and emancipation.

The idea that knowledge is deconstructed and reconstructed is not antithetic to social constructivists. However, the emphasis for constructivists might be placed on contemporary knowledge rising out of individual reconstructions, coalescing around consensus. For social constructivists the constructions of an individual are context specific, i.e., relationally, culturally, historically, and politically bound. In the same way that kaupapa Māori researchers use critical analysis, social constructivists include structural analysis as it contributes to the specific understanding of a context.

During this research I have asked myself the following ontological and paradigm questions: How do I make use of Western paradigms in the construction of a Māori research paradigm? Can kaupapa Māori research accommodate a social constructivist paradigm perspective? What, as a Māori researcher carrying out iwi research, do I call what I am doing?

The role of Western knowledge in the formulation of Māori research paradigms is generally seen to be some form of accommodation, i.e., that indigenous theory is not 'pure' or seen to be developed in a vacuum (Smith, 1999). To isolate ourselves from Western knowledge and research paradigms because of the cultural values these impose and the historical and ongoing impact these have on our people, is to deny an opportunity to take the best of whatever is offered and use it to develop our own systems, rules, knowledge, institutions and processes. Gergen (1999) suggested careful and caring elaboration of a constructivist alternative would enable academics and researchers to "find ways of reconstituting the modernist tradition" or, in the case of Māori academics and theoreticians reconstituting Western forms of knowledge, "to retain some of its virtues while removing its threatening potentials" (Gergen, 1999, p. 50).

I believe we can apply Ratima's (2001) concept of interconnectedness as a theme of Māori inquiry paradigm across disciplines and knowledge frameworks, to enhance our strategic positioning as Māori. The reality of Māori research is that very little is carried out that does not have some sort of accommodation with Western knowledge and the components of Western research methodology.

In terms of the second question, can a paradigm that does not have an emancipatory goal as its major purpose and does not operate out of a singly defined set of philosophical beliefs and a defined set of social practices fit with kaupapa Māori research? Within academic writing there is a strong emphasis on kaupapa Māori research as critique and transformation (Smith, 1997; 1999), and a number of Māori academics have attempted to define a set of principles that encompass kaupapa Māori research (Cram, 1995; Crengle, 1997; Glover, 2002; Henry & Pene, 2001; Henry, no date; Irwin, 1994; Smith, 1999). Kaupapa Māori research has been defined as research that is culturally safe, relevant and appropriate, is controlled by Māori, for Māori and with Māori, addresses Māori needs and gives full recognition to Māori culture and value systems, upholds the interests and mana of the group, and embraces traditional beliefs and ethics while incorporating contemporary resistance strategies that embody the drive for tino rangatiratanga. There is much overlap in each of the frameworks presented, and on reflection this research would definitely fit within the range of features described by the authors.

I believe the answer to the question posed previously is that social constructivism as a paradigm can usefully be used by researchers conducting kaupapa Māori research because one of the driving principles in social constructivism is to explore and define knowledge from the participant's worldview, and as the researcher is a critical part of the process, then together as Māori, whānau and iwi we can determine the research process for ourselves. This self-determination forms an integral part of a kaupapa Māori approach to research. Defining our own responses to the social issues raised in the research, and using structures and principles relevant to the whānau and hapū involved in the study are key components of both kaupapa Māori research and social constructivism. Social constructivism, and in particular a relativist viewpoint, can be used for the generation of contemporary Māori knowledge and for emancipatory purposes if this is the desire of participants. In addition, social constructivism can be used as a paradigm to inform kaupapa Māori research because Māori knowledge is developmental and needs to accommodate diverse realities and this knowledge

also needs to be developed and transmitted in ways that make sense to the people who are most implicated. Positive Māori development will also require access to customary knowledge as well as innovation if we are to take advantage of both traditional and contemporary knowledge. In this particular study whānau and hapū and iwi will drive the project and will make it a reality in their own terms, and as individuals we all have the right to define our own reality in relationship to others, in this case whānau and hapū and iwi.

It is important to note that the particular social constructivist approach used in this research provides a critical analysis of the historical, cultural, and political factors (including structural determinants) influencing participants' views of the world. While the research can, through interactive discussion with participants, result in the achievement of emancipatory goals, it does not take a "one approach fits all" perspective and does not have as its principal aim to "emancipate the people" in the same way that some critical theory does.

As previously mentioned, there is fairly close alignment between social constructivist and critical theory epistemology, in that both declare certain values and researchers working from both paradigms engage in an interactive manner with the participants. However, what I wish to discuss in this next section is how this accommodation fits with kaupapa Māori epistemology.

Kaupapa Māori Epistemology

If we are talking about the relationship of the knower to the known and the nature of human knowing, Nepe, cited in Smith (1999), stated that as Māori :

> *We have a different epistemological tradition which frames the way we see the world, the way we organize ourselves in it, the questions we ask and the solutions which we seek. It is larger than the individuals in it and the specific moment in which we are currently living.* (p. 187)

I would agree with this statement and, like Smith, I believe it is possible in kaupapa Māori research to address the different constructions of Māori knowledge. However, Smith (1999) proposed a position of "critically engaging in the way it has been and is being constructed". This critical engagement is about taking an epistemological position from a critical theory perspective that questions how what is has come to be, whose interests are served by

particular institutional arrangements, and where our own frames of reference come from. The work is about transformative praxis that leads to social change.

While many Māori researchers would agree with this position (Cram, 1995; Henry & Pene, 2001; Henry, no date; Irwin, 1994; Kiro, 2001; Robson & Reid, 2001; Smith, 1999), others hold views more akin with what might be described as Māori centred research, Māori health research, or Māori inquiry paradigm (Aspin, 2000; Bishop, 1994; Cunningham, 1998; Durie, 1996; Ratima, 2001). These authors can be seen as taking a view similar to a constructivist approach: a belief in the power of critical reflection to improve the wellbeing of Māori, but connecting the interpretive project less directly to political transformation and more closely to dialogue, conversation, and education understood as an interpretational interchange that is self transformative (Denzin & Lincoln, 2000). I believe there are strong similarities in all these approaches, even though some may come from slightly different paradigms.

Social constructivism and kaupapa Māori research both acknowledge:

- working out the meaning and finding joint understandings of what is safe, appropriate, relevant, and holds mana for participants is highly valued;
- exploring traditional values, ethics and principles is a necessary part of moving forward with agreed understandings;
- working from an understanding that we are all value driven and our understanding of relationship is limited by culture and history, while at the same time being viewed as holistic and integrated, is acknowledged; and
- emancipation is an intrinsically valued goal.

In claiming this research and declaring a position from an epistemological viewpoint I would say I am a Māori researcher carrying out research with whānau, hapū and iwi, with the endorsement and leadership of kuia and kaumātua in the iwi. This research will benefit whānau, hapū and iwi development. It not only operates from a Hauititanga perspective as understood by some tribal members, seeking to explore the meaning of Hauititanga from the wider whānau and hapū perspective, but it also seeks to generate solutions to issues that are located in a culturally specific context.

Kaupapa Māori Methodology

As previously mentioned, methodology is about "the process of inquiry that determines the method(s) used". Smith (1999) cited a definition by Harding describing methodology as "a theory and analysis of how research does or should proceed".

This implies a need for consistency between the ontological, epistemological and methodological viewpoints one takes as the researcher. It implies that the following questions need to be asked. What are the advantages and disadvantages of the methods I will use? How will they enable me to answer the research question? What are the values and assumptions I am making? Who am I, and what is my role in the research process? What is the role of the participants? What methods will I employ? How will the analysis occur?

Smith (1999) stated:

> *Within an indigenous framework, methodological debates are ones concerned with the broader politics and strategic goals of indigenous research, it is at this level that researchers have to clarify and justify their intentions.* (p. 143)

There is a general acceptance among Māori academics that kaupapa Māori research is formative, that it has its own methodologies and may employ a range of contemporary and traditional methods, and that within this a range of methodological approaches (including qualitative and quantitative) is appropriate (Cram, 1995; Durie, 1996; Ratima, 2001; Smith, 1999) as long as it meets the ongoing needs of Māori development. After the Māori Research and Development Conference in 1998 Durie (1998) concluded that it was important to employ multiple methods for Māori research provided appropriate frameworks were used and Māori values were factored into the design, ethicality and analysis of the research.

On this basis, if one can clarify and justify a particular methodological approach, and there is consistency not only with Māori values and aspirations, but also with the overarching values and assumptions of the research approach, then kaupapa Māori research can include the methods and methodological approaches of social constructivism and critical theory.

To summarise the discussion on values and assumptions underpinning this research, and the contribution such research makes to the discussion on what can be kaupapa Māori research, I conclude that a particular social constructivist approach will be the paradigm used in this research. Though there are strong similarities with the developing kaupapa Māori research approach described in this thesis, there remains some tension, most notably the issue that some social constructivists are likely to critically evaluate the goal of emancipation and not simply assume it, and in fact that some constructivists may be trapped by having to see emancipation as another social construction. The question of the accommodation between social constructivism and kaupapa Māori research remains open and will need to be further explored in the wider arena of Māoridom.

What can be said at this time is that the approach to this research project is a Māori approach to research with a particular reference to Hauititanga. It is largely a social constructivist approach with some elements of critical theory used in the analytical phase of the research. And all these elements are consistent with a developing kaupapa Māori research paradigm.

CHAPTER THREE
RESEARCH METHODS

The Researcher

Ko Heather Gifford tōku ingoa
Ko Ngāti Hauiti te iwi
Ko Tākitimu te waka
Ko Ruahine te pae maunga
Ko Rangitīkei te awa
Ko Ngāti Haukaha te hapū
Ko Rātā te marae
Ko Tawhara Pirere te kuia
Ko Barney Tamatea Hyland te matua

The importance of connecting oneself with the research participants and the research context, and of declaring oneself as the researcher, is expected and valued in both qualitative research and in a Māori research approach.

From a Māori research perspective, locating oneself in the research project needs to be addressed for a number of reasons. Identifying as Māori and as a Māori researcher is a critical element of an emerging kaupapa Māori research approach; my values as a Māori researcher and the ideological position I take on issues related to Māori development need to be explored, and connections with whānau involved in the research and with the research

context are vital for gaining access and for supervising and organising the research. These issues will be explored below.

From a qualitative research perspective putting oneself as the researcher in the text of the research is important for different reasons: qualitative research encompasses looking at relationships within systems and cultures, including those of the researcher; qualitative design sometimes uses the researcher as instrument, and this may require participation in the setting and interaction with participants; qualitative design incorporates room for a description of the role of the researcher as well as a description of the researcher's bias and ideological preference; qualitative design includes the holistic and concern with the personal, face to face and immediate (Denzin & Lincoln, 2000; Guba & Lincoln, 1994).

In terms of the context of this research project, I am a member of Ngāti Hauiti, I work as a voluntary manager for Ngāti Hauiti health and social services delivery arm, I represent the iwi on several Māori health governance boards in the region, and I am a Māori researcher carrying out research for Ngāti Hauiti.

This placing of myself in the research context gives me a sense of ongoing safety and confidence in carrying out research in an iwi context. I feel safe not only because I have the support of my immediate whānau, but also an iwi whānau of support. This wider whānau guides the research, and provides tikanga supervision and ethical supervision (Irwin, 1994). My involvement in Hauiti development has also given me skills and knowledge, and a sense of the context in which the research is being carried out; and this in turn has provided the confidence not only to proceed with the research, but also to guide and lead the project.

The other issue I wish to discuss as part of belonging to and carrying out iwi-based research, is the affinity I feel with the general strategic direction chosen by Ngāti Hauiti, and the processes and practices that are part of this development. This is not so much an issue of identifying as Māori and as Ngāti Hauiti and the affinity or sense of comfort and confidence that comes with being an insider (although it is partly that), it is more an issue of agreeing with how Ngāti Hauiti carry out business or development, which resonates with my own value structure.

These values are described in Ngāti Hauiti policy documents[1] as mana whenua, mana tangata, rangatiratanga, kaitiakitanga, manaakitanga and whanaungatanga.

I experience whanaungatanga in the connections I feel to whānau and hapū; kaitiakitanga is practised in our health and social service delivery, and I am guided by a person who is seen as a leader and has taken up the mantle of leadership. However, I also feel part of the way the iwi has chosen to proceed strategically. That is:

- working proactively and positively;
- progressing self-reliance;
- improving well-being;
- seeking intergenerational development;
- advancing collective rights and responsibilities;
- integrating services and technology;
- fostering leadership;
- empowering hapū;
- strengthening relationships; and,
- building unity of purpose.

These values and ways of working are part of my own value system and as a researcher they are incorporated not only in ways in which this research is carried out but also in the final tobacco control framework.

Research Purpose

The ultimate outcome from this research project is to reduce the uptake of tobacco smoking in the tamariki/rangatahi population of Ngāti Hauiti. As previously mentioned, this will be achieved in several phases. Phase One, this doctoral research, will develop multiple sets of principles and strategies (the conceptual framework) to guide the implementation of a tobacco intervention strategy for Ngāti Hauiti. Phases Two and Three, the intervention research (yet to be undertaken), will use these principles and strategies in the ongoing

[1] Te Uru Koea o Puanga: An Intergenerational Strategy for Ngāti Hauiti Development. Draft August 1999, Te Rūnanga o Ngāti Hauiti

tobacco control research with Ngāti Hauiti; in particular, in the development, design, pilot testing and final evaluation of the tobacco control intervention programme.

The tobacco control research with Ngāti Hauiti is a long-term research programme, focusing on the Māori-centric mechanisms for reducing uptake. The doctoral research will provide the iwi with a three-tier framework for advancing tobacco intervention work: it will provide an overarching set of principles that will drive all tobacco research in the iwi; it will provide a subset of Māori health promotion principles that will drive development of the intervention itself; and it will provide a set of strategies to form the basis of the intervention programme.

This thesis seeks to answer the question: how can multiple data sources from a constructivist perspective inform a tobacco intervention strategy for an iwi?

The qualitative paradigm used in this study comes from a social constructivist perspective and seeks to establish context and meaning surrounding the uptake of tobacco smoking. The research was conducted with a group of Ngāti Hauiti tamariki/rangatahi. While the primary focus was youth, these youth were viewed in the context of their whānau, hapū and iwi; and the historical, social, economic and cultural context of smoking was analysed.

The research builds on a previous study of alcohol and drug use by Ngāti Hauiti Rangatahi (Tauwhare, 1999) that identified a youth prevalence rate of smoking in this population above the Māori national average. However, this study did not explore the reasons for this high prevalence rate as it was outside the scope of the study. Some of the objectives of the doctoral research were to gather data on the historical, social, economic and cultural context of smoking for Ngāti Hauiti tamariki and rangatahi and to analyse the data in an attempt to understand the issues more fully.

For all New Zealanders, smoking remains the highest risk factor for avoidable mortality and disability and is therefore responsive to primary prevention (Ministry of Health, 1999). As the principal researcher I believe a comprehensive Māori public health model, based on traditional values, using current iwi development principles and incorporating contemporary evidence may impact in significant ways on the attitude to smoking in Ngāti Hauiti.

Substantial knowledge already exists. For example, based on an indepth understanding of the community, iwi members understand the context for the intervention. There is evidence of effective community-based interventions to reduce youth smoking (Ministry of Health, 2002a; NFO CM & Research, 2000; Reid, McNeill, & Glynn, 1995; Stead, Hastings, & Tudor-Smith, 1996), and there are Māori health promotion models (Durie, 2000; Ratima, 2001) and evaluation studies of Māori smoking cessation initiatives (Glover, 2000).

What Ngāti Hauiti community leaders did not have was indepth information on what the whānau of Ngāti Hauiti thought about the uptake of smoking in their whānau and what they thought would be an effective intervention. This doctoral research intends to synthesise all the knowledge available and, from this synthesis, develop the tobacco control framework for a particular community context.

The value of the research can be considered in several ways. In academic terms, the research presents the first comprehensive attempt by an iwi to formulate a theoretical and evidence-based framework to reduce uptake of nicotine in its youth population. The Ngāti Hauiti Tobacco Control Framework is the main product of this research. The framework has the potential to contribute to national tobacco control strategies and frameworks and may also be generalisable to other iwi contexts. The research also contributes to further development of Māori specific research, and in particular will guide the intervention research that will be carried out by the iwi over the next 5 years. The framework has the potential to contribute to a common understanding between academics as to what constitutes an iwi development approach to tobacco control and what contributes to indigenous tobacco control theoretical development.

In applying this research Ngāti Hauiti will conceptualise an intervention approach based on theory and empirical research results delivered in the PhD research. Critical to this objective will be developing the approach indicated in this research to the specific cultural and community setting that is Ngāti Hauiti.

Data-gathering Procedures

The primary method of data gathering was open-ended ethnographic interviewing. Denzin described this as a situation where the interviewer is an active participant alongside the respondent, and interviews are seen as negotiated accomplishments between all players and

are shaped by the contexts and situations in which they take place (Denzin & Lincoln, 2000). Kanohi ki te kanohi (face to face) is an essential element of interviewing in a Māori context and was taken as a given in this research. My experience as a Māori researcher has reinforced the idea that data gathering involving written surveys or other less direct contact does not always give the depth or richness of information that can be gained in face-to-face, open-ended interviews, and as this research was about exploring meaning I needed an approach that would elicit depth and richness.

Data gathering in qualitative methodology is often broken down into task-sized bites, e.g., accessing the setting, understanding the language and culture of the respondents, deciding how to present oneself, locating an informant, gaining trust, establishing rapport, and finally collecting data. A similar process was used to carry out this research and is a useful way to describe the data-gathering procedures used.

Access

Access to the research site and to participants is often seen as problematic in research with Māori; however, this is only the case if the research is considered unsafe, inappropriate or irrelevant for the group affected by the research, i.e., Māori. While it is fitting and appropriate that control of the research is held with Māori and, where possible, the researchers are Māori, this does not necessarily result in access being automatically granted. Principles (tikanga) and adequate processes need to be adhered to. For example, negotiating the mandate to carry out research, particularly outside of your own rohe, is complex, sometimes time consuming, and requires an understanding about the tikanga of the iwi (or in some cases the organisation). If you do not have networks into the setting you may need help with access. Even then, if the research is unsafe, inappropriate or irrelevant, access is unlikely to be given.

Gaining access was not an issue for me in this research project because I am a member of the group being researched; the rūnanga decided it was a worthwhile research project for the iwi; the whānau were happy to talk with me about something they thought was relevant; and I went through the 'right' process in getting the mandate to carry out the research. The 'right' process here was to discuss the project with iwi leaders and get some buy in, take it to the rūnanga to get permission, go to the Ngāti Hauiti health and social service provider to see if

we could get sufficient whānau and hapū members to interview, then use iwi networks to gain entry.

Understanding the Language and Culture of the Participants

It may seem slightly odd to talk about this issue in the context of this research project because I am presumed to be an insider; however, the issues of class and age difference at times made me an outsider in the research process.

The whānau interviews were carried out in whānau homes, and many of these situations made me aware both of my own privileged situation, and at the same time the relativity of the situation. I was also aware of the different value system I held about things such as the importance of education, the value placed on career aspirations, and the value placed on long-term health goals. Having that awareness and acknowledging the differences and tensions (mostly to myself) is part of the dialogic process of constantly reviewing our part in the research process, in particular the meaning of interactions and the values and attitudes we bring to this interaction. Having said that there were differences (based on background values and experiences), there was also a strong feeling of acceptance that overrode these differences, and this was based on whanaungatanga. I was often greeted as a whānau member, for example, "Hi, aunty, come in", or "Hi, cuz, come in. You want a cup of coffee?" I was expected to stay for tea or generally participate in whatever was happening at the time.

The other context in which I became aware of differences was when I carried out hui with groups of tamariki and rangatahi.[2] Here I felt the age difference[3], even though I have teenagers myself. The idiom (slang) they used was sometimes difficult to interpret and I felt an age difference that did not allow me to connect easily with where they were coming from. This was not an issue in the whānau interviews, only in the group interviews. I overcame this to some extent by using rangatahi, working in the auahi kore field, to carry out the interviews as peers, and I participated only as an observer. However, I lost some of the expertise in carrying out the actual interviews by doing this. In the end I decided carrying out the interviews in the whānau setting produced the richest data and whanaungatanga, and the

[2] Separate hui were conducted with rangatahi to deepen my understanding about the issues, these are described in the next section

[3] I am 50 years old

comfort the interviewees felt at being in their own place, enabled me to move past any other differences.

Locating an Informant

I was fortunate in being able to access the best informant possible in this research, Ngāti Hauiti's hapū and cultural development officer. She has extensive networks and is well liked by the whānau. I employed her to organise the interviews and she came with me to tautoko the project. Her help and introductions to those whānau I had not already met were invaluable. Her presence enabled the process of establishing rapport and trust to happen much quicker than if she had not been there.

Collecting Data

Five different settings for data collection through interviews took place during this study: whānau interviews based on hapū affiliation; rangatahi hui facilitated by rangatahi auahi kore kaimahi; school-based interviews in small groups; opportunistic interviewing; and key informant interviews.

Research Questions

A discussion guide was formulated to focus the interviews. It was developed after extensive reading of the literature, including previous Maori research data, on determinants of adolescent smoking and initiation factors in adolescent smoking (Wahlgren et al., 1997; Glover, 2000; Nichter et al, 1997; Reid & Pouwhare, 1991; Glendinning et al., 1997). The questions were developed around themes identified as important initiating factors. The questions were also designed to encourage discussion from a whānau perspective. I wanted to know what they thought about issues and what they saw as solutions. The questions were used as a guide only and further questions and discussion arose during the interview that might not have been covered directly by the questions in the guide. There were also opportunities to ask questions of me as the researcher. This was an important step in first engagement in what is to be a long-term research project. The set of open-ended questions[4] was aimed at encouraging discussion and understanding of the following issues: smoking history of whānau; the context of uptake of tobacco; attitudes to tobacco smoking in the whānau; what were considered to have been the influences; self-perception as a smoker; whānau knowledge of effects of smoking; concepts of addiction; possible reasons why some

[4] The questions are included in the document as Appendix One

rangatahi do not smoke; awareness of broader issues of smoking; and Māori options at a whānau, hapū and iwi level for reducing uptake.

Whānau Interviews

A segmented sampling approach (Patton, 1990) was initially used to match categories of participants, for example, age, gender and whānau and hapū groupings were taken into consideration. We decided to interview two whānau from each of the six hapū groups. The decision to interview according to hapū groups was made as we anticipated the final intervention model would be based on iwi development and that representation across all the hapū would be beneficial at the implementation stage of the model. We attempted a gender balance, but as our first priority was to get whānau from different hapū, then to get whānau who had experience with tobacco uptake with their tamariki and rangatahi, we ended with little choice in gender balance and it happened that most of the tamariki we interviewed were girls. In total, I interviewed 11 whānau, consisting of 27 individuals: 15 rangatahi (4 males, 11 females) and 12 adults. Obviously this created a gender imbalance in the qualitative data collected, but I am unable to say in what ways this might have influenced the results, as I did not have a comparison group. The difference in results between this research and other Māori research into smoking may partly be due to gender difference; however, it may just as likely be due to other factors such as the small sample size.

The interviews were carried out in the home settings. Sometimes the interviews were carried out with everyone in the same room, at other times the tamariki were interviewed on their own. The decision was usually one taken informally and with reference to each other, for example, "Are you okay about talking in front of each other or do you want to do this separately?" Usually whānau were happy to discuss the questions openly together. When the whānau decided I should interview the 'kids' separately it did not appear to be based on any tension within the whānau but rather that this was the 'norm' for this household, meaning the children or parents preferred it that way. Separate interviews with children alone did not appear to produce different information from those interviews conducted with the whole whānau.

I wish to point out here the uncontrolled nature of the interviewing process. It was generally not possible to predict who was going to be home when we arrived, and I sometimes ended up interviewing a cousin or aunty who happened to be present. On other occasions, the

children had 'taken off' and we only interviewed the mother or father. As previously mentioned, we were sometimes expected to have dinner, and interviews had to be fitted around this, or around other whānau tasks, for example, going to collect the children. In a way this added to the rapport and trust building or might well have been a reflection of the trust they had in us, as they felt happy to be themselves.

Contacting rangatahi who had left home (but were happy to be interviewed) or tamariki who were meant to be at whānau interviews but were unavailable on the day, was a problem, mainly because they were hard to contact and several attempts were necessary before we could actually organise interviews.

Rangatahi Hui

After carrying out most of the whānau/hapū-based interviews, I became concerned that I was not getting enough depth in the data; for example, the tamariki and rangatahi we interviewed in the first round were generally confirming our existing knowledge. I was concerned this might have been a reflection on my ability to communicate effectively with the younger participants (or the whānau situation might not have been suitable for exploring the issues), or that we did not have the sufficient participants to allow us to get the necessary depth of opinions and understanding of the issue.

To overcome this problem I did several things. First, I used my networks in the auahi kore sector and asked some Māori youth workers, working in the cessation field, to organise some hui with rangatahi, both smokers and non-smokers, to talk about the issues outlined in the interview guide. Second, I carried out two training sessions with the auahi kore youth workers on research and interviewing techniques, after which they facilitated the hui. The hui was conducted at the health provider's premises with eight participants. The approach did not work well in terms of gaining richer deeper knowledge of the smoking issues for rangatahi. In the first instance, two sessions were not sufficient to train interviewers, and they did not have the skills to be able to explore and extend the debate; we had technical problems with the recording equipment in the larger room we were using and could not hear the resulting tapes; one or two rangatahi tended to dominate the korero; and it was difficult to organise the hui as we had to coordinate between schools and whānau.

Opportunistic Interviews and School-based Interviews

I also took the opportunity to carry out interviews with my sons' friends who were smoking. In addition to the interviews discussed above, we carried out interviews at Ratana School with twenty 10- to 13-year-olds. Ratana School children were chosen because we had feedback (from other participants) that the situation at the school might have been able to offer some insight into the gender differences in Māori youth smoking, because we had three trained interviewers available who could facilitate small group discussion, and because we had contacts in the community who facilitated the access.

In total twenty-eight interviews were carried out using the three approaches, i.e., youth facilitated hui, opportunistic interviews, and school-based interviews using trained interviewers. Written consent was gained from caregivers for all interviews not conducted at home. The participants ranged in age from 10 to 16, and all were Māori.

After listening to the rangatahi hui and school transcripts I decided we had reached saturation with the data, i.e., no new insights were emerging. I came to this conclusion as the same themes started to appear continually and I heard nothing new. We made the decision that no more hui/interviews would be carried out. With hindsight, I believe the whānau setting produced the richest data and whanaungatanga, and the comfort participants felt at being in their own area/homes allowed me to gain a reasonable understanding of the issues as whānau saw them.

The interviews were recorded using a Dictaphone. We tried a number of Dictaphones, including recorders with external multi-directional microphones. We initially had problems with the quality of the sound recording. As kai is a core part of interaction in the Māori world as it demonstrates manaakitanga and symbolises whanaungatanga, and young people in particular are often comfortable eating and talking with each other, we therefore had kai on the table during the rangatahi hui interviews. This meant we had a major problem with background noise on the tapes: for example, the microphone picked up the noise of the bowl being dragged over the table, people eating chips were noisy, and compounding this the rangatahi tended to mumble their responses. Background noise was also initially a major problem in the whānau home setting as there was usually a number of people present and others carried on with life as usual – the phone rang, the baby cried, the younger children wanted things, or the neighbour visited. We overcame this problem about half way through

the study by using a good quality Dictaphone with an external microphone, having smaller groups of participants, and organising the quietest participant to wear the microphone on his/her shirt.

As time was an issue for me in this research I employed someone to transcribe the interviews. However, the sound quality was so poor that the completion of interview transcripts took a long time. The end result also suffered, and there were significant gaps in the transcripts as the transcriber was unable to interpret all the tape. The transcriber had not been part of the interviews and therefore was not always able to sense what might have been said. I then decided to transcribe the interviews myself. This meant I could play and replay the tapes and achieve a fuller sense of the data or a better understanding of what might be meant by various responses.

Key Informant Interviews

After I had completed all the interviews described above and had carried out some initial analysis, I discussed initial findings with other Māori working in the area of Māori tobacco control. This was to explore initial impressions further and to discuss possible intervention ideas, in particular the best practice for intervening in tobacco uptake using an iwi development and multi-level community approach.

In-depth interviews were carried out with the following key informants: Apārangi Tautoko Auahi Kore (Māori Smoke-free Coalition); Te Rōpū Rangahau Hauora a Eru Pōmare; and Whanganui Smoke-free Educator-Public Health. Relationships had already been developed with auahi kore workers/researchers at the beginning of the study. The questions asked included, what did they consider the key issues in the uptake of smoking by rangatahi, and what was the most effective strategy to reduce uptake of smoking?

Iwi organisations within Ngāti Hauiti were also interviewed to determine policy approaches and practice regarding smoking within the iwi institutional setting. The following groups were interviewed: members of Ngāti Hauiti Rūnanga; Health and Social Services staff at Te Maru o Ruahine Trust; and the Rata Marae Komiti.

The responses from the key informant interviews were used to inform Ngāti Hauiti Rūnanga and Te Maru o Ruahine Trust, and both these groups were asked the additional question,

how should Ngāti Hauiti then proceed in terms of an iwi initiative to prevent the uptake of smoking in our rangatahi?

Data Analysis Procedures

The purpose of constructivist inquiry in this research is to:

- analyse the implicit meaning in the uptake and establishment of youth smoking;
- produce informed and well-developed analysis of the various factors influencing smoking uptake and responses considered appropriate by the whānau; and,
- generate a framework for responding to smoking on which there is substantial consensus (Guba, 1990; Skrtic, 1990).

Goodman, cited in Denzin (1998), stated the cognitive purpose is to:

> *...construct something that works cognitively, that fits together and handles new cases, and may implement further inquiry and invention.* (p. 239)

The tobacco-control framework produced in this thesis will hopefully meet all these criteria. It will work cognitively if it gets approval both from whānau and hapū and can be used by them to respond to the smoking issue, and if it gets approval from peers and examiners. The three components of the framework build on each other as well as fit together as a cohesive whole, and the framework will be used to guide the intervention research being carried out by the iwi.

Patton (1990) described the challenge of analysis as making sense of the data, reducing the volume of information, identifying significant patterns, and constructing a framework for communicating the essence of what the data reveals.

In this study, I used the interview guide as a descriptive analytical framework for analysis, i.e., the guide was used to group topics. In the course of gathering the data, ideas about possible analysis began. Patton (1990) described this overlapping of data collection and analysis as improving both the quality of the analysis and the data collected; however, he warned that these initial impressions should not be allowed to distort additional data

collection, either by omitting topics for further discussion too early in the data collection process, or by grouping topics inappropriately.

However, the role of the researcher as a participant should not be overlooked in this process, and in reality the production of the text and the role of interpretation is significant. Patton (1990) also warned of the need to be constantly aware of our influence in the text:

> *The analyst's constructs should not dominate the analysis but should facilitate the reader's understanding of the world under study.* (p. 392)

Patton (1990) maintained the best and most stringent test of observer constructions is their recognisability to the participants themselves. This is particularly pertinent for researchers wanting to gain respondent validity or wanting whānau to own the data and act on it in the future. This process of participant feedback will be particularly important in the next phase of the research when we act on the data in the intervention research. Hui will be held with participants to give feedback and check on the intervention design.

Patton (1990) clearly outlined two critical tasks in the interpretation of qualitative data, i.e., convergence of the data (separating data into the various themes of analysis) and divergence of the data (how to flesh out the patterns or categories).

The task of sorting what data fit together is achieved first by finding recurring regularities. These represent patterns that can be sorted into categories. These categories then become the classification system for the data. The researcher then works between the data and the classification system to verify the meaningfulness and accuracy of the categories and the placement of the data in categories. When several different classification systems have been developed some prioritising is necessary. In this study, themes were prioritised if they were believable or held meaning to participants, were of particular interest in the study context, were repeated many times throughout the data, were unique in some way or added to the academic debate on youth and smoking.

The task of creating divergence or fleshing out the data is done by:

- building on items of information already known;
- making connections among different items; and,
- proposing new information that ought to fit and then verifying its existence.

Patton (1990) once again clearly signaled when we can judge closure:

- sources of information have been exhausted;
- sets of categories have been saturated;
- clear regularities have emerged that feel integrated; and,
- when analysis begins to overextend beyond the boundaries of the issues and concerns guiding it.

Once the data are sorted, organised and described, it is appropriate to move onto consideration of causes, consequences and relationships. Interpreting the data involves attaching significance to what has been found, offering explanations, and drawing conclusions. In answering the challenge about validity of the data interpretation it is important to deal with rival explanations, disconfirming cases, and data irregularities. In some constructivist approaches the researcher must not only own the interpretation and make clear the difference between description and interpretation, but must also work with participants towards developing a consensus approach to the interpretation. While this is not always easy as participants have their own understandings of the world, I will attempt to achieve such agreement on how to progress the framework to the next phase of the research. To achieve this I will need agreement between whānau and hapū participants in the research.

Quality and Credibility Issues

To inform the debate on quality and credibility issues I make use of the interpretations of Guba and Lincoln. Criteria provided by Guba and Lincoln are grounded in a social constructivist paradigm. Where I can I will also refer this discussion back to what I understand as a kaupapa Māori research paradigm.

According to Guba and Lincoln (1989), the criteria for authenticity or for judging the processes and outcomes of constructivist inquiry are:

- fairness;
- ontological authenticity;
- educative authenticity;
- catalytic authenticity; and,
- tactical authenticity.

Fairness

Fairness is described as a type of inclusiveness where all participants' voices are reflected and included in the text. This inclusiveness or balance is an attempt to prevent marginalisation, to act affirmatively about inclusion.

Māori would confirm this a desirable principle, especially in regard to the history of colonisation of Māori knowledge, where exclusion and marginalisation have been commonplace, and knowledge and information has been misappropriated and relocated outside the community of interest.

Ontological and Educative Authenticity

This criterion relates to determining a raised level of awareness, first of participants in the research, but also of those with whom the participants are engaged either for social or organisational purposes. This concept has been linked to the capacity to engage in moral critique or enhance or cultivate critical intelligence in the parties to the research encounter.

This raised level of awareness is particularly relevant to this study as we ask questions of ourselves as participants about: the meaning of smoking in our lives; the future role of iwi and Māori structures and processes in any response to the issue; the desirable whānau goals for wellbeing: the meaning colonisation holds in the contemporary situation of tobacco use in Māori.

Kaupapa Māori research, based on a critical theory approach, would see the application of the criterion of a raised critical intelligence in research participants as highly desirable.

Catalytic and Tactical Authenticity

These criteria refer to the ability of the research to prompt activity by research participants and require the involvement of the researcher as trainer or facilitator of social and political action (if this is desired by participants).

These criteria fit very strongly with kaupapa Māori research, as this approach is predicted on creating the capacity in research participants for positive social change and forms of emancipatory community action. The criteria also fit well with this particular research project, as we will put in action the ideas provided by participants, and will use my knowledge and skills to lead the development and implementation of the intervention (as requested by iwi leaders).

Ethical Issues

There has been widespread discussion about the need for a Māori health research code of ethics; however, debate continues about whether this needs to be a national or regional code developed by all those participating in Māori research or whether each iwi or hapū or Māori organization determines what is ethical conduct of research according to their particular kawa or tikanga. My personal preference is to leave the autonomy with individual iwi and Māori organizations and, at the same time, to develop some guidelines, e.g., The Hongoeka Declaration for Māori Health Research[5], that might inform those decisions made at a local level.

Glover (2002) discussed the concepts of tapu and the relevance of this to Māori research ethics, pointing out that research is an interaction between living beings, and as such is subject to the dynamics of tapu, which can be constructive or destructive but never neutral, and can be violated whenever people meet. The correct observance of tikanga, and ethical guidance by kaumātua and kuia are desirable to keep safe all participants in the research.

Guidance was sought from iwi leaders, including kuia and kaumātua, throughout this research project, particularly in relationship to: acceptability of the research project; the

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[5] The Hongoeka Declaration *The Proceedings of the Hui Whakapiripiri: A hui to discuss strategic directions for Māori health research, Hongoeka marae, September*. Plimmerton: Te Ropu Rangahau Hauora a Eru Pomare, Wellington School of Medicine.

paradigm that would guide it; the collection, storage and use of data; the involvement of whānau and hapū; and the telling of our iwi history. These issues relate to Māori control over the research, the use of taonga iwi, the tapu nature of data, and kaitiakitanga of the knowledge.

I was aware of referring back to iwi supervision whenever I thought I was developing in a direction that might not be compatible with where the iwi or hapū/whānau wished to head, or when I was aware there were issues of the kaitiakitanga of the knowledge. For example, a discussion was attempted with iwi members on the use of social constructivism as opposed to critical theory and the fit with kaupapa Māori research. This was necessary as most Māori development is underpinned by the discourse on colonisation and I needed to check whether the use of a social constructivist approach was appropriate in this iwi research. It was difficult to raise much engagement on this issue. When I asked iwi leaders to read what I had written about the research paradigm, it was considered too academic to be of much relevance to iwi leaders. However, there was interesting debate on the issues and some common understandings about research paradigms and iwi development were reached: namely that the values inherent in the type of constructivist approach I was taking did not conflict with the values inherent in what we were doing in Ngāti Hauiti development. Another important moment in the research was the writing up of Chapter Five, Ngāti Hauiti: The Contexts of the Study. This Chapter was written using the direct guidance of two iwi leaders, and there was discussion about what was safe to include and how the knowledge would be used.

I was mindful of the concepts of manaakitanga and reciprocity when whānau members agreed to participate in the research project. We gave a koha (movie passes) to rangatahi participating in the project, and took kai at other times when we visited whānau.

There were other ethical issues relating to this research that were wider than the debate about Māori health research ethics. I was aware at times of tension about some particular aspects of the research. One aspect that created tension was between using a particular situation both to inform participants about the harm of tobacco and to advocate health education, and at the same time the need to remain non-judgmental about tobacco use in children so that participants felt free to engage fully with me as the researcher. I tended to err on the side of neutral participant (other than answering questions they might ask me) and used the time I had with whānau to understand their position on the issue more fully. Another tension was a

concern about raising potentially conflicting views between whānau members, and then leaving them to sort it out or, worse still, being asked to take sides on an issue. When this situation arose I tried to express my views on the subject honestly, offered backup support for resolution, e.g., the iwi social worker, and sometimes left our hapū development co-ordinator with the whānau (as she sometimes knew them better) to "let off steam". On most occasions, however, there did not appear to be tensions between caregivers and children over smoking, as either it was felt we were discussing an historical situation and tensions about it were no longer valid, or the parents were fairly philosophical about their ability to influence the situation.

Another concern was confidentiality of information. While this was not a problem for whānau (meaning that it did not appear to be an issue for the whānau themselves), it was an issue in the rangatahi hui. The participants in these hui were concerned that information they gave us did not get back to parents or caregivers. We assured them this would not happen and spent time at the beginning of the hui talking about issues such as respect, confidentiality and data use. Confidentiality of the overall data in such a small community will be difficult. I made a judgement to use a significant amount of the direct transcripts from the qualitative interviews in Chapter Nine, and it may be possible from the statements to identify individual whānau. To overcome any problems with this I will first release the data to participants and then iwi members; if this meets with general approval, data will then be released to the wider community of interest. It was not possible in such a small community to guarantee participant anonymity. However, this did not appear to be a particular concern for the whānau involved as they talked freely among the extended whānau about the interviews taking place and their role in the research.

The process used to gain consent from participants for this project demonstrates the difference in approach used by University Ethics Committees and Māori communities themselves. Part of gaining approval from the Massey University Human Ethics Committee (MUHEC) was participant approval of a written consent form that would be provided to participants. However, what turned out to be a more appropriate method was the kanohi ki te kanohi approach by our hapū development officer. She visited whānau, often for some other reason other than the research, and talked about the project, engaged their interest and received permission from them for my visit. In this way I believe they were better informed about what they were agreeing to. Gaining consent to interview children not in the home

setting was a separate issue and we did send the written consent form to whānau and did not carry out research without caregivers' written consent.

MUHEC regarded my position as Manager of Ngāti Hauiti health and social services sector as potentially a conflict of interest. Having multiple roles in small iwi organizations is, from my observations, typical and well handled. This never became an issue in the research and the only time I was aware of my management role was when I saw the potential to help whānau by informing them of services available. I did not feel there were issues of power that might have been an issue with my role in the iwi as a health manager. I was aware the ties of whanaungatanga were stronger than any roles that I may be performing with the iwi, and as such I was treated as either 'aunty' or 'cousin'.

Ownership and Use of the Data

All information that has been gathered during this research remains the property of Ngāti Hauiti whānau and hapū; however, permission will be sought from the iwi participants and governance to publish the final research report.

The final report will be disseminated in three ways:

- to local and national Māori communities;
- to the wider academic community, through publication;
- to policy makers, District Health Boards and health professionals.

The results will be disseminated to Māori by sharing the findings with the respondents and participants, by presentation of the final report to Te Rūnanga o Ngāti Hauiti, and by presentation at a hui a iwi. The wider Māori smoke-free community will also be included in the dissemination using networks such as the Smoke-free Coalition, Health Sponsorship Council, Te Hotu Manawa Māori and the Central Region Māori Smoke-free Coordinator.

This process has already begun with: the discussion of the framework with a number of national auahi kore networks; dissemination of the thesis for peer review; presentation of the results at a doctoral students seminar at Te Pūtahi-a-Toi, Massey University; and, submission of the study results and the intervention framework to the Foundation for Research, Science and Technology (FRST) and the Health Research Council (HRC) for funding of the next

phase of the research. The submission to FRST and HRC has resulted in funding of phase two of the research project.

CHAPTER FOUR
MĀORI, YOUTH, AND SMOKING

This chapter introduces the reader to the significant public health problem of Māori youth and smoking. Smoking is discussed under the following headings: historical context; time trends; the contemporary context of Māori youth smoking. To provide some background information, the issue of Māori identity, the demographic profile for Māori, and Māori health generally are briefly discussed.

Māori Identity

Māori are sometimes referred to as the indigenous population of New Zealand. The term indigenous in reference to Māori is not used strictly according to definition[6] but is rather used in a political context, to claim a separate identity from others residing in the same country, implying a shared experience of colonisation and entitlement to distinctive rights, including the right to self determination (Cobo, 1987; Robson & Reid, 2001). Māori are tangata whenua or people belonging to the land. Using the term tangata whenua denotes a sense of distinctiveness as 'other' and includes the choice to perpetuate cultural uniqueness, and the choice to self-identify, and refers to the "special relationship of the people to the land" (Daes, 1996). New Zealand has a history of recognising indigeneity as opposed to Australia, where the land was declared terra nullius. This is apparent in the 1835 Declaration of Independence (an acknowledgment of indigenous rights) and the 1840 Treaty of Waitangi, that acknowledged "distinctive rights that flowed from notions of the doctrine of aboriginal title" (Durie, undated).

[6] Indigenous means originating or occurring naturally in a country – Māori were settlers in New Zealand from the Pacific and Melanesia.

Māori means normal or usual or ordinary, and the term was used by Pākehā to describe the ordinary inhabitants of Aotearoa. There are several competing theories as to how and when Aotearoa/New Zealand was first settled (Bellich, 1996; King, 1997); however, it appears likely Te Ika a Māui and Te Wai Pounamu (the pre-colonial names given to the North and South Islands) were settled in the 11th century. Bellich and King concluded this settlement was a planned voyage from Polynesia, with Māori descending from both Melanesian and Polynesian populations.

Traditional belief systems helped define a separate identity as Māori. A key concept of this traditional belief system was the relationship between people and their natural environment, and the necessary balance and interdependence between the two that was required for well-being. This example of a traditional Māori belief system generated for some an enduring and significant relationship with their tribal land, and for some still remains a significant part of a separate Māori identity in the contemporary world. However, identity as Māori in a contemporary sense is diverse, and beliefs and values encompass a range similar to that found in the wider population as a whole.

Traditional Māori identity was founded on three closely bound social entities: whānau, hapū and iwi. The whānau remains the basic social unit of Māori society and generally includes a wide kinship network inclusive of spouses or partners of adults. In the contemporary setting, the term whānau has been extended to include a range of social situations: single parent households, same sex relationships, childless couples, and even organisational settings. However, some argue against this latter use of the term and propose whānau should only be used in relationship to whakapapa links or kinship ties. Whānau in this study is used not only as the main method for data collection and the unit of analysis, but also as a key concept in the intervention framework. The central positioning of whānau in this study relates to: the use of an iwi development framework for advancing tobacco control; whānau as a key component in advancing iwi development; and whānau as a key influencing factor in youth tobacco uptake.

The traditional hapū was a more extensive network of kinship than whānau. Hapū groupings were politically independent corporate and social groupings able to trace their descent from a common ancestor (Ballara, 1998). Hapū in a contemporary sense remains a living concept

for some Māori, especially those who are strongly involved with iwi development. For example, Ngāti Hauiti Rūnanga use hapū affiliation to the wider iwi as one of the criteria for participation. Ballara also stated that hapūtanga is in a state of revival and can be seen in academic studies of hapū, in Waitangi claims and counter claims, and in personal searches for identity (Ballara, 1998). Hapū are central to this study as they are the identified collectives of whānau that make up the community of Ngāti Hauiti and as such will be engaged with in the design and implementation of the Tobacco Control intervention.

Iwi are alliances of hapū that operate as mutually interdependent socio-political units, with distinct geographical boundaries and distinct group ideology (Henare, 1988b). This tribal identity or group ideology, often expressed in terms such as Hauititanga, argues against the concept of a cultural homogeneity amongst all Māori. Not only is there a separation from a common cultural identity based on tribal affiliation, in contemporary times Māori have challenged traditional tribal structures in favour of recognition of other groupings of Māori, e.g., urban authorities, as a means of acting collectively in a socio-political, cultural and economic manner (Tamihere, 1994).

These recent challenges to traditional structures have come as a result of the increased recognition that Māori live in diverse worlds. There is not a single reality, nor is there any longer a single definition that will encompass the range of Māori lifestyles (Durie, 1995). However, in this study iwi identity is a critical component in all phases of the research, including: identification of the research question; design and implementation of the research by an iwi member; and funding of a joint iwi and university proposal for an intervention study.

Demographic Characteristics[7]

The total Māori ethnic group for New Zealand in 2001 was 526 281. By the middle of the next century, the Māori ethnic group is projected to double in number to reach almost one million people and make up 22% of the total population. The Māori population of New Zealand is growing at a greater rate than non-Māori, and the number of people registering

[7] For the purpose of this study national and regional data will be used. Regional data will be based on Territorial Authority Data from the Whanganui and Rangitikei District as all the research participants live within this area.

themselves in the population census as Māori ethnicity has grown 21% between the 1991 and 2001 censuses (Statistics NZ, 2002). Among the factors contributing to national Māori population growth have been historically high rates of fertility and a greater concentration of people in the reproductive age groups compared with the non-Māori population (Statistics New Zealand, 1998).

In the Whanganui Rangitīkei region too, the Māori population is steadily growing, while the non-Māori population rate of increase is declining. The 2001 census showed the population of Māori residing in the Whanganui region is 14 097 or 22% of the total Whanganui population (Statistics NZ, 2002). This is significantly higher when compared with the total percentage of Māori population of New Zealand, which is 15% (Census 2001).

Nationally and regionally Māori are a youthful population. It is apparent from 2001 census data that Māori in the Whanganui region are relatively young compared with the rest of the regional populace: with 34.4% total Māori under the age of 15 compared with 24.4% of the rest (Census 2001). While consistently high fertility rates have led to a younger Māori population in comparison to the total population, several trends will see age structures change nationally in the future. Reductions in Māori mortality rates, ongoing urbanisation, migration out of New Zealand, contraception, better education and employment will all contribute to children being more likely to make up a smaller proportion of the Māori population in 2051, around 26% compared with 37% in 1996 (Statistics New Zealand, 1998).

Māori household composition and family formation are diverse, and Māori respond to the same economic pressures and social trends as the general population. The traditional view of whānau as extended and multi-generational units, often taking responsibility for care and financial support, is still evident. In 1996, 28.1% of Māori children with sole parents lived in extended families, compared with 13.7% of those in two parent families. Of Māori residing in private dwellings 20% lived in extended families, compared with 7.7% of the non-Māori population (Statistics New Zealand, 1998). In 1996, the most common extended whānau was a couple with children and grandchildren.

These extended support networks are not necessarily the reality for all Māori whānau. Greater proportions of Māori children live in one-parent families than non-Māori (33.1% compared with 12.3%) (Statistics New Zealand, 1998). In recent times there has been a

smaller rise in the number of Māori single parent families compared with the sharp rise that occurred from 1986 to 1991, indicating rates of formation of single parent families are levelling off, albeit at a significantly higher level.

Within the range of Māori whānau and household profiles it is important to remember that the majority of Māori people live in nuclear households. In 1996, 82.4% of the Māori population lived in families, with the majority of these (55.9%) being two-parent families. However, Māori tend to live in larger households than non-Māori. In 1996, 22.9% of Māori lived in households containing six or more people, compared with 9.9% of non-Māori (Statistics New Zealand, 1998).

Figures from the 1996 census for Whanganui Māori indicated relatively more Māori households with sole/single parents and two parent families when compared with Māori in New Zealand overall; relatively fewer households with more than one family and couples with no children; and relatively more Māori living alone than Māori in New Zealand overall.

In summary, the Māori demographic profile for the Whanganui region would suggest a growing Māori population with significant numbers of youth. There are also significant numbers of lone/single parents, younger families, and a number of people living alone. Many of our whānau live either in smaller urban centres with small populations or rurally. These data are of particular importance to this smoking study for a number of reasons. Youth smoking rates are high among Māori, and the numbers of youth in this particular population group indicate this will be an ongoing concern for this community. The response of low-income, lone/single parents to health promotion initiatives aimed at smoking cessation has not been successful at reducing the prevalence rate of smoking in this group, and there is an indication they have particular needs in respect to smoking (Graham, 1998). The ruralism and low population numbers in small urban centres also indicate particular needs in terms of service provision and access to a range of health promotion public health initiatives aimed at smoking cessation.

Māori Health

Data are collected on Māori for a range of purposes, including: to illustrate both the current situation and the processes of change occurring for Māori; to inform public debate; and to provide an accurate basis for policy initiatives. Where possible, this information is presented

over time and compared with non-Māori to highlight changes and disparities between Māori and non-Māori (Statistics New Zealand, 1998). Measuring ethnicity and the further analysis of these data allow us to comment on disparities between Māori and non-Māori. Māori, like many other indigenous peoples, have a profile of significant disparities across a spectrum of social indicators. In almost every instance, Māori outcomes are significantly worse than non-Māori (Howden-Chapman & Tobias, 2000; Robson & Reid, 2001; Te Puni Kōkiri, 1998).

Many issues arise in the collection and analysis of these data that raise questions of validity and reliability[8]; for example, it appears mortality data may have been undercounting rates for Māori over the last 20 years, therefore under-estimating the disparities that exist between Pākehā and Māori mortality (Ajwani, Blakely, Robson, Tobias, & Bonne M, 2003). The widening differential between Māori and non-Māori mortality rates identified by Ajwani et al. (2003) reflects mortality in middle and old age from chronic disease states such as cancer and cardiovascular and chronic lung disease.

Overall, cancer rates have tended to increase for Māori compared with a steady decrease in the non-Māori population. As well as an increase in breast and prostate cancer, there has been an increase in lung cancer rates. This increase has been seen in both Māori males and females, so that for the period 1996–1999 the relative risk of lung cancer was 3.50 for Māori males, and 4.91 for Māori females (Ajwani et al., 2003). The epidemiological evidence linking smoking and lung cancer is now voluminous, having accumulated over the past century (Slovic, 2001).

While cardiovascular disease mortality has tended to decrease over time for all members of the population, it has decreased at a lesser rate for Māori. Comparing the rate of non-Māori and Māori mortality from cardiovascular disease between 1996 and 1999, it is apparent the rate for Māori males is three times that of non-Māori, and 2.5 times the rate for Māori females (Ajwani et al., 2003). Cardiovascular diseases caused by smoking include coronary heart disease, artherosclerosis, and cerebral vascular disease. The epidemiological evidence of the relationship of smoking to cardiovascular disease is significant, coming from case control studies and a number of cohort studies. These studies have identified risk increases

[8] A significant amount of work is currently being carried out by Māori and other academics on issues related to ethnicity data collection. The subject is complex and outside the scope of this study; however, the reader is referred to (Robson & Reid, 2001).

with the number of cigarettes smoked per day and with the duration of smoking (Slovic, 2001). This is particularly relevant for Māori, as initiation of tobacco tends to occur in late childhood early adolescents, therefore smoking may continue for 40 or more years. For coronary heart disease, the risk tends to decline rapidly immediately following cessation.

Respiratory disease mortality rates have decreased overall; however, Māori rates remain high when compared with non-Māori rates. This too is largely attributable to high smoking rates in Māori (Ajwani et al., 2003).

Māori Sudden Infant Death Syndrome rates were almost five times the non-Māori rate in 1994 (Statistics New Zealand, 1998). Exposure to tobacco smoke during pregnancy is linked with an increased risk of late foetal and perinatal death, and exposure to tobacco smoke is also a major risk factor in sudden infant death syndrome (Mitchell, Tuohy, & Brunt, 1997).

The average annual Māori mortality rate in Whanganui for the period 1996–1998 appears to be higher than the total Māori average annual mortality rate. However, caution should be exercised when interpreting these data, as the numbers of deaths are low, making rates unstable. In addition, differences in the accuracy and coding of ethnicity between regions make comparison of rates difficult (Public Health Consultancy: Wellington School of Medicine and Health Sciences, 2001).

Hospital discharge data are the most common sources of information about levels and patterns of disease in the community (Statistics New Zealand, 1998). Data from Te Puni Kōkiri in 1993 indicates Māori were hospitalised at a greater rate than non-Māori, but the average length of stay tended to be shorter (Te Puni Kōkiri, 1993). The most common causes of hospitalisation for Māori, in order, were: childbearing and its consequences; injury and accidents; asthma and bronchitis.

More recent national hospitalisation data (1996–97) reviewed by ethnicity and deprivation for different age groups presents a slightly different picture. Hospitalisation increases with increasing deprivation, although among the younger age groups and the older population (over 75 yrs) Māori gain access to public hospital services at rates lower than Pākehā (Reid, 2001).

Current data presented by Good Health Wanganui reflect the differences in hospitalisation rates. The average annual admission rate per 1000 people is higher for Māori than for non-Māori, at 88 for Māori and 79 for non-Māori. Māori make up 23% of all acute admissions to GHW, excluding maternity, and are over represented in all age groups. Māori constitute almost 40% of all acute admissions for children aged 0 to 14. Māori have disproportionately high admission rates for acute respiratory infections, other infectious diseases, asthma, other respiratory disorders, and conditions related to pregnancy and birth (Good Health Wanganui & Wanganui District Council, 2000). There is significant evidence on respiratory health and health status in relation to smoking. Studies have described the association of smoking with respiratory symptoms such as coughing, sputum production, wheezing, and dyspnea (shortness of breath). There is also mounting and consistent evidence that smoking increases the risk of respiratory infection (Slovic, 2001).

Social Determinants

In addition to the above epidemiological factors, more distal social determinants impact on the issue of health outcomes and smoking for Māori. Smoking prevalence is strongly associated with poverty and low socio-economic status as measured by a range of indicators such as income, social class, educational level (Graham & Der, 1999; The World Bank, 1999). Deprivation is also independently associated with disparities in health outcomes (Howden-Chapman & Tobias, 2000), and structural changes in New Zealand during the 1980s have impacted differentially on Māori, resulting in increasing disparity between Māori and non-Māori across a spectrum of social indicators.

Factors that influence health include individual lifestyle, social and community influences, living and working conditions, culture and gender, and general socio-economic and environmental conditions. Of these factors, the most noted determinants of health are components of socio-economic status, namely employment, income and poverty, housing and education. (Good Health Wanganui & Wanganui District Council, 2000; Health Funding Authority, 2000; Howden-Chapman & Tobias, 2000).

There is now considerable evidence linking poor health and low income. People with low incomes have poorer self-reported health, higher rates of disability, and higher rates of death, disease and injury than the general population (Howden-Chapman & Tobias, 2000; National Health Committee, 1998). Low income is linked to inadequate housing and reduced spending

on food and heating, which are in turn linked to poor nutrition and cold and/or damp housing.

Between 1986 and 1991 the gap between Māori and non-Māori income levels widened (Te Puni Kōkiri, 1993). In 1996, Māori had a lower annual median income than non-Māori: $12,900 compared with $16,200 (Taumata HauoraTrust, 1999).

Māori in Whanganui may be disadvantaged by lower than average incomes when compared with the median equivalised household income for Māori households in private dwellings across 12 DHB areas (Public Health Consultancy: Wellington School of Medicine and Health Sciences, 2001). In 1996, 50% of Māori in the Whanganui Region had NZ Dep[9] decile ratings of 9(20%) or 10 (30%), representing high levels of socio-economic deprivation. In comparison, 14% of non-Māori within the region had a decile rating of 10, while just over 14% were given a decile rating of 9 (Taumata HauoraTrust, 1999). Bearing in mind the structure of the Māori population, it can be deduced that a large proportion of young Māori are experiencing high levels of deprivation. This has negative implications for the future health status of Māori.

Compounding the high levels of deprivation for Māori in this region are the financial costs associated with larger households. In addition to this are the economic costs of maintaining contact with whānau hapū and iwi, and upholding responsibilities associated with whānau obligations and celebrations (Taiapa, 1998).

Low income, and a related measure of social class as indicated by occupation, not only affect physical health, they also impact on mental health and health behaviours. For example, social class has been linked to the under utilisation of health services, particularly preventative services, by those likely to have the greatest need for them (Te Puni Kōkiri, 1993). Smoking is one of the health-related behaviours affected by social class. Smoking in New Zealand is concentrated in poorer families and amongst Māori and Pacific peoples. New Zealand research has shown a clear income gradient for smoking rates, with higher rates in low

[9] The NZ Dep96 deprivation index combines 9 variables that reflect material and social deprivation: two income variables; transport; living space; home ownership; employment; education; qualifications; support; and communication. The NZ Dep. provides a score of 1–10 for each mesh block in New Zealand. A score of 1 represents the lowest level of deprivation; a score of 10 represents the highest level of deprivation.

income groups (Howden-Chapman & Tobias, 2000; Ministry of Health, 1999b). Smokers in the most deprived areas are less likely to give up, and those that choose to quit may be likely to relapse (Thompson, et al., 2000). Low-income groups also have a higher exposure to second-hand smoke (Whitlock, et al., 1998).

Durie (1994) suggested cultural factors also impact on health outcomes, and measures such as tribal connection, fluency in Māori language, spiritual awareness, involvement in marae activities, and integration within a family have an impact on Māori well-being. Reid (2001) discussed the impact of colonisation and racism on Māori as a major influence on whānau and Māori community well-being, which in turn, influence health outcomes. She argued that there is some support for the thesis of a gradient of stigma and marginalisation underpinning the misdistribution of deprivation among Māori, and cautions against framing Māori as "other" in the discussion about determinants of health. She warned that framing Māori in this way promotes narrow explanations of disparities and that Māori behaviour, genes, culture, socio-economic status and engagement of services are seen as the problem (Reid, 2001).

There is evidence to suggest that the poor state of Māori health may reflect the performance of health systems, in particular the performance of secondary and tertiary services (Te Puni Kōkiri, 1993). He Kākano presented evidence that while there are inadequacies with primary health care services, Māori sometimes receive unequal access to and treatment by secondary and tertiary services.

A reduction in the rate of avoidable hospitalisation is an indicator of effective health promotion or disease prevention, good primary health care and better management of patients in the community. Recent Whanganui District Health Board data indicate Māori have higher than average rates of avoidable hospitalisation (Public Health Consultancy: Wellington School of Medicine and Health Sciences, 2001). This is likely to be attributable to significant proportions of Māori living in deprived circumstances, to higher rates of disease due to a variety of lifestyle factors including smoking, and to difficulty accessing quality primary health care services.

A low level of education is also associated with poor health status. The links between education and health status are seen as relating to poverty and poor living conditions, access to health information and services, lifestyle practices, child rearing practices, stress and low

self-esteem, and dangerous work environments. Data presented by Good Health Wanganui (Good Health Wanganui & Wanganui District Council, 2000) indicated people in the GHW region aged over 15 years of age have lower levels of formal education compared with New Zealand overall. Contributing to this picture is the high number of schools in the Wanganui Area that have a decile rating of between 1 and 3, which is considered a major barrier to educational achievement.

Lack of qualifications is identified as a barrier to employment, and those who have never had a job and those who are long-term unemployed experience the greatest health effects of unemployment. Long-term unemployed are particularly at risk of poor mental health and the health risks of poverty. Youth who have left school and never had a job have been found to have an increase in psychological and psychosomatic symptoms, a decrease in organised social activity, increased abuse of alcohol and narcotics, and make increased use of health services (Te Puni Kōkiri, 1993).

Statistics for unemployment indicate more people over 15 years of age in the Good Health Wanganui region were unemployed in 1996 (5.7%) than nationally (4.9%). Of these, Māori were experiencing a higher rate than non-Māori. The absolute percentage difference in the unemployment rate for Māori in the GHW region is 0.8% higher than the national rate (Good Health Wanganui & Wanganui District Council, 2000).

It is likely the high numbers of Māori youth leaving school without a qualification mean they are over represented in the number of unemployed in the Whanganui region. Both these statistics will have an impact on Māori youth smoking, as smoking has been closely associated with both educational and occupational trajectories (Glendinning, Shucksmith, & Hendry, 1997), and with boredom and increased leisure time and daily routines (Bancroft, Wiltshire, Parry, & Amos, 2003).

Effects of Tobacco use on Māori Health

In summary, along with more structural issues such as changes to New Zealand society, differential access to health care and disparities in the quality of health care provided, smoking is a major contributor to the alarming Māori health statistics. A number of key issues can be identified that impact on Māori mortality rates, particularly smoking. Smokers are significantly more likely to die from vascular diseases and cancers of various types than

non-smokers (The World Bank, 1999), death from these diseases contributes significantly to the current disparity in mortality rates for Māori (Ajwani et al., 2003), Māori prevalence rates of smoking are higher than for non-Māori as smoking consumption has reduced less in the Māori population than in the non-Māori population over the last 20 years (Borman, Wilson, & Mailing, 1999), and, should current rates of tobacco uptake in the Māori youth population continue, this will contribute to maintaining high future levels of Māori smoking prevalence.

Tobacco use has a particularly adverse impact on Māori health, with an estimated 31% of Māori deaths being attributable to tobacco use (Laugesan & Clements, 1998). An estimated 14–15% more Māori would survive middle age if no Māori smoked after age of 35. Several key issues emerge from the health status data that indicate smoking-related conditions are impacting significantly for Māori: Māori have a high incidence of lung cancer; Māori sudden infant death syndrome rates are significantly higher than non-Māori rates; respiratory conditions, especially in children, are of particular concern and are likely to be related partly to the effects of second-hand smoke; and hospital admissions related to pregnancy and birth may be associated with the high rates of Māori female smoking. Smoking is also likely to be a major reason for the higher rates of heart disease, respiratory infections and conditions such as asthma, otitis media, and the adverse outcomes of diabetes (Ministry of Health, 2002a). The higher Māori rate of tobacco-related cancers, such as stomach, liver and cervix, is almost certainly largely due to the high prevalence of smoking by Māori.

Reducing smoking rates in Māori is one of the most significant public health interventions that will help reduce disparity in Māori health outcomes. To reduce smoking rates it is important to intervene in the uptake of tobacco.

There are several very good reasons why we should focus on a prevention approach. Tobacco is an addictive substance that establishes quickly in early adolescence, and the average levels of nicotine inhaled are sufficient to have a pharmacological effect and play a role in reinforcing smoking (The World Bank, 1999). Many young smokers underestimate the risks of their becoming addicted and have unrealistic expectations of their ability to quit (Slovic, 2001). While adolescence may experience some immediate health effects from smoking, the usual long delay between exposure and disease results in decisions to start smoking or continue smoking. In addition, the evidence suggests individuals who avoid

starting to smoke in adolescence or young adulthood are less likely to become smokers as older adults (The World Bank, 1999).

Smokers affect not only their own health but also the health of those around them. Exposure to tobacco smoke during pregnancy is linked to an increased risk of late foetal and perinatal death, and exposure to tobacco smoke is also a major risk factor in sudden infant death syndrome (Mitchell et al., 1997). Smoking may also play a role in the higher rate of meningococcal disease among Māori, as the number of smokers in a household has been shown to be a significant risk factor in the disease (Baker, McNicholas, Garrett, et al., 2000).

Evidence indicates that a comprehensive approach must be taken to reduce uptake of tobacco in the Māori youth population. Reducing smoking in Māori youth will require not only changes at a whānau level but also at a macro- or structural level if we are to make an impact on the more distal social determinants of health. Some possibilities for addressing these issues will be discussed throughout the study.

Māori and Tobacco

Before colonisation, Māori recognized the importance of healthy communities and also recognised the importance of a comprehensive public health system to ensure this goal was met:

> *A public health system evolved which was based on a set of values that reflected the close and intimate relationship between people and the environment...the effectiveness of the system depended on an unwritten regulatory system enforced by a shared belief in communal safety and the integrity of a collective entity.* (Durie, 1998: 9)

It is this traditional shared belief in communal safety and collective responsibility that members of Ngāti Hauiti wish to restore and harness as a basis for a contemporary public health intervention to curb the uptake of tobacco smoking in its tamariki/rangatahi population.

Before European contact there was no smoking of tobacco or any other substances by Māori (Broughton, 1996). Tobacco was introduced to New Zealand by early Pākehā explorers and

traders and was used as a currency and article of trade. Its use quickly became popular among Māori as evidenced both by data on smoking rates collected for the New Zealand Official Year Book 1883, and by many photographs and portraits of the day that depicted Māori and pipe smoking as virtually synonymous (Reid & Pouwhare, 1991). The New Zealand Government acknowledged the heavy involvement of Māori with tobacco as early as 1894, and as early as 1900 Māori public health leaders such as Maui Pomare recognised the adverse effect smoking was having on Māori health (Broughton, 1996).

During the first half of the 1900s, Māori, like their Pākehā counterparts, changed from pipe smoking to cigarettes. Cigarettes were made commercially viable by the invention of the cigarette rolling machine and the introduction of safety matches, and consumption was greatly facilitated by free distribution of cigarettes to soldiers during both World Wars. The change from pipe smoking to cigarette smoking, with its associated increase in uptake of nicotine, accelerated Māori death rates from tobacco use.

Around 80% of all men born before 1926 went through a regular smoking phase, and a very high proportion of these men would have had service experience (Easton, 1995). The smoking prevalence among Māori men was consistently 75–80% for the whole period (1896–1951). During the same period there was an increase in women's smoking in the Western world, facilitated by targeted advertising, women's increasing independence and increasing social acceptability of women smoking (Reid & Pouwhare, 1991). For the generation of women born in the 1920s, the prevalence was about 50%, a level that continued at least to those born in the early 1950s (Easton, 1995).

By the 1950s, early reports emerged linking tobacco use with illness, especially lung cancer. While this resulted in a decline in smoking prevalence for Pākehā males, the same rate of decline in prevalence was not initially seen in Pākehā women. This trend has now reversed, with 23% of Pākehā men smoking compared with 19% of Pākehā women, as reported in the 1996 census data (Te Puni Kōkiri, 1999).

Overall, smoking prevalence for all the New Zealand population continued to decrease during the last decade of the 20th century. Smoking prevalence for the year 2000, among those aged 15 years and over, was 25%. However, the rates of decline were not consistent across age, ethnicity and sex.

The decline in smoking prevalence experienced by all groups during the 1980s appears to have discontinued for those aged 15–24, with no decrease in prevalence for either gender during the 1990s. In 2000, approximately one quarter of 15- to 19-year-olds indicated they were smokers, and this increased to about one third for 20- to 24-year-olds.

There is also a regional variation in the smoking prevalence statistics, with Whanganui District Health Board region showing statistically high smoking prevalence rates for female smoking and Māori (Public Health Consultancy: Wellington School of Medicine and Health Sciences, 2001).

Smoking prevalence rates for Māori over the greater part of the 1900s remained high for both Māori men and women (Reid & Pouwhare, 1991), and a decline in the percentage of Māori smoking was not evidenced till after 1980. In 1981, tobacco consumption per Māori adult was higher than in any other Western industrialised country, and 56% of the Māori population smoked regularly (Laugesan & Clements, 1998).

Whatever forces reduced the prevalence of smoking in the population as a whole, they were not as effective for Māori. Māori researchers (Reid & Pouwhare, 1991; Te Puni Kōkiri, 1999) have noted a decline in prevalence for Māori to 44% smoking regularly in 1996, and have attributed that decline partly to funding being provided for Māori smoke-free health promotion messages and policies such as increased tobacco taxation and regulation of tobacco smoking. Having achieved some success with a decline in Māori male smokers, several disturbing trends remain outstanding that have serious health consequences for Māori. The 1996/97 New Zealand Health Survey (Ministry of Health, 1999b) confirmed that nearly half of all Māori aged 15 years and over reported they were current smokers; disparity in smoking rates remains high, with both Māori women and men being twice as likely to smoke as non-Māori; and nearly 60% of Māori women aged between 15 and 44 were smokers.

Socio-economic status, as indicated by both individual measures and area deprivation, shows a direct relationship between smoking prevalence and an increase in prevalence with greater levels of disadvantage (Jarvis & Wardle, 1999). A recent study (Crampton, Salmond, Woodward, & Reid, 2000) that explored the relative importance of socio-economic

deprivation and ethnicity for smoking in New Zealand discovered the relationship between smoking and area deprivation, using the NZDep96 scale, was continuous across the range of deprivation categories measured. Māori, in all age groups, at all levels of deprivation, smoked more than European and other ethnic groups.

One reason given for this disparity is the marginalized position of Māori with respect to mainstream New Zealand society (Te Puni Kōkiri, 1993). Any intervention to reduce smoking in Māori will need to consider the importance of tackling the range of determinants, including socio-economic disparity and ethnic differences. Crampton et al. (2000) suggested effective tobacco control activities should address both ethnic differences in smoking behaviour as well as socio-economic deprivation, and must operate at the level of populations, places and environments, as well as individuals. A broader approach to tackling the upstream determinants of health inequality, particularly for reducing smoking prevalence, was proposed by Graham (1998). She suggested interventions should form part of a wider investment in the social wage and be part of a long-term strategic investment in public housing, in roads and pedestrian safety, in safe play spaces and amenities, in public transport, in childcare, and in personal social services.

This view finds support with other researchers. Lawlor and colleagues defined effective intervention as those measures designed to improve the material circumstances of those individuals least advantaged (Lawler, Frankel, Shaw, Ebrahim, & Smith, 2003). This study identified that disadvantaged groups are still suffering a substantial burden resulting from non-smoking-related morbidity and premature mortality, for example, increased mortality from accidents. Lawlor et al. (2003) suggested smoking in these circumstances is a rational choice when poor housing conditions, occupational hazards, and environmental dangers are more immediate threats than smoking. They concluded that:

> *Smoking behaviours among members of deprived populations will continue to resist health promotion measures until their general health and well-being show improvements equivalent to those that preceded the earlier abandonment of smoking by more advantaged population groups.* (p. 267)

Though the decline in prevalence rates has slowed, especially for those in the younger age brackets, there are indications that consumption has declined. During the last 10 years the

average number of cigarette equivalents consumed per adult (estimated by the amount of manufactured cigarettes and loose tobacco released for consumption) decreased by more than 30%, suggesting that on average each adult smoker smoked about 15 cigarettes per day (Ministry of Health, 2001) Consumption data for Māori based on AC Nielsen research and NFO CM Research (Ministry of Health, 2001; NFO CM & Research, 2000) reported average Māori smokers consuming 12–13.9 cigarettes per day.

Consumption data for Māori youth is contradictory, and comparing across studies is difficult because of the age group differences in the study groups. Research carried out by Shaw, Crane and O'Donnell (1991) indicated smoking consumption in a rural largely Māori population had risen in adolescent school age females between 1975 and 1989 (median per week 15 vs 30). However, research by Whāriki Māori Research Group (Dacey & Moewaka-Barnes, 2000) placed smoking consumption of 15- to 29-year-olds largely between 1 and 10 cigarettes per day.

Issues of concern are evident when reviewing the data on Māori youth and smoking, or Māori youth and all drug use. It has been reported (Broughton & Lawrence, 1993) that Māori women start smoking at a very young age, with children starting as young as 10 and peaking at age 13–15. These data are reinforced in other reports, with initiation ages as young as 7 being cited (NFO CM & Research, 2000). Tauwhare's study (Tauwhare, 1999) of Ngāti Hauiti rangatahi reported similar findings that identified pre-teenage to early teenage years as being important for the uptake of nicotine and other drugs. Research undertaken on behalf of the Health Sponsorship Council in 2000 (NFO CM & Research, 2000) indicated 82% of Māori aged 12–16 (classes 10 to 12 students) had smoked; this rate was higher among females (88%). It is clear the number of children who have tried smoking is far greater than the number of regular smokers. Glover (1999) concluded experimentation with smoking is likely to occur at earlier ages for Māori youth and consequently the graduation to regular smoking occurs earlier. She continued that this earlier starting age most likely contributed to higher rates of smoking-related illness and death among Māori. The report, Te Ao Taru Kino (Dacey & Moewaka-Barnes, 1998) concluded that an environment exists that is conducive to increasing drug use among Māori.

This increasing drug use is particularly evident if one looks at the increase in smoking in younger Māori females, particularly over the last 10 years. Analysis of the 1992 and 1997

National Survey of Fourth Formers, showed daily smoking increased from 30.8% to 38.4% for Māori girls and from 15.0% to 24.2% for Māori boys (Laugesan & Scragg, 1999). Ford et al. (1995) found that Māori youth had a higher relative risk of smoking when compared with other ethnic minority groups of similar socio economic disadvantage. However, more recent data from surveys of fourth-form students (year 10) indicated a decline in prevalence in Māori girls from 39.2% in 1997 to 32.4% in 1999. In contrast, the results suggest prevalence among boys had not changed since 1997 and might be increasing (Scragg, 2001). Further surveys of schools are required to determine national trends with certainty. The 72 schools included in the survey had a slightly higher mean socio-economic decile ranking[10] than most New Zealand schools, and this may have affected the results of the study.

Whatever the yearly fluctuations are in overall prevalence rates in student daily smoking rates, it appears disparities remain for Māori youth and females. In 2002, daily smoking of all year 10 and 12 students surveyed in the Youth Lifestyle Study, fell from 14.9% in 2000 to 12.9% in 2002. However, more Māori reported being daily smokers than non-Māori (25.5% and 10.6% respectively), and more girls reported smoking than boys in 2002 (15.5% and 10.5% respectively) (Health Sponsorship Council, 2002).

The literature identifies various predictive factors for young Māori taking up tobacco including: a poor knowledge of the health effects (Waa, Fukofuka, & Dawson, 1999); the influence of parents who smoke (Laugesan & Scragg, 1999); parental encouragement or endorsement to smoke (Reid & Pouwhare, 1991); family stress or anxiety-producing situations (Glover, 1999); smoking ensuring membership in the family and in their peer group (Glover, 1999); links between identifying as Māori and being a smoker (Mitchell, 1983); and availability of cigarettes (Reid & Pouwhare, 1991). These factors will be discussed in further detail in Chapter Nine and compared with the whānau and rangatahi interview data gathered in this study.

It can be concluded that Māori have high rates of smoking, that they continue to take up smoking at rates higher than non-Māori, and that these rates are particularly high for young Māori women. We also know that smoking is a significant contributor to health disparities

[10] Socio-economic decile ranking in New Zealand schools is different from NZ Dep. ranking, with lower numbers representing greater disadvantage as opposed to NZ Dep. where lower numbers represent greater advantage.

that exist for Māori, and current public health interventions are limited in their ability to influence the situation. It is clear for a number of reasons that reducing the uptake of tobacco in the first instance is an effective approach to intervening in the tobacco epidemic. It can also be concluded from the evidence presented later in this study that a comprehensive approach must be taken to reduce uptake of tobacco in the Māori youth population. For the above reasons Ngāti Hauiti, through the principal researcher in this study, intend to formulate a framework to address the serious public health issue of smoking in its youth population with the long-term aim of improving the health outcomes of its tribal population.

CHAPTER FIVE

THEORETICAL APPROACHES TO PREVENTING TOBACCO UPTAKE

Interventions aimed at preventing or reducing youth tobacco uptake include school-based programmes, mass-media campaigns, environmental measures, and community interventions. Using a framework described by Beattie, cited in Gabe, Calnan and Bury (1991), this chapter will discuss the theories behind these interventions. Having examined the different theoretical stances used by individual approaches, a more comprehensive theoretical approach will be explored by examining models such as the ecological model and tobacco control frameworks. The chapter starts with an explanation of the terms 'theory' and 'prevention'.

Definitions of Theory and Prevention

A definition of theory as applied to health promotion is cited in Nutbeam and Harris (1998):

> *Systematically organised knowledge applicable in a relatively wide variety of circumstances devised to analyse, predict, or otherwise explain the nature or behaviour of a specified set of phenomena that can be used as the basis for action.* (p. 10)

Theory can be used in health promotion to shape the answers to why, what, and how: Why people are not following health advice or caring for themselves in healthy ways; what one needs to know before developing an intervention or programme; and how to shape programmes or strategies for best effect (Glanz, Lewis, & Rimer, 1997).

Braithwaite (1993) argued that practitioners who are interpretively flexible, and who read situations from different angles, can be well informed by theory. However, he warned against the positivist view of theory, i.e., theory that is constructed from a set of eternally true propositional building blocks, each supported by a substantial body of empirical evidence. He suggested theory should rather be used in a way that integrates policies, carries out contextual analysis, eschews static models in favour of dynamic "thinking in time" and intertwining rather than separating normative theories (about what ought to be) and explanatory theories (about what is). Implementation of theory in health promotion, therefore, would enable the practitioner to use competing theories to construct integrated strategies for specific contextually conceived problems.

De Leeuw supported this relativist approach, arguing that health promotion can never be a scientific discipline per se as the complexity and multicausality of human health dictate a multi disciplinary and interdisciplinary view of science (De Leeuw, 1989).

There appears to be significant support for a move to more explicitly critical and interpretive research methodology to enable health promotion to respond effectively to the holistic and ecological stance that has been argued for.

The idea that theory is an ongoing process open to new influences and constantly being challenged was discussed by Smith (1999), who argued for an indigenous approach to theory development being grounded in a real sense of, and sensitivity towards, what it means to be an indigenous person. She reinforced the importance of theory to ground research from an indigenous perspective and provided compelling arguments for its continued role in indigenous research:

> *At the very least it helps make sense of reality. It gives us space to plan, to strategize, to take greater control over our resistances. The language of theory can also be used as a way of organising and determining action. ...If it is a good theory it also allows for new ideas and ways of looking at things to be incorporated constantly without the need to search for new theories.* (p.38)

Seedhouse (1997) suggested theory development and application in health promotion requires a more cohesive approach:

> *If health promotion is to mature, other thinkers must offer other theoretically justified ways forward. There must be deep and continuing dialogue between the different theorists, and there must be either unity in the profession or markedly different types of health promotion must emerge.* (p.5)

Clark and McLeroy (1995) agreed that we need clarification of constructs but would probably argue for categorizing and clarifying rather than unity of theory. They provided a useful explanation of the difference between theory, frameworks and theoretical principles. Theories and models are an attempt to predict or explain why people behave as they do in relation to their health; frameworks describe conditions under which health education interventions can be made effective and efficacious; and theoretical principles have evolved from theories and frameworks and have been associated with evidence that health status and/or behaviour change has occurred.

Nutbeam and Harris (1998) summed up the issues of theory and health promotion as follows:

> *No single theory dominates health promotion practice, and nor could it, given the range of health problems and their determinants, the diversity of populations and settings, and the differences in available resources and skills among practitioners.* (p. 15)

However, there are many calls to improve the quality of health promotion, ranging from calls for more rigorous debate and research on fundamental issues of ethics and values (Downie, Tannahill, & Tannahill, 1997; Seedhouse, 1997) to improvement of the quality of practice by reflection on practice, and "trying to systemise our knowledge" (Gerjo, 1993; Hollnsteiner, 1982).

While there are many examples in the literature of evaluation of interventions with clearly articulated theoretical perspectives and models (Braithwaite, 1993; McKinley, 1993; Robertson & Minkler, 1994), the evidence linking theory, practice and outcome is limited. Fincham (1992) concluded:

> *Because of the conceptual overlap between theories and models, it may be impossible to accurately test specific theories with the appropriate scientific rigour.* (p. 247)

There is a need to acknowledge that current health promotion models and mid-range theories are not necessarily applicable cross culturally (Frye, 1995; Turton, 1997), and there is also a need to base health promotion strategies on relevant cultural knowledge and emerging indigenous theory.

The published literature on indigenous health promotion and theory development is extremely limited and until quite recently virtually non-existent for Māori. Ratima (2001) stated:

> *Although the existence of distinctly Māori worldviews (with particular reference to health promotion) is widely acknowledged, they have not yet been articulated in the literature as a Māori inquiry paradigm....at this stage there are no sound theoretical underpinnings that rely entirely on Māori knowledge and insight.* (p. 221)

Smith (1999) contended that theory development by indigenous scholars, which attempts to explain our existence in contemporary society, is only just beginning. These new theories are not developed in a vacuum, separated from other theoretical approaches or other ideologies, rather they are grounded in a real sense of, and sensitivity towards, what it means to be an indigenous person.

Ratima (2001) acknowledged this development of indigenous theory:

> *Te Pae Mahutonga, a Māori model for health promotion proposed by Durie, is the first step towards the development of macro theory for Māori health promotion.* (p. 237)

Ratima herself has contributed significantly to the conceptualising of Māori health promotion with her writings on the subject and her description of the defining characteristics

of Māori health promotion: *Kia Uruuru Mai A Hauora, Being Healthy Being Māori* (Ratima, 2001). Both Te Pae Mahutonga and Kia Uruuru Mai A Hauora will be discussed in detail in the following chapter.

The use of theory in this PhD is probably best described as interpretively flexible. I will review the range of theories and principles that underpin health promotion research and activities with particular reference to tobacco prevention initiatives, and develop a framework of principles that can be translated into indigenous practice as action-based research in the specific community context of Ngāti Hauiti.

Definitions of prevention, like definitions of theory, can be sought from different disciplines and philosophies. A starting point for defining prevention in health promotion is to take a public health definition of primary, secondary and tertiary prevention. This approach allows practitioners to intervene preventively at different points in time. Coohey and Marsh (1995) cited a definition by Lorian, Price and Eaton as being representative of the public health definition:

> *Primary prevention efforts reduce the number of individuals in whom the pathogenic sequence is initiated. (Such approaches) are distinguished by their intent to avoid entirely the onset of pathogenic sequence. Secondary efforts reduce the number of active cases of a condition in a population, that is its prevalence... such strategies are designed to interrupt the continued evolution of pathogenic processes and thereby avoid the complete clinical manifestation of the disorder. Tertiary efforts seek to minimize the long term and secondary consequences of disorder, including those related to chronicity and to participation in a treatment protocol.* (p. 526)

Downie et al. (1997) argued against this definition on three grounds: definitions of primary, secondary and tertiary prevention are not standard and are therefore meaningless; the classification focuses on disease; and the various schemes include an implication of treatment of ill health. They suggested instead an approach that seeks to prevent ill health while simultaneously enhancing positive health, and they concluded that the overall goal of health promotion should be:

> *The balanced enhancement of physical, mental and social facets of positive health, coupled with the prevention of physical, mental and social ill health.* (p. 26)

Seedhouse (1997) suggested this definition does not stand up to rigorous scrutiny from a philosophical perspective, and claimed Downie et al. had assumed the promotion of positive health is an objective good and is objectively justifiable:

> *The authors are not privy to objective knowledge about the ideal type of health promotion. They do not have objective knowledge of the good life because this is not something that anyone can have objective knowledge about.* (p. 95)

Lupton (1995) provided a useful discussion on this topic of the "moral regulation of society" through health promotion's use of concepts, theories and insights to categorize and construct the human actor. She argued that while health promotion may have been associated with improvements in health status at the population level, the discourses and practices of public health and health promotion have resulted in subjects or groups of individuals being drawn as binary oppositions associated with discriminatory moral judgements. This is particularly pertinent in the responses to smoking prevention, where the discourse on smoking categorises smokers as victims of addiction and lacking self-control or needing to be controlled through regulation because they pollute others. More importantly, smokers are punished through the mechanisms of self-surveillance, evoking feelings of guilt, anxiety and repulsion towards themselves.

The idea that research and knowledge is neutral in its objectification of the other is further explored in indigenous critiques of Western knowledge. Smith (1999) claimed theory has been used to oppress indigenous people and has not been used sympathetically or ethically.

It is difficult to find a definition of prevention that does not imply some form of moral good. Once again a balance needs to be found between competing ideologies. Guyer et al. (1989) provided a definition I find potentially useful as it both implies an ability to self determine and provides for an ecological approach. Prevention is:

> *A proactive process that empowers individuals and systems to meet the challenges of life events and transitions creating and reinforcing conditions that promote healthy behaviour and life styles.* (p. 92)

Interventions and Theory

Health promotion theory is eclectic and derivative (Glanz et al., 1997). Adaptations and refinements of theories of health behaviour and health education occur in response to both scientists and practitioners concerns, and often occur through collaborative action research.

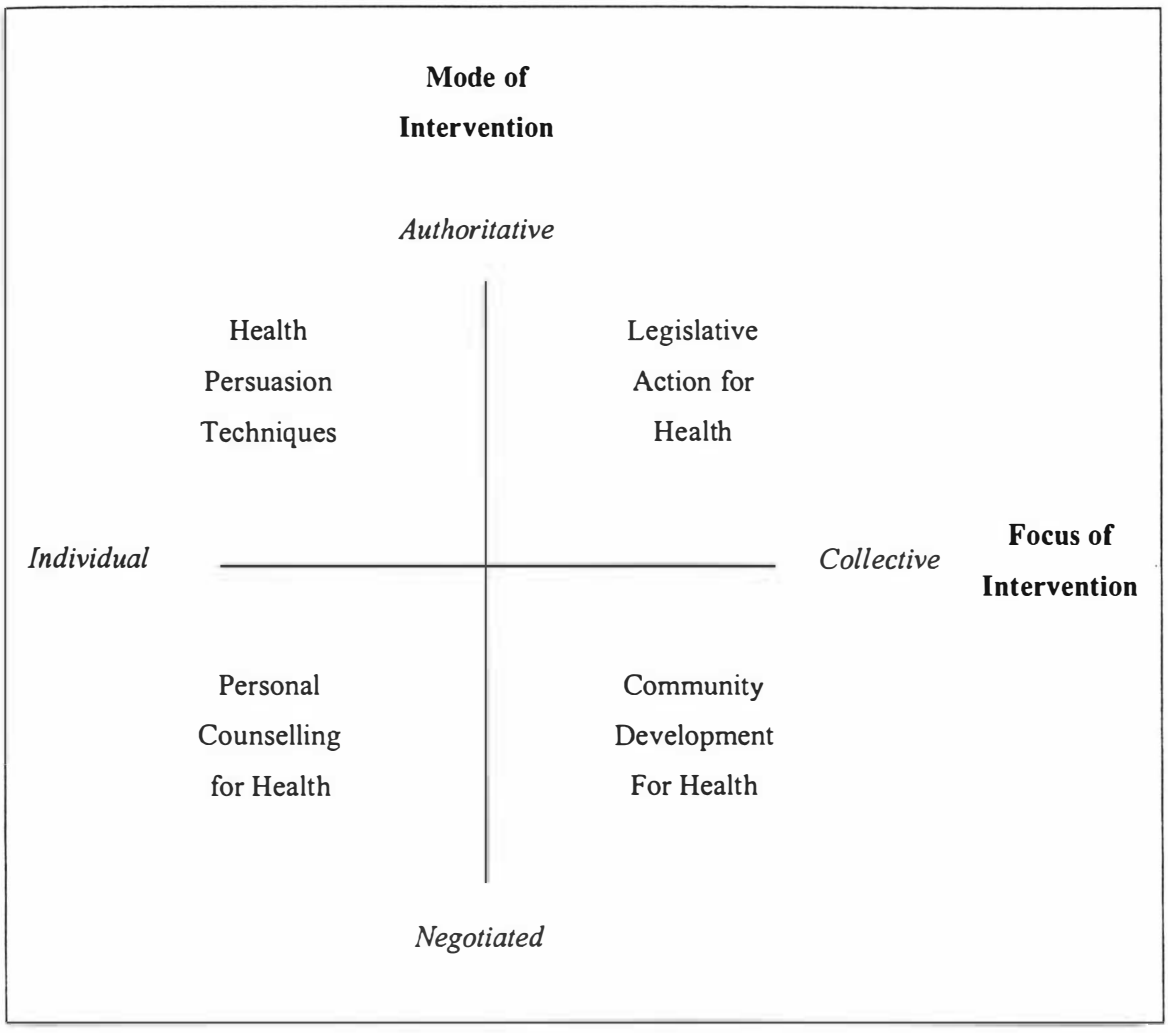
This eclectic approach is clearly demonstrated in tobacco prevention work. The following is an attempt to outline theories behind various approaches; however, only those with the most relevance to tobacco control and youth will be highlighted.

As previously mentioned, interventions aimed at preventing or reducing youth tobacco uptake include school-based programmes, mass-media campaigns, environmental measures and community interventions. The theoretical frameworks underpinning these approaches will be discussed in this chapter; however the evidence of effectiveness of these approaches is covered only briefly and in general terms and a fuller review of the various approaches is covered in a later chapter.

These interventions and the theories underpinning them fall neatly into the structural map of health promotion proposed by Beattie in the *Sociology of Health* (Gabe et al., 1991). This map sets out the different strategies available in contemporary health promotion in terms of two bipolar dimensions, namely mode of intervention and focus of intervention.

Figure 1:

Structural map of health promotion proposed by Beattie in the *Sociology of Health* (Gabe et al., 1991).



The map can be usefully aligned with a range of theoretical frameworks. The authoritative negotiated dimension can be used to highlight the debate between paternalist prescriptive or top-down forms of social intervention versus participative or bottom-up forms. While the individual or collective dimensions are self-explanatory, Beattie (cited in Gabe et al., 1991) pointed out that they have been the most enduring axes of conflict in social theory and social policy. He used the term 'health persuasion techniques' to characterise the cluster of interventions that employ the authority of public health expertise to redirect the behaviour of individuals in top-down prescriptive manner. 'Legislative action' uses public health expertise to change civic policies to improve health, e.g., taxation, again in a top-down manner. The

term 'personal counselling for health' characterises the cluster of interventions in which individual clients (whether alone or in groups) are invited to engage in active reflection and review their personal lifestyle and their individual scope for change. The final term, 'community development for health', involves groups of people who have similar health concerns or who are in similar circumstances coming together to take action to improve health prospects.

The theoretical frameworks underpinning each approach will be discussed in the following section.

Health Persuasion Techniques – Mass-media Campaigns and Smoking

Mass-media campaigns are increasingly popular as a strategy for delivering preventative health messages and are seen as a particularly appropriate method by governments and public health expertise for delivering anti-smoking messages to young people. Television and other media such as print, inter-net, radio, recorded music, film and advertising are thought to influence young peoples' perceptions of the real world and acceptable social behaviour, and also help define cultural norms.

The Communication-behaviour change model and Laswell's communication model, present media and communication as an abstract model cut off from the social contexts in which they make sense. Both these media models identify a process of source or sender, the message and channel, the receiver and feedback or destination (Nutbeam & Harris, 1998; Spoonley, Pearson, & Shirley, 1994).

Media campaigns, in particular those related to health promotion, also rely heavily on the concepts of social marketing. Social marketing arose from a commercial marketing model, where a strong competitive advantage was demonstrated by those businesses using a marketing approach (Hastings & Haywood, 1991). Kotler and Levy (1969) argued that marketing should be seen as a universal human activity. Its principles could be applied to people organizations and even ideas. Kotler and Levy's definition of social marketing is about the design, implementation, and control of programmes seeking to increase the acceptability of a social idea, cause or practice in a target group. It uses market segmentation, consumer research, concept development, communication, facilitation incentives, and exchange theory to maximise target group response (Hastings & Haywood, 1991).

The Health Belief Model (HBM) is also used as a theory to inform the design of health promotion campaigns. In general, the HBM believes individuals will take action to ward off, to screen for, or to control an ill-health condition for the following reasons: if they regard themselves as susceptible to the condition; if they believe it to have potentially serious consequences; if they believe a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition; and if they believe the anticipated barriers to taking the action are outweighed by the benefits (Glanz et al., 1997).

Strecher and Rosenstock (1997) reviewed the literature regarding the use of the HBM and cigarette smoking behaviour and concluded the model is not widely used in cigarette smoking research, which suggests smokers already perceive a health threat, thereby making one of the central constructs of the HBM less relevant. Fear arousal messages, therefore, may actually increase frequency of smoking as a response to stress. Other research suggests that smokers, including adolescents, are generally aware of their increased risks of disease, but that they judge the size of these risks to be smaller or less well established than do non-smokers. They also appear to have a distorted perception of the health risks of smoking compared with other health risks. Moreover, even where individuals have a reasonably accurate perception of the health risks faced by smokers as a group, they minimize the personal relevance of this information, believing other smokers' risk to be greater than their own (Slovic, 2001; The World Bank, 1999). This evidence would suggest there is more work to do to increase awareness of the relative risk of smoking, and to encourage an approach of stronger government regulation controlling all aspects of tobacco production and consumption.

Beattie (1991) commented on the overall effectiveness of health persuasion tactics and stated that reviews of this strategy:

> *have repeatedly shown that it is for the most part strikingly unsuccessful, on its own, in bringing about lifestyle changes.* (p. 168)

He also discussed the reluctance of major state agencies of health promotion to accept this conclusion, and cited insider accounts from the United Kingdom as pointing the finger firmly at government departments as the source of directives to persist with campaign tactics. He

suggested this might be a deliberate avoidance of confrontations with vested interests inimical to more wide-ranging health promotion initiatives.

Legislative Action for Public Health and Smoking

Legislative and environmental measures to reduce smoking within the population include: controls on advertising; packaging; price and retailing of tobacco; taxation and a variety of regulatory smoking policies.

Political and theoretical ideologies influence how governments respond to the task of developing and implementing healthy public policy. Spoonley et al. (1994) discussed the amalgam of contradictory ideals and interests:

> *Of crusading liberalism with its confidence in individual human progress and self determination; of traditional conservatism with its emphasis on paternalistic charity and self order; and of democratic socialism with its faith in the benign power of the state to exercise collective responsibility on behalf of its citizenry.* (p. 133)

Tensions continue over competing values such as liberty, equality, justice and security. Academics and practitioners of public health and health promotion have supported the rights of governments to make policy and laws on behalf of "communal good" (Beaglehole, 1991; McKinley, 1993; Paul, 1996). However, there have been voices that claim the role of any social policy initiative must be clearly linked to a reduction in mortality and morbidity, and that caution should be exercised regarding interventionist welfare policies in the name of "communal good" (Lupton, 1995; Seedhouse, 1997).

Nutbeam and Harris (1998) referred to an ecological framework in the development of healthy public policy. This framework describes discrete but not necessarily linear progress of policy through various social and political processes and stages. A number of key determinants of influencing policy development are identified: the social, economic, and political context; areas of influence; and the capacity of those developing or influencing policy. Beaglehole (1991) provided an example of this framework in the passage of the New Zealand Smoke-Free Environments Act:

> *The essential components were: the international scientific evidence and the New Zealand estimates of mortality caused by active and passive smoking; the advocacy groups supported by the established health charities and health professionals; conscientious and dedicated health department bureaucrats; a committed and powerful Minister of Health; and a relatively ineffective tobacco industry.* (p. 181)

The case for intervention to improve health by legislative and environmental measures has been gaining in force and vigour since the 1980s (Gabe et al., 1991), and evidence supporting this approach has been raised in a number of reports on social and economic inequalities in health and disease (Black Report, 1980; National Health Committee, 1998). These reports have made recommendations for economic, environmental and legislative action to diminish the widening gap between the health experiences of different social classes.

However, Beattie (Gabe et al., 1991) noted that this activity has mostly been within the defined limits of local environments, and that broader environments, in which the larger vested interests of commerce and industry play a significant role, are largely ignored. Some of the tobacco control activity in New Zealand, such as restrictions on tobacco sales to minors, restrictions on the consumption of smokes in public places, and restrictions on advertising may affect tobacco industry sales and consumption levels of tobacco.

Some writers from within the new public health movement have cautioned against reviving the tradition of legislative action for health promotion and suggest we need to be aware of the cultural, moral, and ethical dimensions of the key instances of successful reform on the part of the "old" public health movement. They have warned of the dangers of "collectivist authoritianism" in social reform focused too exclusively on health itself as opposed to the problems of the community at large (Garside, 1987). Lupton (1995) applied Foucault's notion of governmentality to public health, pointing out the diffuse and covert nature of control exercised within a range of organizations, sites, and social groups, and exercised at all levels of society. She was cautious about the role public health has as a strongly coercive agent in the shaping and normalizing of human behaviours in contemporary society.

As a Māori tobacco control researcher, I agree that we need to view interventions in a critical manner to ensure the position of Māori is not further marginalised. However, the evidence would suggest healthy public policy on tobacco purchasing and consumption is one of the more effective tools we have to curb what is an extremely serious public health problem for Māori.

Personal Counselling for Health – School-based Programmes to Prevent Smoking

The adoption of counselling and group work techniques and personal development programmes for health promotion has been rapid and far reaching in many different settings within the last decade (Gabe et al., 1991). Recent school-based interventions have focused on social factors thought to influence smoking, and have drawn heavily on psycho-social theories such as social cognitive theory and theory of reasoned action and planned behaviour. Emphasis has been placed on acquisition of skills to resist pressures to smoke. However, some school-based initiatives are also looking at an environmental approach, and aim to achieve healthy lifestyles for all school members by developing and implementing policies and creating supportive environments.

According to Nutbeam and Harris (1998), social cognitive theory is considered to be the most complete theory applied to health promotion because it addresses both underlying determinants of health behaviour and methods of promoting change. A determinant in this context does not to refer to the wider socio-economic determinants of health. This lack of recognition of socio economic determinants is obviously a significant barrier to implementing this theory with groups experiencing high levels of deprivation, such as Māori, as it does not provide for a key determinant in health outcomes.

Social cognitive theory (SCT) arises from classic learning principles and motivational ideas espoused by Hull in 1943, and further extended by Bandura and Mischel in the later part of the 20th century (Glanz et al., 1997).

SCT proposes that everything we do is learned, including personality, and describes the process by which that learning takes place. Bandura (1977) stated that learning results from observing the behaviour of others and from imagining the consequences of our own behaviour. However, the relationship between people and their environment is subtle and complex, and behaviour and environment are continuously interacting and influencing each

other. Understanding this interaction and the way in which social norms can impact on behaviour, offers an important insight into how behaviours can be modified through health promotion interventions. For example:

> *In circumstances where a significant number of people are non-smokers and are assertive about their desire to restrict smoking in a given environment, even without formal regulation, it becomes far less rewarding for the individual who smokes. They are then likely to modify their behaviour.* (Nutbeam & Harris, 1998: 30)

Three specific personal cognitive factors play a part in how we learn. First, modelling or imitating others is seen as a key factor in learning, and we are most likely to imitate someone we admire or want to be like. The tendency to identify with role models is particularly powerful among children. Nutbeam and Harris (1998) provided an example using smoking as the behaviour:

> *If they observe and value the rewards they associate with smoking, such as sexual attractiveness, or a desirable self- image, then they are more likely to smoke themselves.* (p. 31)

Second, the idea of automatically imitating behaviour, even someone you like, is modified by whether that behaviour has been reinforcing for that individual. Glantz et al. (1997) described three different types of reinforcement – direct reinforcement, vicarious reinforcement (as in observational learning), and self-reinforcement (as in self-control). SGT emphasises the importance of understanding personal beliefs, values and motivations underlying different behaviours. For example, if you believe smoking will help you lose weight, and place great value on losing weight, then you are more likely to take up smoking or continue with smoking. In other words, an emphasis on immediate positive expectations is more likely to influence the initiation of a particular behaviour than an emphasis on long-range expectations. However, SGT believes health promotion programmes can change our expectations. For example, in adolescent smoking prevention programmes peers are taught to direct discussions to the more immediate negative social consequences of smoking and how to handle pressure to smoke from other adolescents.

Another personal cognitive factor relating to social learning is the idea of self-efficacy. People imitate someone else's behaviour only if they have a sense of self-efficacy, i.e., the perception that they themselves could perform the task successfully. The concept of self-efficacy influences behaviour about quitting smoking. For example, people who believe they can quit smoking have a reasonable chance of succeeding. People who doubt their ability to quit may try hard at first, but sooner or later they have one cigarette, decide they are a hopeless case, and give up (Curry, Marlett, & Gordon, 1987).

Bandura (1977) proposed that both observational and participatory learning (e.g., by supervised practice and repetition) will lead to the development of the knowledge and skills necessary for behaviour change and are extremely important in building self-confidence and self-efficacy.

Glanz et al. (1997) cited several large, funded, intervention studies that had been designed using SCT constructs with disappointing results for behaviour change. They provide a range of reasons for the results, including: poor use of theory by programme designers; problems with the evaluation design; and inadequacy of the theory. They indicated some problems with the theory, namely that SCT may not take account of the varied choices available between alternative behaviours or the many and complex ways in which environment affects personal and behavioural characteristics.

Another theory widely applied to the development of programmes to reduce the uptake of smoking among youth during the 1980s was the Theory of Reasoned Action (TRA) (Nutbeam & Harris, 1998). There are many similarities between this theory and social learning theory, especially in the importance on behaviour of normative beliefs, attitudes towards behaviour, and perceived behavioural control. Nutbeam and Harris (1998) provided an example of normative beliefs and the effect on smoking behaviour:

> *If an individual who smokes feels that most people do not smoke and that most of their valued friends and colleagues want them to quit, then it is most likely that the person would consider that there is a norm which favours quitting smoking.* (p. 23)

An important aspect of this theory for smoking prevention work is the concept of individuals as rational actors. TRA assumes there are underlying reasons that determine an individual's motivation to perform in a particular manner. These reasons, made up of a person's behavioural and normative beliefs, determine that person's attitude and subjective norm, regardless of whether those beliefs are rational, logical, or correct by some objective standard (Glanz et al., 1997). This concept of rational actors has been used in several studies to describe the motivation and possible reasons for continued smoking in particular groups resistant to smoking prevention and cessation messages (Graham & Der, 1999; Lawlor et al., 2003). However, Slovic points out the limitations in the concept of smoking as a rational choice for beginning smokers, and states that smokers do not appreciate how their future selves will perceive the risks from smoking and nor do they value the trade off between health and the need to smoke. In various research studies, smokers given the choice to smoke again would have chosen not to, knowing what they subsequently knew, particularly what they had learned about the addictive nature of nicotine (Slovic, 2001).

The theories of SCT and TRA are pertinent to our understanding of Māori youth and smoking uptake. Tamariki grow up observing tobacco smoking by people they love and admire, so there are strong observational learning opportunities and role modelling. They also have opportunities at a relatively early age to take part in participatory learning through practising to smoke with peers. Smoking behaviour is normalised as part of the culture and is embedded as a belief and attitude. Māori youth, like other beginning smokers, have a strong sense of self-efficacy in the belief that they can quit in the future. It is only as they experience the addictive nature of nicotine that they realise it is far more difficult to quit than they anticipated. The theories of SCT and TRA will be used as part of the comprehensive approach to reduce uptake and increase cessation; however, a broader view of socio-economic and cultural determinants will be incorporated to ensure an individual behavioural model is not the only strategy used.

Community Development for Health

Community development for health or community-based approaches to health promotion and disease prevention have become increasingly popular since the mid-1970s because they are thought to provide an effective strategy for addressing health problems in a cost-effective manner (Guldan, 1996). Several influences are thought to have been linked to the rise of community development: the women's movement; health action by black and minority

ethnic groups; increasing public dissatisfaction with conventional approaches to health care; community workers becoming involved with local health issues; and health workers seeking more democratic ways of working that address the social, economic, and political determinants of health (Farrant, 1991).

The call for community-based approaches to health promotion was picked up by international health organizations and various governments around the world, and in 1986 at the first international health promotion conference the Ottawa Charter (World Health Organization, 1986) spoke of "the process of enabling people to increase control over and improve their health". It was generally thought that community groups could be helped to identify problems or common goals, mobilize resources, and in other ways develop and implement strategies for reaching the goals they collectively have set (Glanz et al., 1997). The emphasis of health promotion in the community is about changing lifestyle by changing socio-economic-political structures in the local environment (Guldan, 1996). Community participation, empowerment, enablement, and ownership were established as the underlying principles driving community development (Nilsen, 1996). Minkler and Wallerstein (1996) added critical consciousness, community competence and issue selection to the list of principles and concepts underpinning community development, and provide a useful table of definitions of key concepts.

Community Organisation and Community Building

Defining communities has been problematic for health promotion, though notions of community are generally based on locality, common ties or identity, or shared action. As discussed in the previous chapter, Ngāti Hauiti is defined as a community through whakapapa ties, whenua ties, and more recently through some tribal members desire to build capacity through iwi development processes, i.e., shared action.

Figure 2:

Community Organisation and Community Building (Minkler & Wallerstein, 1996).

Concept	*Definition*	*Application*
Participation and relevance	Community organising starts where people are at and engages community members as equals	Community members create own agenda based on felt needs, shared power, and awareness of resources
Empowerment	Social action process for people to gain mastery over their lives and the lives of their communities	Community members assume greater power or expand their power from within to create desired changes
Critical Consciousness	Consciousness based on reflection and action in making change	Community members engage in dialogue that links root causes and community actions
Community competence	Community ability to engage in effective problem solving	Community members work to identify problems, create consensus, and agree on change strategies to reach goals
Issue selection	Identification of winnable and specific targets of change that unify and build community strength	Community members identify issues through community participation, decide on targets as part of larger strategy

Community interventions to prevent smoking in youth cover a diverse range of approaches using traditional and non-traditional channels to target young people, parents and the community. Community programmes and activities can include:

- engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations;
- conducting educational programmes for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others;
- promoting governmental and voluntary policies to promote clean indoor air, restrict access to tobacco products, provide coverage for treatment, and achieve other policy objectives (CDC, 1999).

Community interventions are often based on recognition that young people's decisions to smoke are made within a broad social context, and are an acknowledgement of the influences of this context on decisions to smoke.

When discussing community development it is important to note the distinction between community-based interventions and community development. Community development interventions are based on notions of partnership, advocacy and lobbying for change, community workers as agents of social change, empowerment, enablement and participation. Labonte (1996) defined community development as:

> *Those intentional efforts on part of government or non-government institutions to improve the capacity of less powerful groups to address their social, economic and political needs, many of which may play a role in determining health status.* (p. 5)

In contrast, community-based interventions use communities as the setting for the intervention. However, the power is normally held by the health agency that in most cases holds the funding and sets the goals. Interventions are often about behavioural or lifestyle changes as opposed to addressing determinants of health. Interventions carried out in this manner may not be broad or long lasting, they are likely to affect only those narrow sets of conditions to which they are targeted, and are often dependent on the goodwill and commitment of those immediately involved (Brown, 1991).

The newer social determinants phase in health promotion (which is played out in many community development initiatives) was a response in part to the lifestyle model being used to heap blame on the individual for their poor health choices. However, Eberhard (1997)

considered the recognition by public health practitioners that health is developed in the context of everyday life, which itself is structured by its related social system, has not led to fundamental reconsideration of the social science basis of public health concepts and its incorporation into planning and activity. He argued that individuals are still expected primarily to change their behaviour despite the relevance that the public health discourse allocates to the socio-structural and cultural conditions of human life.

Neighbors et al. (1995) argued that this is a simplistic dichotomous debate pitting victim blame against system blame as if the two must be viewed as polar opposites. They proposed a greater emphasis on personal responsibility should not replace system blame and social change perspectives, and believed the challenge is to better incorporate individual behaviour change and personal responsibility into a health promotion paradigm that is sensitive to the historical and situational circumstances of people.

Friere provided a theoretical model of this balance between personal and social responsibility and advocated a participatory education process in which people are not objects or recipients of political and educational projects, but actors in history, able to identify their community problems and the necessary solutions to transform themselves while changing oppressive circumstances. Friere advanced a concept of conscientization that provides a foundation for linking individual, organisational, and societal levels of social system. Conscientization involves the development of a sense of identification with a group, of shared fate with that group, and a sense of collective efficacy. The latter component involves both the belief that effective action is possible, and the capability (skills and resources) to develop effective strategies for action. Through a dialectical process of collective reflection and action (that is praxis), individuals, organizations, and the community at large can develop the capacity to act effectively to create social change (Friere, 1973; Wallerstein & Bernstein, 1988).

Another major theory that explains community level change is diffusion of innovation (Nutbeam & Harris, 1998). Briefly, this theory classifies people on the basis of their innovativeness, as innovators, early adopters, early majority, late majority or late adopters. The theory maintains the collaboration of opinion leaders within the system is needed to achieve adequate adoption of the behaviour being promoted. Community organization, mobilization of resources and rapid diffusion require a good understanding of the needs and aspirations of the target community. In the same way that the diffusion of innovation theory

picks up on key social networks within a community to effect change, Israel (1985) noted that key approaches within social network theory and social support may be applied in the development of competent communities. She suggested mapping of the social ties in which individuals are embedded may be employed to identify leaders who in turn identify their own networks, target groups, and needs assessments and action priorities.

Comprehensive Frameworks and Models

It is generally accepted that a comprehensive approach is needed if we are to address smoking prevalence in the population. One such model is an ecological model.

Ecological Model

This model captures many of the theories described in the previous section and focuses attention on both individual and social environmental factors as targets for health promotion interventions. It addresses the importance of interventions directed at changing interpersonal, organizational, community, and public policy, factors that support and maintain unhealthy behaviours (McLeroy, Bibeau, Steckler, & Glanz, 1988).

An early theorist of ecological theory was Bronfenbrenner, whose ecological theory (based on human development theory) helped clarify the meaning of settings in health promotion (Eberhard, 1997). According to Bronfenbrenner, development takes place in relation to four different layers of social system, i.e., the microsystem, the mesosystem, the exosystem and, finally, the macrosystem. He conceptualised these systems as being interconnected on the one hand and as providing separate opportunities of social interaction on the other. Human development takes place in specific socially, culturally, politically and economically defined environments that may change over the lifespan. Influence is exerted by the individual, significant others, by agencies in relation to the specific environment, and by changes in the environment itself.

McLeroy et al. (1998) provided a variation on Broffenbrenner's model and used the following determinants headings to discuss a particular ecological model for health promotion: intrapersonal factors; interpersonal processes and primary groups; institutional factors; community factors; and public policy (McLeroy et al., 1988).

Interventions focusing on intrapersonal factors use many of the psychological models mentioned previously in this chapter such as the health belief model, theory of reasoned action, and social learning theory. However, McLeroy et al. (1998) suggested ecological theory at this level can also use a range of theory and interventions such as techniques to modify the nature and extent of social influences; for example, peer pressure resistance training used in adolescent smoking prevention programmes. The theory of change is one of changing individuals, and the targets of intervention include characteristics of the individual such as knowledge, attitudes, skills, or intentions to comply with behavioural norms (McLeroy et al., 1988).

Interpersonal relationships with family and friends are seen as important influences in health-related behaviours such as alcohol and drug use behaviours. However, the writers acknowledged interventions at this level have typically focused on changing individuals through social influences, rather than changing social norms and social influences. They suggested the problem needs to be reframed to acknowledge: overlapping friendship networks that might have varying degrees of influence on individuals behaviours; the importance to the individual of the various networks; and the conflicting information an individual gets exposed to with multiple networks:

> *This reframing of the problem of adolescent drug use from one of nebulous peer influences to one of how existing network structures may influence individuals behaviours, allows one to think about non-individual interventions for drug abuse prevention.* (McLeroy et al., 1988: 358)

Implicit in this statement is the assumption that an ecological perspective tends to refocus attention away from strictly intra-individual factors towards an environmental determinants perspective. Which brings us to the other factors mentioned in the model: organisational factors; community factors; and public policy. One of the purposes of focusing on organisational contexts is to bring about a change in corporate culture, to include health concerns in both tactical and strategic organisational decision making, and to include health related norms and values as part of organisational ideology. McLeroy et al. suggested community practitioners and intervention designers need to be cognisant of community as: a mediating structure that is able to influence change and is an important source of social resource and social identity; as a series of organizations that need to work collectively; and

as a series of power structures that need to be influenced to advantage groups that are currently not accessing political processes and community power structures. Finally, they saw the role of health promotion professionals – whether in policy development, advocacy, or analysis – as:

> *Strengthening the ability of mediating structures to influence policy: thereby, strengthening the mediating structures and their ability to meet the needs of their members.* (p. 366)

Glantz et al. (1997) pointed out the difficulties in operationalizing the general principles of ecological models to specific health behaviours, as the level of discourse in most writing on the subject is very general and that environmental influences are behaviour specific. They suggested that specific ecological models would be needed to guide research and intervention for each behaviour.

National and International Frameworks for Tobacco Control

At a macro-level several frameworks guide the tobacco control movement, and in particular work with youth, nationally and internationally, including: the World Health Organization (WHO) Framework on Tobacco; the United Nations (UN) Convention on the Rights of the Child; the Tobacco Action Plan released by the current New Zealand Government in Dec 2000; and recently Clearing the Smoke: A Five-Year Plan for Tobacco Control in New Zealand (Ministry of Health, 2002a).

However, governments, policy makers, and advocates use other generic international frameworks for health such as the Ottawa Charter and, more recently, the Peoples Charter for Health, a charter adopted by 92 countries attending the Peoples Health Assembly in Bangladesh in November 2000, to lobby for changes such as: reformulating, implementing and enforcing policies and practices that respect the right to health; incorporating health and human rights into national constitutions and legislation; and fighting the exploitation of people's health needs for purposes of profit. Some of the more generic frameworks such as the UN Convention on the Rights of the Child and the Ottawa Charter do not specifically include reference to tobacco; however, articles often refer to overarching values essential to safe and healthy development.

The WHO Framework on Tobacco and the Tobacco Action Plan of the New Zealand Government (TAP) are both aimed at providing a strategic approach to tobacco as an important public health issue and at decreasing the prevalence of both global and national tobacco use. The WHO framework operates at a broader level than the NZ Government Plan and intends to: stimulate global support for evidence-based tobacco control policies and actions; build new partnerships; heighten awareness of the issues; accelerate implementation of national, regional and global strategies; commission policy research; and mobilize resources. TAP addresses tobacco control for New Zealand by providing for policy and legislative programmes, assessment, advice and treatment services, health promotion, and law enforcement.

Conclusion

The intention of this chapter was to review the range of theories and principles that underpin health promotion research and activities, with particular reference to tobacco prevention initiatives, and to develop a framework of research principles that can be translated into indigenous practice as action-based research in the specific community context of Ngāti Hauiti.

I have come to several conclusions that are syntheses of the various authors reviewed in this chapter. As previously mentioned, I wish to use theories in an interpretively flexible manner, enabling me to construct an integrated strategy that will advance the tobacco control initiative in our iwi. In this way I am both building on previous theoretical approaches and, as an indigenous scholar, deciding what constitutes a research principles framework for our particular context. What follows is a brief discussion of each principle chosen.

Methodologies and methods of research, the theories that inform them, the questions that they generate and the writing styles they employ, all become significant acts which need to be considered carefully and critically before being applied (Smith, 1999). This principle is important for two reasons: first, as an indigenous scholar and a practitioner in my own iwi I am mindful of the role methodology and methods of research have played in the colonisation of our people, and any research carried out in the iwi needs to advance Māori development; second, as a person who uses principles of social constructivism, I am aware of the continuing role some health promotion and public health initiatives play in constructing our lives in particular ways that may have social, political, moral and ethical implications.

Research needs to be grounded in and sympathetic to the context of local cultures and communities. This principle was included to ensure the intervention setting that is Ngāti Hauiti, and the particular personal and collective identities that make up the community, are protected and nurtured.

Community action, following an overall philosophy of community development, is the centre for the diverse action areas needed to respond to tobacco control. Evidence would suggest that a comprehensive approach is needed to reduce tobacco prevalence. The community action, community development, is the focus because this is an iwi development initiative to reduce tobacco prevalence and to achieve results we need to harness our traditional collective social structures of whānau hapū and iwi.

Development can only proceed inductively, with new associations emerging as a consequence of new knowledge and experiences penetrating indigenous social systems. The need to proceed inductively is clearly identified in the literature as an appropriate way to build on health promotion theory (Green, 2000). This thesis provides a framework for further intervention research from an indigenous perspective and hence will provide an opportunity to work from theory to intervention to outcomes, and to inform theory inductively from an indigenous perspective.

A problem-based applied research can enable the systematic translation of theory to practice. The tobacco control framework has been developed in response to an issue identified by the iwi, the intended intervention framework has been, and will continue to be, a partnership between me as the researcher and whānau and hapū of Ngāti Hauiti. In this way we will together develop indigenous theory and then test those theories in practice.

Planning and interventions must be conceived in a context that connects research to action, in an environment that is able to move research findings into policy and programme interventions. This principle was included for several reasons: first, I feel a strong commitment to repay some of the advantages that have been provided to me as the researcher pursuing an academic career using data and support from my iwi; second, the context for the intervention is suitable for moving findings into policy and programmes; and

third, the principle of research as benefiting participants is worthwhile in its own right as a principle of equity and fairness.

Working from a thorough understanding of the community in which we intend to work, and working with community partners, we will be able to make sound judgments of which theories, which methods, and which services are best used in a specific setting. I believe this principle is self-explanatory and builds on principles of community development.

Communities and individuals living in communities need to be brought actively into the work in an enabling manner. The term enabling has been critiqued by many academics, including Grace (1991), Green and Raeburn (1988), and Guldan (1996). Much of the critique centres on the notion of "empowerment or enabling" being used as a discourse for the community being in control when in fact in a background role has controlling implications there is often an external agent. The concept, as applied to this thesis and the intended intervention research that will follow, means iwi members and the various organisational governance bodies that make up the iwi will hold the power and control any decisions made regarding the intervention.

The following make up the framework of research principles that will guide the tobacco control intervention research for Ngāti Hauiti:

- methodologies and methods of research, the theories that inform them, the questions they generate and the writing styles they employ, all become significant acts that need to be considered carefully and critically before being applied;
- research needs to be grounded in and sympathetic to the context of local cultures and communities;
- community action, following an overall philosophy of community development, is the centre for the diverse action areas needed to respond to tobacco control;
- development can only proceed inductively, with new associations emerging as a consequence of new knowledge and experiences penetrating indigenous social systems;
- a problem-based applied research can enable the systematic translation of theory to practice;

- planning and interventions must be conceived in a context that connects research to action; in an environment that is able to move research findings into policy and programme interventions;
- working from a thorough understanding of the community in which we intend to work, and working with community partners, we will be able to make sound judgments with respect to which theories, which methods, and which services are best used in a specific setting;
- communities and individuals living in communities need to be brought actively into the work in an enabling manner.

CHAPTER SIX
MĀORI MODELS OF HEALTH AND HEALTH PROMOTION

This chapter will start with a brief introduction to Māori health development and concepts of Māori health. It then provides an analysis of three contemporary approaches to Māori health promotion: Whānau Ora, the framework that guides the delivery of health promotion services to tangata whenua in the tribal rohe of Ngāti Apa, Ngā Rauru, Otaihape, and Whanganui (Gifford, 1999); Kia Uruuru Mai A Hauora, a framework to conceptualise Māori Health Promotion (Ratima, 2001); and Te Pae Mahutonga, a model for Māori health promotion (Durie, 2000). These models and frameworks will be discussed in terms of similarities and differences, and the common components will be considered by all models to be contributing factors necessary for either the effective delivery of Māori health promotion or factors necessary for Māori themselves to be healthy are presented.

Māori Health and Development

Before colonisation, Māori had in place a public health system that ensured the well-being of communities. This public health system was based on a set of values that reflected the close and intimate relationship between people and the natural environment. The system operated through an unwritten regulatory system based on the division of people, places, or events as either tapu or noa, and ensured clean water, adequate sanitation, ventilated houses and effective drainage (Durie, 1994). Early British explorers commented on the good health of Māori people (Pool, 1991), which was likely to be a reflection of well-established public health systems. At the time of European contact in the 18th century, the Māori life expectancy was estimated at 28–30 years, similar to that of the French (29 years), Italians (28 years), and Spanish (27 years) (Pool, 1991).

The values on which the traditional system of Māori public health was based were largely broken down by the process of colonisation, resulting in a major decline in Māori standards of health during the latter parts of the nineteenth century (Durie, 1994). Introduced infectious disease, the musket, political oppression, and the alienation of Māori from their land were key factors in reducing Māori confidence in their own health systems, and in the decimation of the Māori population in the late 1800s (MacLean, 1964; Walker, 1990). However, Māori were not prepared to take a passive role in this decline, and by the late 19th and early 20th century a number of health reforms in Māori communities had begun. One of the first modern-day public health initiatives was the formation in 1903 of Māori Councils, which resulted in the appointment of Māori health inspectors, usually male community leaders. While these councils provided one of the first mechanisms for increased Māori participation in the public health system, they were abandoned in 1909 in response to the call for medicalisation of Māori health, and were replaced by district nurses who were mainly Pākehā. In 1920, the Department of Health was reorganised and a division of Māori hygiene established. Peter Buck, who was leading the initiative, saw this as an opportunity for stronger links with Māori councils and, he hoped, stronger Māori leadership of public health. However, the division was disestablished by 1930 and, as Durie notes, with this went the likelihood of a Māori health workforce closely linked to Māori communities and skilled in Māori approaches to health that were able to offer effective Māori leadership (Durie, 1998).

Following this, in 1937, the Māori Women's Health League was formed and established marae health committees. These committees were concerned with infectious diseases, child health, maternal health and nutrition. Women again became the leaders in Māori health development with the establishment of the Māori Women's Welfare League in 1951. This body had a national health promotion and health advocacy focus concentrating on health issues such as tuberculosis, nutrition, access to medical treatment, and the improvement of child health (Durie, 1994). Both these organizations attempted to promote Western public health principles alongside Māori beliefs and values, considering the two complementary. From the late 1800s to mid-1900s this position of accommodation was generally accepted among Māori health practitioners and practice was often based within a Western medical framework.

However, by the latter part of the 20th century the more immediate public health issues of infectious diseases, housing, sanitation and nutrition were to some extent contained. Māori were then able to turn their attention to broader issues such as Māori health perspectives and the delivery of health services by Māori for Māori.

Catalysts for Change

As previously mentioned, Māori and western concepts of health co-existed in a relatively silent partnership up until the latter part of the 20th century, with many Māori public health initiatives focusing predominantly on Western medical frameworks. A number of changes occurred that highlighted the differences between Western and Māori concepts of health: Māori political activism started in the 1960s; national Māori health hui enabled identification of Māori health concepts separate from western paradigms; increased acknowledgement of the Treaty of Waitangi; and the New Zealand health reforms implemented over the last 20 years.

Māori undertook a range of political activities in the 1970s that resulted in increased acknowledgment of a separate Māori identity and increased recognition of rights needing to be addressed as a result of breaches to the Treaty of Waitangi. These activities included the occupation of Takaparawha, the Land March, and the presentation of the Māori language petition to Parliament.

There were also activities at a health-provider level that increased awareness of Māori health issues, namely Māori health workers became more vocal and more organised, the National Council of Māori Nurses was established and Māori doctors met to discuss the state of Māori health.

In addition to the above activities research was being used to highlight issues for Māori health. Pomare (Te Röpü Rangahau Hauora a Eru Pömare Hauora, 1995) cited several research reports (Pomare, 1986; Murchie, 1984; Smith & Pearce, 1984) published in the 1980s that helped renew interest in Māori health. These reports highlighted disparities in Māori and non-Māori health status, proposed reasons for the disparities, and explored attitudes towards health and health care delivery, and the importance of Māoritanga. Kaumātua were integral in the research process, and provided useful reminders of the

complex set of relationships between social, economic, political, cultural and spiritual factors that made up Māori well-being.

The Treaty of Waitangi, and the increased recognition given to it by Government, has been a significant catalyst for these more recent developments.

The Treaty of Waitangi

The Treaty of Waitangi, signed in 1840 between representatives of the British Crown and New Zealand's Māori chiefs, is generally regarded as the treaty of cession that established the modern state of New Zealand (Barrett, 1997).The three articles, contained in the English version of the Treaty, provided for a transfer of sovereignty (Article One), a continuation of existing property rights (Article Two), and citizenship rights (Article Three) (Durie, 1994). The Treaty was translated into Māori; however, the Māori text conveyed quite different meaning to that in the English text. Māori generally understood Article One to be the transfer of governance rights, therefore legitimating the New Zealand Government. Article Two provided for Tino rangatiratanga, the right for tribes to exercise authority over their own affairs. Article Three, by promising "all the Rights and Privileges of British subjects", implied equity as much as citizenship, and as such implied there would be no serious gaps between Māori and other New Zealanders (Durie, 1994).

Up until the last 30 years, the New Zealand Government largely ignored the Treaty, especially for health, education, welfare, and housing; since 1970 it has been given increased recognition. This recognition has resulted in a range of responses, the most important of which was the establishment in 1975 of the Waitangi Tribunal, whose task is to investigate and report on breaches of the Treaty. Other responses relevant to health and public policy, according to Durie (1994), have included:

- 1985 Standing Committee on Māori Health's recommendation that the Treaty be regarded as a foundation for good health;
- 1986 Director General of Health's recommendation that the Treaty be integrated into health services;
- 1988 Royal Commission on Social Policy's recommendation of the three principles relevant to both social policy and the Treaty: partnership, participation, and protection; and,
- 1992 Government's key statement on the Treaty as it applies to health, gives recognition of Article Three rights.

Although it has been used to help general interpretation of the law, the Treaty of Waitangi has been enforceable only when it has been incorporated into legislation, and then only principles are considered. For example, the Health and Disability Services Act 1993 referred to Māori interests but fell short of specifying the Treaty as an obligation on the Crown (Durie, 1994). More recent legislation, the New Zealand Public Health and Disability Services Act 2000, Part 1 (4), Treaty of Waitangi, provides mechanisms to enable Māori to contribute to decision making on and to participate in the delivery of health and disability services. In particular, District Health Boards (DHBs) are to:

- reduce health disparities by improving health outcomes for Māori;
- establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori improvement; and,
- foster the development of Māori capacity for participating in the health and disability sector.

In developing relationships, DHBs are required by the Act to work with Māori at both governance and an operational level. At a local level (meaning greater Whanganui region) this has required iwi and hapū to decide collectively on the mechanism for representation at a mana whenua level to the DHB. This may provide opportunities to influence planning and purchasing and how mainstream services are provided to Māori. Under this latest health legislation, the government has recognised the need to "consider and address" disparities in health outcomes, in particular the need to improve health gains for Māori, and to support the desire of Māori to take increasing responsibility for their own health care.

At the level of service provision, and in particular services aimed at health promotion, there have been attempts to operationalise the Treaty, for example, the TUHANZ model (Treaty Understanding of Hauora, Aotearoa New Zealand), developed by the Health Promotion Forum (Health Promotion Forum of New Zealand, 2000). However, it has tended to be the principles of partnership, protection and participation that are incorporated into practice as goals, objectives and audit measures rather than a strict application of the articles of the Treaty. Both approaches – the interpretation of the Treaty article by article and the interpretation by principles – are problematic. My observation in Māori health development at governance, management and operational levels has been of an increasing understanding and acknowledgement of Treaty rights and responsibilities, and consequently an attempt to

operationalise this knowledge. However, this is still a conscious process, with the Māori partner often having to think about the Crown's responsibilities (and to inform the Crown about appropriate action) as well as their own responses to a particular situation.

Health Reforms

One of the most significant contributors to reorienting health services were the health reforms undertaken in this country over the latter part of the last century. New Zealand, like many other industrialised countries, has undergone significant restructuring of its health care systems in the last 10 to 20 years. These occurred in part due to the perceived need to manage the financing and delivery of health care. New Zealand has managed this restructuring in a rapid and radical manner (Boston, 1991).

The White Paper of 1975 proposed the establishment of a new structure, New Zealand Health Authority, to coordinate the purchasing of health services and to operate on the belief that health was a social service rather than a 'marketable product'. However, the recommended reforms were never implemented.

The subsequent National Government of 1979 focused reforms on the hospital board funding formula. National reforms were implemented under the Area Health Boards Act 1983, which saw the establishment of Area Health Boards in place of Hospital Boards to undertake the planning and co-ordination of medical services to address public health and service provision within each district.

In response to ongoing problems of excessive cost, in 1984, the fourth Labour Government commissioned two major reviews, the Health Benefits review and the Gibbs Report. None of the recommendations from either report were implemented; however, the two documents stimulated much public discussion about the appropriate roles of state and market in the funding and provision of health care.

The National Government in 1990 resumed radical reforms. The Health and Disability Services Act 1993 was passed, establishing four Regional Health Authorities (RHAs) to purchase health care services, and the Public Health Commission to purchase public health services. The existing Area Health Boards became 23 Crown Health Enterprises (CHEs). The five purchasing bodies purchased services through contracts with competing providers

and monitored provider performance. To achieve greater integration, the RHAs were given responsibility for purchasing primary and secondary care, and disability support services.

A National Advisory Committee on core health and disability support services and the Public Health Commission were also established. The Public Health Commission was later disestablished and reconstituted as a unit within the Ministry of Health in 1995/96.

During this period many solo and group general practices in the primary care sector amalgamated under umbrella groupings known as Independent Practitioner Associations (IPA). These groupings enabled an effective lobbying platform and were intended to coordinate and improve primary health care provision.

The current Labour Government, elected in 1999, has delivered more reforms. These reforms focus on the needs of individuals and communities at a local level and on improved sector collaboration to achieve a non-commercial, collaborative and accountable environment for health service purchasing and provision. The objectives of the reforms are to reduce disparities in health and improve overall health status by addressing the determinants of health. Measures have included the disestablishment of the HFA and the establishment of District Health Boards (DHB). The roles and responsibilities of the HFA have been divided between the Ministry of Health (MOH) and DHBs. A significant part of the latest reforms has been the changes to the primary care sector with the establishment of primary health organizations. The intention is to give the community a greater role in primary care decision-making and to shift the focus to better health for populations and reduction of health inequalities. This is to be achieved by greater co-ordination between services, improved access, and workforce development. The outcomes sought are outlined in the New Zealand Health Strategy (King, 2000) and the Primary Health Care Strategy (King, 2001).

Health reforms did not occur in isolation from Māori development. During the period the central government was reforming health, Māori were proceeding with health development within a Māori development framework. This framework focused on social and economic reform aimed at Māori advancement. Māori development, during the decade before the 1991 health reforms, was based on principles such as: Māori self sufficiency, Māori control, reduced reliance on the state, confidence in tribal delivery systems and an emphasis on the Treaty of Waitangi as the basis for interaction with the Government (Durie, 1994). The

aspirations of Māori development, based on these principles, were never fully realised during the period 1984–1994, mainly due to lack of any real autonomy, underfunding of initiatives and centrally imposed regulations and policy.

The development of health policies by Māori for Māori was greatly advanced by two significant national hui. The 1984 Hui Whakaoranga in clearly stated that Māori health was an integral component of Māori development. The hui made it clear Māori intended to define health for themselves, and linked advances in health with other areas such as Māori language development, marae development, tribal development and Māori aspirations for greater autonomy (Komiti Whakahaere, 1984). The Hui Ara Ahu Whakamua provided the opportunity to review gains in Māori health and allowed for a re-evaluation of the goals and objectives associated with Māori health development.

The dual thrust of the reforms and the call from Māori for advances in Māori health purchasing and delivery resulted in clear policy responses. In 1995, policy guidelines for Regional Health Authority (RHAs) and the Public Health Commission (PHC) 1995–96, stated the need to recognise Māori aspirations and structures such as those based around whānau, hapū and iwi, and the desire of Māori to take responsibility for their own health care (Public Health Commission, 1995). More recently, the Māori Health Strategy, He Korowai Oranga, (King 2000), acknowledged the principles of the Treaty of Waitangi (partnership, participation and protection) as the underpinning philosophy of the Māori health strategy and reinforced the previous government's policy directions of reduced health inequalities and increased control for Māori over the direction and shape of Māori institutions, communities and development.

The state reforms, specifically those in the health sector, have had significant implications for Māori. There have been increasing opportunities for Māori development, and greater attention has been paid by Government to the Treaty of Waitangi (Boston, 1996). This has resulted in increased Māori participation in health service planning and delivery and the development of health policies by Māori for Māori. Since the mid-1980s, achievements in Māori health development have included: growth and upskilling of Māori providers; expansion of the Māori workforce at all levels of the health sector; enhancement of mainstream providers ability to meet Māori needs and expectations; and increased Māori participation at all levels of the public health sector (King, 2000).

While these gains are acknowledged, reforms to the health sector over the last 20 years have left Māori in the position of constantly responding to changes imposed by Government. The transitions have been achieved with some success, even though there has been a level of scepticism that the changes would have positive impact for Māori. Changes have required resources and energy to be invested in new arrangements at a time when wider Māori development, and in particular Māori health development, needs to focus on increasing its own capacity and consolidating initiatives and progress. The situation of responding to requests for participation and restructuring of health organizations at a variety of levels places undue stress on an often-limited pool of Māori health workers with the expertise to manage and respond effectively to the changes. One has only to look at the significant shift of focus for key health organizations over the last 20 years to realise the impact these changes have on Māori. For example, emphasis shifted from local-level involvement with area health boards to involvement with regional bodies, such as regional health authorities, to a national focus with health funding authorities and now back to local participation through district health boards.

To consolidate the Māori health gains made over the past 20 years (at least in terms of greater numbers of Māori providers, an increasing focus on mainstream services on Māori health, and expanded opportunities for Māori input into policy development), several things will need to be put in place. Sufficient funding must be allocated to Māori health to ensure gains can be built on; mechanisms must be put in place whereby Māori are represented at all levels in the health care system; the disparities focus needs to be maintained to ensure progress on Māori health gain priority areas; and central Government needs to ensure the protection of Māori rights under a Treaty framework are maintained in the shift to decentralisation. An understanding of Māori health concepts is an important component in implementing strategies and reform that will benefit Māori and reduce Māori health outcomes. The following section briefly summarises Māori health concepts.

Māori Concepts of Health and Well-being

Increasingly, the role of culture and ethnicity is being acknowledged as a significant determinant of health outcomes; a determinant separate from socio-economic status. As part of this movement away from a strict biomedical behaviourist approach towards a more

ecological holistic approach it has become important to understand what cultural concepts of health and well-being mean.

As a result of increased Māori participation in the health sector and general Māori development occurring in the late 20th century, kuia and koroua reminded us that Māori well-being was the result of a complex set of relationships that included social, economic, political, cultural and spiritual factors (Te Röpü Rangahau Hauora a Eru Pömare Hauora, 1995). It was timely to review culturally appropriate practices and models of Māori health.

Tapu, in particular its application to health and wellbeing, has played a central part in Māori values from historical to contemporary times. Durie (1994) describes tapu as enabling the social life of the community to be maintained by the law and order it imposed, and it is used as a safety measure designed to invoke a sense of caution and to warn of threatened dangers. Illness for some Māori is closely associated with infringements of tapu (Durie, 1994).

The concept of tapu is closely associated with the concept of mana. To say that something is tapu is usually understood as a prohibition, but essentially tapu functions as a protective device. Something becomes tapu by virtue of being imbued with mana, and the prohibition on associating with a tapu object can be seen as a protection against being harmed by contact with the potency of that mana (Patterson, 1992).

Mana in turn can be seen as a supernatural power that can be present in a person, place, object or spirit. It is commonly understood as power or authority. Durie conceptualised Māori theories of disease causation in terms of mana, in particular mana atua (gods or supernatural forces), mana tangata (human activities or genetics), mana whenua (access to tribal lands), and mana Māori (opportunities for Māori control) (Durie, 1994).

Mana atua was used to explain disease not able to be attributed to man or to be explained by ordinary means. Epidemics of the 19th century and the period before that, for example, were attributed to mana atua. Mana tangata refers to the direct actions of people and communities that affect well-being. Colonisation bought with it many changes to traditional values, beliefs and practices that had previously provided protection and ensured well-being; mana tangata was directly affected by these changes. Mana whenua in this context refers to "tribal strength, integrity and survival", which are closely associated with tribal land ownership, the

alienation of which as a result of colonisation has been linked closely with ill health and depopulation. Finally, a lack of opportunities for Māori control over their own destinies (mana Māori) was considered to be a source of ill health.

The mana theory of disease causation underlies Māori models of health. Three of these models, Whare Tapa Whā, Te Wheke and Nga Pou Mana, will be discussed.

Te Whare Tapa Whā was developed from various themes presented at a health hui in 1982. Durie, who drew these themes together, defined the model as "a view of health which accorded with contemporary Māori thinking". The model compares health to the four walls of a house, all four being necessary for strength and symmetry, though each representing a different dimension; taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), taha whānau (family) (Durie, 1994).

Taha wairua is given primacy in this model. It describes one's "capacity to have faith and to be able to understand the links between the human situation and the environment " (Durie, 1994, p. 70). Land, lakes, mountains and reefs take on a spiritual significance quite apart from any economic advantages these aspects of our environment may convey. The natural environment is considered "integral to identity and fundamental to a sense of well-being". Taha wairua can also be expressed through acknowledgement of a higher spiritual being, for some this encompasses formal religious beliefs and practices.

The concept of te taha hinengaro, as expressed by Durie in Whare Tapa Whā, describes the importance of the Māori approach to organising and expressing thoughts and feelings, and its implication for well-being. It draws the distinction between a western emphasis on the spoken word (as a way of communicating) and the more covert approach by Māori, with an emphasis on subtle gesture, eye movements, bland expression and, at times, silence. Durie also described the difference between integrative thinking (searching outwards for explanations), which he sees as typical of a Māori style of thinking, and the more analytical approach of breaking things down to small components (typical of a Western approach). He provides linguistic examples of these using Māori words that have a personal meaning and a broader external meaning (even though they are the same word).

Taha Tinana refers to bodily health. However, the difference is in the Māori emphasis on tapu and noa. Certain parts of the body are regarded as special (tapu) and certain bodily functions, e.g., sleeping, eating, and defecating have their own significance and rituals attached to them. For example, separation of food from toileting is regarded as necessary to maintain good health, and the removal and disposing of body parts (including hair and nail clippings) need to be conducted in certain ways.

Taha whānau relates to the role of immediate and extended family in the care, support and cultural nurturing of the individual. Whānau in Māori terms is inclusive of extended family, e.g., children, grandchildren, great-grandchildren, and spouses. Durie describes how whānau are sometimes held responsible for the ill health of an individual even though there may be no obvious causal link. Where there is genuine concern about the ability of a whānau to care for other whānau members (as in the case of abuse) the responsibility may be removed and extended whānau may step in and take over the role of caregiver, thereby ensuring the rights and the interests of the whānau and tribe supersede the rights of the individual. This focus on the greater good and communal needs also means the idea of the independence or self-sufficiency of the individual as a health goal is not compatible with Māori concepts of health. A healthier goal would be interdependence.

Other models of Māori health gained credibility in the 1980s. Rose Pere was asked to write a statement about Māori health to present at the Hui Whakaoranga in 1984. It is interesting to note that not only in her model but also in her introductory statement she demonstrates several of the concepts named in Te Whare Tapa Whā. Taha whānau is succinctly expressed in her statement:

> *I do not express my views as an expert but as a grandchild of many grandmothers and grandfathers who have influenced my philosophy of life.* (1984: 19)

The model, Te Wheke, was symbolised as an octopus: the eight tentacles representing a particular dimension of health, and the body and head the family unit. The intertwining of the tentacles represented the interrelatedness of the concepts. Te Wheke bears many similarities to Te Whare Tapa Whā. Wairuatanga, taha tinana, taha hinengaro and whanaungatanga similar to taha whānau were all components of the model. In addition to

these, other concepts were included such as Mauri or the life principle or spiritual power contained in animate and inanimate life; Ha A Kore Ma A Kui Ma, the breath of life that has come down from our forebears and the strength gained from knowing ones heritage; Whatumanawa, sustenance and an understanding of emotional development; and finally Waiora, the idea that when all the symbolic tentacles receive sufficient sustenance then well-being will be reflected through the eyes of the body (the family unit).

In 1988, the Royal Commission on Social Policy described another set of values and beliefs, Nga Pou Mana (four supports). While these were developed as foundations for social policy and social well-being, they are also relevant as prerequisites for health and wellbeing. The four supports – Whanaungatanga (family, sense of belonging and social responsibilities), Taonga tuku iho (cultural heritage including language, behaviour and practices, and cultural knowledge), Te Ao Tūroa (the physical environment), and Tūrangawaewae (land base) – were once again seen as interactive, and emphasised that the external environment, access to Māori resources and a secure Māori identity are necessary for Māori good health (Henare, 1988a).

Both Ratima and Durie provided some critique of these models and discussed the following issues: the difficulty of measuring concepts as diffuse as taha wairua; the problems health workers may encounter while operationalising the concepts; and finally the implication that good health for Māori is dependent on a range of Māori concepts not available, or sometimes even relevant, to all Māori. The next part of the chapter will discuss three particular models used in Māori health promotion. These models all build on the previous frameworks, models and values described previously in this chapter.

The Whānau Ora Model

The Whānau Ora framework (Gifford, 1999) is based on the analysis of interviews with Māori community health workers and Māori nurses implementing a health promotion model, Whānau Ora. Whānau Ora, as a concept to be used in the delivery of health services to Māori in Whanganui, was first discussed in 1996 by the then CEO of Te Oranganui Iwi Health Authority, Tariana Turia. The concept built on traditional Māori concepts of whānau, tikanga, and health, and combined these with contemporary ideas about Māori health and development as discussed in hui such as the Hui Whakaoranga (Ministry of Health, 1984) and Te Ara Ahu Whakamua (Te Puni Kōkiri, 1994). The vision clearly identified a model of health service delivery that attempted to address a broad and complex range of health and

social issues affecting whānau in the Whanganui region. Whānau Ora was described as a model of service delivery that restored and maintained the rangatiratanga of whānau, hapū and iwi, and was based on tikanga in terms of values, attitudes and practices. In implementing the vision, some components of the original vision were clearly used, while other components, probably those most difficult to implement, were altered or not fully implemented. A number of new perspectives emerged during the time of implementation, probably in an attempt to improve efficiency and effectiveness.

> *The current service is being carried out from a broad range of perspectives, often based on passionately held beliefs and values, with no evidence in the research of a strong direction being exerted in any one direction. Having said that however there is enough evidence to suggest that what is now operating can be placed within a framework that identifies the philosophy of Whānau Ora.* (Gifford, 1999, p. 45)

The model, is based on five key concepts:

- services to Māori are delivered at a *whānau* or family level;
- service delivery is based on *Māori concepts of health and well-being;*
- the model operates on the principles and processes of *tikanga;*
- the model is driven by organisations with a commitment to *tino rangatiratanga;*
- the work itself is about *whanaungatanga.*

The term whānau, when applied to the model, is about delivering services to an extended family group, sometimes comprising three or more generations of the one family and extending to aunts, uncles and cousins.

The concept of working with or from a community perspective is a strongly held belief in many health promotion models. The Ottawa Charter (World Health Organisation, 1986) has, as one of the key principles strengthening community action, Critical Pedagogy (Minkler, 1997), which talks about co-organising with members of the community, while several of the key themes teased out in the Whānau Ora study talked about community ownership and building on existing social systems (Gifford, 1999).

Working from a whānau basis extends commonly held concepts regarding working in communities, for example, working from a locality perspective, with groups with similar interests; or working at grass-roots level. Working from a whānau basis implies much more than working in a community with families.

The idea of collective responsibility and involvement in whānau matters, I believe, is an essential difference between Māori and non-Māori models of community practice. Patterson (1992) claimed this concept of collective responsibility as central to a Māori world-view and compared it with the Pākehā view that sees individuals as the bearer of responsibility. He maintained that whānau are the ultimate source of collective responsibility. Tariana Turia, in her initial development of the Whānau Ora model, talked about strengthening families so they would be able to take up responsibilities (Gifford, 1999). Pere (1984) described whanaunatanga as all generations supporting and working alongside each other; families are expected to work alongside each other in the community to help strengthen the whole.

Gifford (1999) discussed what this means for Māori health promotion models such as Whānau Ora:

> *Health promotion is not something that is done to someone or even to some group at arms distance, it is about a process of intimate involvement and responsibility and requires an understanding of fundamental differences in value bases between Māori and non-Māori approaches. In particular an understanding of whānau dynamics, including relationships within the whānau and an understanding of the history of these relationships is essential. Workers on the Whānau Ora programme are not immune to the responsibilities of working for the collective good in the way other health workers delivering health promotion programmes may be. Because of the kinship ties to the families they are working with they are subject to the same expectations as other members of the whānau. This sometimes involves the workers in situations that challenge professional ethics and boundaries and creates conflicts between personal and professional roles.* (p. 47)

This concept of collective responsibility raises many issues for a health service provider operationalizing the concept. The concept of privacy and confidentiality is challenged by ideas of collective responsibility, as is the idea of professional boundaries.

Māori concepts of health and well-being already discussed in this chapter are consistent with the values discussed in the Whānau Ora model.

Patterson (1992) described tikanga as deriving from the word 'tika', which means natural (from a tribal point of view). He stated that tikanga of human beings includes:

> *Our appearance, conduct, habits, etc. The way in which we act can be called our tikanga, but more importantly it is an inner form of life that manifests itself in the way that we behave. Our tikanga is not simply how we behave it is something within us that makes us behave in the way we do.* (p. 103)

In the Whānau Ora study, the concept of tikanga as a core value for delivering the Whānau Ora model was found to be problematic:

> *Issues arose mainly due to implementing tikanga into an organisational structure that had representation from more than one iwi or tribal group, and whose employees included the diverse range of Māori identity found in contemporary society.* (Gifford, 1999, p. 90)

Gifford explained the issue of trying to implement tikanga if one accepted Patterson's (1992) definition of tikanga as "*being something within us*" or something learnt or inherited:

> *If this is where one learns about tikanga, and tikanga is the sense of being in accord with tribal nature, being 'natural' and hence reasonable and correct (Patterson, 1992), then the issue of practising using the principles of tikanga will be problematic for those who are in some way disconnected from these traditions. There are many in the Māori health workforce who will feel some difficulty in practising from a tikanga perspective because of feelings of disconnection or alienation from traditional sources of knowledge accelerated by urbanisation and government policies that have actively discouraged tribal links.* (p. 50)

Many Māori use the terms rangatiratanga and particularly tino rangatiratanga to convey a political will for self-determination. The use of the word in the context of the Whānau Ora model is intended to mean Māori self-determination that can be defined as the advancement of Māori people as Māori, a commitment to strengthening economic standing, social

wellbeing, and cultural identity. The term also captures the idea of power and control being vested in Māori hands

The final concept, whanaungatanga, is described well in Whakapiripiri Whānau (Ratima et al., 1996), a framework developed to conceptualise whanaungatanga. The framework describes six principles: Tātau Tātau or Collective Responsibility; Mana Tiaki or Guardianship; Manaakitanga or Caring; Whakamana or Enablement; Whakatakato Tūtoro or Planning; and Whai Wāhitanga or Participation.

Gifford proposed that these principles provide a useful guideline not only to guide whānau members enrolled with a programme based on a Whānau Ora model, but also to guide the workers themselves (Gifford, 1999).

The research describes the concept of participation as, central to the Whānau Ora model and a key factor in ensuring the model's success:

> *The principles of participation, collective responsibility and guardianship require whānau members to be fully involved in not only care, but also aspects of decision-making and management of whānau and hapū development. As workers often belong to whānau that they are providing care for the boundaries set out by other frameworks, such as Seedhouse (1997), often conflict with expectations set down by Māori concepts of whanaungatanga.* (Gifford, 1999, p. 51)

According to the model:

> *Concepts such as planning and guardianship fall neatly into the overall concept of collective responsibility. The concept of caring is integral to any health service delivery and the remaining concept of empowerment relates specifically to the practice of health promotion and is a key ideal in many health promotion models.* (Gifford, 1999, *p. 55)*

Te Pae Māhutonga

Te Pae Māhutonga is a model of Māori health promotion first presented by Durie in 1999 at the Health Promotion Conference held in Napier, New Zealand (Durie, 2000). This model builds on existing frameworks such as the Ottawa Charter and the work carried out by Dr

Maui Pomare, a Māori public health specialist, at the beginning of the 20th century. It also takes into account the challenges for future health promotion and the need to integrate approaches to health gains.

Te Pae Mahutonga is the name for the constellation of stars called the Southern Cross. The constellation has four central stars arranged in the form of a cross and two stars arranged in a straight line that point to the cross. Durie (2000) used these as a symbol to bring together the components of health promotion not only for Māori but other New Zealanders. The fact that this constellation has been used as a navigational aid for our tīpuna (ancestors) is once again recognition of the important role history plays in contemporary Māori society:

> *The four central stars can be used to represent the four key tasks of health promotion and might be named according to reflect particular goals of health promotion: Mauriora, Waiora, Toiora, Te Oranga. The two pointers are Ngā Manukura and Te Mana Whakahaere.* (p. 5)

Mauriora as previously mentioned relates to the life principle – it involves receiving and containing the strength of the ancestors and spiritual powers. In the context of Te Pae Mahutonga it relates to a secure cultural identity. The tasks necessary to secure this for health promotion include:

- access to language and knowledge;
- access to culture and cultural institutions such as marae;
- access to Māori economic resources such as land, fisheries, forests;
- access to social resources such as whānau, Māori services, networks; and,
- access to societal domains where being Māori is facilitated.

Waiora is the spiritual, intellectual, physical, emotional and psychic development of each individual, and this development is intrinsically tied to the natural environment and its resources. Waiora describes a spiritual element that connects human wellness with cosmic, terrestrial and water environments (Durie, 2000). In the context of Te Pae Mahutonga, health promotion is about harmonising people with their environments. It is about protecting the environment so that:

- water is free of pollutants;

- air is free of pollutants;
- vegetation is abundant;
- noise levels are "compatible human frequencies and harmonies"; and,
- people have opportunities to experience the natural environment.

Toiora relates to healthy lifestyles. Toiora, as distinct from mauriora and waiora, depends on personal behaviour and in particular reducing risk-laden lifestyles that affect well-being. However the influence of poverty, deculturation and the role of governments and macro-approaches to solutions are acknowledged.

Key areas for consideration under this concept include:

- harm minimisation;
- targeted interventions;
- risk management;
- cultural relevance; and,
- positive development.

Te Oranga is about well-being achieved through full participation of Māori in the wider society. To achieve well-being this participation needs to increase in the following areas: participation in the economy, education, employment, decision making and the knowledge society.

Ngā Manukura (leadership) and Te Mau Whakahaere (autonomy) are the last two concepts and are seen as prerequisites for the effectiveness of this health promotion framework. Leadership in this model needs to reflect a shared approach from diverse areas and relies on good communication and strategic alliances between communities, tribes and health professionals. Autonomy is reflected in the participation people have in health promotion and their control of it, and includes acknowledgment of such aspects such as the degree of control by communities and participants, recognition of aspirations, relevant processes, sensible measures, and self-governance.

Kia Uruuru Mai a Hauora

The final Māori health promotion framework or model to be discussed is Kia Uruuru Mai a Hauora (Ratima, 2001). Through this framework, Ratima attempted to make Māori health promotion explicit. She described the framework as an intersection between Māori development and generic health promotion and states that:

> *It is the health focus that is the key distinction between Māori health promotion and Māori development, and it is the Māori focus that distinguishes Māori health promotion from generic health promotion.* (p. 230)

Ratima conceptualised the framework through ten characteristics: concept of health and Māori health promotion, purpose, paradigm, theoretical base, values, principles, processes, strategies, and markers.

Māori health promotion is defined as:

> *the process of enabling Māori to increase control over the determinants of health and strengthen their identity as Māori, and thereby improve their health and position in society.* (p. 234)

At a minimum, Māori health promotion requires interventions to be consistent with Māori world-views, embrace a holistic concept of health, focus on Māori identity, increase control for Māori, and lead to health gains (defined by participants).

The purpose of Māori health promotion is to lead to health gains, and these are defined as the retention and strengthening of Māori identity and the realisation of Māori potential.

The paradigm is founded on Māori worldviews and, in particular, on interconnectedness, Māori potential, self-determination, collectivity, and Māori identity.

Ratima saw the theory underlying Māori health promotion as implicit, including influences such as Te Whare Tapa Whā, Te Pae Māhutonga and generic health promotion theory. While the values guiding Māori health promotion are "inherently political" and are based on emancipatory goals, Ratima does not exclude the role of evidence as an ideological driver of Māori health promotion. The values identified in her research include Māori identity, collective autonomy, social justice, and equity.

Principles are seen as providing the practical guidance, as opposed to the moral guidance provided by values. The principles identified in her research were holism, self-determination, cultural integrity, diversity, sustainability, and quality.

Processes identified from a range of settings and a variety of issues included empowerment, mediation, connectedness, advocacy, capacity building, relevance, resourcing, and cultural responsiveness.

The strategies of Māori development and generic health promotion, and consistency with identified characteristics of Māori health promotion, form the basis from which Ratima explained the overlapping strategies of Māori health promotion. The six strategies identified include:

- reorientating health systems and services;
- increasing Māori participation;
- capacity building;
- healthy and culturally affirming public policy;
- intra- and inter-sectoral measures to address determinants of health; and,
- adequate, efficient, and relevant resourcing of Māori health.

Markers identified in Ratima's research indicate conventional indicators and broader markers are desirable to measure the contribution interventions make to such things as increased control over the determinants of health, the attainment of health including a secure Māori identity, and progress towards Māori advancement. Ratima also believed they are achievable.

The three health promotion models and frameworks described all attempt to conceptualise Māori health promotion and inform the practice of Māori health promoters, and there are useful components in all three models for purchasers, policy makers, managers of health services and academics. Two of the models, Whānau Ora and Te Pae Mahutonga, originated from Māori health leadership. Whānau Ora was developed by Tariana Turia in an attempt to inform health promotion practice at a local level (Whanganui); and Mason Durie first presented Te Pae Mahutonga, acknowledging Māori health leadership from the turn of the century, at the New Zealand Health Promotion Forum Conference in 1999. The writing of

Whānau Ora and the framework development for Kia Uruuru Mai A Hauora were a result of the research and analysis of Māori health promotion case studies.

All three models have components in common; however, these key concepts are presented and discussed in very different ways. Whānau Ora attempts a description and analysis of the values and principles of Māori health promotion practice and a discussion of the problems implementing these, and in this respect the model is useful for informing workforce development. While Te Pae Mahutonga describes some broad overarching concepts derived from the Māori world-view, these broad concepts are given specific tasks relevant to health promotion. In this way the model becomes a very practical guide that can inform a range of health promotion stakeholders. Kia Uruuru Mai a Hauora is the most ambitious of the models as it attempts to conceptualise not only purposes paradigms and theoretical bases but also processes, strategies and markers for Māori health promotion. Time will tell if the complexity of the model detracts from its usefulness in further advancing Māori health promotion.

All three models were analysed for common components considered by the authors to contribute factors necessary either for the effective delivery of Māori health promotion or for Māori themselves to be healthy. The results of the analysis concluded that the following components made a set of core principles for Māori health promotion:

- a sense of control or ability to self-determine;
- participation in all respects: in the whānau, hapū and iwi context, and at a broader systems level;
- a secure Māori identity: both as providers and consumers of health systems;
- collectivity: either as whānau or as hapū and iwi; and also in the wider context of working collectively with a range of people to achieve Māori well-being;
- social justice and equity: whether this is pursued through tino rangatiratanga, equitable access to resources, or as the ideological driver for the Māori health promotion workforce; and,
- interconnectedness: either a connection with the environment, a sense of connection with the past through our tipuna, or a sense of being connected as whānau, hapū and iwi.

These principles will be used as part of the comprehensive tobacco control framework Ngāti Hauiti will implement in the intervention research phase (to be carried out as post-doctoral research). The principles will be further discussed in Chapter Ten to reveal and examine implications for service planning, and to connect this set of Māori health promotion principles both to the overarching research principles and to the tobacco control intervention strategy.

CHAPTER SEVEN

MĀORI TOBACCO CONTROL ACTIVITIES: THE EVIDENCE OF EFFECTIVENESS AT REDUCING MĀORI YOUTH UPTAKE

This chapter starts with a brief overview of tobacco control activities in New Zealand from the mid 1900s to 2002. Initiatives aimed at Māori and focused on prevention or reduction of uptake will be discussed under the Ottawa Charter framework; building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and reorientating health services. The chapter will attempt to review the evidence of the effectiveness of prevention programmes in general, and with specific reference to evaluation studies undertaken in Aotearoa. This information will then be used to inform the tobacco control intervention framework for Ngāti Hauiti.

Background

Tobacco control and the impact of tobacco use were largely ignored by successive governments until the 1980s, even though the Department of Health first began to publicise the impact tobacco use was having on health as early as 1940 (Reid & Pouwhare, 1991; Toxic Substances Board, 1989). By the late 1940s the high rates of smoking among Māori was "well-known" (Reid & Pouwhare, 1991), and by the 1950s the association between lung cancer and smoking was recognised (Doll R & et al, 1956).

At the same time as the health impacts of tobacco was being acknowledged, smoking among New Zealanders had become the norm (Thompson & Wilson, 1997). The Department of

Health reflected this cultural norm and appeared to be more interested in promoting smoking reduction rather than quitting.

In the late 1970s, as a result of analysis of the 1976 census data, it became obvious that government measures to eradicate smoking were not reaching Māori (Easton, 1995; Reid & Pouwhare, 1991). The census data highlighted that smoking prevalence among Māori was extremely high compared with the rest of the New Zealand population. The 1976 census also showed that more Māori women had been smokers compared with all women, and that Māori women had experienced the lowest quit rates compared with all other New Zealanders (Easton, 1995).

By the 1980s the implications for tobacco smoking on health were, according to Thomson and Wilson (1997), "clearly on the New Zealand health policy agenda". A significant influence may have been the publicising of authoritative information on the effects of tobacco use. Social attitudes to smoking by the general public were also slowly changing. Furthermore, more evidence was published during this decade on the effects of passive smoking, and there was a significant increase in wider smoking research, including analysis of data from the census, smoking prevalence surveys, and research on the impact of media campaigns and advertising.

Currently, Māori are disproportionately affected by tobacco-related morbidity and mortality, with an estimated 31% of all Māori deaths being attributed to tobacco use (Laugeson & Clements, 1998).

Tobacco Control Activities since mid-80s

New Zealand's tobacco control programme, begun in 1985, included among other things, advertising restrictions, tobacco tax increases, and smoke-free legislation. During the period 1985 to 1998 the programme effectively reduced tobacco consumption for all NZ adults, lung cancer mortality rates for adult males, and the proportion of cancer death rates attributable to smoking (Laugesan & Swinburn, 2000). However, rates for Māori adolescent smoking prevalence were largely unaffected by the wider tobacco control strategy, despite restrictions on sales to minors, mass media campaigns and tobacco tax increases (Thomson & Wilson, 2000). Up to 1983 the government had made no significant attempts to see that Māori had particular access to information and intervention programmes, and it was not until

1984 that the government began to fund Māori smoke-free health promotion strategies (Reid & Pouwhare, 1991). However, funding for Māori-specific tobacco control initiatives in the period 1990–1998 has been modest (Thompson et al., 2000).

During the 1990s Māori were themselves attempting to reduce Māori smoking prevalence rates. Key initiatives occurred during this period and were generally focused on Māori cessation, national co-ordination, health promotion, and advocacy services. While discussion of these initiatives is outside the scope of this thesis, a summary list is presented:

- the first Noho Marae Smoking Cessation programme in 1992;
- a national hui of Māori health workers in 1993 to discuss goals for a nationally focused Māori smoke-free coordination service;
- the establishment of Te Hotu Manawa Māori in 1994 to develop and provide a smoke-free co-ordination service;
- the establishment of the Māori Smokefree Coalition (Apärangi Tautoko Auahi Kore) in 1997 to influence national tobacco control policy and programmes;
- the launch of the national Quitline programme in 1999;
- the piloting and later national roll out of Aukati Kai Paipa (a cessation programme targeting Māori women and their whānau) in 2000; and,
- the hosting of two National Auahi Kore hui in the late 1990s.

Many of these initiatives have a Māori youth focus as part of an overall whānau approach to tobacco control and as a component in the tobacco control programme; however, youth are not the prime focus, nor is prevention.

Programmes aimed specifically at Māori Youth and Prevention

The Ottawa Charter for Health Promotion provides a strategic framework for a preventive approach to tobacco control, recognising the need for a comprehensive approach. The five headings of the Ottawa Charter will be discussed in turn, with particular attention to and discussion of initiatives aimed at Māori and focused on prevention or reduction of uptake.

Developing Personal Skills

Developing personal skills is about supporting personal and social development through providing information, education for health, and enhancing life skills. By so doing people

can make choices from a range of options presented to them, and this information allows them more control over their lives (World Health Organization, 1986).

From an individual perspective the main approach to preventing tobacco use in youth is school-based education. However, school-based education also includes aspects of healthy public policy implementation; the policy component will be discussed here.

School-based Education

At primary, intermediate and secondary school level, drug education in schools has always been delivered as part of the health education curriculum.

The Government has at times injected additional funding into drug education and piloted and evaluated particular approaches. For example, in June 1997 the Ministry of Education set up the Drug Education Development Programme (DEDP) aimed at preventing uptake and reducing current drug use in schools. The programme, a joint project between The Ministry of Education and The Alcohol Advisory Council, was designed to increase self-efficacy skills and influence attitudes about drug taking. The programme was evaluated and a report produced for the Ministry of Education in October 2000 concluded: "there is little evidence to suggest that the DEDP model was either feasible or effective for the delivery of drugs education to improve young peoples decision not to use, delay use or reduce the misuse of drugs" (Education Review Office, 2002).

Drug education, including smoking, is currently delivered as a component of the health and physical education curriculum and has a well-being and mental health focus. Schools are encouraged to assess students' needs and develop drug education programmes designed to meet those needs. To support the provision of this component, the Ministry of Education published a guide for schools, *Drug Education: A Guide for Principals and Boards of Trustees*, in 2000. School-based resources are provided by the Public Health Group in the Ministry of Health, Cancer Society, New Zealand Heart Foundation, Te Hotu Manawa Māori, The Health Sponsorship Council, Foundation for Alcohol and Drug Education, and ASH.

Other education and promotion activity is community specific but is largely provided by public health services based within District Health Boards and health promotion units within Māori health providers.

A report, *Drug Education in Schools, June 2002*, has recently been published by the Education Review Office. This report presented the results of a nation-wide survey relating to the implementation of drug education programmes in primary and secondary schools between October and December 2001.

Some of the results of this survey have implications for Māori youth tobacco smoking and the role of school-based education in preventing uptake. Only half the primary schools surveyed had a drug education programme compared with about 90% of intermediate, composite and secondary schools. Smoking and tobacco education was delivered more commonly between years 7 to 11, and the average amount of time spent on total drug education was from 10.8–15.2 hours per year.

In a 1993 survey of 1400 Wellington fourth formers, only 48% reported they had received teaching at school about smoking (McGee, 1993).

The need to target smoking prevention education at an earlier age and to deliver sessions regularly through from primary to secondary school is reinforced by international evidence (Glynn, 1989; Sorensen, Emmons, Hunt, & Johnston, 1998).

There is also evidence to suggest school-based programmes alone are less effective at combating the social pressures to smoke, and efforts to prevent onset and effect long-term change need multiple complementary components (Reid et al., 1995; Rissel & Hughes, 1999; Stead et al., 1996).

Evidence also suggests smoking education programmes are likely to impact on those at lower risk of becoming smokers. Young people at most risk of smoking may be least likely to respond to the school environment, may not be present when education is delivered, and there is even a suggestion that school-delivered programmes may be counter productive for such young people (Blewden, Waa, Spinola, & Moewaka-Barnes, 1997; Rissel & Hughes, 1999).

As Māori youth are at higher risk of smoking, leave school on average at a younger age, and are most at risk from expulsion or suspension from school for drug use (including tobacco), we can assume drug education in schools may be less effective for Māori youth. Further research would be needed to confirm this assumption.

Evidence suggests social reinforcement and social norms-type programmes that include curricular components on the short-term health consequences of smoking, combined with information on the social influences that encourage smoking, together with training on how to resist the pressures to smoke, are more effective than traditional knowledge-based interventions (Effective Health Care, 1999; Lloyd & Lucus, 1998; Stead et al., 1996).

Schools in the ERO survey identified that having smoke-free policies, smoke-free events or sponsorship, and counselling and support staff to deal with drug issues were the main factors that could contribute to the goals of drug education. Overall, only 64% of schools surveyed had a statement or policy about drug education (Education Review Office, 2002).

As part of the ERO study, follow-up interviews were carried out with 25 schools that had a comprehensive approach to drug education. Key features of effective drug education in these schools included: developing and reviewing policies for education outside the classroom; providing support and training for teachers; providing adequate teaching time; and consulting with the community on needs of students and whānau. An example of a comprehensive approach to drug education and support was:

> *A group of Northland secondary schools, with local health and police support, have had recent success in supporting students involved in drug-related incidents. They are helping these students maintain their education through specific intervention strategies involving specialist drug counselling.*
>
> *Programmes that appear to be successful in providing students with a second chance after drug offending should be evaluated. There is anecdotal evidence suggesting that early intervention and ongoing monitoring can support students through initial offending and provide incentives to continue schooling.* (Education Review Office, 2002, p. 16)

At a Māori health workers hui, organised by the Public Health commission in 1993, it was recommended that any programme aimed at reducing Māori failure in schools was beneficial to reducing the prevalence of smoking, as failure at school was identified as a risk factor in smoking in rangatahi.

Waa et al. (1999) suggested that in New Zealand there is a need to rethink schools-based interventions by continuing to implement smoke-free policies across all schools, by moving the smoke-free message into a lifestyle approach conducive to the physical education curriculum, and by including tobacco industry disclosures in social studies-type classes.

The "healthy lifestyles approach", to be achieved by implementing policy and creating supportive environments, and the importance of this for all school members including teachers and parents, was reinforced by the WHO and the European Commission and the Council for Europe (Effective Health Care, 1999).

The best school health education programmes appear to be capable of delaying, but not preventing, recruitment to smoking. Delay is likely to result in gains to health because later starters may stop smoking earlier, and so are at a reduced risk from smoking-related disease (Reid et al., 1995, Stead et al., 1996, Lloyd & Lucus, 1998).

Healthy Public Policy

Healthy public policy is about putting health on the agenda of policy makers in all sectors and at all levels, and directing them to be aware of the health consequences of their decisions and to accept responsibilities for health (World Health Organization, 1986).

Healthy public policies for all addictive substances has been shown to have preventative value (Anderson, 1994). To be effective, these policies need to be inter-sectoral, covering not only health, social welfare and criminal justice sectors, but also those sectors relating to trade, agriculture and education.

Price Increase of Tobacco Products

Willemsen and Zwart (1999), in their review of the literature on the effectiveness of policy and health education strategies for reducing adolescent smoking, found:

> *Price increase is the single most effective policy option for reducing tobacco consumption and several studies showed that higher price elasticity* [11] *was found among youth than among adults.* (p. 590)

However, this paper did not reflect on the effects of price changes on those in low- income brackets. The gradient in cigarette smoking prevalence by occupational class is well known, as is the high rate of smoking in lone parents (Jarvis & Wardle, 1999).

Compared with Pākehā, Māori are five times more likely to live in the most deprived socio-economic decile, and Pacific peoples seven times more likely (Tobias & Cheng, 2001). The socio-economic gradient of tobacco consumption is particularly marked for Māori (Whitlock, MacMahon, Hoorn, & Davis, 1997), for each socio-economic deprivation quintile, Māori have a higher smoking rate than non-Māori (Crampton, Salmond, Blakely, & Howden-Chapman, 2000). The consequence for Māori is that they are more likely to live in high socio-economic deprivation area households with smokers, and are more likely to be affected by tobacco use (Thompson et al., 2000).

The question then is what is the likely impact of tobacco tax increase on poorer Māori households and on the uptake of nicotine in Māori youth.

There appears to be conflicting evidence regarding the issue of price increases reducing consumption in poorer populations (Jarvis & Wardle 1999), with some evidence that price increases, through increased taxation, are successful in reducing smoking in all social classes (Borren & Sutton, 1992).

New Zealand estimates have concluded that there is some indication that average 'sole adult and children' households and Māori 'sole adult and children' households reduced the number of cigarettes purchased after a price rise to a greater extent than other types of household (Thompson et al., 2000).

[11] Price changes on smoking behaviour are expressed as price elasticity.

However, those Māori households continuing to smoke after tobacco tax increases would be adversely affected by this policy due to decreased disposable income through increased expenditure on tobacco. Thompson et al. (2000) suggested that without broader policy changes to ensure the position of these groups is improved, tobacco taxation increases could adversely affect the financial welfare of some of those in the most deprived populations.

There appear to be no New Zealand data on the effectiveness of price increases on the uptake or tobacco prevalence rates for youth. One recent international study that used focus groups to interview 785 youth from various ethnic and social backgrounds concludes that:

> *In every focus group in each of the 13 sites, regardless of the method of presentation, only two policies consistently stimulated youth to stop and think about their smoking: a large price increase, and listing ingredients with common uses.* (Crawford, Balch, & Mermeistein, 2002, p. 17).

This result was consistent across sex and ethnicity.

Broader Socio-economic Determinants Policies

There is a growing body of evidence that substantial and often increasing social inequalities in health exist in all countries (Dahlgren, 1996), and that social and economic factors such as income and poverty, employment and occupation, education, housing, culture and ethnicity have the greatest influence on health outcomes (National Health Committee, 1998).

Smoking in particular has an independent association with almost any marker of disadvantage, whether personal, material or cultural (Jarvis & Wardle, 1999). Hence, Māori smoking prevalence and the associated disproportionate burden of morbidity and mortality that Māori carry, can be seen as an outcome of the disadvantaged circumstances in which many Māori find themselves as a result of colonisation.

Strategies that address the wider determinants of health are seen as the most promising approach to reducing disparities in health. These strategies include increasing benefits so they are in line with average earnings, improving access to public housing, improving education outcomes for those currently not succeeding in the education system, and increasing employment. At a broader level, governments could introduce policies that

included: subsidies to tobacco growers being reallocated to other healthy income-generating activities; loans not being provided for tobacco industries; and, using social marketing techniques, a popular movement against tobacco enabling the reduction of the value of tobacco company shares on the stock market. In addition, product modification could make smoking less harmful.

Substantial progress in all these areas would greatly facilitate reductions in smoking. However, there are many reasons why this type of approach is not implemented. The policies themselves are difficult to implement. There may not be the political will to implement them. They may not be seen as cost effective. And they may not be directly attributable to specific improvements in health. As a result, most government policy has sought to influence the downstream factors that more proximally influence smoking behaviour.

New Zealand tobacco control policy has in the past been an example of this approach and has tended to avoid the wider determinants affecting tobacco use in disadvantaged populations. However, there is some attempt by national tobacco advocacy groups, and to some extent the Government, to implement a comprehensive tobacco control strategy. This approach, with an emphasis on multifactoral influences including the physical and socio-economic environment, as opposed to an individualistic, behaviourist approach, may result in changes to the disparities apparent in tobacco use in this country.

Restricting Access to Tobacco

The 1990 Smoke-free Environments Act aimed to reduce exposure to passive smoking through the development of smoke-free workplaces and other public places, the restriction of sales to minors, the reduction of tobacco advertising, the elimination of tobacco sponsorship, and the provision of alternative sponsorship through the Health Sponsorship Council.

In 1994, amendments were made to the act that raised the purchase age for tobacco to 18 years and older, and restricted the sale of smaller size packets of cigarettes.

Designated Smoke-free Officers located within Public Health Units of District Health Boards are charged with the responsibility of enforcing and monitoring the requirements of the Act on behalf of the Minister of Health. Guidelines have been produced for regional enforcement

services, training for field officers is available, and some funding is provided for prosecutions.

The philosophy behind limiting access to tobacco is that if minors have difficulty obtaining tobacco, they may be prevented from experimenting and later becoming addicted. Blewden et al. (1997) cited two studies where tobacco prevalence had declined with interventions involving legislative restrictions and retailer and community education.

However, a systematic review of nine studies found there was no detectable relationship between the level of merchant compliance with laws restricting access and smoking prevalence (Fichtenburg, Caroline, Glantz, & Stanton, 2002; Ling, Landman, & Glantz, 2002); there was also no evidence that an increase in compliance with these restrictions was associated with a decrease in smoking prevalence. Furthermore, there was no significant difference in youth smoking in communities with youth access interventions compared with control communities.

Another systematic review of 27 studies, of which 13 included controls, came to similar conclusions, stating that law enforcement and community policies had an effect on retailer behaviour, but the impact on smoking prevalence was small. It reported that interventions with retailers could lead to large decreases in the number of outlets selling tobacco to youths. However, there was limited evidence for an effect of this intervention on youth perception of ease of access to tobacco and on smoking behaviour (Effective Health Care, 1999).

A recent report produced for the Ministry of Health, *Clearing the Smoke: A Five-Year Plan for Tobacco Control in New Zealand, (2003–2007)* (2002a) discussed the New Zealand evidence for effectiveness of retailer interventions. The New Zealand data indicated that major changes in cigarette purchasing behaviour by fourth form students occurred between 1992 and 1997. This period was a time when there was increased enforcement against underage sales of tobacco. These changes included:

> *Self-purchasing of cigarettes decreased by 37% (95% CI: -40, -34) but acquiring cigarettes from other people increased.*

> *There was decreased purchasing from dairies and supermarkets but increases from other sources such as take-away shops, tobacconists and vending machines.*
>
> *Weekly buying increased by 23%, students who were refused a sale increased by 153% and students who had difficulty in buying increased by 324%. The students who had difficulty in buying were less likely to buy weekly than students who did not have difficulty (31% vs 41%).*
>
> *Yet over this period daily, weekly or monthly combined smoking prevalence* increased *by 27% (from 23.4% in 1992 to 28.5% in 1997) among fourth form students. Daily smoking increased from 11.6% in 1992 to 15.5% in 1997.*
>
> (Laugeson & Scragg, 1999, in Ministry of Health, 2002a)

Other New Zealand data for 14- to 17-year-old students indicate that around two in every three respondents had experienced no difficulties in buying cigarettes (Health Sponsorship Council, 2000).

Given that Māori youth are among the higher spenders on cigarettes per week, are more likely to be regular smokers, and are more likely than others to buy cigarettes from retail outlets (Ministry of Health, 2002b), it is important that interventions aimed at enforcing restrictions on sales of cigarettes to minors be continued. A recommendation in the draft Five-Year Plan for Tobacco Control in New Zealand 2003–2007, (Ministry of Health, 2002a) stated that cost savings to the health sector could be made by transferring this responsibility for law enforcement to the police, allowing smoke-free officers to devote more time to enforcing smoke-free environments legislation.

I would suggest that if this responsibility is passed to the police the focus for any action is clearly on penalising the vendor rather than the buyer, and should not criminalise teenage smokers by prohibiting possession. Māori youth may already be disadvantaged in the justice system, and further exacerbating the situation may be counterproductive to overall well-being.

It has been argued that the focus on limiting access may contribute to enhancing the "forbidden fruit" aspect of smoking and to highlighting smoking as an "adult behaviour". Indeed, youth access programmes have been described as reinforcing the "tobacco industry's central marketing message that kids should smoke because it will make them appear more adult" (Blewden et al., 1997; Reid et al., 1995). A recent survey of Māori youth attitudes to smoking stated that 40% of Māori thought "smoking makes you look older" (Health Sponsorship Council, 2000). If this is a widely held belief then some credence may need to be given to the arguments presented.

Supportive Environments

There is an inextricable link between people and their environment, and this constitutes the basis for a socio-ecological approach to health. The overall guiding principle is the need to encourage reciprocal maintenance implying taking care of each other, our communities and our natural environment (World Health Organization, 1986).

The political, social, economic, religious and physical environments in which people live have a major impact on consumption of addictive substances such as tobacco. One reason given for this is the use of tobacco as self-medication, as a way of coping with poor socio-economic circumstances (Graham, 1987).

An environment in which tobacco use is widely accepted results in widespread use as well as an increase in the number of particularly heavy users (Anderson, 1994; Marmot & Wilkinson, 1999). Conversely, an environment that discourages prohibits or restricts use of tobacco results in reduced use and smaller numbers of heavy smokers. There are many settings, including home, schools, work places and health care organisations, which offer opportunities for healthy behaviour, improvement of social support, and the strengthening of attitudes that favour reduced use of tobacco.

The major approaches to preventing youth uptake in New Zealand are the development and enforcement of smoke-free environments and mass media campaigns.

According to Goldman and Glantz (1998), mass media campaigns aimed at tobacco control tend to fall into several categories:

- industry manipulation strategies that aim to expose and delegitimise the industry and deglamourise smoking;
- cessation strategies aimed at encouraging current smokers to quit;
- youth access strategies that expose the ease of youth access to cigarettes and promote awareness and specific efforts to reduce access;
- strategies to portray the immediate adverse health and cosmetic effects of smoking, along with strategies that emphasise the long-term adverse health effects of smoking; and,
- romantic rejection strategies that try to counter industry portrayals of smoking as sexy and alluring and to convince smokers and those contemplating smoking that they will be undesirable if they smoke.

In 1996, the Ministry of Health began its low budget media campaign, He Aha Te Kai Paipa/Why Start? This campaign was largely aimed at reducing the uptake of smoking in youth, particularly Māori youth (Thompson et al., 2000). The campaign featured TV and radio commercials, advertising in buses and bus shelters, Māori radio advertising and health education material. The message was that "smoking has nothing going for it" (Smokefree Coalition, 1997). The campaign was discontinued in 1999. The Ministry of Health: Five-Year Tobacco Control Strategy states:

This campaign was not associated in time with any reduction in the national smoking prevalence levels of school students. However, this campaign was a relatively low budget and the campaign themes were generally not particularly "hard hitting" (ie, relative to campaigns used for young people in Florida and Massachusetts). (2002a: 69)

There is evidence that mass media campaigns are most effective in reducing smoking prevalence in adolescents when combined with other interventions. For example school-based programmes, excise-tax increases, contests, and community education programmes (Stead et al., 1996).

The particular approach used also influences effectiveness. While campaigns that target exposure of the industry and second-hand smoke appear most effective, addiction and cessation messages used in conjunction with "industry manipulation" and second-hand

smoke were also considered to be effective (Goldman & Glantz, 1998). The duration and intensity of the campaign also influence effectiveness.

A Cochrane systematic review has also examined mass media interventions for preventing smoking among young people (Sowden & Arblaster, 2001). It concluded that there is some evidence that the mass media can be effective in preventing the uptake of smoking in young people, but overall the evidence is not strong.

Involvement of youth in the design and implementation of youth-targeted media campaigns, consideration of the most appropriate theoretical approach, review of effective mediums for different age groups, ongoing audience research, and use of the same language as youth may help enhance the effectiveness of youth tobacco-control media campaigns.

In response to the disproportionate tobacco statistics for Māori, Te Roopu Whakatairanga Hauora, the Health Sponsorship Council (HSC), created "Auahi Kore", a media campaign and related community capacity building activities designed to reaffirm a smoke-free Māori culture as a central source of positive identity for young Māori people (Waa et al., 1999).Established in 1990 under the Smokefree Environments Act, the HSC promotes health by using a social marketing approach, including sponsorship, to influence attitudes of at risk audiences.

The HSC uses a range of strategies:

- partnerships with other organizations, e.g., Te Taura Whiri I te Reo Māori, (Māori Language Commission) and Toi Māori Aotearoa, (Moari Performing Arts);
- encouraging smoke-free settings, e.g., marae Auahi Kore;
- sponsorship of community based events, e.g., Te Kiwai Auahi Kore and linkages and sponsorship with Māori sport and Māori arts; and,
- communication strategies and the provision of merchandise and resources.

They use these strategies to work towards a number of key objectives: gaining wider acknowledgement and understanding of auahi kore, associating auahi kore with Māori identity and removing the cultural acceptability of smoking, raising the awareness of the benefits of auhi kore for the community, and increasing the number of auahi kore settings.

While there appears to be no independent evaluation of auahi kore as a strategy for reduction in Māori smoking prevalence, HSC does commission independent research on brand awareness, attitudes to smoking, and smoking behaviour. In 2000, in collaboration with the Cancer Society, HSC commissioned NFO CM Research to carry out a Youth Lifestyle Survey. The survey was conducted in 53 schools in 5 regions, and summary results for brand awareness states that the smoke-free brand provides:

> *A strong platform for any communication – brand awareness is high, the events it sponsors are generally liked and people feel that they know what smokefree is about. Quit/Me Mutu and Auahi Kore are better known among Māori. There is less certainty about the messages sent by the auahi kore brand. The smokefree events are generally drawing their target audience with smokers much more likely to have attended the events than non-smokers.*
> (NFO CM & Research, 2000)

There appears to be no direct evidence that social marketing and sponsorship lead directly to a reduction in smoking prevalence; however, there are other reasons that would support the continuance of these activities, especially those targeted directly at Māori youth. Funding for a range of Māori initiatives needs to continue so that disparities in smoking rates can be addressed, and as there is a need for tobacco activity to be broad based and comprehensive it will be important to continue the HSC work. Sponsorship can create environments more conducive to tobacco control measures in general; and social marketing and sponsorship specifically using the auahi kore brand has been successful in raising awareness and reaching the target audience. Sponsorship of events such as kapa haka, smoke-free speech competitions and waka ama are likely to increase self-esteem and strengthen cultural identity and therefore improve overall Māori well being. In addition to increased well-being, there is some evidence participation in sports may discourage the uptake of smoking. Sponsorship and social marketing can also provide opportunities for environmental modification for example permanent smoke-free policies such as smoke-free marae.

Smoke-free Environments

Evidence cited in the Ministry of Health Five-Year Tobacco Control Plan (including published meta-analyses), in reports of the United States (US) Surgeon General, in research

undertaken by the US National Research Council, and in major reviews, clearly outline the risks associated with second-hand tobacco smoke (SHS). These risks include lung cancer, heart disease, respiratory illness, and increased severity of asthma episodes and symptoms (Ministry of Health, 2002a).

In New Zealand, the Smoke-free Environment Act (1990) effectively banned smoking in offices, but not in many other interior workplaces. The Ministry of Health recently reviewed the New Zealand evidence regarding SHS in the workplace. They concluded that exposure to SHS is a continuing problem in a number of workplace settings, with some workers, for example Māori, blue-collar and hospitality workers, being particularly at risk. The report concluded that strong scientific evidence exists both nationally and internationally that smoking bans and restrictions reduce exposure to SHS in the workplace and that such interventions may also have an effect on tobacco consumption and cessation (Ministry of Health, 2002a).

In the mid-1990s The Ministry of Health produced new guidelines for smoke-free schools programmes as part of its Healthy Schools package. Under this policy schools are required to have a written policy on smoking and to comply with at least the minimum requirements under the Smokefree Environments Act. It was hoped that schools would go beyond this minimum requirement and establish totally smoke-free policies. A recent study by the Education Review Office identified that while a statement or policy about drug education existed in 420 (64%) of the 661 sample schools, primary schools were less likely to have developed such a statement than were secondary or composite schools. The study then selected 25 secondary and intermediate schools that had demonstrated good practice in drug education and carried out qualitative interviews to determine how drug education was being implemented in these schools. The report identifies "that more than half the schools surveyed had a smoke-free policy" (Education Review Office, 2002).

Exposure to SHS in the Home

A Cochrane review highlights the significant documentation on the subject of health consequences for children who are exposed to second-hand smoke (SHS). The range of conditions include: sudden infant death syndrome (SIDS), bronchial hyper-responsiveness, atopy, asthma, acute and lower respiratory disease, reduced lung function and middle ear disease. (Waters et al., 2002, in Ministry of Health, 2002a)

These authors also quoted evidence that children whose parents smoke are more likely to smoke themselves later in their lives.

Awareness of these hazards in the community is far from complete. One study of Pacific mothers in New Zealand has found that only 32% knew that maternal smoking was a risk factors for SIDS (Paterson, Tukuitonga, Butler, & Williams, 2002).

A recent survey of New Zealand teenagers in Year 10 and Year 12 found that nearly half the respondents (46%) were exposed to second-hand smoke in their home during the week before the survey, and Māori, Pacific Islands youth, and those from lower decile schools were more likely to have been exposed to SHS (Health Sponsorship Council, 2000).

The Ministry of Health also provides evidence that the number of smokers smoking in the home has an added impact on SHS exposure. There is New Zealand evidence that children's exposure to SHS is related to the number of smokers in the home setting (based on nicotine levels in hair) (Al-Delaimy, Crane, & Woodward , 2000, in Ministry of Health, 2002a).

A Cochrane systematic review on "family and carer smoking control programmes" for reducing children's exposure to SHS indicates programmes that include practical advice, suggestions, and follow up may significantly reduce smoking and effect positive behavioural change among family and carers (Waters et al., 2002 in Ministry of Health, 2002a).

The Ministry of Health note that mass media messages have dealt with SHS exposure, for example, "It's about whānau" campaign, and educational materials have addressed SHS exposure in the home. However, interventions have not been particularly intensive and no evaluation studies appear to have been published (Ministry of Health, 2002a).

New Zealand data indicate levels of nicotine in hair and cotinine in urine are lower in children who live with caregivers who smoke outside the house than inside the house (Al-Delaimy et al., 2000).

Evidence of high rates of smoking prevalence among younger Māori women, the group likely to be in closest contact with children, of high rates of exposure to SHS by Māori

children, combined with high rates of respiratory, middle ear infections and SIDS, and evidence of the increased likelihood of children themselves smoking due to exposure to parents that smoke, would suggest an intensive intervention that encourages smoke-free whānau will have significant impact on whānau wellbeing.

In New Zealand there is evidence for fairly high acceptability of smoke-free workplaces (Ministry of Health, 2002a). Whether we can achieve this same level of acceptance in the home setting is debatable. Several issues come to mind that may be barriers to implementing a widespread adoption of smoke-free homes. The concept that "my home is my castle and I'll do what I want here," and the rational choice for some whānau to smoke to alleviate stress may inhibit widespread uptake of the policy.

However, appealing to women and to the concepts of caring for future generations may make the policy more acceptable. Data from Australia suggest messages concerning SHS exposure in the home should possibly be primarily orientated at women, as this group appears to be more likely to quit (NSW Health, 2001).

Community Action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health (World Health Organization, 1986). Individual and whānau responses are insufficient to prevent the use or harm resulting from tobacco consumption, and tobacco control interventions need to be supported by community intervention and action.

Community interventions cover a diverse range of approaches using traditional and non-traditional channels to target young people, parents and the community. Community programmes and activities can include: engaging youth in developing and implementing tobacco-control interventions; developing partnerships with local organizations; conducting educational programmes for young people, parents, community and business leaders, health care providers, school personnel, and others; forming support groups and advocacy groups; and mobilising communities around tobacco control activities.

With the increase in recent years of the Māori health workforce focused on smoking cessation and health promotion, and the activities of national organisations such as Te Hotu

Manawa Māori, ATAK, HSC, Quit/ Me Mutu, Aukati Kai Paipa, there is likely to be a range of local Māori community-based or community-development programmes that include, or are focused solely on, tobacco control activities in New Zealand. However, with the exception of major cessation-focused activities such as Aukati Kai Paipa and Quit/Me Mutu and some of the media initiatives, most of the community-based initiatives are not written up in academic journals or disseminated in other ways to the wider public, and are less rigorously evaluated.

Some examples in New Zealand include:

- The smoke-free marae programme developed by Tahuna Minhinick from Waiuku near Auckland. This programme uses traditional Māori legends, positive role modelling for tamariki, haka, poi and tauparapara to deliver smoke-free messages.

- Tipu ora, a child health programme begun in the Bay of Plenty region, uses non-smoking young grandmothers as kaitiaki, or caregivers, to promote smoke-free homes.

- Smokebusters, a positive peer-led approach was conducted at both Tararua and Mana Colleges and included diversionary tactics at lunchtime, newsletters, awards in the media and recognition of smoke-free events.

- KOFF (keep our kids off fags) was an initiative introduced by parents in the Hawke's Bay area.

Internationally, there are several comprehensive community-based programmes that have been well documented and evaluated. The Truth campaign, launched in Florida, USA, used themes of tobacco industry manipulation of youth and encouraged youth to rebel against the tobacco industry. Key elements of the campaign included the formation of youth advocacy groups, the development of mass media campaigns and an integrated approach that enhanced and lay within a wider tobacco control approach, including engaging community based organizations (Hicks, 2001). Cross-sectional studies indicated the campaign had high rates of recall, was associated with significant positive changes in smoking-related attitudes and

beliefs, and was associated with reductions in smoking prevalence among youth in Florida (Sly, Heald, & Ray, 2001).

Two other USA programmes in Minnesota and North Karelia, which combined school-based programmes, mass media campaigns and activities in the workplace, also showed promising results, with 10% reductions in teenage smoking prevalence at 6- and 8-year followups (Reid et al., 1995). However, other broadly similar programmes such as that in Stanford, California, showed no effect on teenage smoking (Reid et al., 1995).

There is limited support for the effectiveness of community programmes to prevent the uptake of smoking in young people (Reid et al., 1995; Effective Health Care, 1999; Sowden & Alabaster, 2002). However, the following recommendations may increase the likelihood of success:

- targeting multiple sites and multiple levels of influence;
- placing youth at the centre of the activity;
- using a policy approach targeting use, access and supply;
- addressing social inequalities in disease risk;
- involving communities in programme planning;
- implementing and incorporating approaches for tailoring interventions at a population level (Sorensen et al., 1998).

Reorientating Health Services

In the Ottawa Charter, reorientating health services is described as containing the following elements:

- shared responsibility among individuals, community groups, health professionals, health services and governments to work together towards a health care system which contributes to the pursuits of health;
- a move of the health sector in a health promotion direction, beyond clinical and curative services;
- a need for health services to embrace an expanded mandate that is sensitive and respects cultural needs; and,

- a stronger attention paid to health research and professional education and training conducive to changes in the organization of health services, so they refocus on the total need of the individual as a whole person (World Health Organization, 1986).

If these elements are applied to tobacco control prevention work with Māori youth it is apparent that a component of each of the elements has been achieved, for example, there has been a building of partnerships over the last 8 years that has enabled the framework for a comprehensive tobacco control approach to be put in place for Māori; health promotion and advocacy is one approach in the tobacco control programme, and the specific issues of Māori tobacco control have been acknowledged. However, significant gaps remain in terms of reorientating the health services to reduce effectively both the prevalence rate of Māori tobacco use and the level of illness and number of deaths attributed to tobacco use.

Some of these gaps have been identified in the draft National Māori Tobacco Control Strategy: lack of support from other sectors, for example, education for an intersectoral approach to Māori tobacco control; insufficient funding for a comprehensive approach to tobacco control; poor commitment by Government to Māori tobacco-control needs; poor national coordination between Māori smoke-free community and the wider Māori community; and gaps in knowledge and skills in Māori smoke-free workforce and the subsequent need to extend this training in tobacco control to allied workforces (Apārangi Tautoko Auahi Kore: Māori Smokefree Coalition, 2002).

Conclusion

The main approaches used in New Zealand to prevent the uptake of tobacco in youth are: developing personal skills through school-based education; influencing public policy including initiatives such as price increases of tobacco products and restricted access to tobacco; creating supportive environments by the development and enforcement of smoke-free environments and mass media campaigns; supporting community action initiatives such as smoke-free marae; attempts to reorientate health services by partnership building; and a focus on advocacy and prevention.

It appears from the evidence that none of these initiatives, used singly, will significantly reduce the uptake of tobacco or decrease prevalence rates of tobacco use in youth. What is needed is a comprehensive approach that targets multiple sites and multiple levels, and uses

complementary components from each intervention type. Used in this way the range of approaches available to prevent tobacco use in youth may result in some postive changes.

It is my intention that the evidence presented in this chapter will contribute to the final Ngāti Hauiti Tobacco Control Framework. How this evidence will be incorporated is discussed in Chapter Ten.

CHAPTER EIGHT

NGĀTI HAUITI: THE CONTEXTS OF THE STUDY

Piki ake ki te Taumata o Mekura kei Ruahine. Titiro atu ki te maunga tapu ko Aorangi. Heke iho ki te awa e rere nei ko Rangitīkei. Ka pari a ki uta ki Patea, ka pari a ki uta ki Otoea, ka pari a ki uta ki Otara, ka tatū ki Te Hou Hou nei. Ko Ngāti Hauiti e tū atu nei. Hī ha aue!

Ascend the summit of Ruahine at Mekura and gaze yonder to the sanctified mountain of Aorangi. Descend upon the currents of the Rangitīkei River. To gush at Pātea, to swirl at Otoea, to flow at Otara, finally reaching Te Hou Hou. Ngāti Hauiti stand before you! [12]

This chapter focuses on the specific tribal area in which the study is being carried out and presents a profile of this community with particular reference to historical and contemporary tribal development and the opportunities provided by this environment to prevent tobacco uptake in its youth population[13].

Historical Overview

Ngāti Hauiti can be described as the people who have maintained ancestral rights derived from the tupuna Hauiti. Ngāti Hauiti forms part of the confederated hapū that originated from Mōkai Patea, and include Ngāti Whitikaupeka, Ngāti Tamakōpiri, Ngāti Hinemanu and

[12] From the Patere Taua Hokia written by Wirihana Winiata.
[13] This chapter has been written using material gathered by iwi members over a period of time, and has been reviewed by iwi members before submitting to outside academic examination.

Ngāti Upokoiri. The confederation shares some common traditions, ancestry and land interests, and is mentioned in the following patere[14].

Taua hokia i Pa o te rangi o te ora kei ōku pāpā, kei ōku whāea, kei ōku tūpuna, kei a Ngāti Whiti, kei a Ngāti Tama, kei a Ngāti Hinemanu, kei a Ngāti Upokoiri, kei a Ngāti Hauiti. Ka huihui rātou ki runga o Pikitara, ka tū ko tōku koroua ko te Ƙawepō me te whakapono.

The avenging expedition has returned from the elevated platform of life of my fathers, mothers and ancestors; from Ngāti Whiti, Ngāti Tama, Ngāti Hinemanu, Ngāti Upokoiri, and from Ngāti Hauiti. They will assemble on Pikitara where my old man Kawepō and his biblical belief will prevail.

Kāti rā ko ōku tūpuna ka wehewehea i kona te mana o te tangata me te whenua e takoto nei ngā roherohe moana i wehewehea ai a Whanganui, a Ngāti Rangi, a Tuwharetoa, a Ngāti Kahungunu, a Rangitāne a Ngāti Kauwhata, a Ngāti Raukawa, a Ngāti Apa, a Waiariki.

So be it, my ancestors will be scattered where the prestige of man and land is lying separated by the waters dividing Whanganui, Ngāti Rangi, Tuwharetoa, Ngāti Kahungunu, Rangitāne, Ngāti Kauwhata, Ngāti Raukawa, Ngāti Apa and Waiariki.

[14] From the Patere Taua Hokia written by Wirihana Winiata.

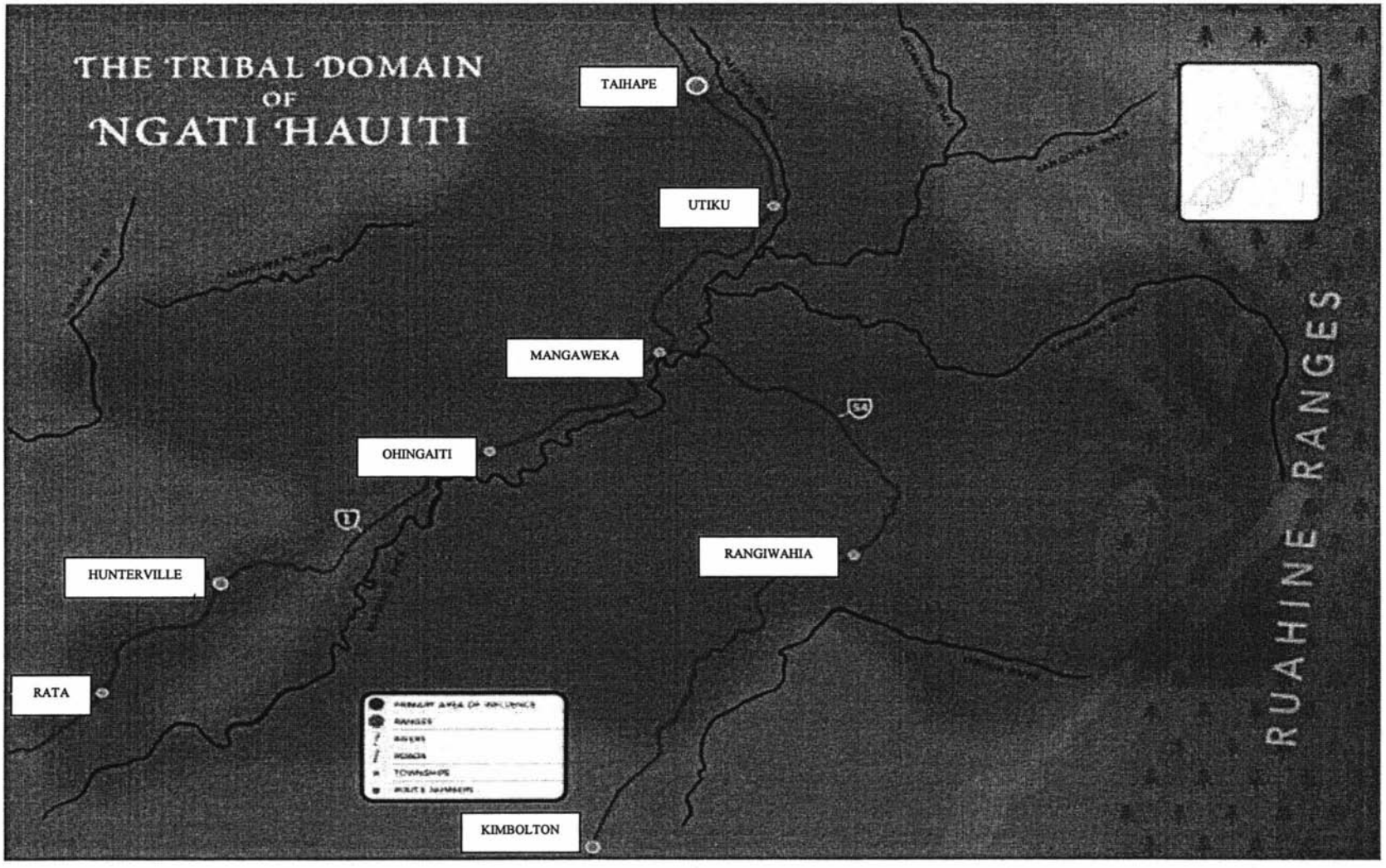


Figure 3:

The Tribal Domain of Ngati Hauiti

Initial Settlement

Oral tribal history[15] identifies Hauiti as descended from the eponymous explorer Tamatea Pōkai Whenua, whose grandfather, Tamatea Arikinui, came to Aotearoa aboard the Tākitimu waka. Tamatea Pōkai Whenua is attributed with naming many places in the Rangitīkei district and with leaving a number of mōkai (pets) at certain locations.

Another tupuna of note was Mātangi who came to the Rangitīkei from the Wairarapa in search of flocks of birds. On his journey he named various places along the central Rangitīkei River before leaving the district. His descendants married various members of Ngāti Hauiti and this gave rise to the Ngāti Tumokai hapū.

Neither Tamatea Pōkai Whenua nor Mātangi stayed in the district for long, and it was some generations later that Punua, a descendant of Tamatea, settled in the Mōkai Patea area. Punua is reputed to have brought the talisman Kahukura with him. At this time Tupakihi, brother of Tuwharaukiekie and a descendant of Orotu and Tamatea, came to prominence. He was instrumental in arranging Ngāti Apa's migration from Taupō to the southern Rangitīkei district.

It was during this initial period of settlement that Hauiti arrived and permanently occupied the central Rangitīkei valley. He was a contemporary and cousin of Whitikaupeka and built several pā and kāinga throughout the tribal area, including Okahupokia and Omanono at Otara. Battles with Ngāti Apa and Ngāti Kahungunu were becoming more frequent, and these pa and kainga helped Hauiti defend the area from enemy forces.

Hauiti's Descent from Key Tūpuna

Ngāti Hauiti are a tribal collective based in the Central Rangitikei who claim descent from their tupuna Hauiti.

While through his mother, Hauiti's descent lines link him to Orotu and Kahungunu, his principal rights to the Rangitīkei were derived through his lineage from Ruaehu.

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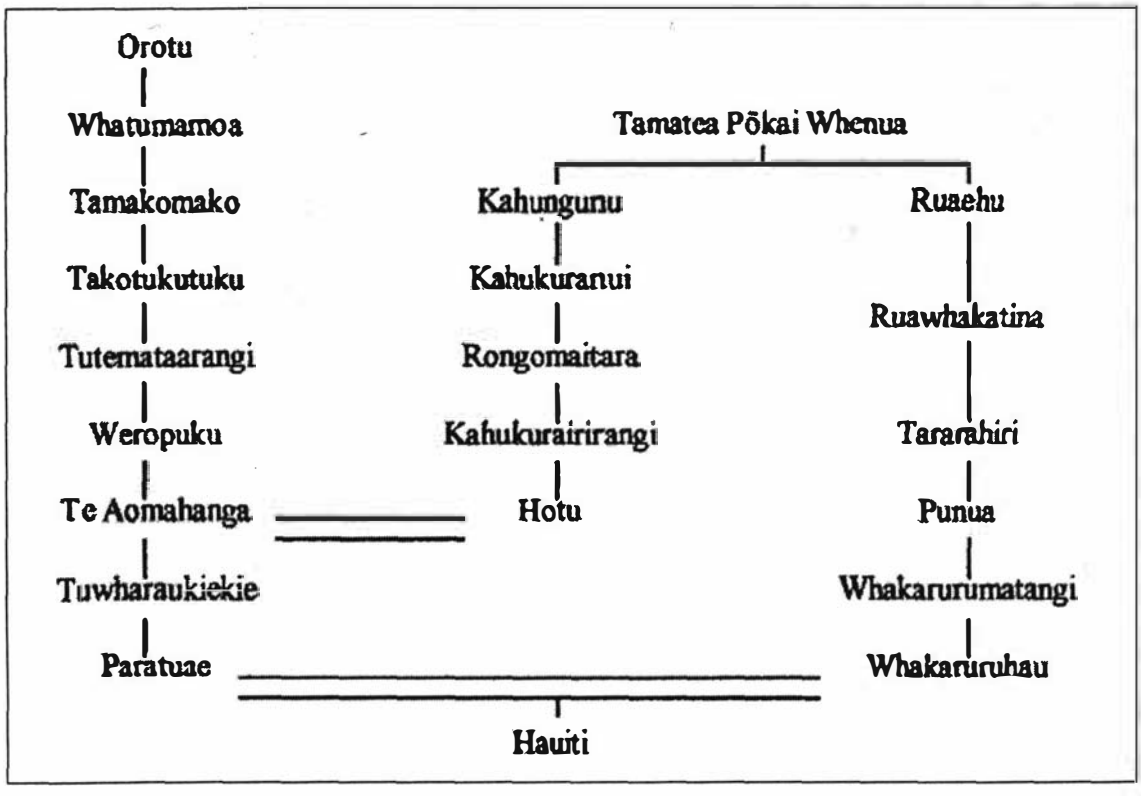
[15] Paper presented by Utiku Potaka at Utiku School Reunion 1997.



Ngāti Hauiti Whakapapa[16]

Consolidating Ancestral Rights[17]

Through ancestry, occupation, and military force, Hauiti was successful in establishing the traditional boundaries of Ngāti Hauiti as we know them today. However, his descendants could only legitimise the rights established by Hauiti through the continued occupation of the area.

Hauiti's daughter, Hinehuanoa, married Waihoto, a descendant of Mātangi, and was successful in strengthening Ngāti Hauiti's claims to the westward side of the Rangitīkei River. About the same time, her nephew Tamatereka, along with their relative Tutemohuta, was successful in repelling a superior force of Ngāti Kahungunu, who sought retribution for an earlier defeat.

Tautahi, the mokopuna of Hinehuanoa, married Hinemanu, thus creating a frail but lasting link with Ngāti Kahungunu. They lived primarily in the central reaches of the Rangitikei

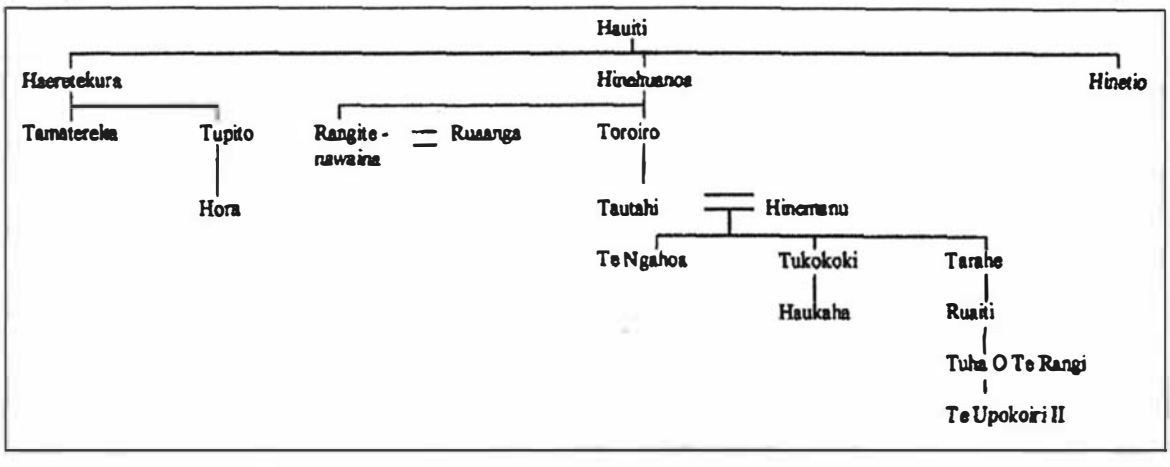
[16] Whakapapa Overview, te Rūnanga o Ngāti Hauiti, revised April 2002.
[17] This section is taken from personal manuscripts of Utiku Potaka.

and their descendants dominated Ngāti Hauiti affairs, with some eventually forming their own autonomous hapū (Ngāti Hinemanu).

Major Hapū of Ngāti Hauiti

Hauiti had three children who founded the hapū as we know it today. Some of their descendants became prominent in their own right and eventually gave their name to the focal point of a hapū such as Tamatereka and Haukaha. Collectively, these hapū form the iwi of Ngāti Hauiti.

Several whānau collectives affiliate to form a hapū. The following whakapapa outlines the major hapū, and identifies some of the tūpuna from the late 1800s who affilitated to them. The descendants of these tūpuna joined to form whānau groupings that are the basis of Ngāti Hauiti society. For example, Tapui Potaka was the partiarch of the Potaka whānau and Wi Ngatoa was the patriarch of the Ngatoa whānau.



Major Hapū of Ngāti Hauiti

Inter-tribal Conflicts[18]

At the start of the 19th century, the central and northern Rangitikei was controlled by a strong confederation of tribes consisting of Ngāti Tama, Ngāti Whiti, Ngāi Te Ohuake, Ngāti Hinemanu, Ngāti Te Upokoiri and Ngāti Hauiti: The Ngāti Hauiti people held or shared mana whenua over the following land blocks in the Rangitīkei: Awarua, Ōtamakapua, Mangoira, Ōtairi, Rangatira, Ōtumore and Taraketi. The people coexisted with their whanaunga of Ngāti Tama, Ngāti Whiti and Ngāti Te Upokoiri and related hapū

[18] Information for this section comes from the personal manuscripts of UK Potaka.

in the area between the upper reaches of the Rangitīkei in the north, the Ruahine Range in the east, south to Pourewa stream on the Rangitīkei River on the western boundary, and across to Pohangina on the southern Ruahine boundary.

During this period Ngāti Hauiti was in a state of social and cultural upheaval. Mounting intertribal pressures continued to be settled through intertribal skirmishes and battles. From the north came Ngāti Toa and Ngāti Raukawa seeking to acquire a new homeland in the Manawatū and Horowhenua districts. From the west came allied forces of Whanganui crossing to Heretaunga to settle disputes with Ngāti Kahungunu.

One battle occurred when Ngāti Apa and Ngāti Rangituhia besieged Potaka pā at Mōkai Patea. Ngāti Hinemanu and Ngāti Hauiti leaders, including Te Kea, Taami, Te Urukahika and Te Moeroa, son of Haukaha, drove off the initial attack. The attacks continued but the pā stood firm and eventually peace was made.[19]

Another battle was fought at Kai Īnanga, resulting from the desecration of tapu. Te Moeroa called upon his Ngāti Apa relatives to seek utu on Ngāti Tamakōpiri. While Ngāti Hauiti withstood the siege at Te Hue pā, Ngāti Tamakōpiri were routed at Kai Īnanga and returned to Taupō. Te Moeroa was forced into exile with Ngāti Apa for a time before returning to Otamakapua to live with Potaka in the 1840s.[20]

Following this battle, differences between Ngāti Hauiti and Ngāti Apa were resolved by an arranged alliance between Ruta Kau of Ngāti Hauiti and Ngāti Te Upokoiri and Kawana Hunia, the son of Te Hakeke, paramount chief of Ngāti Apa. The marriage of a high-ranking Ngāti Raukawa woman, Nihoiti, to Tapui Potaka of Ngāti Hauiti also provided added protection, of mutual benefit to all those iwi within the Rangitīkei takiwā.[21]

Members of Ngāti Hauiti were to provide assistance to Te Momo of Ngāti Te Kohera and Ngāti Raukawa, in the battle against Ngāti Te Whatuiapiti, in defence of his settlement at Roto A Tara at Heretaunga. Another party, including Potaka, went to the assistance of Ngāti Raukawa in the battle at Haowhenua.

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[19] Transactions of the NZ Insitute, Vol. XL11, 1909.
[20] 1886 Nga Pakanga o Awarua, briefing paper to the Māori Land court.
[21] WR Metekingi, personal manuscript.

With alliances cemented, peaceful co-existence within the Rangitīkei Takiwā was ensured.

Colonisation

Early Contact and Christianity

Until the mid-1800s the only contact Ngāti Hauiti had made with pākehā was through their visits to the Kapiti area where pākehā had begun trading.

However, this changed when the missionaries, William Colenso and Richard Taylor, entered the Rangitikei. They were readily listened to by Māori in the district and Renata Kawepo, who was of high rank amongst the hapū of Mokai Patea, including Ngāti Hauiti, helped spread the Christian message throughout the region.

The first Māori church for Ngāti Hauiti was built at the settlement of Pourewa sometime in the late 1800s. Significantly, the building was used as a boundary marker between Ngāti Te Upokoiri hapū and the remainder of Ngāti Hauiti. In 1915, Bishop Sprott consecrated Te Ohaki, a new church built at Rata. While members of Ngāti Hauiti built the church, it was an event for all people of the district and notices of invitation were sent throughout the country. Unfortunately, the church subsequently fell into disrepair and was dismantled.[22]

Land Alienation

By 1850 significant amounts of Wellington, Whanganui and Manawatu land had been sold. Manunui Te Heu Heu of Tūwharetoa and other principal chiefs could see that it would not be long before the land-hungry settlers would be looking towards the northern Rangitīkei, Mokai Patea and Taupo in their quest for more land for farming. This threat required new battles to be waged in the Native Land Court.

During the 1880s and 1890s the Native Land Court was actively establishing title to Māori land. It was up to claimants to provide evidence of the rights to land. Ngāti Hauiti's principal spokesperson, Utiku Potaka, and others such as Te Rina Mete Kingi, Ema Te Naihe, Wi Wheko and Paramena Te Naonao, repeatedly testified in court to protect the

[22] With two remaining churches at Rata there continues to be a religious bond between members of Ngāti Hauiti and Christian institutions. However, congregation numbers in both these churches are very small, and tend to be older members of the community.

interests of Ngāti Hauiti, while still trying to maintain some remnant of Māori customary rights through the establishment of land reserves. They were successful in claiming some 300 000 acres of land during this time. They gave evidence of rent occupation and listed the names of every site within the tribal estate.

Title was generally awarded to hapū representatives who were placed on the title as individual owners, as per government policy. Individual title enabled easy access by the government and settlers to purchase or acquire Ngāti Hauiti land. Between 1880 and 1910 significant tracts of tribal estate were alienated. For example, the Otamakapua Number One block, containing approximately 110 000 acres, was alienated to the crown as wastelands. By the early 1900s there remained only three major land blocks set aside for Ngāti Hauiti occupation: a small reserve at Te Hou Hou (present day Rata); a second at Otara, (straddling the Rangitikei and including present day Ohingaiti and extending to Rangiwahia at the foot of the Ruahine ranges); and the third major reserve, (south of Taihape to Utiku and extending through to the Kawhatau Valley).

The reserves that remained were given individual titles with lists of owners. From 1910 onwards the individual owners progressively sold portions of the reserves. Selling of land was facilitated because many owners were absent from the land and had formed stronger bonds with other tribes thereby reducing their affiliation to Hauiti. Money was also needed to support the new lifestyle introduced by the Pākehā.

By and large the only lands were retained were those on which tribal members were living. It should be noted that the tribal conflicts of the early to mid-1800s had greatly reduced tribal numbers, and by the end of the 19th century Hauiti numbered approximately 300 people. The predominant families remaining in the rohe were those farming the land, and included the Potaka, Hunia, Winiata, Te Rango, Pirere, and Merehira Te Taipu whānau. However, as the old rangatira died the strong kinship ties they had maintained began to crumble and more and more families began to sell their land and take up the manual labouring work the rural economy provided.

Responses to Colonisation

Addressing land claims issues in the courts was not the only strategy employed by Ngāti Hauiti to ensure survival during the period from the mid-1800s to the early 20th century.

Forming alliances to strengthen their individual position was always a key strategy for Ngāti Hauiti. However, these alliances were now being forged in response to the Crown's insistence on negotiating and recognising only the larger iwi groups. To maintain tribal influence, Ngāti Hauiti decided to affiliate itself directly with Ngāti Kahungungu, because of strong whakapapa links and the increasing emphasis given by the Crown to waka affiliation. However, the alliance with Kahangungu was difficult to sustain due to the geographical isolation imposed by the Ruahine ranges.

Other key strategic policy decisions were made in response to changes brought about by colonisation. Ngāti Hauiti's strategy for survival was to work with rather than against the inevitable changes. They realised the benefits of prosperity and wealth gained from modern technology, which usually meant the adoption of Western values and ways of living. The resulting effect longer term, however, was a loss of cultural identity and the eventual urbanisation of the iwi.

Education became an important issue for some whānau within the iwi. Leaders of these whānau recognised the need for the young people of the tribe to obtain the best possible education to ensure their survival within the world of the new dominant Pākehā culture. The success of the Māori Parliament set up in the 1880s, and the accomplishments achieved by the recently graduated Māori scholars, demonstrated to many iwi the advantages a good education could provide for individual members and for the future wellbeing of the whānau, hapū and iwi as a whole unit. Some Ngāti Hauiti whānau had been fortunate in being able to hold most of the land allocated to them as individual members, as a result of the Land Court hearings of the previous 30 years, and, due to the financial resources that farming of the land provided, were in a position to ensure as many young people as possible completed their secondary school education. Te Aute College, Turakina Māori Girls College and Queen Victoria College became the favoured secondary schools for the young people of the iwi. An example of the results this policy achieved was the case of Dr Louis Hauiti (Ike) Potaka, a grandson of Utiku Potaka, who, after a period of medical studies at Otago University, became a member of the Byrd Expedition to Antarctica in the 1930s.

World Wars

Ngāti Hauiti became involved in the First and Second World Wars. Both Wars were to take their toll on Ngāti Hauiti men in a number of ways. Although conscription of Māori men for active service during the First World War did not eventuate, many young Ngāti Hauiti men volunteered to serve in the Pioneer Battalion, which left New Zealand for active service in Turkey and Europe. Although some iwi members died fighting, most returned home safely. However, death was not the only manner in which whānau and hapū structures were disrupted during this period. The departure of many of Hauiti's young men during the Second World War depleted the already small population of iwi members. A further breakdown in this iwi structure occurred on their return. Many found it difficult to readjust to a civilian lifestyle and to settle back into their pre-war occupations in close proximity to their whānau. Their battle experiences were not easy to forget and the loss of so many of their friends and comrades during these battles had affected them quite dramatically. Alcohol became a symptom of this disruption. It was also difficult for some to adjust to the re-establishment of relationships within their whānau and hapū.

Moving to the City

A number of young Ngāti Hauiti returned servicemen found themselves in this position and it took many years for them to make the adjustment. The lifestyles they had experienced in overseas cities had also influenced the choices they would make, and several moved out of the district and into the city to take advantage of opportunities offered by larger centres.

A robust post-war economy provided many opportunities for employment, and the Welfare State provided housing finance for all who wished to build a home on any, except Māori, land. This availability of housing finance and restriction on building on multiple-owned Māori land, encouraged more Māori whānau to build and stay in the cities rather than return to their tupuna whenua

Depleted Resources

By the early 1960s virtually all the Ngāti Hauiti kaumātua born in the 19th century had died, and the communities around the marae were almost deserted. Little interest was taken in marae and iwi affairs, and with the deaths of so many kuia and koroua it was not long before marae life became spasmodic and, in the case of the Rata Marae, the marae committee disbanded and the wharepuni and wharekai were left to decay.

Very few whānau were now living close to the marae, and speakers of Te Reo Māori within the iwi were almost non-existent. The earlier encouragement for children of Ngāti Hauiti to excel in the pākehā education system had advanced at the expense of Te Reo Rangatira. Government policy over many years had led Ngāti Hauiti tūpuna to believe that there was no future for the Māori language and tikanga Māori and that children would experience difficulties in their education if they did not concentrate on learning the now dominant English language.

The disruption of Ngāti Hauiti infrastructure can partly be attributed to the effects of colonisation on the tribe. It is appropriate at this point to digress slightly and discuss the concept of colonisation.

Concepts of Colonisation

Smith (1999) tied the concept of colonisation to European imperialism and the role colonisation played in the economic expansion of Europe, which necessarily meant securing and subjugating the indigenous populations.

Bell (1996) placed the issue of subjugation of indigenous populations in a framework of creating new states and common national identity. She argued that once established, modern states deliberately set out to create their own national/ethnic cultures, which are created out of some form of violence; their successful creation depends on forgetting that violence:

> *This society (meaning New Zealand), in the late twentieth century is the product of the systematic attempts to produce a fictive ethnicity via the assimilation of Māori to a new European based ethnicity / nationality of New Zealander. That process of colonisation/ assimilation has involved a variety of forms of violence (military, judicial, economic, symbolic) all aimed at destroying the linguistic and cultural difference of the Māori way of life.* (p. 151)

This 'forgetting' is particularly pertinent to contemporary iwi and hapū development as we reclaim and restate the history of our colonisation.

Te Whati, McCarthy, & Durie, (1997) provided an example of how members of parliament viewed Māori in the mid-1800s and how the task of assimilation could be carried out. Parliamentary records identified a Mr Carlton as declaring:

> *The traditional Māori lifestlye could not be tolerated to continue, that things have now come to pass that it was necessary either to exterminate the natives or to civilise them.* (Te Whati et al., 1997: 153)

This civilisation took place in Native schools, in churches, and in the work place:

> *The long-term effects of these factors combined have been the continued decline of Te Reo Māori, a decline in Māori custom and lifestyle as the basis for identity formation, and an intergenerational discontinuity where knowledgeable elders have not always considered members of the next generation to have the necessary qualities to succeed them as repositories of knowledge of high value.* (Te Whati et al., 1997: 154)

Much of the history that has been taught to New Zealanders, in particular the violence between Māori and Pākehā, has been sanitised, with emphasis being placed on heroism and nobility of both sides and concluding with their ultimate unity. (Bell, 1996)

Bell (1996) provided examples of this 'social amnesia' continuing in the contemporary teaching of history in New Zealand classrooms. Not only is this evident in the teaching of social studies curricula to schoolchildren, it is apparent in a range of other contemporary contexts. At a recent hearing of the select committee on the Smokefree Environments Bill, a Māori woman showed a Goldie painting of her kuia smoking a pipe; however, the whānau history spoke of this kuia as a non-smoker. It was suggested to the select committee that Goldie had painted in the pipe afterwards, in much the same way one would paint in props or background. The result of this action not only reinforced the image of Māori as smokers but also imposed a European view of Māori that denied the reality of the situation. Broughton and Lawrence (1993) provide many examples from the mid-1800s of postcards and cartoons where tobacco use by Māori was used to convey a sense of racial

and cultural inferiority, and where Goldie paintings were lampooned by cartoonists of the time with the pipe and enlarged lips becoming focal points in the cartoons.

The reclaiming of history by Māori is often met with strong Pākehā backlash. The Honorable TarianaTuria, Associate Minister of Corrections, Health, Housing, Māori Affairs and Social Services and Employment, spoke of the role of the media in perpetuating a negative view of Māori, and the role of the media in the colonisation debate, in a speech to the Australasian Society for Traumatic Stress Studies on Trauma and Colonisation, in 2003. She stated:

> *Election year is always a traumatic time for tangata whenua, it is the year when "the bash" in the media intensifies as politicians vie for votes hoping to switch on prejudicial buttons.* (p. 2, speech notes)

A challenge was issued to the media at the conference, and to the wider institution of the media:

> *Can they honestly say they have been working in good faith given the hysteria they generate each time I mention colonisation and the history of this country*? (p. 3, speech notes)

Smith (1999) described the subtle nuances of colonisation. In New Zealand's case this approach was a result of previous British encounters with indigenous people elsewhere, and from this previous experience more sophisticated rules of practice were developed. For example, in the case of Ngāti Hauiti, land was not confiscated, the iwi was not declared rebellious or invaded militarily, and land was lost in large tracts through legislation.

Like many other iwi, Ngāti Hauiti suffered a range of losses as a result of colonisation and the adoption of European values. These included loss of land either through voluntary land sales or acquisition under European law; loss of language; loss of symbols and institutions that strengthened and maintained Hauititanga; loss of tribal identity and tribal members as a result of urbanisation; and loss of autonomy and mana. Ngāti Hauiti was quick to adopt western values, including Christianity, which further hastened the effects of colonisation.

The debate around colonisation and the effects of colonisation are central to iwi hapū development. The understanding of Ngāti Hauiti's history of colonisation and its relationship to the contemporary situation is critical if iwi members are to approach the issue of revitalisation with an informed understanding. Turia (speech notes to Colonisation and Trauma Conference, 2003) stated that if Māori are to recover from the effects of colonisation then we must tell the stories of the impact of colonisation in the 19th century and continue to stress the effect of that behaviour. That is not to say we should dwell on the injustices, as this is as disempowering as the injustice itself. Rather it is a matter of acknowledging the past and how it contributed to the present, gaining redress for past injustices, maintaining vigilance at all times about the current forms of colonisation, and moving forward with knowledge and authority.

Restoration of Ngāti Hauiti

This section will provide a stock-take of what remained of Ngāti Hauiti in the late 1900s and discuss how iwi development is being constructed in the year 2002.

As previously mentioned, by 1970 tribal identity had been largely lost, numbers affiliating with Ngāti Hauiti were small, most tribal members lived outside the traditional tribal boundaries, the number of tribal members able to converse in te reo was dangerously low, tribal institutions and structures were virtually non-existent, and the tribal estate was non-existent. It is also important to review the wider community in which Ngāti Hauiti is located and discuss briefly how this community is situated in the contemporary context.

Wider Community Context

The wider community of Central Rangitīkei is largely made up of farming families, both dairy and sheep. There are no major industries within the tribal boundary, with most people travelling to find work. The small townships of Hunterville, Ohingaiti and Mangaweka are the only settlements of any size within the boundary, and the largest of these is Hunterville. This township has a Post Shop, a hotel, a restaurant, two garages and a few shops.

Townships have been severely affected by the gradual decline in the rural sector over the past decade and have become more reliant on local small businesses that export goods and services outside the district. Unfortunately, the small industrial sector has also been

affected by the national economy with either closures or downsizing of the already fragile sector.

The resulting effect is a depressed local economy, overshadowed by its neighbours in the Manawatū and Whanganui. With a high number of Māori youth seeking employment, there is a growing concern about unemployment in the district.

Catalysts for Change

Several events came together in the late 1980s to facilitate the revival of Ngāti Hauiti. These were: the development of Te Kōhanga Reo movement and the establishment of three kōhanga reo within the rohe or tribal boundary; the strengthening of whānau involvement in Hauiti development and the restoration of several marae; the devolution policy outlined in Te Urupare Rangapu and the consequences of this policy on Ngāti Hauiti Rūnanga development; the availability of leadership and the acknowledgement of this leadership by whānau and hapū; and finally the support of key kaumātua and kuia at a critical stage in the restoration of Ngāti Hauiti.

All these were happening in a climate of more general, positive Māori development throughout the country. Themes from the decade of Māori development included: the Treaty of Waitangi; tino rangatiratanga; iwi development; economic self-reliance; social equity; and cultural advancement. These themes were reflected strongly in Ngāti Hauiti restoration. It is important to outline some of these developments in detail as they provide the structure for future initiatives, including the tobacco control initiative being developed in this study.

Identity as Ngāti Hauiti

Whānau development was seen both as an integral component in wider iwi development and as an essential starting point in the restoration of Hauititanga. The emphasis was on wānanga to inform whānau of whakapapa links and whenua links. Starting with a large Potaka whānau hui at Parewahawaha Marae in 1979, whānau hui are a current key feature in strengthening identity as Ngāti Hauiti.

Tribal affiliation, and an acknowledgement of this in the census survey, is being nurtured in a range of ways, including: whakapapa wānanga; *Te Karere*, a newsletter for Ngāti Hauiti

members; and tribal activities such as the biennial waka hoe, taonga exhibition, and tribal dinners. According to the 2001 census the tribal population of Ngāti Hauiti is 1002:[23] 82% of Ngāti Hauiti members live outside the tribal boundary; 47% live in the Whanganui-Manawatū region, with the next highest concentrations being Wellington (135) and Auckland (105). Most of Ngāti Hauiti members live in urban areas (80%),[24] with nearly eight out of ten living in areas of population of 30 000 or more. Ngāti Hauiti aged under 15 were the most likely (24%) to live in rural areas. Many Ngāti Hauiti living outside the tribal boundaries have stronger affiliation to, and recognition of, other iwi they whakapapa to. Getting members to acknowledge and reclaim their Ngāti Hauiti whakapapa is an ongoing task and requires many hours of research into whakapapa so that information is presented as accurately as possible. However, some progress is being made in the number of people identifying as Ngāti Hauiti, as witnessed by changes in the census count from previous years.

Cultural Capital

With the development of Kōhanga Reo throughout the country during the early 1980s, a renewed awareness of things Māori took place. Three Kōhanga Reo were established within the Ngāti Hauiti rohe: Te Kōhanga Reo o Te Katoa at Rata, Te Kōhanga Reo o Te Whakanae at Utiku, and Te Kōhanga Reo o Otamakapua at Ohingaiti. As a result, the children and grandchildren attending these kōhanga reo were asking questions of their parents and grandparents about whānau, hapū and iwi matters, for which the answers were not always readily available. The problem of not knowing the answers to many of the questions became a catalyst for change and prompted some members to return to study; some gathered information from older whānau members who might remember such matters; and others became involved in the Kōhanga Reo movement itself.[24]

Three marae in the Central Rangitīkei were also restored and are used frequently for a range of activities that strengthen our identity as Ngāti Hauiti. Marae committees have been established to maintain the marae and there are generally sufficient numbers of people to carry out those duties and responsibilities associated with the marae. However, a succession plan will need to be implemented to ensure those older members of the iwi

[23]Calculations undertaken by the iwi, based on hapū affiliation, puts the potential number of iwi members at around 3000 members.
[24] Unfortunately, one of the Kohanga Reo is now closed due to declining numbers.

currently holding the knowledge and skills to maintain the kawa and tikanga pass on this knowledge to others and ensure younger iwi leadership is nurtured.

A number of tribal members are involved in learning te reo Māori and mātauranga Māori and are being encouraged to be involved in iwi activities. In 2001, census data indicated that 29% of Ngāti Hauiti could hold a conversation about everyday things in te reo Māori, which was higher than for all Māori (22%).[25] This figure seems particularly high and does not reflect my understanding of the current situation. The figure may be due to people overestimating their ability or it may be that those directly linked to iwi development are not aware of a potential human resource available to help with cultural development. Tikanga hui are held occasionally to discuss specific tikanga issues and to confirm the kawa for each marae. And one member of the iwi has waiata practices in her home in the evenings to ensure there is a group who can sing pātere and waiata specific to Ngāti Hauiti.

A small group, therefore, holds the cultural knowledge for the iwi, and this group is highly dedicated and passionate about working for Ngāti Hauiti development.

Iwi Leadership

There is a range of leadership within the iwi that supports ongoing development. For example, there are individuals who take a leadership role in marae management. There is strong kuia and kaumātua leadership, with several individuals actively involved in a range of iwi activities. There are also Rūnanga leadership and iwi organisational leadership. To acknowledge the contribution of these people and the continued whānau support in the contemporary development of Ngāti Hauiti is important.

The iwi has also been fortunate to have a young man who took a key leadership role early in the development and, with support from kuia and kaumātua, was able effectively to initiate many of the developments that are now being implemented.

This person operates in a democratic manner and tries to ensure that the communities of whānau and hapū, as represented at a rūnanga level, are active participants in decision-making. He is able to be decisive when necessary and holds particularly strong (and

[25] Information from Iwi Profiles, New Zealand Statistics, 2001 Census.

informed) views on iwi development. These views can be influenced if others can present an adequate reason why things should be otherwise. He has a mix of skills, knowledge and attributes that have been beneficial to the iwi, including academic and practical knowledge of Māori development issues; policy development skills; administration and management skills; te reo; knowledge of whakapapa and tikanga; strong whakapapa links and until recently he lived within the tribal boundaries.

While he is in a sense the acknowledged leader for the iwi,[26] this has not been formalised in any obvious manner, other than he holds management and governance positions in the iwi.

There is an obvious risk in the current situation of relying heavily on one person to lead iwi development. However, succession strategies have been put in place and others who show potential to help in a leadership role are being provided with opportunities to develop into these roles.

Policy Frameworks and Infrastructure

In 1988 the Minister of Māori Affairs released a new policy initiative, Te Urupare Rangapu, aimed at strengthening distinctive Māori social institutions such as iwi and hapū, and actively developing these structures to enable them to implement and administer government programmes. Certain criteria needed to be met by iwi wanting to participate. For example, they needed to be a legal entity with whom contracts could be made; they needed the capacity to administer and account for public monies; and they would need to agree to participate in particular training and management programmes. To enable Ngāti Hauiti to participate in the initiative it was decided to join with Ngāti Apa and have representation on Te Rūnanga O Ngāti Apa. This was not the first time in Ngāti Hauiti's tribal history alliances were forced on them by the Government policy of the day. When the policy was not fully implemented Ngāti Apa Rūnanga had to re-evaluate its function and role, and as a result, review the hapū representation on this committee. As a consequence of this review, Ngāti Hauiti withdrew their representation in early 1990.

This change stimulated the leadership of Ngāti Hauiti to rethink the type of structure needed to guide their tribal development into the future, without the constraints of

[26] This acknowledgement is most obvious in the way iwi members defer to his judgement on issues and rely on him to make key decisions about iwi development

Government policy. Several iwi leaders met to plan the structure needed in the long term, and how it might look. Some key principles were used in the development of the governance structure. Traditional whakapapa and whenua links were to be activated and used as the basis for organization and representation, and the core values of mana, rangatiratanga, kaitiakitanga, manaaki tangata and whanaungatanga were confirmed.

Te Rūnanga o Ngāti Hauiti was established in 1995 with a clear purpose to develop and protect everything related to Ngāti Hauiti whānui. The role of the Rūnanga was to provide leadership through governance, which involved giving guidance and direction. It would also provide a collective and unified voice to ensure the enhancement and preservation of Hauititanga. The Rūnanga would focus its activities in three key areas: tribal development; whānau and hapū development; and service provision at an iwi level where necessary.

Because the Rūnanga was not a legal entity, unnecessary in terms of meeting the tribal needs, a separate organization, Te Maru o Ruahine Trust (TMORT), was established in 1996 to provide service delivery to the whānau of Ngāti Hauiti. This clear delineation of roles both allowed the rūnanga to concentrate on tribal development, free of the constraints of crown and funder expectations, and also separated the functions of governance and service provision. At the same time it provided a legal entity that could receive government funding. Initially, TMORT provided an integrated and holistic approach to whānau well-being, focusing on cultural affirmation, health and social well-being, economic prosperity, and environmental management. As the environmental arm developed expertise and started to generate income in its own right, and as TMORT, with charitable Trust status, was unable to hold assets, it was decided to establish the Rakautaonga Foundation. This newest entity has the following functions: asset holding; economic planning; commerce and employment; and environmental services.

Several policy documents[27] have been written to guide iwi development. *Te Uru Koea O Puanga* (Draft), an intergenerational strategy for Ngāti Hauiti development, *Kaupapa Taiao*, the environmental policy statement, and *Puau Te Oranga*, an integrated approach to strengthening the wellbeing of Ngāti Hauiti whānau and hapū, are all substantial key policy documents driving the development of Ngāti Hauiti.

[27] The leadership team of Ngāti Hauiti has taken responsibility for developing these policy documents, and some are still in draft and require ongoing consultation with wider iwi whānau.

Te Uru Koea O Puanga[28] is the overriding policy document that guides Ngāti Hauiti development and informs all other policy. It has been designed in a manner consistent with Ngāti Hauiti views, thoughts and aspirations. Extensive consultation was undertaken and feedback sought from as many members, whānau and hapū as possible.

At the core of the strategy is its inter-generational nature. It identifies and uses a generation "span", which is the period that any particular group of people has control and influence. By linking the spans, the strategy becomes inter-generational.

Another key feature of the framework is the use of whakapapa as a means to chronicle history through the deeds and exploits of Hauiti tūpuna. In a similar manner, it is possible to suggest the future directions of present and future generations by setting development themes. These themes give the broad direction towards which a generation may work and gives possible areas of activity (generation characteristics) on which they may focus their attention. These characteristics are only intended as guidelines, as it is the responsibility of each generation to plan and achieve their own development by establishing a Generation Plan.

The final feature of *Te Uru Koea O Puanga* is that the strategy is designed for all members of the iwi, including individuals, whānau, hapū, or any group affiliated to Ngāti Hauiti. There is an expectation that, in one way or another, everyone will be working towards achieving the strategies for their respective generation.

The overarching purpose and values are captured in the section 'Nga Whetu Arahi', the guiding stars.[29]

Traditionally, whakatauki are used as mediums to impart knowledge, advice and wisdom. The following whakatauki encapsulates the vision of Ngāti Hauiti tūpuna and helps guide the iwi, hapū and whānau in a contemporary society.

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[28] Draft policy document, Te Uru Koea Puanga, Te Rūnanga o Ngāti Hauiti.

[29] Stars were used as navigational aids to cross the ocean currents of Te Moananui a Kiwa. The stars in this context figuratively signpost the guidance and direction required to achieve our desired outcomes. Hence the first sail is called 'Ngā Whetū Ārahi' or 'The Guiding Stars'.

Kia mau ki te ōha a o koutou tūpuna Te Tiriti o Waitangi te ture tangata te ture Atua I puta ai tana ki te whaiao ki te ao mārama	Heed the revelation of your ancestors. The Treaty of Waitangi, the law of people and the law of God from whom this saying came: "Seek the world of light and understanding"

The collective purpose, the enhancement and preservation of Hauititanga, adds clarity to the whakatauki and is used as a means of focusing joint energies.

As previously mentioned, the core values that drive the strategy are Mana Whenua Mana Tangata, Rangatiratanga, Kaitiakitanga, Manaakitanga, and Whanaungatanga.

Mana whenua, mana tangata refers to Ngāti Hauiti authority and prestige over the land, waterways and people. This also implies duty and obligation. Rangatiratanga refers to Ngāti Hauiti chieftainship passed down from Hauiti tūpuna and guaranteed under the Treaty of Waitangi. It includes rights of self-determination and self-governance that advance the well-being of Ngāti Hauiti. Kaitiakitanga essentially embraces the responsibility for protecting and caring for all those things that relate to Ngāti Hauiti. Manaakitanga is about the caring and nurturing of people. It places a special responsibility on showing hospitality to all people, while manaaki manuhiri places particular emphasis on ensuring other people resident within the takiwā are cared for. Whanaungatanga relates primarily to the kinship relations between Ngāti Hauiti whānau and hapū that are expressed through aspects of whakapapa and whenua. In a broader sense, whanaungatanga also refers to inter-relationships between Ngāti Hauiti and other hapū and iwi.

The strategic statements are intended to identify and highlight the ways in which Ngāti Hauiti will work, and this part of the document is headed 'Nga Ara Whakamua'.[30]

[30] In modern society, we are faced with experiencing an increasing number of complex and varied issues, thus the second sail is called 'Ngā Ara Whakamua' or 'Pathways Forward'. It refers to the multi-faceted choices we make that ultimately influence our future.

Nga Ara Whakamua-strategic Statements

Working proactively and positively	Integrating services and technology
Progressing self-reliance	Fostering leadership
Improving well-being	Empowering hapū
Seeking inter-generation development	Strengthening relationships
Advancing collective rights & responsibilities	Building unity of purpose

Five key issues were identified that spanned generation. While they have been described individually in the document to give clarity, they are inherently interrelated and should be viewed in that light.

The issues are infrastructure and capacity, cultural and spiritual affirmation, social well-being, economic prosperity, and environmental heritage.

Capacity involves providing sound infrastructure and processes that encourage ability. Among other things, the area addresses the issues of organisational structure, leadership, planning, people development, process and policy management, and information technology.

In the policy, cultural and spiritual affirmation is defined as the confidence and assertiveness of knowing and living by the cultural values and beliefs of Ngāti Hauiti. Among other things, this area focuses on gaining a better understanding of Hauiti history, turangawaewae, whakapapa, tikanga, values and beliefs.

Social well-being accounts for the diverse social and welfare needs of Ngāti Hauiti. Among other things, the area addresses issues of health, education, housing and welfare.

Economic prosperity involves rebuilding the economic base and having sufficient resources to sustain the whānau, hapū and iwi. Among other things, the area addresses the issues of economic development, wealth creation, and employment and income generation.

Participation in the management of the natural environment has historically been the domain of central and local government. However, since the introduction of the Resource Management Act 1993, there has been greater opportunity for tangata whenua to participate in environmental matters. Environmental heritage involves the care and protection of the natural environment and highlights the responsibilities as Kaitiaki. Among other things, the area addresses issues of resource sustainability, management and protection.

In conclusion, Ngāti Hauiti can be considered as a distinct community possessing a number of distinctive characteristics. The community has been actively redeveloping itself under a Hauititanga framework for the last decade. It has strong leadership and, for a smaller community, it has an effective organisational infrastructure with a range of long-term strategic policies that can guide development. The members actively identifying with the community are small in number and many of them live outside the tribal boundary. However, members are drawn back into the community for various development activities and these activities can be useful for the tobacco control intervention. The iwi has good links, not only with neighbouring iwi but also with a range of national and local organizations. These relationships will be used to strengthen the community in the intervention phase of the tobacco control programme. There is a strong sense of whānau identity in the study group and this extends to close whānau networks outside the immediate household. It will be necessary to link whānau networks to the broader level of hapū and iwi during the intervention phase if we are to use some of the tobacco control framework concepts successfully.

Community as Health Promotion Context

This chapter has attempted to develop a conceptual understanding of the community as a context of implementation. Community can be described as a specific group living in a defined geographical area who share a common culture, are arranged in social structure, and exhibit some awareness of their identity as a group (Nutbeam, 1986).

This chapter has discussed community identity as Ngāti Hauiti members and the approaches the iwi are undertaking to strengthen that identity. Whānau members have started to become involved in this study as a collective group and those of us involved in the research hope a feeling of local belonging and identification may influence participation in the intervention itself. Nilsen (1996) argued that where there are feelings of local belonging and collective identification, greater engagement in health promotion and disease prevention activities might occur.

The separate issue of a global identity as youth will be explored in the last chapter. However, it is important to identify here that the confusion created by the flow of media images, signs, and symbols leaves individuals with no traditional perceptual schemes for interpreting their social environment (Nilsen, 1996). But as Nilsen points out, the confusion itself can be harnessed as a source of local mobilization.

A number of articles have been written on the attributes necessary for a community context to work effectively as a health promotion intervention site. Some of these attributes include: the need arising from the community, organisational flexibility, community decision making, democratic leadership, healthy conflict between community groups, clear direction of where community is heading, strong community identity, sustainability, and a passion for social change (Jackson, Mitchell, & Wright, 1998; Kinne, Thompson, Chrisman, & Hanley, 1989; Labonte, 1993).

The strengths this community brings to the intervention and the risks it presents in effectively implementing the framework will be discussed in detail in the final chapter. However, there are some issues that can be briefly highlighted here. The strengths presented by this community include:

- robust plans and strategies that can be used to guide the wider task of cultural restoration and strengthening identity;
- ability for these plans to help the community know where it is going;
- an effective organisational infrastructure for providing potential tobacco prevention services;
- the ability to maintain these services on a longer term basis;

- a small team of loyal committed and passionate iwi members who believe in social change;
- academic research and strategic management expertise;
- effective democratic iwi leadership that can be used to mobilize the community; and,
- good links and relationships with a range of internal and external organizations that can support future developments of the tobacco control intervention.

Weaknesses and threats include:

- a relatively small tribal population making human resource an issue;
- geographically widely dispersed tribal population making cohesion and a sense of collectivity difficult;
- limited economic resource;
- iwi development strategies that are not strongly supported at a grass roots level;[31] and,
- limited cultural capital.

[31] An evaluation of TMORT health and social services revealed that support at a grass-roots level needed to be strengthened by greater awareness of services and initiatives undertaken by the iwi, and greater participation by whānau.

CHAPTER NINE

THE WHĀNAU MEANING OF SMOKING; ANALYSIS OF THE QUALITATIVE INTERVIEWS

Bad for Me and Good for Me

This chapter presents the findings from the whānau interviews and includes some data gathered from opportunistic interviews and rangatahi hui. The qualitative interviews[32] were conducted using key themes for exploration: descriptions of smoking, context of the initiation, whānau responses to smoking, access to smokes, whānau rules around smoking, what influences smoking once established, whānau knowledge of effects of smoking, whānau understandings about why more Māori smoke, and ideas for prevention of uptake from an iwi perspective.

The themes were developed from the literature search into youth smoking, in particular the data on initiators and determinants of smoking in youth. In addition, information was sought from participants to help my understanding of Māori youth and smoking in a whānau, hapū and iwi context, to inform future interventions.

The interviews were semi-structured, with several open questions included under each theme.[33] The interviews were carried out in the home setting and lasted about an hour.

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[32] Methodological detail is described in Chapter Three, including sample selection, data gathering procedures, data collection and analysis.

[33] The type of questions asked are included as Appendices One and Two.

The interviews were transcribed and data were analysed under each theme. The following data are taken from transcripts of 11 whānau interviews, consisting of 27 individuals: 15 rangatahi (4 males, 11 females) and 12 adults.

The analysis of the data will inform the comprehensive tobacco control framework for Ngāti Hauiti, and key themes emerging in this chapter will be carried forward and discussed in more detail in the next chapter.

Descriptions of Smoking

Three themes emerged clearly in whānau descriptions of smoking: the sense of smoking being a progression; there were judgments about how well one smoked; and distinctions were also made between social smokers and others.

Smoking was described by both parents and rangatahi as a journey or as a progression from one point to another, with starting out consisting of trying it out:

Tried out at 13 (17-year-old female);
I had the odd puff now and then, I didn't start properly (15-year-old male);
and progression marked by some sense of seriousness or regularity about the behaviour:
Took it up fully; fourth form it was regular (18-year-old female);
I didn't start hard out till about 12 (15-year-old female).

Hard out or regular could mean anything from one to up to 10 cigarettes a day. However, hard out was consistently marked by the more regular nature of the smoking.

While the results from this study tend to confirm the chronological process of initiation in Māori adolescents described by Glover (1999), these results should be viewed with caution as there is also much variability and transience in initiation and maintenance of youth smoking (Lloyd & Lucus, 1998), and studies that describe a single point in time with categories of smoking that do not capture the complexity of youth smoking may not provide the complete picture.

Whether this regularity is associated with increasing nicotine dependence was not established by this study. However, a recent study into adolescents' perspectives on the

need to smoke found that tobacco dependence extended beyond nicotine addiction and proposes that the developmental pathways for increasing tobacco use may be associated with pathways of dependence related to social, emotional, and adolescent developmental needs (Johnson et al., 2003).

In describing smoking, two other themes were repeated in the interviews: one was the issue of "real" smokers; the other was "social smoking".

In the real smoking category there was a sense of judging how well you smoked. The term *humbug smokers* was used by more serious smokers to describe smokers who:

Don't do it properly;
I didn't know how to smoke properly (16-year-old female);
She's only just playing around (mother of 14-year-old).

The issue of how well one smokes or "judging the authenticity of smoking" was explored in a recent study of smoking in the media by McCool, Cameron, & Petrie (2003). The teenagers in the study judged authenticity of smoking in film media and were aware of smoking as a performance. Awkward smokers were readily identified as novices, still to develop poise in the smoking performance. Clearly this same awareness of authenticity applies in real life situations. The issue here is that there may be pressure from others to learn to smoke 'properly' to be part of the group, hence creating a greater risk of embedding in the behaviour.

There was also mention of social smoking as opposed to other smokers. Social smokers were typically described as not having their own smokes or not purchasing smokes for themselves but rather relying on others to share smokes. Social smoking was something you did with mates when you were out in groups, and often one smoke was shared around between many. Social interaction may have been enhanced by the physical sharing of a smoke as well as by the conversation that has to be started when asking for a smoke.

The influence of social situations on the consumption of cigarettes is widely documented in the literature; however, what is not widely documented is social smoking as a category of smoking status in adolescents. The closest description would be that of hesitant smoker

(Lloyd & Lucus, 1998; Nichter, 1997) or occasional smoker. There is support in the literature for more research into the contexts in which teenage smoking occurs and into the meaning of smoking across social environments (Nichter, 1997).

Johnson et al. (2003) explored the social aspect of smoking as a stage of tobacco dependence in youth. The informants in their study indicated that young people who are socially dependent on tobacco do not necessarily smoke because they crave or desire nicotine, but rather because of their perceived need to use cigarettes to manage social situations and to maintain their social connections.

Context of Initiation

Age of Uptake

Most of the rangatahi interviewed identified first trying smokes between 9 and 10 years of age, but not seriously taking it up till intermediate age (between ages 11 and 13). A common response was:

Started at 10 and hard out at 12 (16-year-old female).

This research tends to contradict other research on age of initiation in Māori youth (Broughton & Lawrence, 1993; Glover, 1999; Health Sponsorship Council, 2000; Reid & Pouwhare, 1991) as it places the average age of regular smoking at slightly younger than previously mentioned in the literature, for example, age 11 to 13, as opposed to 13 to 15 as claimed by Reid and Broughton, and age 16 in Glover's study. However, this result needs to be interpreted in the context of the small sample size and the particular attributes of the sample.[34] The results cannot be generalised or taken as anything other than an indication for this community.

Two separate interviews identified the extremes of the age range in this study:

[34] There is a gender imbalance towards females in the study group, and most participants live in a small provincial town or in a rural setting.

We were living in a small place and my daughter had a group of mates... there was a gang of them... 5 to 6 of them, and they were all quite heavy smokers, and they were aged between 5 and 7 (30-year-old mother);

I was quite late ...16 when I took it up (21-year-old female).

There is evidence that initiation between the ages of 11 and 14 is accelerated by availability or the presentation of opportunity (Whalgren, 1997). In Whalgren's study, ethnic differences in initiation rates were diminished when ease of cigarette acquisition was taken into account. This is very pertinent to the initiation rates for Māori as access to tobacco and the social norms associated with smoking, may be less prohibitive than in other groups of the population.

Accessibility is not just about the availability of cigarettes but also about the structural and social norms operating in a community that supports smoking. A recent study that explored contexts of smoking for youth concluded that accessibility could be understood in terms of the ways in which the rules and resources manifest themselves and are employed by populations. For example, while one community examined had a significant number of resources[35] restricting smoking, adolescents interviewed did not feel, despite the resource data, that there was much possibility of remaining a non-smoker (Frohlich, Potvin, Chabot, & Corin, 2002). This implies accessibility is not just about the goods themselves but also about the capabilities or choices available to act on the goods. It is about what people can actually extract from the goods, given their particular needs, abilities and desires. In this study, Māori youth aged between 9 and 12 were asked whether they thought they would be smokers when they got older. The majority said they would, or indicated they would like to try it out. This desire to smoke is still evident in an increasing climate of smoke-free social marketing targeted at Māori youth and resources that are aimed at discouraging uptake. What this may indicate is that the social norm to smoke in this group, including the relatively free access to tobacco and strong role modelling in the whānau, is stronger than any resources targeted towards non-smoking.

[35] Resources in this context means symbolic or material resources that either promote or impede smoking, for example, non-smoking zones and cigarettes sales are considered resources.

Context of Initiation

The following questions were asked to find out more about the context of initiation: What was happening? Who were you with? Where were you? Several themes emerged as predominant in the responses to these questions: mates, cousins and wider whānau were highlighted as the social context; school as a physical context; and a range of reasons were given for taking up smoking, for example, the thrill or buzz, being part of the group, being cool, and trying it out as early reasons for uptake.

Social Context

There is some discussion in the literature regarding the different influences on the uptake of tobacco in adolescents, particularly the effect of family and friends or peer groups on uptake (Glover, 1999; Lloyd & Lucus, 1998; Reid & Pouwhare, 1991; West, 1999). Glover's study (1999) had initiation for Māori associated equally between the home environment or family members and peers and school environment, Reid et al. (1991) cited similar research implicating whānau in the uptake of Māori youth and smoking. It is important to differentiate between whānau members as a whole and whānau members who, because of being a similar age or slightly older, are members of your peer group. My study would suggest the influence of peers, including cousins and sisters or brothers, at the actual time of initiation is greater than a general whānau influence. I would propose that for this particular community, whānau influences provide the backdrop for a smoking career; however, the actual act of starting to smoke is initiated in one's peer group (including cousins, brothers and sisters), and occurs predominantly outside the home environment.

The concept of whānau as a backdrop to a smoking career includes strong role modelling of smoking, in particular access to tobacco products and teaching how to use tobacco products:

I used to roll smokes for Dad when I was little...I think 8 or 10 he taught me to roll smokes (45-year-old female).

It is also possible children learn to associate tobacco with stress relief as they observe some of the ways tobacco helps their parents cope with everyday stresses.

There were many examples given by participants of smoking initiation occurring within a peer group environment and of the expectation that one would smoke to be part of the group:

We used to smoke heaps at boarding school.... We did it to break the rules.... if everyone smoked you were expected to smoke....it was a general acceptance (20-year-old female).

Started when I was about 8 ...Mum had some girlfriends that had daughters bit older than us, we used to go by the stream and puff up. ...it was only 'cos they were smoking why I started... I didn't start hard out till about 12 (at least daily smoking) then by the time I got to high school I was smoking a packet a week...they moved out from around the corner so I didn't have it so much (18-year-old female).

Whalgren's (1997) study showed those living with a tobacco user and lacking friends who avoided tobacco users were associated with greater rates of initiation. There is some evidence that family influences are restricted to the younger age groups, e.g., 11 to 14 (Oygard, 1995), and that influence on uptake after age 16 is relatively slight (Krosnick, 1982; West, 1999).

Various reasons are proposed in the literature for the role of peers and smoking initiation: providing models for imitation (Whalgren, 1997); facilitating social interaction, reciprocity and sharing as a means of establishing a relationship (Nichter, 1997); providing a sense of togetherness and signifying a distinction from other groups (Broughton & Lawrence, 1993; Koivusilta, Rimpela, & Rimpela, 1999). I believe all these reasons hold resonance for Māori youth, in particular the idea of sharing and group belonging:

I was about 10 (cousin in the background laughing and saying she had showed her how to smoke; everyone laughing) *started at home, just me and my Mum ... got them from her and anyone... smoked with friends... all girls... all Māori... did it with cousins... it was cool just going for a smoke* (15-year-old female).

Influence from my cousins... we all wanted to hang around... they were older...we did what they did, it was just the hit... we got a buzz out of it (18-year-old female).

Started at 9... whenever I could get my hands on a cigarette... pinched them from Mum's packet and smoked them at school... me and all my mates smoked... about ten of us... we'd go down to the school and smoke (16-year-old male).

Much of the language describing smoking initiation and maintenance indicates a sense of identity as a group and smoking as a marker of belonging and mutual friendship:

Only me and Dad that smoke... my Mum's sister smokes... she's my smoking buddy (16-year-old male).

I was considered a country bumpkin, green you know... they thought I was a bit different 'cos I had Pākehā friends so they called me stuck up... stuck up Māori girl they used to call me ...I hated it ...couldn't stand it ...I wanted to be friendly with them ... yeah, for me it was about trying to get in ...in to the fold, you know, being part of their group (40-year-old female).

Physical Context

This study highlights the association between school and the initiation and maintenance of smoking behaviours. A significant number of the participants interviewed stated they had started smoking at school. This further reinforces the idea that initiation takes place within one's peer group, as school is a major part of group adolescent life both in terms of the time spent at school and the socialising influence of the school environment. When questioned about where at school this happened participants replied, on the field, behind the sheds and at the bus stop. School for some was a place to smoke:

They're not really going to school for education or worrying about they haven't got their maths and that, they're just going there saying, oh gees, I've got, like, space, I'll go hang out with my mates and smoke (23-year-old female).

Participants were also questioned about how the school responded. It was interesting to note that participants felt it was generally fairly easy to smoke at school and only those teachers who were more experienced or held stronger views intervened:

Teachers never bothered us... the stronger teachers came over and told us off (15-year-old male).

Glover (1999) differentiated between initiation within the whānau environment and initiation at school. In my study I have defined the whānau environment as a physical context, i.e., initiation starting at the physical place called home. However, I believe Glover was referring to general whānau influences, e.g., initiation with wider whānau members. She claimed that initiation within a school environment might be more about curiosity rather than smoking initiation in a whānau environment being triggered by an emotionally laden event. My study does not agree with this view. Very few of the rangatahi or their parents initiated smoking within the whānau environment, and none discussed an emotional trigger as the starting point of smoking. However, many identified stress as a factor influencing the maintenance of smoking. This result is consistent with Broughton and Lawrence's study (1993), in which only 2.4% cited stress as a reason for initiation.

There are wider implications for Māori youth if the school environment is proved to be a major site of initiation of tobacco use. The youth in this study are already at risk of failing in the mainstream education system (Good Health Wanganui & Wanganui District Council, 2000), and schools that take a punitive approach, as opposed to the harm-minimisation approach recommended by the NZ Drug Foundation and Drug Guidelines for Schools (MOE), may further alienate those students most in need of support and guidance. There appears to be evidence that adult smoking status is shaped by adolescent experiences, such as school-leaving age and school qualifications, that anticipate adult socio-economic status (Glendinning et al., 1997; Graham & Der, 1999).

Reasons for Uptake

A variety of reasons was given for why rangatahi and tamariki started smoking: trying it out, wanting to look cool, rebellion, doing it because everyone else was, boredom, pressure, belonging to the group. Some participants initially took it up to look cool (at age 10 to 12) but as they got older (15 onwards) they no longer thought it was cool, it "just was". This idea of "just was" or "just is" may relate to the level of addiction as a more regular smoker. Johnson et al. (2003) described a fully fledged dependence level in youth smoking as smoking to feel normal, and smoking to be normal. Another explanation may be that "just is" is about the normalization that occurs for some groups around smoking behaviour. The

range of reasons provided by the small sample in this study reflects similar reasons given in larger studies (Nichter, 1997); however, the strongest theme present in initiation for the participants in this study was the influence of friends and peer groups. This is reflected in other studies (West, 1999), and I propose is even more significant in Māori youth as there is a strong cultural precedence for collective identity and "hanging out with everyone". The range of responses below reflect the diversity in reasons given for uptake:

Best mates... all girls... smoked everywhere except school or home, smoked walking home from school... I was just normal, wasn't unhappy or anything (15-year-old female).

I took it up out of boredom, it wasn't peer pressure, most of my mates were non-smokers...I was already rebelling when I started smoking...the hard times had come earlier (16-year-old male).

I was 9 when I first tasted one... my cousin would come over, she'd say "Go steal your Mum's smokes"... she was older and I was scared she would give me the bash if I didn't, then she said "Have a go...go on draw it in," It was 'cos I was pressured in to doing it (20-year-old female).

Whānau Responses

Glendinning et al. (1997) and West (1999) found in their studies that parenting practices and family structure had a significant effect on the likelihood of young people smoking. In particular, families demonstrating poorer relationships and family conflict, unsupportive home environments with fewer controls, and an inconsistent approach within a chaotic home environment, were all related to raised smoking prevalences and placed young people at greatest risk of smoking.

This study did not explore the individual family circumstances and style of parenting, and relate these to smoking initiation. What was being attempted in this study was to explore the meaning of smoking in the whānau context, to understand how the actors in this situation responded to smoking initiation by their children and how actions of the children might impact on the adults. In other words, this study was trying to situate the behaviour or practice in a social structure or context. In a similar but more sophisticated way, Frohlich et al. (2002) are currently exploring a heuristic tool entitled Collective Lifestyles that brings

together notions of social structure, social practices and agency[36] to explain how health outcomes may come to be differentially distributed (Frohlich et al., 2002).

Questions around the whānau response to first discovering rangatahi or tamariki smoking were elicited to understand the importance smoking held as a whānau issue. There was a general range of responses, as would be expected, but strong themes also emerged. There were feelings of fatalism or powerlessness resulting probably from several things, the perceived limited nature of the choices open to whānau in this study, the reality of trying to control or manage teenage behaviour, the sense that other issues are of more concern, a feeling of hypocrisy so nothing is said, and the feeling of inevitability of smoking in a whānau were everyone else does.

The powerlessness was reflected in statements such as:
What can you do about it? You say no smoking at home but they're still gonna go out and do it (mother of 14-year-old female).

Mum didn't like me smoking, she said I shouldn't but I did (15-year-old female).

Uptake of smoking in the whānau often met with no response, which may be about powerlessness or may be about the silencing of the critic by accusations of "well, you do it":

Mum didn't say much, I remember (14-year-old female).

She knew I was smoking; she didn't do anything. I used to ask her for a smoke and she'd give it (15-year-old female).

For some whānau, smoking uptake was considered in relationship to other issues happening in the whānau:

[36] Agency in this context refers to the ability of people to deploy a range of causal powers to make a difference to a pre-existing state of affairs or course of events and structure refers to consistent social patterns and organisational arrangements.

Dad was fairly laid back at that stage... smoking was least of the issues... took it as it came, probably... came after a lot of things I had tried on (18-year-old female).

While for some uptake did not appear to be a significant issue, I wonder whether part of this response was the feeling of non-judgement because they themselves were smokers or whether the health risks were not fully appreciated:

I didn't feel upset, I did the same thing myself (mother of 14-year-old female);

It was socially acceptable and nobody in my family had great points of view on the issue (45-year-old female).

For some, the approach was to talk about the issue, and at times there was bargaining:

I got sent away to boarding school ...a private one. I got caught smoking in the first week. My uncle said how dare I embarrass him like that, so he made a pact with me: "I'll let you smoke at home but don't you dare smoke at school." This particular example may be a class issue; breaking "outside" rules associated with expected forms of conduct in a private school leading to a concern about social exposure.

Some of the responses may have been about managing relationships within the whānau, especially trying to maintain some sort of relationship with teenagers:

I couldn't stronghold them...I wanted to keep the relationship going on a nice level... I didn't want to get hard on them (43-year-old mother).

For some the choice to smoke was obviously influenced by the wider whānau, and decisions made by grandparents and wider whānau members impacted significantly on the immediate whānau involved, particularly on their ability to influence the decision to smoke:

I remember when I found out she was smoking (referring to her 14-year-old daughter) *I was quite upset about it. She was staying with mum and mum gave her cigarettes occasionally so it became quite a focal issue in our family...you know, my role as her mother, 'cos I*

didn't want her too. Mum used to give them to her. It became a bone of contention with my brother as well, 'cos he said, "If she wants to smoke you can't stop her"... which I was quite taken aback by that. The rules in this house then were no smoking (38-year-old mother).

For most parents/caregivers there was a sense of not liking the situation and feeling upset or feeling concerned; however, the options for intervening once the decision to smoke had been made appeared limited to most parents:

As her Mum, it's constant with me, I always tell her to give it up. I give her a nudge... I'm angry... I'm angry with myself.... Other than that I'm relaxed with it, I don't know how to deal with it really, I've offered her cessation stuff... it's not cool, but... (mother of 13-year-old);

My parents knew about it 'cos I got caught at primary school. They used to rain down on me ... they didn't like it at all... Got lots of growlings about it (15-year-old female).

The strong language expressed by some parents not only to their tamariki or rangatahi who take up smoking but towards themselves – *I wanted to bash her; I went ballistic at her; I'm angry with myself* – indicates a possibility for change. The transcripts suggest a whānau approach where parents and children can give up together may hold promise as an intervention technique.

The added economic cost to the whānau of children smoking was identified as an issue:

Well, go buy your own, I can't afford yours as well, you're not getting mine but go hard (33-year-old mother of 14-year-old smoker).

I can't afford to have you smoking. I went ballistic at her 'cos my other girl was smoking as well (10-year-old). *They were stealing them off me or they'd ask their Nanny and she'd give them to them* (38-year-old mother).

Even in whānau where strong feelings were expressed by tamariki about "smoking as a bad thing" there seemed a certain inevitability about the progression to smoking once they were

older. The following example reflects the idea of agency discussed previously, about individuals' capabilities or choices available to act on the resources given to them. The reaction of the parents to the no-smoking signs may have influenced the idea that there is a choice about smoking:

I tell you what I said to her when I found out she was smoking ... I said to her "Miss clever dicky," 'cos she used to go round our house and draw up no-smoking signs all over our house to her father and me, so we used to screw them up. I used to rip them off, and then what happened to her... she was so clever... and I thought it was quite sad that she had followed our example and become a smoker (60-year-old grandmother talking about her daughter taking up smoking).[38]

Rules

Rules about smoking are indicators of the values the whānau hold about smoking and of the modes of social conduct surrounding smoking. However, whānau rules need to be viewed in the wider context of parents' sense of power to implement the consequences if rules are broken, parental skills and knowledge about effective tactics for problem behaviour, the practicality of imposing rules in the current family context, and wider whānau support for enforcement.

While the majority of responses indicated there were some rules about smoking behaviour in the whānau, the extent and consistency of the rules appeared to be insufficient to inhibit smoking in the whānau environment; for instance, smoking was allowed in some rooms in the house or at particular times, and rules were not strongly enforced or were reliant on goodwill from the smoker. In other instances rules seemed to be imposed arbitrarily:

you can smoke but don't smoke in front of your father (the father in this whānau was the smoker in the household).

These findings would tend to support Glendinning et al.'s (1997) findings that parents who were seen as exercising fewer controls had higher rates of youth smoking prevalence. The situation of imposing controls is obviously complex. Reid and Pouwhare (1991) quoted research that indicated Māori parents, while strongly disagreeing with young children smoking, were not concerned about tobacco use amongst teenagers. In this study, parents

were concerned, but discussions with rangatahi revealed they were generally fairly scornful of the ability of parents to influence their smoking behaviour. Parents also expressed this viewpoint, stating that *anything they did was probably not going to stop their kids smoking if they really wanted to.* When rules were imposed, it was generally to protect younger children's health, to manage whānau relationships, to restrict smoking activity, and to reduce second-hand smoke in the home environment. The idea of parental authority being both supported in some situations and undermined in others was mentioned:

I was a smoker but I was not allowed to come home and do that... but, you know, there were certain adults, parents of our friends who condoned it. You know, so everyone would go there. You know, you could sit there. But most of my mates, their parent wouldn't let me smoke if I wasn't, they knew that Mum wouldn't let me smoke, so they wouldn't let me smoke in front of them or at their house, but I would. I would just hide in my room, close the door. But they didn't like me to (23-year-old ex-smoker).

There was also a sense of rules as something fluid imposed in some situations but not in others or dependent on the circumstances or people involved at any particular moment:

Nothing hard and fast ...'cos we have a lot of people in and out and you get those that smoke... I know mum just can't stand it, so I'll go outside.... When it's just me, I smoke inside ..(18-year-old female).

There were many examples of self-imposed rules about who you could and could not smoke in front of, and this appeared to be linked to a sense of respect for the other person in regard to non-smoking and a sense of camaraderie or mutual support for those you could smoke in front of:

I don't smoke in front of some of my family... it's embarrassing... if I wanted a smoke I'd go away... I don't smoke in front of my grandparents... I feel funny but my aunties all smoke and they knew mum wouldn't let me so I used to smoke with them... my koro used to smoke, I just won't have a smoke in front of them (19-year-old female).

When a key figure or someone who held some power in the household gave up smoking, new rules were imposed rigorously:

Now I've given up (mum) they can all go out and smoke... if I didn't do it no one else would damn well do it (38-year-old female).

Creating rules, or thinking about smoking behaviour, to protect your health or your children's health was a prominent theme. For some this meant there were no rules or some rules to modify a situation, but the discourse still reflected an awareness of health risks and smoking:

I smoked through seven pregnancies.

I had asthma when I was little (rangatahi)... (mum says) that's why dad..... (partner) *smoked outside, 'cos he could see the effect on her, he stopped other people smoking inside.*

Our house has never been smoke free, had your baby on your titty and smoking with the other hand ...asthma in the kids didn't influence this, we just continued to do it... we made sure the windows were open...we smoked in the car with the kids (40-year-old mother).

For one whānau, rules were externally imposed by Child Youth and Family, possibly as a marker of responsible parenting:

Generally the rule is we smoke outside, when I got the kids back we sat down and talked about it and made the house smoke free (it was one of the stipulations of having the kids back).

Repeatedly throughout the whānau interviews the idea of whānau influences and smoking as being everywhere was discussed. There was a feeling of inevitability and once again the idea of agency in the particular social situation came up:

It's totally about us, we always smoked around her, she was a passive smoker. I always cared about it 'cos smoke in my face as a smoker didn't cut .... I tried to give my kids a choice...but there was heaps of smoke (38-year-old female).

Supply

I asked about the availability of cigarettes as this influences not only uptake but also continuation of smoking. The general response was that they were easy to get, that supply was not a problem. This ease of access was seen across all rangatahi and tamariki age groups. Whalgren's (1997) study found that initiation of tobacco use accelerates much more rapidly among 11 to 14yr olds who have been explicitly offered tobacco compared with those who reported not having received such an offer. This finding combined with the data from our study, i.e., ease of access and a tendency towards sharing tobacco products, would indicate supply could be targeted as an effective component of a multi-point intervention.

Cigarettes were often supplied as a reward or as a symbol of love or closeness as whānau:

My aunty used to buy them smokes... 'cos the kids were good to her and she was close to the kids, so when she got her benefit she'd buy the kids cigarettes (40-year-old mother).

Whānau was not the only social situation among which tobacco and sharing of tobacco products were used as symbols of closeness: friends willingly shared smokes, especially if as a smoker yourself you understood the need for tobacco:

It's really easy getting smokes off people especially if your hanging (16-year-old male).

When smokes weren't given willingly they were taken. Throughout the whānau interviews the words pinching, stealing, or nicking, were used to describe access to tobacco, for example (older sister talking):

He would have nicked them 'cos he was a bit of a thief. Been pinching Mum and Dad's smokes, so I didn't care, I let him do it (18-year-old female).

There was also the idea of stealing smokes not only for personal use but to gain financial advantage from this situation by selling them on:

This mate had a shop and she used to steal them – a packet of 30 – then sell them at school for 50 cents or dollar each, we used to flick them off easy (17-year-old female).

The issue of parents, older siblings or cousins, or wider whānau buying for underage smokers was spoken of reasonably often in the whānau interviews:

We [parents] supply her smokes, actually. We all smoke, she smokes with us (she's just 15). That's what annoys me, she smokes all our smokes – she smokes as much as we do – she's just like us. It's always one of us going to the drawer to roll one up (38-year-old female).

If the smoke-free environments legislation currently in front of the Government is passed as law this action may have implications for those people buying tobacco for under-age smokers as there will be a strengthening of the enforcement of unlawful supply to minors. For some parents this supplying of tobacco was part of a management strategy to deal with difficult behaviour at the time:

Rangatahi: *She didn't let me smoke unless I could pay for them...then when I was in the fourth form I'd give Mum the money and she would go and buy them.* Mother: *It was more involved than that, it was about attitude.... It was quite strong then...it calmed her.* Rangatahi: *If she had've said no, I would have ...*

Access to tobacco was also achieved through direct purchasing from the retailers: smokers as young as 13 and 14 bought cigarettes from retailers with very little difficulty:

We looked old enough at 12 to buy them, give them a video card and they thought we were 18. We sometimes bought them in our school uniform (19-year-old female).

Young smokers identify shops where underage purchasing is relatively easy and such information is very quickly shared among groups.

Current Smoking Context and Influences that Maintain Smoking

The links between stress reduction and tobacco, and tobacco as self-medication, have been identified in a number of studies (Lloyd & Lucus, 1998; Nichter, 1997; Pavis, Cunningham-Burley, & Amos, 1996), and by Glover (2000) and Broughton and Lawrence

(1993) in their studies of Māori smoking in adults. Pavis (1996) identified that adolescents smoking regularly, as opposed to social smokers, used cigarettes as a way of calming down and coping with stress. In this study older adolescents and parents alike associated smoking with a calming or relaxing effect:

When I'm stressed or drinking coffee...when angry... you know that angry feeling thing inside...smoking calms me...calms my nerves down...I feel a little bit calmer (18-year-old female).

Tobacco and its use as self-medication or as a stress reduction mechanism was directly linked to dealing with difficult whānau situations:

I relied on the smokes to help me get through some hard stuff in the family (30-year-old female).

Even when smokers had managed to quit for a period of time, stress was seen as a trigger for starting again:

I stopped for 2 years but then he bashed the shit out of me and I took it up again. It's stress, eh (33-year-old female).

Smoking in adolescence has been closely associated with socialising, particularly socialising and drinking alcohol. Both Lloyd (1998) and Pavis (1996) identified smoking as a social activity linked to drinking and boredom. The whānau interviews confirmed this association:

I do a lot of social smoking if I'm drinking. I can chain smoke then (43-year-old female).

There was also a clear identification of smoking as a social lubricant:

Smoking feeds me if I'm bored or if I'm in company or uncomfortable (17-year-old female).

The social situation for adolescent smokers is a strong influencing factor, even for those who may have quit or are attempting to quit:

...but once I started to socialise and go out with my cousins that was it...that's when I started to pick up smoking again... it was a social thing...you know, it was gone past being cool to it became habitual but mostly in a social situation when you were out drinking (19-year-old female).

Some made choices between smoking and other activities:

I chose smokes instead of sports.... Netball trials were after school and I didn't turn up 'cos I was off smoking. I was good at sport before I took up smoking (16-year-old female).

For some smoking appeared to be associated with boredom or nothing to do:

...probably just bored, got nothing to do. Just sitting there doing nothing, and then people are smoking around you or you say, "Have you got a smoke," and then you think 'Smoke, I'll have another smoke.' ..."Here, have one too" ...People that smoke aren't doing much (16-year-old male).

From my experience of visiting and interviewing whānau in this study I would conclude that for some poverty restricted choices for participation in leisure and sporting activities that may have alleviated boredom or reduced smoking. Education pathways predicted for some of the rangatahi[37] may result in more leisure time, hence more smoking and mixing with groups of smokers, further reinforcing smoking.

Images

Questions were asked about the image smoking created; both the image those interviewed had of themselves and the image they had of others who smoked. I was particularly interested in the responses to the question, Will you be smoking when you are older or do you see yourself as a smoker when you are older? A large number (including data from school interviews) of younger children between 9 and 12 replied positively to this question, in particular those children who had not yet taken up smoking. There was a sense both of

[37] Some of the 15-year-olds interviewed had already left school and were unemployed, and some were experiencing difficulties with schooling.

inevitability and of anticipation[38] in the younger children who looked forward to the event, possibly as some form of marking being older.

Those who had been smoking since their early teens and were currently in their late teens or early twenties were more likely to respond with a desire to quit sometime in the future. I was interested in the sense of self-efficacy older teenagers demonstrated in their statements about quitting in the future:

If I wanted to I could give up (regular smoker)*; I won't smoke when I'm older* (18-year-old smoker).

Others were more ambivalent:

I don't know...I think I'll give up before I'm 20... hope so, I'll probably give up when I'm having kids... pretty bad for kids or for anyone really (15-year-old female).

Slovic (2001) examined the risk perceptions of smoking by adolescents and concluded that 14–22 year olds express unwarranted optimism about the ability of people to quit smoking.

Some whānau, aware of the harm caused by smoking, and identifying smoking as a behaviour that can be changed, believe changes will result in less smoking in the next generation:

I don't think our kids will smoke past 30s (mum of three children who smoke) ...They won't keep on as long as we have.... I think I'm a bloody idiot (45-year-old female).

When probed about what images they held of themselves or others as smokers, those interviewed showed either a neutral or negative image. Lloyd (1998) discussed the contradictory and apparently conflicting nature of descriptions of smoking by adolescent smokers and proposed that this capacity might help teenagers simultaneously hold negative images of both smoking and of smokers, while being smokers themselves. My study was

[38] Younger children were judged to be anticipating when they were excited or energised by the statement "Yeah, I'll be a smoker."

no different: rangatahi used a range of negative descriptions to describe themselves or others smoking: *It's yuk; It's boring; It's gross.*

On occasion the images were neutral or smokers were considered normal: *shrug it off...They're just a smoker.* This idea of normality was also associated with how addicted you were to tobacco; and smoking therefore was just a normal state: *addicting.... just there, just part of me* (16-year-old male).

Why More Māori Smoke

Whānau were asked why they thought more Māori than pākehā children smoked. The majority response to this was that Māori smoke because of whānau influences. In some cases, the responses also included positive reasons for not smoking, for example, the whānau like to sing, therefore they don't smoke because they like singing. However, whānau were generally identified as having a negative effect on the goal of reducing smoking in rangatahi. They were described as influencing the uptake of rangatahi smoking in a range of ways. Whānau described the sheer numbers of smokers to whom children are exposed in a range of social situations:

Everyone else smoking... just everyone else around you smoking (45-year-old female).

Smoking was linked to socialising together as whānau and hapū:

It's a social thing and Māori are social people, aren't they? (16-year-old female).

The influence of learning smoking behaviours from a very early age was highlighted:

Our parents smoked it. We grew up with smoke being puffed into our faces and, you know, it becomes second nature... the cycle just keeps going round and round (43-year-old female).

Smoking was also seen as a condoned or accepted practice even at quite a young age:

A lot of Māori kids are allowed to smoke when they're younger...I've noticed ... 11 to 12 yr olds allowed to smoke (47-year-old female).

Others commented that this permissive approach might be a contributing factor to Māori youth smoking and reasoned that whānau should be able to influence smoking by not supporting it in the way many did:

Don't take it seriously enough; the flexibility of culturally accepting ...things... if wider whānau had've said something when she took it up it might have made a difference ...instead, they gave them to her (38-year-old female).

The idea that smoking was a common practice also helped whānau members feel smoking was an acceptable behaviour:

It's okay, I'm allowed to do it with everyone else (18-year-old female).

Even though most responses clearly highlighted the responsibility of whānau in rangatahi smoking uptake, some of the rangatahi themselves wondered if changes at a whānau level might only postpone the uptake of tobacco:

Having people around me that didn't smoke might have put it off, but it wouldn't have stopped it altogether (18-year-old female).

Some saw smoking as part of an overall mechanism for coping with the stress that was a common reality for many whānau:

Stress relief... you meet others who are in same boat – all goes together, it helps the stress (33-year-old female).

One person summed up the reasons why more Māori smoke than pākehā:

'Cos Māori have more stress... less money...parents working heaps... kids left to manage on own, left to do whatever, and got a lot of free time on their hands, no money for activities or programmes... roaming with their mates... see their parents smoke... Pākehā more secure culturally... I know a lot of Māori kids that smoke (38-year-old female).

Those interviewed were also asked why they felt some Māori youths chose not to smoke and whether they felt there was any difference between their contemporaries who smoked and those who didn't. Generally, no differences were offered, and most stated *they're just like us but don't like it.* This confirmed Broughton and Lawrence's study (1993) where "just not liking it" was the most common reason given for not smoking.

The comment "they are just like us" usually meant the non-smoking adolescents did other things considered by parents and peers as "risky" or "naughty", for example, drinking alcohol, wagging school, going out to parties, going out with boys:

I've got first cousins who didn't get into smoking...but they did everything else ...they didn't like it ...didn't do anything for them (19-year-old female).

Other participants interviewed identified non-smoking adolescents as having clearly different values from adolescents who were smokers; these values were often linked to success or achievement. It is also interesting to note the comment made about the influence of supportive whānau in the decision not to smoke:

The Māori kids that didn't smoke were a bit different from us. They were quite high up in school, didn't go out to parties, weren't rebels, eh... They did have full family support as well (18-year-old female).

For some, playing sport appeared to be a protective factor against uptake of tobacco:

There is a few of them on Mum's side into sport (explanation given by older cousin why others in her whānau didn't smoke) (23-year-old female).

However, one participant pointed out the problems or inconsistency in any attempt to categorise Maori children who smoked:

Nah, there were sports players that were non-smokers who were bad kids, and there were smokers who were really good at the learning stuff (23-year-old female).

Gender Difference

There is clear and consistent evidence that between the ages of 13 and 16 girls smoke more than boys (Lloyd & Lucus, 1998), and this is similar among Māori youth (Health Sponsorship Council, 2000). Various reasons posited for gender difference in smoking prevalence include: smoking used as a mechanism for reducing stress and stress being experienced differently between genders; smoking as rebellion against certain gendered identities; smoking as a social activity and females as social beings; and, smoking to influence body image (Nichter, Nichter, Vuckovic, Quintero, & Ritenbaugh, 1997; Wearing, Wearing, & Kelly, 1994). While this study did not specifically set out to explore the gender aspect of Māori youth smoking, whānau, and in particular rangatahi, were asked whether they understood the reasons for gender difference in smoking uptake in Māori. Some of the responses follow.

The most common response I received was that boys just don't like it. However, some responses alluded to different experiences as women, including stress held as women, contributing to smoking:

Our pressures are different, we are more worried about a lot of things other than what my brothers ... my brothers have got a real stand back attitude to stuff ... I notice it in our family meetings, my brothers don't say much, just yes, no. But us girls all got a say about stuff, we carry the issues as women.

This comment was made by a 45-year-old women, and the example may not hold particular relevance for the type of stress experienced by much younger women. However, gendered roles are learnt early in life, and being "emotionally responsive" to others' problems, especially one's peers, and experiencing some stress as a result of this, may be relevant to adolescent smoking in females.

A 16-year-old male smoker commented:

Nearly every chick that we know smokes but most of the guys don't like smoking... Most of the chicks we know are white ... chicks are weird, they follow each other – if one of them

does something the others just follow... the guys we hang out with have all tried smoking but given up, they just don't like it so they don't do it ...

This comment may be talking about the social influences of female adolescent smoking. Lloyd and Lucus (1998) discussed the image of younger female smokers as belonging to larger social groups than their male counterparts, where smoking was definitely a mark of belonging, and there might have been subtle and overt pressure to smoke if one wanted to stay a member of the group.

For one adolescent female, the gender difference in smoking was identified with character weakness or lacking self-esteem: *Maybe males just think they're shit hot and don't need anything to make them feel shit hot.* Lloyd and Lucus (1998) found this description of low self-esteem applied more to female adolescent smokers than male smokers.

Information about Smoking

I was interested in whether the decision to smoke was an informed one and what those interviewed understood about the harmful effects of tobacco. As health promotion is to be used as one of the approaches to reduce uptake, I was also interested in what they knew already and what effective in terms of anti-smoking messages. A recent New Zealand teen survey covering six regions and 3275 students aged between 14 and 17 found that: 75% of students had discussed the health effects of smoking with someone, almost all the students (94%) knew that smoking was harmful to their health, and a similar number knew that second-hand smoke was harmful to others' health (NFO New Zealand Ltd, 2003).

I found that most of the rangatahi had a reasonable understanding about the harmful effects of tobacco, even though some of the detail and depth of information may not have been significant. Slovic (2001) itemised those issues not fully appreciated by adolescent smokers: years of life lost are not fully understood; young people do not have consistent and realistic knowledge of the addictive nature of smoking; and young people may not know how risky smoking is in relation to other health risks such as dying from gunshots or car accidents or from abusing alcohol and drugs. While the following example identifies the obvious risks of smoking, the actual years lost are not fully understood and the risk of smoking compared with the risk of dying from a car accident is also not fully appreciated:

Bunch of chemicals in them that make you sick ...lung cancer [laughing] *'cos it's on my packet ...gangrene – seen that on the TV ...death, yeah, don't know too much about them ...yeah, we know they're bad for us ...that they can kill us, but so can crossing the road* (16-year-old male smoker).

In another interview a young male smoker talked about the knowledge of addiction as occurring after initiation through the experience of addiction itself:

Knew about addiction... we were already addicted by then [12] all my mates still smoke, eight of us still smoke.

There was a definite generational difference in knowledge with those still at school or having recently been at school more knowledgeable than their parents:

I think ... (referring to the youngest child) *is the most informed one, 'cos she's come through a different stage...but that's her, you know ...a lot more awareness out there ...all the kids are quite informed, eh, really* (38-year-old female).

The more recent changes in awareness among those Māori smokers I interviewed came with a self- and socially imposed message of social ostracism:

The big push with anti-smoking stuff is making a difference... you're made to feel like a second-class citizen (45-year-old female).

Some of the anti-smoking campaign messages such as those about the dangers of second-hand smoke are also influencing where young smokers are smoking:

I wouldn't smoke around babies... I ask if I can smoke around mates (18-year-old female).

I was impressed by the impact of the recently screened Māori auahi kore television advertisements; participants had excellent recall of the key messages from these ads:

I watched those videos on TV and I must admit they have made an impact. You know the one with the oesophagus... it slowly draws out the inside of you so you become cancerous over a long period ...gives you wrinkles (15-year-old female).

Some evidence suggests that unless risk beliefs are related to feelings about smoking, young people disregard the risks of smoking when deciding to smoke their first cigarettes (Slovic, 2001). The following statement is typical of many of the responses that indicated young people knew about the risks but they weren't sufficient to influence the decision to smoke:

I'm aware of what it's doing to me but ... but I want to smoke, I like it, it doesn't have an impact (15-year-old male).

I concluded that while those rangatahi taking up smoking in our area were better informed than previous generations, they might not fully appreciate how they would in the future perceive the risks from smoking nor the difficulties they would experience as addicts attempting to stop.

Ideas for Prevention

Finally, options for prevention were discussed with the whānau. Their ideas on how to reduce the uptake of smoking in our Ngāti Hauiti population generally fitted the following concepts: changing the whānau influences, continuing the anti-smoking messages and marae smoke-free policies, and working collectively.

The following example indicates the intergenerational nature of smoking in Māori whānau and identifies stress as a major influence on continued whānau smoking. Ironically, the feelings of guilt this mother expressed when discussing tobacco use and the harm she identified it might do to her daughter might well heighten such stress. However, this whānau was optimistic and saw value in whānau quitting together and being prepared as a unit to change smoking behaviour:

You got to break the cycle... I kept talking about breaking the patterns... dealing with the stress. I felt upset 'cos I knew what it would do 'cos she was sick. The other one wasn't

going to listen, so I didn't bother with her...They are all thinking about it ... in preparing myself to give up I've been talking to everyone in the family (35-year-old mother).

Stress was linked closely to poverty or to lack of resources (both material and otherwise) that give whānau stability:

Give them more money so can buy shoes, clothes, and other things. My sisters and their husbands all work, they smoke but their kids don't. It's about stability in the home from a pepe, and when there is instability it creates more stress and, um, it draws that type of crowd... it's happened to me and my kids.... They (her brothers and sisters) *didn't have to struggle... It's how we live* (referring to the smoking) ... *It doesn't mean we're stupid or our brains aren't working* (37-year-old mother).

Whānau also discussed the wider collective responsibility of hapū and iwi in reducing youth tobacco uptake:

We have to focus on ourselves and our whānau or we're never gonna change the world. We have to change within ourselves 'cos if we're talking whānau, hapū, iwi stuff then you have to focus on your own to make the difference...you lose the plot otherwise, you have to take it back ... health and wellbeing is about our relationships (43 year-old mother).

Whānau were aware of the power in role modelling non-smoking behaviour and of the particular value of prevention methods in keeping children away from smoking for as long as possible:

Whānau korero...We talk often about it now ... more so than any other time ...It was then I found out she was smoking 12 a day... we talked about cutting back... I need to quit myself to be the role model... Younger one hates smoking ...keep her in that mindset ... to encourage others.... She's aware of the health issues; she's quite sporty (38-year-old mother).

There was an awareness both of the need for caution about the social impact of smoke-free policies and of the broader impacts of policy decisions:

If we are going to try and make the marae smoke-free, how do we do that in a way that we don't end up with all our volunteers walking off in a huff and never coming back? ... You know, making sure that people keep their sort of dignity or something or don't feel... I don't know... 'cos I feel like quite alienated now. I feel more alienated than I ever did and I'm so aware of it now, there's places where I just won't smoke (47-year-old mother).

Some spoke of the frustrations in previous approaches that have been attempted:

whānau quitting, excellent idea...hapū contests, quit and win...working collectively...health promotion can only do so much...group of girls at the college constantly in trouble for smoking. We tried to work with the college it wasn't that successful. They had made up their minds they wanted to smoke. It needs to start from the parents, even though I'm not a good example of this...individually we fall down (42-year-old mother).

The Results of the Qualitative Interviews

This discussion summarises key points taken from the analysis of 11 whānau interviews.

There appeared to be little difference in the experiences of parents' smoking careers and that of their children as smokers, and generational cycles of smoking were relatively short, with many of the parents in these interviews having had their first children before the age of 20. To us as an iwi this indicated the need to intervene in the cycle of whānau smoking.

To do this, however, we need to understand the complexity of youth smoking uptake and maintenance. This study confirmed several key issues in Māori youth smoking initiation:

- smoking was strongly associated with participation in social networks including whānau networks;
- social smoking was a separate and clearly defined category of smoking for youth;
- there was a sense of judgement about how well one smoked;

- learning to smoke properly may be a marker of group belonging, and therefore embedded in smoking behaviour, with the associated risk of addiction making the shift from social smoker to regular smoker more likely.

The age of initiation was similar between generations, with early initiation being a key feature. This early initiation starting as young as 9 to 10 years of age, combined with ease of cigarette acquisition, is very pertinent to the initiation rates for Māori youth, especially when combined with social norms that are less prohibitive about smoking. This finding may hold the key approach to intervening in the cycle of smoking uptake. If we can reduce access at this earlier age and if we can shift social attitudes to smoking uptake at a whānau and hapū level we may postpone smoking till a later age or even halt the rate of smoking uptake in this population group.

This study concluded that whānau operated as a backdrop for a smoking career by strong role modelling of smoking, providing ease of access to tobacco products and at times direct teaching of how to use tobacco products.[39] However, in this study group, initiation occurred mostly within a peer group environment. There was a strong indication that smoking was a marker of group belonging, signifying a distinction from other groups, facilitating social interaction; and that reciprocity and sharing were seen as a means of establishing and maintaining relationships. These social contributors to initiation and maintenance of smoking may be more difficult to influence in the intervention phase for several reasons. They may be related more to Māori youth being marginalised within the wider group of the youth population by broader socio-economic and cultural determinants and feeling a need to establish themselves as a separate identity to manage feelings of isolation. Some of these social contributors are part of the more general social transitions made by youth as they move into adulthood, and some of the social aspects of Māori youth smoking are part of what may be considered a cultural norm of strong social links. What is required therefore is a general improvement in the social economic and cultural position of Māori, and a shifting of the social markers of group belonging from smoking to less harmful and more positive markers such as music and sport.

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[39] This later observation was mostly mentioned by adults in the 30- to 50-years-of-age group, and may not be pertinent to today's youth.

Another interesting finding in this study was that school[40] was identified as a major site of initiation. This poses several issues: Māori children are already marginalised in the education system as seen in the disproportionate rates of suspensions and stand-downs for drug use; many are leaving school without formal school qualifications, which further increases disparities in a range of social and economic indicators; and smoking in this study and in wider studies has been closely linked both to school-leaving qualifications and school-leaving age (Glendinning et al., 1997; Graham & Der, 1999).

As would be expected, responses within whānau to tobacco uptake varied. However, a key feature was a sense of fatalism or powerlessness, probably resulting from several things: the perceived limited nature of the choices open to whānau in this study; the reality of trying to control or manage teenage behaviour; the sense that other issues are of more concern; the feeling of hypocrisy among parental smokers who feel unable to criticise behaviour in which they themselves indulge; the wider whānau influences that parents could not control, and the feeling of inevitability of smoking in a whānau were everyone else does. Most parents were concerned about the situation but options for intervening once the decision had been made to smoke appeared limited to them.

Whānau concerns about tobacco uptake are often manifest as rules within the whānau about smoking. In this study I was interested in exploring these rules as an indicator of the values held by the whānau on the subject. The majority of responses indicated that while there were some whānau rules about smoking behaviour, their extent and consistency appeared to be insufficient to inhibit smoking in the whānau environment. The findings supported previous research that indicated parents who were seen as exercising fewer controls had higher rates of youth smoking prevalence. The situation of imposing controls is obviously complex. In this study, parents were concerned; however, discussions with both parents and children revealed parental ability to influence smoking behaviour was seen to have only a limited effect. When rules were imposed, it was generally to protect younger children's health, to manage whānau relationships, to restrict smoking activity, and to reduce second-hand smoke in the home environment. The idea of parental authority being both supported in some situations and undermined in others was identified.

[40] This included the journey from home to school, as well as smoking during school hours and in the school grounds.

Across all age groups, ease of access to tobacco products was a key concern arising from the whānau interview data. We know from previous research that initiation of tobacco use accelerates much more rapidly among 11- to 14-year-olds who have been explicitly offered tobacco compared with those who reported not having received such an offer (Whalgren, 1997).

Most discussion focused on whānau as a key influence in smoking uptake and maintenance. More importantly, many saw whānau as the key to changing smoking behaviour and attitudes, and provided a range of suggestions for interventions including whānau quit and win competitions, smoke-free marae, whānau korero, pushing the message, focus on ourselves and our whānau, whānau quitting programmes.

Summary

The data gathered from these interviews provided a significant amount of material that deepened my understanding about the values, beliefs and attitudes of whānau, including tamariki and rangatahi, to tobacco uptake and use in a whānau and wider social context.

The data indicated a complex range of initiation influences including both whānau and wider social peer group influences. Initiation at a relatively young age and ease of access to tobacco products accelerated the sense of inevitability felt by many tamariki and rangatahi towards smoking. School played a major role as a site of initiation, to some extent because this is a major source of peer group interaction.

While whānau responses were varied, there was an overriding sense of concern even if it was unable to be acted on due to a sense of powerlessness. Whānau rules about smoking probably reflect this sense of powerlessness, as the rules were inconsistent, limited and often undermined by wider whānau.

The study identified a strong link between smoking and wider socio-economic determinants, in particular, stress linked with a range of issues such as poverty, family violence, and limited control. Whānau was identified by the participants in this study as the principal change agent in reducing tobacco uptake in rangatahi. Any intervention strategy at a whānau level, however, will need to be embedded in broader social change that will

impact on the socio-economic and cultural determinants of smoking for this population group.

CHAPTER TEN

SYNTHESIS OF THE DATA –THE RESEARCH PRINCIPLES, THE INTERVENTION CONTEXT, THE EVIDENCE FOR EFFECTIVE TOBACCO CONTROL, AND THE WHĀNAU KORERO

This chapter brings together data from all the previous chapters and discusses these under the following headings: the research principles that will drive the long-term Tobacco Intervention Strategy for Ngāti Hauiti; the Māori Health Promotion principles that will underpin the intervention programme; the strengths and weaknesses of the intervention context; the results from the qualitative interviews: what whānau say about tobacco use and rangatahi; and what the evidence suggests for effective tobacco control prevention interventions.

This synthesis of the data informs a reducing uptake of tobacco intervention strategy for rangatahi and whānau members of Ngāti Hauiti. There are five sets of data informing the strategy:

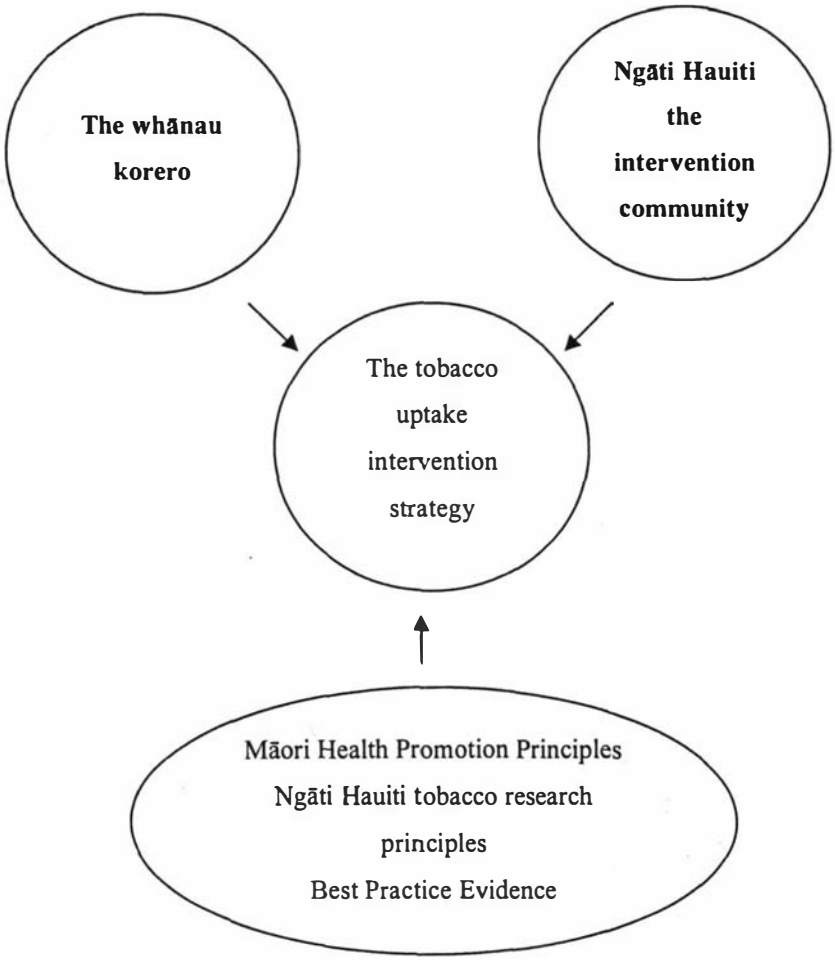
- a set of principles to inform the ongoing Ngāti Hauiti tobacco research practice;
- a set of principles to inform the practice of Māori health promotion that will be the basis of the intervention strategy;
- best practice evidence for effective tobacco prevention intervention strategies from both a national and international perspective;
- the strengths and potential risks inherent in the specific contexts for the intervention and,
- the results from the whānau interviews.

Some of these data are a synthesis of existing data or build on existing concepts, such as the set of principles informing Māori health promotion practice. Other data are original to this study, in particular the results from the qualitative interviews with whānau and the Ngāti Hauiti research principles that have combined existing research data with policies developed by the iwi. Finally, some specific attributes have been identified for the intervention context. These markers of community identity, and the outline of how these attributes and risks will be incorporated and developed or managed during the research intervention phase, are original and an exciting case study for community development.

The following diagram helps summarise the data sets and how the synthesis of all data will inform the tobacco uptake intervention strategy for Ngāti Hauiti.

Figure 4:

Diagram of research results that contribute to Intervention Strategy



As can be seen from the diagram, some concepts emerging from the data sets brought together in this PhD study to inform the intervention strategy hold more importance or are at the core of the specific approach that will be used by Ngāti Hauiti to intervene in the tobacco epidemic for Māori youth. These concepts are the identity markers that make up the community of Ngāti Hauiti, and the whānau that are the core of this identity. Underneath the results from the qualitative interviews with whānau and information about the intervention context, sits the outline of an intervention strategy that will be informed by both Ngāti Hauiti tobacco research and Māori health promotion principles, and by best practice evidence.

To remind readers of the key concepts in each of these data sets the following summaries are given. Incorporated in these are recommendations of how the data will be used in the intervention strategy.

Tobacco Control Research Principles for Ngāti Hauiti

The tobacco control research principles were arrived at first by analysing what I understood to be the research paradigm that would drive the doctoral research, second by analysing the theories behind existing tobacco control programmes aimed at youth prevention and then deciding what fitted best with the context of the intervention and the needs of the key participants in the programme.

The set of principles therefore uses previous theoretical approaches interpretively to construct an integrated strategy that will advance the tobacco control initiative in a particular community context. Some rationale for the selection of the particular principles was given in Chapter Five. A summary is presented again in this chapter with some additional discussion.

Tobacco Control Research Principles for Ngāti Hauiti

Four key themes emerge from the tobacco control research principles outlined in Chapter Five: the notion of research as power; the obligation that research should be used to benefit the participants; the concept that research is used as a tool of community development; and finally that the people living in the community where research is carried out and the local context are significant factors in the research process.

Both indigenous and non-indigenous writers have discussed the idea of research (and the various by-products of research, e.g., policies, knowledge, innovation) as power and control, both in the sense of perpetuating advantage and as a tool for emancipation (Friere, 1973; Hooks, 1994; Lupton, 1995; Smith, 1999). Māori in particular have expressed concern about the way in which Western-based research has been carried out "on" Māori and used to influence perceptions, attitudes, policies and actions (Cram, 1995; Kiro, 2001; Smith, 1999).

However, the issue of using research inappropriately to sustain existing power arrangements is not limited to Western-based research and researchers. We as Māori working as researchers, particularly those working in hierarchical structures (such as those that may exist in Government agencies, iwi or Māori provider arrangements), need to be continually mindful of the influential nature of research and writing. We need to be aware of how the capturing of data, the analysis of those data, and their translation into policies and practice can maintain and perpetuate certain ideologies and can be used by dominant groups to defend their own interests.

The tobacco control research principles caution us to be aware and to consider carefully and critically before acting. Of the many participants – the researchers, professional experts, bureaucrats, the community, iwi-mandated representatives – who needs to consider carefully? In the specific community where the ongoing research is situated, the reality will be that only a small number of people will be actively involved on an ongoing basis in any strategic decision-making. There are many impediments to participation. We are small in terms of numbers of people identifying as iwi members, and even fewer actively participate in iwi development. Additional barriers to participation, such as time, personal inclination, commitment, and specialist training to enable participation, mean we run the risk of making decisions based on defending our own interests.

This research will be translated into public health intervention research, and as such should be exercised with caution. I propose this because public health is based on a set of political, economic and social imperatives, and may be viewed as contributing to the moral regulation of society, focusing as it does on moral and ethical practices of the self (Lupton, 1995). This is particularly pertinent to this research as there can be a tendency with tobacco-control work to value the non-smoking group and marginalize the smokers, who

may already be marginalized by other socio-cultural and economic factors. The key players in this research need to be aware of the covert political and symbolic meanings inherent in any intervention, and to ask questions such as what discourses are being privileged and who is being excluded.

The principles of "working with community partners" and "communities and individuals living in communities being involved in an enabling manner", and the principles of research being "grounded in and sympathetic to the local context" promise that the risks of implementing policies further damaging to individuals and whānau will be modified if not totally overcome providing we can engage whānau and hapū in the programme in a way that is useful to them, and helps them meet their own agendas for tobacco control.

It will be important in this process not to localise or personalise the global problem of tobacco control. The whānau interviews already indicate that whānau see the problem of tobacco as their or their children's problem. This approach minimises both the contribution the tobacco industry makes in recruiting adolescents into tobacco and such things as macro-level decision-making by Governments, which perpetuate the problem of tobacco-related morbidity and mortality.

In this discussion of power and control it is important to clarify what it might mean in an iwi development context "for whānau and hapū to be involved in an enabling manner". For the purpose of this discussion we will use a definition of empowerment that describes:

> *Power as the ability to predict, control and participate in one's environment, and empowerment as the process by which individuals and communities are enabled to take such power and act effectively in transforming their lives and their environment.* (Robertson & Minkler, 1994, p. 296)

This taking of power and acting on behalf of one's own agenda (or the agenda of a particular community of interest) rather than someone else's (central government, professionals, policy advisors and decision makers) is not a new concept to those Māori

who have participated in the Māori self-determination movement in Aotearoa in the past 30 years.[41]

That is not to say that there has been a substantial transfer of power or even that total control is necessarily the agenda of all those involved in self-determination. However, it does imply an understanding, and a working towards as a community, of the importance of being able to set the agenda, control the resources, and decide both the strategies and what is considered to be an effective approach or intervention.

The new challenge for those of us involved in iwi development is not to create or replicate power structures that further oppress whānau and hapū.

The principle of "community action, following an overall philosophy of community development," was chosen as the vehicle for tobacco control activity as it will be necessary to take a comprehensive approach and build capacity as a "community" of whānau hapū and iwi if we are to respond effectively to tobacco control issues. Community action or development also meets an important iwi agenda of redevelopment of whānau and hapū structures to facilitate cultural restoration and to enable iwi members to take advantage of developments currently being generated by iwi leaders, for example service delivery options, economic development initiatives, wānanga. It is anticipated that strengthening individual whānau participation in the hapū and iwi structures (micro-level) will in turn strengthen our ability as an iwi to participate in political and economic decisions at a macro-level, thereby enhancing the health of our community.

That "development proceeds inductively" is an important principle in the tobacco control research as we explore local solutions, gain knowledge based on our own indigenous research, and review current national and international findings. There is also a need to proceed inductively as an iwi to enable the redevelopment of indigenous knowledge based on previous knowledge (e.g., tikanga, moteatea, patere, whakatauki, whakapapa) as well as to incorporate new knowledge and experiences. This will allow us to review and refocus our development in an informed manner, if necessary. We need to work in a way that is open to new knowledge and experiences, explores different solutions and strategies, and

[41] Whānau, hapū and iwi development has been one of the vehicles used to empower Māori communities.

incorporates these in a way that makes sense in the contemporary context and aligns with existing tikanga.

The final principle of connecting research to action from my perspective is about equity and social justice. As a Māori researcher I have a responsibility to translate our iwi-based research into action so the wider community of interest or those on whom the research was based are able to receive some advantage. I believe tobacco use by Māori is a major public health issue[42] and the mortality and morbidity burden threatens the ongoing sustainability of iwi development, especially for smaller iwi like ours. I believe it is our responsibility as researchers and academics to help by contributing what we can in practical and useful ways. There is a general expectation of iwi members that they will help iwi development in whatever way they can. For me, this involves research, policy writing, project management and governance.

Principles of Māori Health Promotion

In addition to the above research principles it was necessary to determine a core set of health promotion principles that would guide the development of the intervention framework or the set of TC strategies for Ngāti Hauiti.

To achieve this a meta-analysis of three Māori health promotion models was carried out and a common set of principles necessary for Māori well-being was identified from the frameworks discussed.

The common components considered by all models to be contributing factors necessary either for the effective delivery of Māori health promotion or for specific Māori are:

- Ability to self-determine
- Participation
- A secure Māori identity
- Collectivity
- Social justice and equity

[42] I do not believe the whānau I interviewed would necessarily see tobacco as a public health issue for the iwi, many see it more as a personal health issue.

- Interconnectedness

These principles will be discussed to find the implications of the framework for service planning and implementation of the tobacco intervention strategy for Ngāti Hauiti, and to connect this set of principles both to the overarching research principles and to the tobacco intervention strategy.

When considering these principles for the tobacco prevention initiative in Ngāti Hauiti, several concepts discussed above resonate well with the overarching policy for Ngāti Hauiti development, Te Uru Koea O Puanga.

The principle of securing a sense of control or the ability to self-determine one's own pathway in health promotion is a key concept, critical to Māori health advancement, and is consistent, not only with the other frameworks presented in this study but also with the principles of iwi development. The ability to control or self-determine provides a path forward, and allows concerns regarding the concepts of power and control (discussed previously in the section on research principles) to be ameliorated. The wording in the tobacco intervention strategy to "work with" and "engage the community" implies there will be a sense of control of and self-determination about what actions will be taken at a flax-roots level. However, as previously mentioned, key drivers in the intervention strategy and programme will need to give control to the community or whānau and hapū if any sense of "real" participation and self-determination is to happen. Self-determination also allows inductiveness to be realised as the research is influenced by community participation and by the new knowledge emerging from indigenous realities. Fostering leadership, progressing self-reliance and an empowerment principle highlighted in Te Uru Koea O Puanga will be necessary components in the overall goal of self-determination.

A secure identity is not only a health promotion principle it is also a key goal for the iwi. Cultural and spiritual affirmation is a key strategic area identified in iwi policy, and strategies[43] are in place to ensure this goal is achieved. The intervention approach will take advantage of some of these existing strategies to advance the goal of reduction in uptake of nicotine in our youth population. For example, the intervention programme intends to use

[43] Strategies include hapū wānanga, taonga exhibition, iwi dinners, tikanga hui, waka hoe, fundraising activities, waiata practice.

hapū wānanga to disseminate information and gain feedback and ideas for interventions. Through these wānanga it will be possible to identify key leaders and to further develop the iwi membership database.[44] Using this database and social marketing strategies we will advance the auahi kore message for particular hapū.

Collectivity, the themes of interconnectedness and community partnership permeate the research principles, the health promotion principles, the tobacco intervention strategy, and the iwi policies. Strengthening community identity, advancing collective rights and responsibilities and a unity of purpose are key iwi goals. Research grounded in the community and the principles of community development are defined as research principles. The concept of participation ties closely in with the idea of self-determination. The barriers to participation have been discussed elsewhere in this chapter. These barriers pose a real threat to the implementation of the intervention programme and will need to be carefully considered in the development phase of the project. While community engagement has already started, greater numbers at a whānau level will need to feel ownership of and engagement with the project.

Social justice and equity relates to the research principle of reviewing critically how we proceed with the intervention research in terms of both the process and the outcomes we hope to achieve. As previously mentioned, it is also about the principle of relating research to action. It is a key principle in iwi development as iwi strive to improve the position of a particular population group currently disadvantaged by the political, cultural, economic and social structures that predominate.

Ngāti Hauiti, the Context for the Intervention

The following headings summarise the community context for Ngāti Hauiti's tobacco intervention programme: institutional context for Ngāti Hauiti, local culture and identity, components required for effective community health interventions. A discussion of key influences and critical points in development of the tobacco intervention programme will be interwoven throughout the text.

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[44] The electronic database for Ngāti Hauiti members is already in existence and has several hundred members currently enrolled. This needs to be extended for future initiatives and activitities and to keep community members informed.

Institutional Context of Intervention

For most of the 20th century, Ngāti Hauiti was devoid of any tribal governance structure. It was only in the early 1990s that discussions took place to re-establish some form of governing body that could represent the wider interests of the iwi. In 1995 Te Rūnanga o Ngāti Hauiti was established as a governing council with the task of rebuilding Ngāti Hauiti as an iwi. The Rūnanga consists of hapū representation from four of the six possible hapū that can participate, indicating a need to continue to build on hapū development.

The Rūnanga has strong iwi leadership, although limited to a small number of individuals, with a number of key policy documents that provide a conceptual framework for ongoing iwi development. As previously mentioned, the type of leadership provided may enable the principles of participation and empowerment to be actively engaged with in the intervention programme. The passion and energy I personally hold for the project will ensure progress is made during the intervention phase.[45]

A separate organization, Te Maru O Ruahine Trust, was established in 1996 to provide service delivery to the whānau of Ngāti Hauiti. Initially, Te Maru O Ruahine Trust (TMORT) provided an integrated and holistic approach to whānau wellbeing focusing on cultural affirmation, health and social wellbeing, economic prosperity and environmental management. As the environmental arm developed expertise and started to generate income in its own right it was decided to establish Rakautaonga Trust. Both TMORT and Rakautaonga Trust are small in terms of number of employees (4.5 FTE), and both entities are limited in their capacity to undertake large and complex jobs. To a certain extent a high level of loyalty and commitment by staff and a significant level of voluntary support by other iwi members mediate this situation. The integrated nature of TMORT, the sound infrastructure based on well-developed policies, and the strong leadership and commitment from staff and volunteers provide a promising institutional base on which to build a comprehensive tobacco intervention programme.

Whānau development was seen as an integral component in wider iwi development and also as an essential starting point in the restoration of Hauititanga. The emphasis was on

[45] I have been appointed as part of the management team that will advance Ngāti Hauiti iwi development projects over the next 5 years.

wānanga and whānau hui to inform whānau of whakapapa and whenua links. One of the results of this whānau development was the rededication of three marae in the tribal boundaries of Ngāti Hauiti. These marae can be viewed as the organisational structures that, in the recent past, have been some of the few remaining places where cultural practices or Hauititanga have been practised, therefore making them extremely important in terms of iwi development. While Western culture dominated Ngāti Hauiti, there have been some elders who continued to maintain the traditions of our tūpuna and this has been most noticeable on the marae.

However, there are several weaknesses that make the marae problematic as an institution supporting the tobacco control programme. Very few members are able to lead and articulate strongly the tikanga necessary to counterbalance the effects of contemporary globalised Western culture and the influences this has on Māori thinking, particularly as it applies to many of our Māori youth. Some of the strongest supporters of the marae are smokers and there may be some reluctance to support smoke-free policies.[46] The links between the Rūnanga and the marae are currently not strong enough to support a programme that may directly challenge marae practices and policies. These issues will need to be resolved if we wish to continue to activate our Hauiti institutions and cultural practices, build on our identity as a community, and fully integrate and engage all Ngāti Hauiti institutions in the tobacco control programme.

Ngāti Hauiti institutions do not exist in isolation, there are good links and relationships with neighbouring iwi, and Ngāti Hauiti are currently strengthening their representation on regional collectives of iwi institutions. The existing relationships ensure an environment of co-operation and collaboration that enables additional resource to be brought into the iwi to help the intervention research, and, should the results of the intervention research be promising, will enable the intervention to be extended to other sites.

Other institutions such as local schools are currently linked to the iwi in two ways, through our service provision arm and through whānau networks. The iwi social worker, for example, works with the local school on individual case or project work, and parents have children at the local school. There is potential to extend and strengthen the institutional

[46] During the writing of this thesis a smoke-free marae policy was introduced at a marae komiti meeting, was accepted without resistance, and has since been implemented.

links with the implementation of the tobacco intervention programme as many of the strategies in the Ngāti Hauiti intervention framework require working in partnership with the wider community in a range of tobacco control activities. Through networks established over the last 3 years, an opportunity has recently arisen to work with a number of national tobacco control agencies during the intervention research phase. A keen interest to work with Ngāti Hauiti on the pilot project has been expressed by ATAK, HSC and Quitline. This will provide an excellent opportunity to strengthen our organisational capacity to respond to the issue of tobacco and youth uptake in our community.

Local Culture and Identity

Analysis from several chapters and key iwi policy documents influence the discussion on local culture and identity. These discussions contribute to our understanding of the specific identity of the community where the intervention will be developed, in particular our understanding of what factors are likely to influence community participation and ultimately the success of the tobacco intervention programme.

Youth Identity

A singular focus on youth and what might be understood about Māori youth culture in a broader context was outside the scope of this study. However, the qualitative interviews with youth provided some understanding of Māori youth culture as it applied to smoking in this particular community. The most notable features were that smoking was strongly embedded as part of Māori youth identity from an early age, and that it was part of sharing together as a group and an important component in socialising together. Smoking was seen as a symbol of belonging in the group. As one's smoking career progressed, however, smoking was seen as "just there". This embedding of behaviour was possibly accelerated by a number of things: the competitive element to smoking where youth were judging each other about "smoking properly", the easy access of the group to tobacco, the progression to nicotine dependence, and the role modelling of smoking by wider whānau. All these factors will need to be considered in the design phase of the tobacco control intervention research, for instance, how we are to shift the embeddedness of smoking in the whānau context, how we change the role of smoking as a key component of social interaction, how we find other less harmful ways of identifying and belonging to the group, and how we use the strengths of the group to modify smoking behaviour.

Whānau Identity

Whānau identity, including the extended network of whānau, is strongly intact in the Ngāti Hauiti community. This was evident during qualitative interviews with whānau where the general preference was to discuss issues of smoking together, where whānau were able to put me in touch with other smoking whānau members, and where extended networks of whānau members were often present during interviews. Participants, both youth and adults, identified strongly with whānau in providing a network of social contact, and these networks were current and active.

However, whānau collectives' links to the wider iwi development projects are problematic. During a review of TMORT services it was recognised that some whānau were unaware of many of the initiatives being implemented, and were not active participants in iwi development. This will be a significant impediment to the intervention research and will need to be addressed in the initial stages of the project.

The situation for many of the whānau is not easy. Some felt powerless to control what was happening within the whānau, they felt options were limited, and that some things, like smoking, felt inevitable. Ngāti Hauiti workers are trying to address some of these issues in the whānau by working as an integrated team;[47] recognising and working from a structural as well as behavioural approach to address whānau issues. One approach we are using is to strengthen the cultural identity of whānau and link them to wider networks of whānau through hapū linkages. The focus of hapū then is to learn about and strengthen whakapapa and whenua ties, and to support each other socially, economically, and culturally. These hapū groups will be used as vehicles for the tobacco control programme; initially using one of the more established hapū groups, but eventually working through all six hapū groups.

Ngāti Hauiti Identity

Ngāti Hauiti descends from the tūpuna Hauiti, and iwi members have continued to maintain the ancestral rights and interests derived from him and his immediate descendants. Hauititanga is a term coined to describe all the attributes and spirit that make up Ngāti Hauiti and make the iwi unique.

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[47] Economic development, cultural development, and social and health services working together.

In pre-European times, Ngāti Hauiti was an autonomous, self-governing iwi that controlled the central Rangitīkei River valley. Throughout the 18th and 19th centuries, Ngāti Hauiti became prosperous, so much so, that it was recognised as an iwi with several thousand members. However, by the mid-1800s Ngāti Hauiti was entering a period of social upheaval, and population dropped to an estimated few hundred. This decrease was largely due to continuous intertribal warfare and a falling birthrate. The numbers left in the tribal domain decreased over time due to 'urban drift' or intertribal marriages, which saw Hauiti descendants living with other iwi.

Today, iwi whakapapa reveals several thousand people who can claim descent from those Ngāti Hauiti tūpuna living in the late 1800s. However, of these, just over a thousand people (including children) claimed affiliation to Ngāti Hauiti in the 2001 national census. Of these, only a very small handful resides in the tribal domain. The majority of affiliates live throughout the Whanganui-Rangitīkei region, with a growing number living in Wellington.

Like other iwi, Ngāti Hauiti society was based on an intricate system of long-standing customs and traditions. The system controlled and regulated all aspects of activity including interaction with other iwi and the natural environment. Concepts such as mauri, whakapapa, tapu and noa were integral to maintaining a balance within tribal society. Central to cultural practice and beliefs was wairuatanga or Māori spirituality. Wairuatanga permeated all things and described the connection between people and the environment. This relationship was integral to Hauititanga and the survival of the iwi.

The demise of Ngāti Hauiti authority during the period of British colonisation was centered on the settler Government's determination to remove iwi control of the Māori population. Reasoning that if tribal members were free from hapū and iwi governance they could be encouraged to sell their individual land interests, the Government embarked on an assimilation policy that systematically removed tribal control and authority.

Successive legislation, such as the Suppression of the Tohunga Act, was introduced to help this process, and by the early 20th century, the last of the traditional Ngāti Hauiti Rangatira and Tohunga had died and iwi authority as such had disappeared.

The influx of settlers into the Rangitīkei district in the late 1800s significantly influenced the social and cultural views of Ngāti Hauiti members. Members saw the distinct advantages of the new Western-based culture and readily embraced it. By the turn of the century, Western values and beliefs were replacing the customs and traditions of Ngāti Hauiti. The result was that Ngāti Hauiti members no longer lived collectively but individually.

While Western culture dominated Ngāti Hauiti, there have been some elders who continued to maintain the traditions of our tūpuna. This has been most noticeable on the marae, which has become the last bastion of cultural expression. It is from this base that Ngāti Hauiti members are learning about traditional values. There is now a growing interest from whānau in reclaiming cultural identity through an understanding of whenua and whakapapa ties, understanding Hauititanga, and learning te reo. Iwi members are attempting to align this interest in cultural restoration with a contemporary view of iwi development to enable economic social and cultural advancement.

Ngāti Hauiti exhibits a number of dominant cultural characteristics that have evolved over recent times that place Ngāti Hauiti in a strong position to take advantage of any cultural development opportunities that may arise, including the tobacco control programme. These strengths include a core group of committed members who support each other and provide strong leadership and direction, a proven tribal structure that continues to evolve over time to meet the needs of the whānau and hapū, ample historical records that provide a foundation for Ngāti Hauiti cultural heritage, a feeling of significant cultural progress over the past couple of decades, and prominent cultural facilities such as marae that enhance cultural identity.

Several key issues remain that may pose a threat to the success of cultural development, and in particular the tobacco intervention programme. Knowledge, understanding and adherence to Hauititanga vary from person to person within the iwi. On a scale measuring members' cultural well-being, there are two extremes: no knowledge of Hauititanga and full commitment to Hauititanga. With an estimated potential iwi membership of several thousand, it is estimated the majority would fall in or near the former category. A small group would fall in the full commitment category, while the remainder would be somewhere in between.

There is consequently a range of personal views and values regarding cultural wellbeing and identity. This can be problematic as internal conflict often arises due to totally different values, beliefs and processes within the iwi membership. Indeed, many members do not actually recognise their membership and often have no desire to do so.

The geographic spread of iwi members makes attendance at hapū hui and wānanga difficult, and attendance at other iwi development activities such as waka hoe and taonga exhibitions and Hauiti dinners is limited. However, an extensive email database and newsletter make communication slightly easier, and small groups of Ngāti Hauiti members beyond the hapū/tribal area are starting to meet in the communities in which they live, e.g., Wellington. This geographic spread may be an issue for the TC intervention research as the ideas of community development and collectivity rely on a sense of geographic proximity or identity as a distinctive group. The latter concept is one that holds promise for gaining participation and for a sense of being a community. Building on the idea of belonging not only to whānau but to Ngāti Hauiti hapū groupings may influence participation and ownership, which may in turn influence the outcomes of the intervention.

What Whānau Say: The Results of the Qualitative Interviews

This discussion summarises key points taken from the analysis of eleven whānau interviews. Some particular youth perspectives on smoking have been discussed previously in this chapter. I will restrict discussion here to more general whānau perspectives (which may include youth as whānau members speaking as whānau).

There appeared to be little difference in the experiences of parent's smoking careers and that of their children as smokers. Decisions young people make about whether to use tobacco have lifelong and intergenerational consequences. Repeating patterns of early uptake and continually renewing the numbers of smokers in a given population will need to be addressed if we wish to reduce the prevalence and social costs of tobacco use in Māori. The most effective strategy to do this is to intervene in the initiation uptake cycle and to take a prevention approach.

However, we need to understand the complexity of youth smoking uptake and maintenance for such intervention to be effective.

The early age of initiation holds the key to a successful intervention approach in the cycle of smoking uptake. Engaging tamariki, their whānau and the wider community in reducing access to tobacco products, both through second-hand smoking and the supply of tobacco, while at the same time changing social norms within the whānau and community, may postpone smoking till a later age or even halt the rate of smoking uptake in this population group.

This study concluded that whānau operated as a backdrop for a smoking career. However, in this study group, initiation occurred mostly within a peer group environment. There was a strong indication that smoking was a marker of group belonging, signifying a distinction from other groups; facilitating social interaction; and using reciprocity and sharing as a means of establishing and maintaining relationships. The difficulties of shifting these social contributors to initiation and maintenance of smoking have already been discussed in the study, and a broader social economic and cultural determinants approach has been identified as a way forward to counteract current use of tobacco as a social marker of group belonging.

In this study, school[48] was identified as a major site of initiation and the issues this poses for Māori was explored, including disproportionate rates of suspensions and stand-downs for drug use and low rates of formal school qualifications. There are several responses that may influence smoking in the school environment. Schools could be encouraged to work with the wider community setting to encourage the implementation of a smoke-free policies across a range of settings; take a harm minimisation approach to tobacco use by keeping Māori youth engaged in the education system; provide support and counselling for drug use; incorporate drug education into the wider curriculum, delivered more regularly and focused on tobacco industry exposure and media studies; start drug education in the primary school setting; and work with the wider community setting to support auahi kore events.

Whānau respond to tobacco initiation and uptake in a variety of ways. However, a key feature was a sense of fatalism or powerlessness resulting from a range of issues. One

[48] Included the journey from home to school as well as smoking during school hours and in the school grounds.

approach in the tobacco intervention strategy will be to provide skills and knowledge to whānau to enable them to meet the general demands of parenting adolescents. This training will be focused on generic skills as opposed to specific strategies to deal with smoking.

In this study, rules were explored as an indicator of the values held by the whānau about smoking. The majority of responses indicated there were some rules about smoking behaviour in the whānau; however, the extent and consistency of these rules appeared to be insufficient to inhibit smoking in the whānau environment. The findings tend to indicate that strengthening whānau ability to implement and enforce a set of guidelines about youth smoking will need to be part of the comprehensive approach to reducing uptake of tobacco. Some prioritising of guidelines will need to occur based on the what rules have the most impact on reducing uptake and limiting the health impacts of tobacco smoke in the whānau environment. Having identified a limited set of rules it will be important to encourage wider whānau groupings to support the enforcement of these guidelines.

Ease of access to tobacco products in all age groups was a key concern arising from the whānau interview data. This would indicate reduced access could be targeted as an effective component of a multi-point intervention and might be one of the prioritised tobacco control guidelines implemented by whānau and hapū.

This study reinforced the idea that tobacco is linked to stress reduction in the mind of the smoker, and stress, often linked with poverty and limited choices, was a major part of life for the whānau interviewed. Ngāti Hauiti is attempting to address this issue in its economic development plans and its service delivery configuration, that is, health, social, cultural and economic development is addressed in cohesive manner.

Most discussion focused on whānau as a key influence in smoking uptake and maintenance. More importantly, many saw whānau as the key to changing smoking behaviour and attitudes and provided a range of suggestions for interventions. However, to help whānau achieve this goal the current sense of fatalism about smoking, the lack of control whānau felt about dealing with problem behaviours generally, and the limited choices they were able to exercise, will need to be addressed in the intervention phase.

What the Evidence Tells Us

Chapter Seven, Māori tobacco control activities: the evidence of effectiveness at reducing Māori youth uptake, provided the best practice evidence that will inform the intervention strategy or approach to be taken by Ngāti Hauiti to reduce tobacco uptake. The following section presents key evidence for advancing Māori youth prevention approaches.

New Zealand's tobacco control programme, started in 1985, included advertising restrictions, tobacco tax increases and smoke-free legislation. During the period 1985–1998, the programme effectively reduced tobacco consumption for all NZ adults, lung cancer mortality rates for adult males, and the proportion of cancer death rates attributable to smoking (Laugesan, 2002). However, rates for Māori adolescent smoking prevalence were largely unaffected by restrictions on sales to minors, mass media campaigns and tobacco tax increases (Thomson, 2000). Up to 1983 the Government had made no significant attempts to see Māori had access to information and intervention programmes, and it was not until 1984 that the Government began to fund Māori smoke-free health promotion strategies (Reid & Pouwhare, 1991). However, funding for Māori specific tobacco control initiatives in the period 1990 to 1998 has been modest (Thomson, O'Dea, Wilson, Reid, & Howden-Chapman, 2000).

During the 1990s Māori were organising themselves in an attempt to reduce Māori smoking prevalence rates through the establishment of Māori smoking cessation services, coordinating activities, lobby groups to influence national tobacco control policy and programmes, and national hui. Many of these initiatives contain a Māori youth focus as part of an overall whānau approach to tobacco control and as a component in the tobacco control programme, but neither youth nor prevention are the prime focuses.

However, prevention approaches are contained within the broader tobacco control strategy for New Zealand: developing personal skills through school-based education; influencing public policy including initiatives such as price increases of tobacco products and restricting access to tobacco; creating supportive environments by the development and enforcement of smoke-free environments and mass media campaigns; supporting community action initiatives such as smoke-free marae; and attempts at reorientating health

services by partnership building and a focus on advocacy and prevention. The effectiveness of each of these approaches will now be discussed.

Developing Personal Skills through School-based Education

There is some evidence that social reinforcement and social norms programmes that include curricular components on the short-term health consequences of smoking, combined with information on the social influences that encourage smoking and training on how to resist the pressures to smoke, seem to be more effective than the traditional knowledge-based interventions sometimes used to deliver drug education in schools (Effective Health Care, 1999; Lloyd & Lucus, 1998; Stead et al., 1996).

However, even the most effective model to address smoking prevention in schools may be capable only of delaying not preventing, recruitment to smoking and may not reach Māori soon enough or in sufficient numbers.

Some of the results of the ERO survey have implications for Māori youth tobacco smoking and the role of school-based education in preventing uptake. These include: only half the primary schools surveyed had a drug education programme compared with about 90% of intermediate, composite and secondary schools; smoking and tobacco education was delivered more commonly at years 7 to 11; and the average amount of time spent on total drug education was between 10.8 and 15.2 hours per year (Education Review Office, 2002).

The results from my research into whānau smoking and youth uptake would suggest education needs to be focused at years 4 to 8, which are the early stages of initiation, and more time and a broader comprehensive approach, including whānau, are needed to counteract social influences. The need to target smoking prevention education at 8-year-olds upward and to deliver sessions regularly through primary to secondary school is reinforced by international evidence (Effective Health Care, 1999; Glynn, 1989; Sorensen et al., 1998).

Evidence suggests smoking education programmes are likely to impact on those at lower risk of becoming smokers, and young people at most risk of smoking may be least likely to respond to the school environment, may not be present when education is delivered, and, in

fact, school-delivered programmes may be counter-productive for such young people (Stead et al., 1996; Waa et al., 1999; Rissel et al., 1999).

As Māori youth are at higher risk of smoking, on average leave school at an earlier age, and are most at risk from expulsion or suspension from school for drug use (including tobacco), we can assume drug education in schools may be less effective for Māori youth. Further research would be needed to confirm this assumption. Ngāti Hauiti's tobacco control framework requires iwi to work closely with schools in the region, and to introduce policies and practices that may be more effective with Māori youth. For example, whānau support to help schools implement the Ministry of Education Guidelines on drug use in schools may result in a more effective harm minimisation approach being taken by schools as opposed to the punitive approach currently in place in some schools.

Influencing Public Policy

Healthy public policy in relationship to all addictive substances has been shown to have preventative value (Anderson, 1994). To be effective these policies need to be intersectoral, covering not only the health, social welfare and criminal justice sectors but also those sectors relating to trade, agriculture and education.

Price increase and restricted access to tobacco are the two key policy platforms used in New Zealand to prevent youth uptake. While the effectiveness of price increase on reducing consumption is well documented, and there is evidence to suggest this may apply equally to youth, there is still some uncertainty about the impact of price increases on poorer Māori households and on the uptake of nicotine in Māori youth.

However, those Māori households continuing to smoke after tobacco tax increases would be adversely affected by this policy due to a decrease in disposable income through increased expenditure on tobacco. As previously mentioned in this study, whānau clearly identified the economic burden of smoking on household income, and given this burden, combined with the fact that some whānau were supplying tobacco to younger people living in their household, tobacco tax increase may either exacerbate existing household poverty or stimulate parents to stop the supply of tobacco to children.

Restricting access to tobacco has largely come about through the Smokefree Environments Act, introduced in New Zealand in 1990. Māori youth interviewed in my study commented that "getting cigarettes wasn't a problem". They were supplied either by whānau (including siblings and cousins of similar age) or friends, or they "knew where to buy them".

Access to tobacco for these youth is a broader issue than restricting sales at retail outlets. It is my recommendation that restricting access in a range of settings by encouraging smoke-free whānau, enforcing smoke-free workplaces including schools, encouraging smoke-free marae, and reducing consumption for everyone in the whānau are more effective approaches.

However, these individual approaches need to be part of a comprehensive approach to tobacco control, and given that Māori youth are among the higher spenders on cigarettes per week, are more likely than others to be regular smokers and to buy cigarettes from retail outlets (HSC, 2000), it is important that interventions aimed at enforcing restrictions on sales of cigarettes to minors be continued. The focus for any action should clearly be on penalising the vendor rather than the buyer, and should not criminalise teenage smokers by prohibiting possession.

It is argued that a focus on limiting access may contribute to enhancing the "forbidden fruit" aspect of smoking and may portray smoking as "adult behaviour". Indeed, youth access programmes have been described as reinforcing the "tobacco industry's central marketing message that kids should smoke because it will make them appear more adult" (Blewden et al., 1997; Reid et al. 1995). A recent survey of Māori youth attitudes to smoking states that 40% of Māori thought "smoking makes you look older" (HSC, 2000). If this is a widely held belief then some credence should be given to the arguments presented. However, interviews with youth in the current study suggested they either held neutral or negative images of themselves and of other Māori youth, as smokers.

Creating Supportive Environments

The political, social, economic, religious and physical environments in which people live have a major impact on the consumption of addictive substances such as tobacco. An environment in which tobacco use is widely accepted results both in widespread use and in an increase in the number of particularly heavy users (Anderson, 1994; Jarvis & Wardle,

1999). Conversely, an environment that discourages, prohibits or restricts use of tobacco results in reduced use and smaller numbers of heavy smokers. There are many settings, including home, schools, work places and health-care organisations, which offer opportunities for healthy behaviour, improvement of social support and strengthening of attitudes that favour reduced use of tobacco.

The major approaches in preventing youth uptake in New Zealand are the development and enforcement of smoke-free environments and mass media campaigns.

There appears to be no direct evidence that social marketing and sponsorship lead directly to a reduction in smoking prevalence; however, there are other reasons to support the continuation of these activities, especially those targeted directly to Māori youth. Among other things, social marketing and sponsorship fund a range of Māori initiatives that need to continue so disparities in smoking rates can be addressed. Tobacco reduction activity needs to be broad based and comprehensive, and sponsorship can create environments more conducive to tobacco control measures in general. Social marketing and sponsorship using the auahi kore brand have been successful in raising awareness and reaching the target audience, and support for events such as kapa haka, smoke-free speech competitions and waka ama are likely to increase self esteem, strengthen cultural identity, and therefore improve overall Māori wellbeing. The promotion of sports may also discourage the uptake of smoking, and sponsorship and social marketing can provide opportunities for environmental modification, for example, permanent smoke-free policies such as smoke-free marae.

Evidence clearly outlines the risks associated with second-hand tobacco smoke (SHS), particularly SHS in the home (Ministry of Health, 2002a).

Reviewing the evidence – high rates of prevalence of smoking among younger Māori women, the group most likely to be in closest contact with children; high rates of exposure to SHS by Māori children combined with high rates of respiratory, middle-ear infections and SIDS; the increased likelihood of children themselves smoking having been exposed to parents who smoke – suggests an intensive intervention that encourages smoke-free whānau would have significant impact on whānau well-being. Using existing whānau

networks and a concerted social marketing approach may result in the adoption of a smoke-free homes policy within this community.

Supporting Community Action

Individual and whānau responses are insufficient to prevent the use of tobacco consumption or the harm resulting from it, and any intervention needs to be supported by community intervention and action. As a collective of whānau and hapū we can work to support intervention strategies aimed at a micro-level.

Community interventions cover a range of approaches using traditional and non-traditional channels to target young people, parents and the community. Community programmes and activities can include engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations; conducting educational programmes for the community; forming support and advocacy groups; and mobilising communities around tobacco control activities.

This study was unable to find evaluation studies of community-based or community development programmes aimed at tobacco control and Māori. International evidence suggests there is limited support for the effectiveness of community programmes to prevent the uptake of smoking in young people (Reid et al., 1995; Effective Health Care, 1999; Sowden & Alabaster, 2002). Some recommendations, however, can be made that may increase the likelihood of success: targeting multiple sites and multiple levels of influence; placing youth at the centre of the activity; using a policy approach targeting use, access and supply; addressing social inequalities in disease risk; involving communities in programme planning and implementation; and incorporating approaches for tailoring interventions at a population level (Sorensen et al., 1998).

The proposed community development approach Ngāti Hauiti intend to use for their tobacco control programme will make use of some of these recommendations. Multiple sites are being targeted, including schools, marae, whānau, and hapū collectives. There are multiple levels of influence, including policy development, cessation interventions, social marketing approaches, and education strategies. Youth leaders will be targeted to lead the approach alongside whānau and hapū leaders. A whole-of-community approach is being

used within a specific context, and participation at all levels is essential if we are to implement the intervention successfully.

Reorientating Health Services

If one is to review the elements required for reorientating health services, using the Ottawa Charter Framework, and apply these elements to tobacco prevention work with Māori youth, it is apparent that a component of each of the elements has been achieved. Partnerships built over the last 8 years, for example, have enabled a framework for a comprehensive tobacco control approach to be put in place for Māori health promotion and advocacy, and the specific issues for Māori tobacco control have been acknowledged. However, significant gaps remain in terms of reorienting the health services to reduce effectively both the prevalence rate of Māori tobacco use and the levels of illness and numbers of deaths attributed to tobacco use.

The following gaps are identified in the draft National Māori Tobacco Control Strategy: a lack of support for an intersectoral approach to Māori tobacco control; insufficient funding for a comprehensive approach to tobacco control; poor commitment by Government to Māori tobacco control needs; poor national co-ordination between a Māori smoke-free community and the wider Māori community; gaps in knowledge and skills in Māori smoke-free workforce; and the subsequent need to extend this training to allied workforces.

Ngāti Hauiti, in our own small way, intend to address some of these gaps. First through the steps already taken in the wider tobacco research project, and second through the intended intervention research. We intend to build relationships between the iwi and education sector to influence policy. The Health Research Council has provided funding both for the current research and, through a post-doctoral scholarship, for the key researcher position in the intervention phase. Funding for the intervention research has been approved by the Foundation for Research, Science and Technology and the Health Research Council. The interest from national tobacco control agencies in the intervention phase will enable valuable resources both human and possibly financial to be directed into the intervention project and will create an important link between a Māori community and national Māori smoke-free organizations. Having developed some community expertise in and knowledge of tobacco control and Māori youth, this skill and knowledge will be used to influence the delivery of services to Māori.

Summary

A set of research principles has been identified that define how research into tobacco control will be conducted in the Ngāti Hauiti community.

In addition, a core set of health promotion principles has been defined to guide the development of the tobacco control intervention framework. The relationship of these principles to service planning and intervention implementation and also to compatibility with the strategic development policies developed by Ngāti Hauiti was discussed. Health promotion principles were identified as consistent with iwi development principles, therefore aligning the tobacco control intervention with a wider whānau, hapū, iwi development role, is seen as advantageous to both goals.

The context for the intervention was defined and key influences and critical issues in the implementation phase were explored. In conclusion, Ngāti Hauiti in its re-establishment over the last decade can be clearly identified as a distinctive community setting with a range of strengths that will allow effective implementation of the tobacco control intervention. This study also highlighted potential risks in the community setting that will need to be managed during the next implementation phase.

The whānau interviews contributed significant data that have been used to deepen understanding of issues around tamariki and rangatahi uptake of tobacco in the Ngāti Hauiti community, in particular in the whānau context. This knowledge will now be incorporated in the intervention approach.

Finally, I will use evidence from both international studies and evaluation of Māori youth tobacco intervention approaches to inform the strategy for Ngāti Hauiti. It is clear that a comprehensive approach that targets multiple sites and multiple levels and uses complementary components from each intervention type is needed. Used in this way the range of approaches available to prevent tobacco use in youth may result in some positive changes.

CHAPTER ELEVEN

THE TOBACCO UPTAKE INTERVENTION STRATEGY FOR NGĀTI HAUITI: PRESENTING THE FINDINGS

Primary Outcome and the Long-term Research Position

The overarching goal of the research project is to reduce the uptake of tobacco smoking in the tamariki/rangatahi population of Ngāti Hauiti. This would be achieved in several phases.

Phase One, the doctoral research, has developed multiple sets of principles and strategies (the conceptual framework) to guide the implementation of a tobacco intervention programme for Ngāti Hauiti.

Phases Two and Three, the intervention research, will use these principles and strategies in the ongoing tobacco control research with Ngāti Hauiti, in particular the development, standardisation, piloting, testing and finally evaluation of the uptake intervention programme. The tobacco control research with Ngāti Hauiti is a long-term research programme, focusing on the Māori-centric mechanisms for reducing uptake.

The doctoral research has provided the iwi with a three-pronged approach to advance the tobacco uptake intervention strategy, including:

- an overarching set of principles that will drive all tobacco research in the iwi;
- a subset of Māori health promotion principles that will drive development of the intervention itself, and,

- a set of strategies that will form the basis of the tobacco uptake intervention strategy.

The set of strategies is informed by analysis of the whānau interviews, analysis of the intervention context, and evidence of best practice guidelines.

In addition, the research has enabled engagement of whānau at an early stage in the programme and has also provided a greater understanding of the whānau perspective on tobacco use so that strategies can be targeted effectively to meet the needs of the community of interest.

The primary focus, however, was on youth, and they were viewed within the context of their whānau, hapū, and iwi. The focus was broadened for several reasons to accommodate a Māori plus iwi development perspective (where the wider whānau and hapū was the focus). We knew from previous research that whānau was a significant influence in tobacco uptake, and we knew from the evidence of effective strategies that a comprehensive approach was likely to be more successful. Extending the focus to the wider whānau context enabled whānau to hear each other's stories about tobacco (sometimes for the first time), which provided an opportunity for greater understanding about issues such as influences in uptake, perceptions of tobacco use, responses to tobacco in a whānau setting, and difficulties or barriers to reducing uptake and prevalence.

The results of the doctoral research have been discussed in Chapter Ten. What is now presented is the outline of a framework for a Ngāti Hauiti tobacco intervention strategy.

Ngāti Hauiti Tobacco Intervention Strategy

A multiple data source approach was taken to develop the strategy. Through this I hoped to produce a strategy that was evidence based, was specific and sensitive to the needs of the community, and was compatible with iwi development policies for Ngāti Hauiti.

It is clear that a comprehensive range of strategies is needed to reduce the prevalence of smoking in youth, and that a single intervention is not sufficient to counteract the many determinants of smoking. To influence uptake strategies need first to be feasible or realistic in the setting within which they will take place; they need to be based on evidence to

increase the likelihood of success; they need to be cost effective both in terms of government spending and in the cost to the community that initiates and participates in any intervention; they need to be targeted in a way that will reduce the existing disparities in prevalence; and finally they need to be acceptable to the community of interest. I would suggest the following approach be used as the tobacco control intervention strategy for reducing uptake in Ngāti Hauiti youth:

- Working with whānau hapū and iwi structures, and using Ngāti Hauiti tikanga, reduce the prevalence of tobacco use in all Hauiti whānau. Make auahi kore part of Ngāti Hauiti tikanga.
- Work with the school setting as part of wider community setting to encourage the implementation of smoke-free policies. Encourage schools to take a harm-minimisation approach to tobacco use by keeping tamariki and rangatahi engaged in the education system and providing support and counselling about a range of drug issues. Encourage drug education to be part of a wider curriculum approach, delivered more regularly and focused on tobacco industry exposure and media studies. Start drug education in the primary school setting. Work with the wider community setting to support auahi kore events.
- Continue to support and advocate tobacco tax increases while at the same time supporting policies that reduce poverty overall; for example, upward adjustment of benefit levels, rural development schemes, iwi economic development support, and the provision of scholarships that encourage further training or education.
- Support and advocate a comprehensive approach to tobacco control by modelling this approach at a community level, for example, through supporting national networks advocating this approach, and through lobbying government to increase tobacco control funding.
- Support the general reduction of access, though the focus for our community needs to be on reducing access from the wider Māori community. A particular focus on the whānau through encouraging a kaupapa of manaakitanga based on sharing non-harmful goods and services is necessary.
- Encourage an ongoing relationship with organisations such as the Health Sponsorship Council to enable our community to use sponsorship and social marketing strategies currently provided under the auahi kore brand name.

- Actively strive for an increase in smoke-free environments in the home setting and for acceptance of smoke-free environments in other iwi settings, e.g., marae, kōhanga reo, iwi service providers.
- Actively engage the community of Ngāti Hauiti, in conjunction with other tobacco control workers and organizations nationally, in a range of tobacco control activities. This can be achieved by: increasing the number of iwi members committed to the kaupapa; getting those people involved in designing the intervention; working to influence whānau and hapū groups using a range of existing approaches at various levels; building on strengths; keeping the approach realistic and achievable; and ensuring small successes along the way.

In summary, this thesis has answered the question: how can multiple data sources from a constructivist perspective inform a tobacco intervention strategy for an iwi? The study has produced a tobacco uptake intervention strategy using five separate data sources. The following presents key components of the intervention study.

Figure 5:

Key components of the Intervention Strategy

Ngāti Hauiti as community contexts

1. active redevelopment of community
2. strong framework for development
3. democratic leadership
4. effective organisational infrastructure
5. strong sense of whānau identity at whānau level
6. effective links outside of the community
7. small community

Whānau constructions of tobacco uptake

1. intergenerational nature of smoking
2. smoking linked to broader socio-economic determinants
3. whānau providing backdrop to smoking initiation
4. easy youth access to tobacco
5. smoking linked to peer group behaviour
6. early age of initiation
7. smoking as a marker of belonging
8. whānau as the principal change agent
9. need for whānau empowerment

Figure 6:

Ngāti Hauiti Tobacco Uptake Intervention Strategy for Rangatahi and Whānau

Ngāti Hauiti Tobacco Research Principles	Māori Health Promotion Principles	Strategy Approaches
Research is viewed as power	A sense of control or ability to self determine	Make auahi kore part of Ngāti Hauiti tikanga
Research is used to benefit the participants	Participation in whānau, hapū and iwi and at a broader systems level	Engaging the community
Research is a tool of community development	Secure Māori identity both as providers and consumers of health systems	Working with schools
Community local context are significant factors in the research process	Whānau, hapū and iwi and working collectively in the broader context	Taking a healthy public policy approach
	Pursuit of social justice and equity goals	Modelling a comprehensive approach
	Interconnectedness	Reducing access to tobacco
		Using social marketing for social change

To be effective an intervention would need to operate consistently with the research, health promotion and best-practice principles, and understand and support the context within Hauiti and its whānau. This research has contributed by identifying and synthesising a parallel set of principles that inform the development of the intervention so that it builds on the strengths of the relevant existing evidence. While meeting these principles is necessary, the distinctive contribution of this research is that it documents the context-specific expectations that are essential determinants of the success of the intervention. By the addition of this new evidence I have sought to move beyond descriptive analysis to provide the basis for a relevant and responsive applied study. Such a study will be the focus of the ongoing intervention research.

EPILOGUE: ONGOING INTERVENTION RESEARCH

In my role as both an iwi Manager and the holder of an HRC post-doctoral fellowship, and in conjunction with whānau and hapū, we are now in a strong position to further this doctoral research.

We have knowledge of the context for the intervention; knowledge of evidence for effective community-based interventions to reduce youth smoking; knowledge of Māori health promotion models and evaluation studies of Māori initiatives with cessation; and with the completion of the current research, we now have a conceptual framework to advance tobacco intervention in the community.

To advance the next stage of the research, Ngāti Hauiti, in conjunction with Te Pūmanawa Hauora, Massey University, applied to the HRC FORST Māori Youth Development Fund for funding, and were successful in their application. This funding will further extend this PhD research into intervention research. The intervention framework presented in the PhD thesis was submitted for peer review as part of the application process. The success of the application indicates the methodology and methods are robust and the intervention framework is likely to make a strong contribution to Māori health development.

Intervention Research

In a classic sense there are six phases to intervention research: (1) Project Analysis and Project Planning; (2) Information Gathering and Synthesis; (3) Design; (4) Early

Development and Pilot Testing; (5) Evaluation and Advanced Development; and (6) Dissemination (Rothman & Thomas, 1994).

The first two phases have been completed within this doctoral research. Phases 3 and 4 are the subject of the intervention research to be completed over the next 2 years. Phases 5 and 6 will be planned but completed only after the completion of Phases 3 and 4. This ongoing research will deliver a researched pilot intervention for wider application.

Phases 3 and 4 of the intervention research will involve the purposive transformation of the theoretical framework and qualitative data from the doctoral research into a form that has strong intervention implications, both for practice and policy. The intervention research will specify the programme components in more detail than currently outlined in the thesis.

In particular, the intervention research will develop a comprehensive programme manual, which will include the intervention logic, outcome measures, protocols and policies for implementing the intervention programme, and training goals for the kaiāwhina whānau to provide the programme at the whānau level.

A draft programme document will be developed in the first 6 months of the intervention and will be reviewed and adapted on an ongoing basis. This review will be based on field-testing the programme tools (including measures) in a pilot test site. On the basis of field-generated data, the intervention design will be refined and further retested. This latter activity may require several test–refine–retest cycles.

The intervention phase will be critically reviewed and written as papers that can be shared with others developing community-based interventions. It is my intention during this phase to comment particularly on engagement of the community, effectiveness of the approach, unexpected outcomes, ease or otherwise of implementation, and cultural applicability.

The research of the intervention model and the further research necessary to determine effectiveness and applicability to other sites will contribute significantly to the overall picture of reducing uptake of smoking in Māori. It appears at present that responses to Māori youth smoking are fragmented, and frameworks for reduction are mainly cessation focused. Youth are addressed only in the context of legislation, education through schools,

sponsorship and social marketing campaigns, and these approaches do not appear to be curbing uptake. This doctoral research and future research carried out by Ngāti Hauiti will contribute to the national tobacco control strategy an evidence-based comprehensive Māori model of smoking prevention aimed at rangatahi and whānau.

Risks and Benefits

During the next phase, the implementation research phase, it is anticipated that pakeke, rangatahi and tamariki, as well as hapū groupings, will be involved in the tobacco control programme and that not only uptake but cessation rates may be impacted on. Analysis of the qualitative interviews clearly demonstrated that taking a whānau approach by supporting whānau, helping them with strategies for parenting, working collectively, and helping to influence the predictors of smoking, e.g., easy access to tobacco and role modelling of smoking, might help Ngāti Hauiti achieve the overall goal of reduced uptake of tobacco in our rangatahi population. We will use existing Māori cessation models such as Aukati Kai Paipa to increase our likelihood of good whānau quit rates (which we know influence uptake and cessation in wider whānau). However, we also know that the rate of decline in adult smoking, particularly in Māori, is extremely and disappointingly slow, and our ability to influence smoking uptake may be limited. It is therefore important to review the other likely impacts of this research and decide what is critical to achieve and what might be desirable.

This study shows a high level of exposure to tobacco products in the home and easy access to tobacco products by rangatahi. Taking an incremental approach it may be possible to achieve early success in both these areas by reducing the number of homes where tobacco is consumed indoors and reducing the supply of tobacco products to rangatahi. Reducing access will be achieved by encouraging a kaupapa of manaakitanga based on sharing non-harmful goods and services and smoke-free environments will be part of an iwi-wide initiative to have all iwi settings smoke-free.

Initially we are expecting there will be some secondary impacts from the tobacco control research programme, namely increased participation and engagement by whānau (this has started by whānau agreeing to participate in the initial part of this research), increased knowledge of hapū networks (hapū wānanga will be used as a vehicle to mobilise whānau

and building knowledge about tikanga and whanaungatanga), and whānau capacity building (achieved by increasing knowledge and skills at an individual level).

There are some broader, longer term goals to be achieved that will involve iwi members in various tobacco control activities, for instance, lobbying and influencing policy decisions in wider organizations such as schools, local bodies, government departments, iwi providers. This will result in the building of such skills as project organization, submission writing and public speaking.

Critical to the success of these factors will be gaining participation in the ongoing tobacco control programme, acquiring funding for ongoing research, and building on iwi capacity to deliver on the goals of the programme.

APPENDIX ONE

DISCUSSION GUIDE FOR WHĀNAU INTERVIEWS

Part one

Participant information

1 Whānau Name

2 Hapū

3 Number of members of whānau participating in hui.

4 What is your age?

- Under 15
- 15–24
- 25–34
- 35–44
- 45–54
- over 55

5Gender

- ❑ Male
- ❑ Female

Smoking History/Rates

1 Which of these statements best describes your current smoking

- ❑ Never smoked cigarettes at all, or never smoked regularly, that is one or more a day
- ❑ Used to smoke cigarettes regularly
- ❑ Currently smoke cigarettes regularly

2 If a smoker, at what age did you start smoking regularly?

- ❑ under 15
- ❑ 15–18
- ❑ 18–21
- ❑ over 21

4 How many cigarettes do you smoke on an average day?

- ❑ 0
- ❑ 1–5
- ❑ 6–10
- ❑ 11–20
- ❑ over 20

If you smoke rollies, how long does a 50 or 100 gram tobacco packet last you normally?

50 g packet

- ❑ under 2 days

- ❑ 2–3 days
- ❑ 4–5 days
- ❑ 6–7 days
- ❑ over 7days
- ❑ over 2 weeks

100 g packet

- ❑ under 2 days
- ❑ 2–3 days
- ❑ 4–5 days
- ❑ 6–7 days
- ❑ over 7days
- ❑ over 2 weeks

DISCUSSION GUIDE FOR WHĀNAU FOCUS GROUPS

I would like us to talk about this whānau's experience with smoking

What can you tell me?

Prompts could be:
When did you start?
How did you start?
Where did you get smokes from?
Where did you smoke?
Who does and doesn't smoke in the whānau?
What has influenced people to take up smoking?

What is the whānau knowledge about the health effects of smoking?

What are some of the attitudes both positive and negative to smoking in this whānau, including extended whānau members?
Are there rules around smoking for this whānau? E.g., who is allowed to smoke, when and where?

What has influenced people to give it up?
What are the things that get in the way of quitting or make you start again?

What about being Māori and smoking?
Is anyone aware of our history of smoking as Māori?
What are the things about being Māori that influence us to smoke?
What are the things about being Māori that could help us quit?

Do you think Ngāti Hauiti as an iwi should do something about our kids and smoking?
Should we focus on preventing uptake or should we try both prevention and help with quitting?
Where should the priorities be?

What might work?

What can we do?

What do you think needs to be the approach taken by Hauiti to reduce the uptake of smoking in our rangatahi?

ADDITIONAL GUIDE FOR RANGATAHI

How would you describe yourself as a smoker?

What do you remember about your first smoking experience?
E.g., where were you?
Who were you with?
How old were you?
What did it feel like?

How do you get smokes?

Do you think you can give up at anytime?
Have any of you tried to give up?
What was it like?

What do you think you look like as a smoker?
What sort of pressures are there to smoke?
What keeps you smoking?
When do you smoke most?

What do you think about smoking?

What about mates and school experiences?

What does smoking do for you?

What would work to stop rangatahi taking it up?

What is your whānau's attitude to smoking?

Do you know kids that don't smoke, what are they like?

Why do you think some people choose to smoke?

Where do you see or hear messages about smoking outside of your whānau, e.g., music, movies?

What do the messages say?

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This certificate confirms that the research carried out for the thesis entitled *He Arorangi Whakamua: Reducing the uptake of tobacco in Ngāti Hauiti Rangatahi* and undertaken within the School of Māori Studies, College of Humanities & Social Sciences, Massey University (Wellington Campus):

- Was undertaken by Heather Hyland Gifford as sole researcher;
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