Understanding the Quit Smoking Journeys of Ngāti Raukawa Women: Barriers and Supports

A thesis presented in partial fulfilment of the requirements for the degree of Master of Philosophy

at Massey University,
Palmerston North, New Zealand

Sharon Taite

2004

Abstract

The purpose of this thesis was to record the journeys of 6 Ngāti Raukawa women who had tried to quit smoking and to identify the barriers and supports which the women experienced during quitting. A key focus of this thesis was to examine the barriers and supports for quitting which occurred within the marae, hapū and iwi environments of these women.

A qualitative research approach using kaupapa Māori and Māori-centred research methods were used. The objective was achieved by undertaking in-depth qualitative interviews which identified issues around smoking and quitting within the participants daily lives, namely at work, home and in other social situations and compared these with other studies.

This study extends the knowledge base about Māori women and smoking by contributing and extending the information available to influence policies and strategies at all levels, but more specifically at hapū, marae, iwi and Māori. The prominence of addressing hapū, marae and iwi issues is a unique aspect of this thesis.

The participants experiences were reflective of the literature, however factors which impacted on smoking and quitting within Ngāti Raukawa hapū, marae and iwi settings were exacerbated given that in these instances cultural influences combined with other environmental factors to bring about high smoking rates. At the same time this study also showed that there is the potential to reduce smoking rates within these same settings although this will require a concerted effort from hapū, marae and iwi. What is required is a change in policy and behaviour across the whole community.

Acknowledgements

This thesis could not have been completed without the aroha and support of many people. Firstly I would like to thank the women who participated in this study. I was humbled at the privilege of listening to the stories and taonga which you were willing to share. My heartfelt thanks go to my supervisors, Wheturangi, Maureen, and Rachael for your unfailing patience, advice and encouragement. Thanks also go to my work colleagues at Te Pūmanawa Hauora, Te Pūtahi-a-Toi, to Aunty Jean and Ngawari for your valuable contribution in editing and formatting this work, to Karyn for all your help with the bibliography and to the staff in the School of Sociology, Social Policy and Social Work.

I would also like to thank my whanau, hapū and iwi. Special thanks must also go to Annemarie, Casey, Frances and Kahurangi and again to Aunty Jean and my supervisors, you gave me strength.

Māori/English Glossary Of Words

aroha	love
auahi kore	smokefree
hapū	subtribe
hui	social gathering including meetings and tangi
kanohi ki te kanohi	face to face
kaupapa	subject, topic
kohanga reo	preschool, total immersion te reo
marae	traditional Māori meeting place
iwi	tribe
kaumatua/kuia	Māori elder
pakeke	adults
rangatahi	young people, adolescents
tangi	funeral
turangawaewae	a place of belonging, identity
whakapapa	genealogical ties, relationships
whakama	nervous, shy
whanau	immediate and extended family
whanaunga	relative or relations

Abbreviations

ACSH	Advisory Committee on Smoking and Health. A Department of Health advisory committee established in 1976.
AKP 2000	Aukati Kai Paipa 2000, a quit smoking pilot programme which targetted Māori women.
AKP	AKP 2000 name shortened following pilot programme
ASH	Action on Smoking and Health. A lobby group focused on tobacco control.
ATAK	Aparangi Tautoko Auahi Kore, the Māori Smokefree Coalition, a political advocacy and lobby group
FoRST	Foundation of Research, Science and Technology
HFA	Health Funding Authority
HSC	Health Sponsorship Council
MUHEC	Massey University Human Ethics Committee
NMSCP	Noho Marae Smoking Cessation Programme
NRT	nicotine replacement therapy patches and gum
PHC	Public Health Commission, established in 1993, ceased to be operational in 1995
THMM	Te Hotu Manawa Māori, the Māori arm of the National Heart Foundation

Table of Contents

List of Tables

CHAPTER ONE

Introduction

Background

The smoking rates for Māori women are among the highest known in the world. This has serious implications not only for the health of Māori women but also for whanau, hapū (sub-tribe), iwi (tribe) and Māori society. Within my hapū, Ngāti Pikiahu-Waewae, and iwi, Ngāti Raukawa[1] the number of Māori women who smoke is extreme. The objective of this research was to identify the barriers and supports for Ngāti Pikiahu-Waewae and Ngāti Raukawa women wanting to quit smoking.

This chapter provides an introduction and overview of this study. The research objectives are identified followed by the rationale for this study. The background to this study looks at the history of smoking and government activities to the late 1980s. Factors which impacted on my personal research journey in undertaking this study are presented. Marae, hapū and iwi involved in this research and an explanation of concepts utilised in this study like whanau, whanaunga and whakawhanaungatanga are defined. Finally an outline of each chapter of this thesis is provided.

This research recorded the experiences of 6 Ngāti Pikiahu-Waewae and Ngāti Raukawa women who had tried to quit smoking. The study aimed to capture a sense of the women's experiences through in-depth qualitative interviews. To identify the reasons why these women had become smokers and to look at the barriers and supports they had experienced during quitting, the interview schedule included questions on the participants' smoking history, their education and employment backgrounds, their reasons for smoking, their experiences during quitting and their aspirations for the future for their whanau, marae, hapū and iwi. Although this study involved a small sample it was felt that these qualitative interviews would offer a valuable contribution by

[1] Ngati Raukawa ki Te Tonga, namely southern Ngati Raukawa.

extending the knowledge base about Māori women and smoking. I hoped to add to the lack of information currently available to influence future policies and strategies at all levels, namely marae, hapū, iwi and Māori. Initially however, the information from this study was to be used for a Masters thesis.

Reasons for choosing this topic

Tobacco smoking impacts on high mortality and morbidity rates among Māori and particularly Māori women. Due to my own experiences and concerns about the high smoking rates within my hapū and iwi I was interested in looking at the influences of whanau, marae, hapū, iwi and Māori society on smoking and quitting and to identify what had been the barriers and supports for the participants during quitting. At the time of the 1996 census, 40% of Ngāti Raukawa descendants were smokers and for all age groups under 55 years, Ngāti Raukawa women were more likely to smoke compared to Ngāti Raukawa men (Statistics New Zealand, 1999).

I wanted to use this research to listen to the stories of the research participants who had tried to quit smoking and I wanted to see if their stories were similar or different from the current literature. In addition by examining the barriers and supports for quitting within the participants cultural environments I felt this process would empower them as well as their marae, hapū and iwi.

Background

Following the introduction of tobacco in the 1800s by Europeans, high tobacco use among Māori instilled the habit of smoking and by the 1850s, nicotine addiction had taken hold. Initially tobacco was used to trade and later Māori began cultivating tobacco for personal use. This led several writers (Broughton, 1996; Reid & Pouwhare, 1991) to suggest that very early in the colonisation period the health of Māori was already being affected by tobacco use.

During this period Māori were immortalised in photographs as "the Māori pipe-smoker" (Reid & Pouwhare, 1991, p. 13). These photographs which were often of elderly Māori and especially older Māori women, served to instil smoking among Māori as "normal"

and acceptable behaviour. This history of smoking among Māori had a significant impact over generations and it was perhaps no surprise then that smoking became, as Broughton and Lawrence (1993, p.109) inferred, a "cultural norm". Widespread use of tobacco among Māori continued for decades.

Prior to the 1940s government responses to smoking had been almost nil. In 1903 the first legislative ruling against tobacco was implemented banning the sale of cigarettes to minors however the literature suggests that this ruling was never enforced in any meaningful way[2] (Thomson & Wilson, 1997).

In the 1940s the Department of Health first publicised the enormous impact which tobacco use was having on health (Reid & Pouwhare, 1991; Toxic Substances Board, 1989). From 1940 to the 1950s the government appeared to be more interested in promoting the reduction of smoking as opposed to quitting. Thomson & Wilson (1997, p. 12) note that "the overall impression of this period was of a few anti-smoking voices crying in a smoking wilderness, with a New Zealand population for whom smoking had become a widespread norm".

An anti-smoking campaign was implemented by the Department of Health in the 1960s. The government also placed a ban on cigarette advertising on both television and radio, however tobacco companies were able to somewhat thwart this restriction by moving to indirect advertising through sponsorship (Thomson & Wilson, 1997).

The 1976 census data highlighted that smoking prevalence among Māori was extremely high in comparison to the rest of the New Zealand population, more Māori women were smokers compared to all women, and as well Māori women had the lowest quit rates compared to all other New Zealanders. In every instance Māori women figured strongly. Largely due to the census findings it had become obvious that government measures to eradicate smoking were not reaching Māori (Reid & Pouwhare, 1991; Easton, 1995).

By the 1980s the implications of tobacco smoking on health were according to Thomson and Wilson (1997, p. 19) "clearly on the New Zealand health policy agenda". During this time the government initiated a number of tobacco control activities mainly in

response to two key developments, firstly, an increase in anti-smoking lobbying by non-government organisations and secondly, the release of research information from several major studies.

Advocates against smoking recognised that to encourage the government to listen to their pleas they needed to gain public support (Thomson & Wilson, 1997). A strategy used by Action on Smoking and Health (ASH) and other non-government lobby groups was to take the path of advocacy rather than education. It was felt that a focus on education generally led to painstakingly slow developments. These lobbyists inundated the media in an attempt to make the issues known to the public, and highlighted the health risks of smoking.

A key development was the newly created position within the Department of Health which saw the appointment of a medical officer to work solely on tobacco control. It was also significant that the Department of Health became the first public service organisation to make all of its buildings smokefree. This occurred in spite of the previous resistance by smokers within the Department to the anti-smoking recommendations which had been made. Soon after, many other public services also made their buildings smokefree (Thomson & Wilson, 1997).

The rise in media releases from both government and non-government organisations served their purpose leading to an increased awareness among the general public of the broader implications of smoking especially in relation to passive smoking. Smoking was no longer about the health of the individual smoker, the rights and protection of non-smokers and children also needed to be considered. As a result social attitudes to smoking by the general public slowly changed around this time (Thomson & Wilson, 1997). Smoking was starting to become viewed as socially unacceptable.

Tobacco advertising had been rife and for much of the 1980s the government, the tobacco industry and smokefree lobby groups played an almost cat and mouse game around implementing and putting up barriers to changes to advertising. Tobacco advertising had an effect on smoking consumption and between 1984 and 1987 a number

[2] In 1981 the ruling was repealed.

of anti-smoking advocates, including the Advisory Committee on Smoking and Health, ASH, the Cancer Society and the National Heart Foundation all made submissions to the government requesting bans on all tobacco advertising. As well several medical specialist groups recommended that a total ban on advertising should be enforced including advertising through sponsorship (Thomson & Wilson, 1997).

Finally in 1987, the tobacco industry came to an "agreement" with the government not to advertise in several magazines (Thomson & Wilson, 1997, p. 27). Unfortunately these were low circulation magazines and saw no change in advertising in any major publications. Following on from the agreement made, in 1988 stronger warnings on tobacco packets were introduced.

The literature indicates that progress made by the Department of Health during 1984 to 1988 was largely due to supportive Ministers of Health (Thomson & Wilson, 1997). Successive ministers profited from the increasing public support for tobacco control measures and by introducing significant tobacco tax increases the government were able to increase their health pool. Funding towards tobacco control activities increased and the government initiated several anti-smoking television campaigns.

While an acknowledgement of the issues around smoking seemed to influence attitudes towards smoking among non-Māori, both the activities of government and non-government organisations appeared to have had no noticeable effect on Māori no doubt due to the overwhelming circumstances around smoking among Māori. Although the government were acutely aware of the consequences of smoking for Māori and for Māori health, it was not until 1984 that funding towards smokefree initiatives which targetted Māori were allocated. Reid and Pouwhare (1991, p. 56) emphasised that prior to this the government had made no significant attempts to see that Māori had "access to information and intervention programmes".

The decade of Māori development, launched in 1984 at the Hui Taumata, challenged state dominance and structural barriers and promoted the development of initiatives which would allow for greater Māori autonomy, self-sufficiency and self-development. Such initiatives included the call for by Māori for Māori services. Government who were working towards privatisation saw this as an opportunity to off-load state

obligations to iwi authorities, as part of the devolution process (Durie, 1998). While iwi and other Māori organisations were given a greater level of control, in effect insufficient funding was provided to deliver what were generally government initiated programmes.

My Journey

I started smoking in the 1980s and since that time I have quit and then returned to smoking many times despite the fact that my smoking habits conflict with everything I believe in, especially my strong desire for the advancement and development of my whanau, hapū, marae and iwi. Having an awareness of the broad implications of smoking does not necessarily mean that giving up or refraining from smoking follows, the habit and the addiction do not instantly disappear. As well, the factors which have influenced so many Māori women, like myself, to smoke are overwhelming and to quit and stay quit requires changes and improvements within one's life, changes which often seem insurmountable.

I was often devastated at having to juggle my time between my commitments to my work, study and to my marae and hapū. Similarly, Selby (1996) during the writing of her Masters thesis spoke of her hapū, Ngāti Pareraukawa, and the time she needed to set aside to uphold her responsibilities. She also noted however, that the relationship was reciprocal and that a key benefit was that her whanau, hapū and iwi kept her "centred and grounded" (Selby, 1996, p. 53). Similarly, I too felt that my involvement with my hapū and my iwi kept me grounded and gave greater meaning to my thesis. While at times my hapū responsibilities seemed draining, at other times thoughts of my whanau, hapū and iwi kept me going and gave me strength especially on occasions when I just wanted to give up writing.

In early 2004, I withdrew from my marae and hapū commitments so that I could focus on my study. I was reluctant to resign from my marae responsibilities but hoped that this research would offer a valuable contribution in the long term to the future development of my marae, hapū and iwi. Staying away has not been easy and whenever a major event has occurred I have been drawn back to my responsibilities as a hapū member. This however caused additional constraints when trying to complete this study.

While undertaking this study I was also faced with personal health problems requiring an extension to complete this thesis. Similar to the literature (McClellan, 1998) this was also a time when I returned to smoking. This caused a major dilemma for myself and only added to my problems. The relapse or return to smoking is often instigated by a significant life event.

The difficult times encountered have taught me not to knock myself out by what others may view as failure. I am all too aware that no matter how much you know about the detrimental effects of smoking on oneself, and the significance of this for whanau, hapū and iwi, unless all four corners of the house are in sync or at least in some kind of balance, giving up smoking and staying quit is difficult.

I have experienced all the trials and tribulations of a long-time heavy smoker. Being a smoker is like being an alcoholic. For some the urge never goes away. As a smoker in almost every setting you become ostracised, except unfortunately at the marae where the situation is reversed. Smoking in public is a definite no-no. The shame attached to smoking has been shown to have an influence on quitting and as well the stigma against smoking has the potential to encourage future generations, especially young Māori women, not to take up smoking. I can say that I have put both my adult children off smoking for life.

Being mindful that my research should never be disempowering to the participants, my hapū and iwi or myself rang through my mind throughout this study. This thesis does not seek to judge others or even myself. As well, like Selby (1996, p. 53) I did not wish to be perceived as one of "those" academics. I have not written about those people over there, I have written about my people and myself. What I envisage is a better world for our people, with increased access to information and resources. I am indebted to those 5 women who shared their stories with me. I believe that this thesis is valuable in that it enabled an insight into the lives of six Māori women, including myself, of Ngāti Raukawa who tried to give up smoking. Some were successful and some were not. The barriers and supports which had an impact on the participants experiences during quitting were identified. Each of the women had a valuable story to share and to each I will always be grateful.

Definitions

Terms used throughout this thesis include whanau and whanaunga. Generally whanau refers to those who are linked by whakapapa or genealogical ties. Whanaunga is a much broader term and includes those who are not only related by genealogy but also those who are connected through links to other marae, hapū and iwi.

Other whanau groupings can include a "whanau of interest" and "kaupapa based whanau" (Bishop, 1996, p. 219). These whanau groups involve those who have a common interest but who may or may not necessarily be related through whakapapa. During this research my whanau included those connected to me through whakapapa, whanaungatanga, kaupapa and aroha. Hence my whanau included the research participants, my supervisors, work colleagues, whanau, hapū and iwi alongside close friends who supported me throughout this study. The term "whakawhanaungatanga", referred to by Bishop (1998, p. 133) as important to kaupapa Māori research, involves building relationships and working to empower others. Within the course of this thesis, the relationship building process engendered strong and lasting relationships and in supporting each other my hope was that we would each be empowered throughout this research journey.

It is my marae, hapū and iwi which gives me a place to stand and signifies the geographical area in which I belong. This gives me my turangawaewae, my identity. My main marae Te Tikanga stands at Tokorangi and overlooks the Rangitikei River. The hapū of Te Tikanga are Ngāti Pikiahu and Ngāti Waewae. Ngāti Pikiahu is a hapū of Ngāti Raukawa iwi and Ngāti Waewae is a sub-tribe of Ngāti Tuwharetoa iwi. Due to intermarriage and the long standing relationships within Ngāti Pikiahu and Ngāti Waewae the name of our hapū became known as Ngāti Pikiahu-Waewae. Our hapū is made up of many whanau groups. We stand on the border, the boundaries, of Ngāti Tuwharetoa and Ngāti Raukawa iwi and hence we are the most southern hapū of Ngāti Tuwharetoa and the most northern hapū of Ngāti Raukawa ki Te Tonga (in the south).

The unplanned inclusion of factors specific to two other marae in this thesis and which I also have whakapapa links to were a bonus. Poutu Marae stands just outside of Shannon.

The hapū is Ngāti Whakatere and the iwi are Ngāti Raukawa. Ngāti Whakatere have close whakapapa links to Ngāti Pikiahu.

Whitikaupeka stands at Moawhango, a 20 minute drive from Taihape. The hapū are Ngāti Tamakopiri and Ngāti Whiti. Ngāti Tamakopiri are descendants of Ngāti Tuwharetoa iwi and Ngāti Whiti has strong whakapapa connections to Ngāti Kahungunu. As well many of the hapū members of Whitikaupeka have close ties to Ngāti Pikiahu, Ngāti Waewae and Ngāti Raukawa. For the purposes of this research, this study focusses on my Ngāti Raukawa side.

Outline of the Thesis

Chapter one describes the objective of this thesis and my reasons for choosing this topic. It also discusses my personal journey and identifies those hapū, marae and iwi which were studied in this research alongside the importance of whanau and whanaungatanga.

The literature review in chapter two describes the broad context in which smoking and quitting occurs and looks at the barriers and supports for those wanting to quit. The review looks at studies and activities that occurred within the context and timeframes of the participants smoking and quitting experiences rather than any literature or developments which took place after 2002 when the women were interviewed.

In reviewing the literature the reasons for high smoking prevalence among Māori women were identified. Factors which have influenced Māori women to quit smoking are followed by a description of factors which have influenced and supported quitting. Tobacco control activities including government policies, programmes and legislation which address the barriers to quitting and provide support for those wanting to quit are identified. Statistics and the implications of these for Māori health are then provided. The literature review also provided a foundation on which to look specifically at issues for Māori women within my hapū and iwi.

Chapter three details the methodology and the processes which took place in this research. A qualitative research approach using kaupapa Māori and Māori-centred research methods were used. The influence of critical theory ensured that positive

processes and outcomes occurred. This chapter includes a discussion on the impact of western colonisation and research. The renaissance within Māori communities has also impacted on research leading to a range of approaches that are inclusive of a Māori worldview. The influence of kaupapa Māori and Māori centred methodologies is pivotal to this research. The research journey describes the sample, the interviews, ethical considerations and the data analysis methods employed.

The data results presented in chapter four enabled the opportunity for the voices of the participants to be heard. The data looks at key factors which influenced the women to become smokers followed by key influences which supported the women once they had made the decision to quit. The barriers and supports which the women experienced during quitting were also identified. The final section presents issues specific to Ngāti Raukawa marae, hapū and iwi and emphasises factors relevant to smoking and quitting within a cultural context.

Chapter five analyses and discusses key factors identified during this study. The findings of this research are analysed against the literature and other studies. The barriers and supports for quitting, many of which were unique to this group of Ngāti Raukawa women, are discussed.

The final chapter in this thesis, chapter six presents the conclusions, the recommendations and suggestions for further research. A summary outlines the key findings of this study and considers the implications of these for future policies and developments at national, iwi, hapū and marae levels.

The purpose of this chapter has been to provide an introduction to the thesis and the area of research undertaken. The next chapter considers the context for the research as discussed in existing literature and in line with the objective of this thesis looks at the barriers and support systems in place which can hinder or enable Māori women during quitting.

CHAPTER TWO

Literature Review

Introduction

This literature review provides the background for the study by describing the broad context in which smoking and quitting smoking takes place and identifying the barriers and supports for those trying to quit. The first section looks at key influences responsible for high smoking rates among Māori women. Next, factors that support and influence quitting are identified. Tobacco control activities from the 1990s onward are then discussed. New Zealand national statistics for smoking, smoking statistics for Māori and for Ngāti Raukawa are provided and this is followed by a review of the impact of smoking on Māori health.

Influences on Smoking

Smoking prevalence among Māori women is attributed to several factors which are long-term, complex and inter-related. The reasons for high smoking rates among Māori women are presented under the following headings: adolescent smoking, habit and addiction, socio-economic influences, tobacco advertising, peer group pressure, social situations, smoking to enhance positive and to reduce negative situations and smoking on the marae. The extent and influence of each of these factors present significant barriers to those wanting to quit smoking.

Adolescent smoking

Research shows that young Māori females are the highest "at risk group" to becoming smokers (Broughton & Lawrence, 1993; Glover, 2000; Klemp, Roberts, Stansfield, Klemp, & Harding, 1998). Māori women tend to start smoking at an early age and this is particularly the case among early school leavers. Linked to lower socio-economics, including lower educational achievements, the smoking rates of Māori female

adolescents are considerably higher than the smoking rates of the non-Māori adolescent population (Broughton & Lawrence, 1993; McGee, Williams, & Stanton, 1995).

Smoking uptake among adolescents often begins as an experiment. Several studies found that it is not unusual for Māori women to have experimented with cigarettes by age 16 (BRC Marketing and Social Research[3] & Te Pumanawa Hauora, 2002; Broughton & Lawrence, 1993; Glover, 2000; Murchie, 1984). Added to this, young women who start smoking while at school will often associate with other smokers in contrast to non-smokers who are more likely to have friends who are also non-smokers. Notably, while schools had access to anti-smoking material in the 1980s it was not until the mid to late 1990s that smokefree areas were introduced to most schools (Thomson & Wilson, 1997).

Young Māori are shown to smoke more regularly, that is, they smoke on a daily basis, and more frequently compared to non-Māori adolescents (Glover, 2000). Most Māori adolescents will start smoking regularly between the ages of 15 and 20. While legislation enacted in 1988 under the Toxic Substances Regulations Amendment made the sale of tobacco products to those under 16 years an offence, it appears that not unlike previous age restrictions which have been implemented, this ruling was never actively enforced (Thomson & Wilson, 1997).

A survey involving Māori youth found that the risk of becoming a smoker increases among those who regularly attend iwi and marae activities. Students who identified as having a "high cultural identity", that is, they know their iwi and marae and frequently attend hui, have much higher levels of smoking (31%) compared to those "classified" as having a "low cultural identity" (14%). The study suggests that higher rates of smoking among the "high cultural identity" group are due to pressure from peers and "identification with a culture" which has a high number of smokers among its adults (Reid & Pouwhare, 1991, p. 53). Clearly then the perception of smoking as a "cultural norm" makes smoking a "cultural issue".

[3] The full name of this research company is Business Research Centre Marketing and Social Research

Habit and addiction

Early initiation to smoking among young Māori women not only leads to early addiction but also instills the habit of smoking. Māori women often smoke longer than non-Māori women, for example from between 17 to 20 years (Broughton & Lawrence, 1993; BRC Marketing and Social Research & Te Pumanawa Hauora, 2002; Glover, 2000; Murchie, 1984). As well, research indicates that Māori consume between 10 to 20 cigarettes per day, although it has been found that smokers often under-estimate their smoking levels by about a third (Glover, 2000; Reid & Pouwhare, 1991).

Socio-economic influences

The literature shows that the strong relationship between low socio-economic status and high smoking rates among young Māori women continues into adulthood. As well, women who are single, separated or divorced are among those most likely to be smokers. Due to low income levels, high rates of unemployment and poverty which many Māori women experience, the relationship between smoking and economic stress is also closely linked (Klemp, et al, 1998; Te Puni Kokiri, 2000).

Tobacco Advertising

Reid & Pouwhare (1991) suggest that advertising had an influence on smoking uptake. Often women were targetted in tobacco advertising which associated smoking with independence, good looks, good health and being successful (Reid & Pouwhare, 1991). Although, smokefree legislation was responsible for the eventual removal of tobacco advertising and sponsorship by tobacco companies (Cancer Society, 2000), it is unfortunate that smoking among actors in movies continues to portray those same images evident in earlier advertising.

Peer Group Pressure

In Broughton and Lawrence's study (1993) peer group pressure was the main reason for taking up smoking among Māori women aged between 12 and 16. Wanting to be in the "in-crowd" had been a major influence in taking up smoking. Other studies (Glover, 2002; Murchie, 1984; Nicther, Nicther, Vuckovic, Quintero, & Ritenbaugh, 1997) indicated that both peer pressure and peer influences caused Māori women to take up smoking. As a consequence of peer pressure, peer influences and targetted tobacco advertising, research showed that smoking appealed to young people because of its

association with maturity and independence (Glover, 2000; Nicther et al, 1997; Reid & Pouwhare, 1991).

Social Situations

Given those factors noted earlier, initiation to smoking and regular smoking was strongly related to socialising mainly with other smokers (BRC Marketing and Social Research & Te Pumanawa Hauora, 2000; Broughton & Lawrence, 1993; Glover, 2000; Murchie, 1984; Reid & Pouwhare, 1991). Growing up surrounded by smokers, young adolescents perceived smoking as an acceptable part of social activity. Smoking was seen as "normal", especially as "everyone smoked" (Glover, 2000, p. 287).

Other key contributors to smoking include living with smokers and working with smokers. Numerous studies also identify that parental smoking has a huge impact on smoking uptake by young Māori (Ford, Scragg, Weir, & Gaiser, 1995; Glover, 2000; Reid & Pouwhare, 1991).

Alongside the influence of social situations on smoking, similarly social settings, such as the marae, home and the work environment can also trigger or cue the inclination of smokers to smoke and to smoke more. Other triggers include simple activities such as drinking coffee, tea or alcohol (BRC Marketing and Social Research & Te Pumanawa Hauora, 2002; Broughton & Lawrence, 1993; Glover, 2000). The combination of smoking when drinking coffee, tea or alcohol often took place due to the so-called pleasant effects which resulted. While drinking coffee, for example, the user experienced a better hit from both by having them together (Glover, 2000).

To Enhance Positive and To Reduce Negative Situations

No studies, other than Glover's (2000), clearly identified that high smoking prevalence among Māori women and low success at quitting were influenced by the fact that Māori women smoked in both positive and negative situations. Glover (2000, p. 287) suggested that "smoking for the stimulating effects of nicotine is ... a pursuit of a positive effect whilst concurrently helping to avoid negative affect". Although other studies alluded to this, none make the connection as distinctly as Glover.

Glover (2000, p. 285) notes that smoking is often used to "induce or enhance positive affect". For instance smoking to enhance a positive situation includes smoking for enjoyment, as a form of time out, and during social occasions. As well Broughton and Lawrence (1993) found that often smokers smoke "for the pleasure of it" and this was also given as a common reason for continuing to smoke.

In addition then, smoking is also used to diminish negative situations. Examples included using smoking as company, a friend, as a relaxant, to improve concentration, as a stimulant to cope with a difficult task, and to avoid further negative effects such as boredom and weight control (Broughton & Lawrence, 1993; Glover, 2000). Stress appeared to be a strong reason for smoking across several studies with smokers often tending to smoke more in stressful situations (Broughton & Lawrence, 1993; Glover, 2000; Reid & Pouwhare, 1991).

Smoking on the marae

The processes around smoking are aptly described by the World Health Organisation (1992, p. 59), namely that

> "social acceptability referred to a situation within a specific cultural context, in which a particular behaviour was considered appropriate, so that those demonstrating the behaviour were permitted to continue, even if they were harming themselves or others. It also implied that societies were reluctant to interfere in this behaviour".

Hence, high smoking rates among Māori are maintained given that among Māori the social situations whereby smoking was generally accepted and considered "normal" were commonplace. Māori women tended to smoke more when around other Māori and during hui (or gatherings) where smoking was viewed as part of the "socialising ritual" (Broughton & Lawrence, 1993).

Given the overwhelming implications of high smoking prevalence on the marae, research undertaken by Masters (2000) aimed to identify what had been useful and what were the barriers to implementing auahi kore or smokefree marae. The study involved interviews with health workers and others associated with marae in two regions in the North Island.

For those marae that had become auahi kore, progress was not possible without lengthy discussions and changes needed to be introduced slowly. A number of processes were involved and often these included a key event, a key person or group on the marae who promoted the initiative, and/or the designation of smokefree areas.

Significant barriers to making marae auahi kore had included marae members who were against making the marae smokefree based on the premise that the rights of smokers should be acknowledged. In some cases non-smokers also opposed the idea, while at other marae Masters (2000) found that discussions around making the marae auahi kore had caused a split between smokers and non-smokers. Undeniably the difficulties highlighted in promoting and initiating smokefree marae (Masters, 2000; Selby, 1999; Devonshire, 1999) continue to perpetuate smoking among Māori.

Factors that Support and Influence Quitting

Research has identified several factors which have supported and influenced Māori women to quit or try to quit smoking. This section is presented under the following headings: health, influence or pressure from others and cost. Several overriding influences on each of these factors include government policies, legislation, and anti-smoking promotions, and are discussed later in this chapter.

Health

Several studies (Broughton & Lawrence, 1993; Glover, 2000; Reid & Pouwhare, 1991) found that smokers quit smoking as a consequence of being advised by medical practitioners to quit and/or due to concerns about their health. Around age 30, smokers often began to experience the health effects of their smoking. In McClellan's (1998) study most people did not identify a specific health concern but indicated that they had quit smoking because they felt that smoking was bad for their overall health. Fear of addiction was also noted as a reason for quitting and some smokers quit because they wanted to improve their level of fitness (Broughton & Lawrence, 1993).

Influence or Pressure from Others

Often smokers gave up smoking because they were influenced or pressured by other people and this involved social disapproval from non-smokers and ex-smokers. Influences to quit smoking included a feeling of responsibility to the family, wanting to

be a role model for children and young people, influences at work, and the influence of ex-smoking friends and family members (Broughton & Lawrence, 1993; Glover, 2000; Williams, 1999).

A significant event or sometimes a series of minor events encouraged smokers to quit. Examples included the birth or expected birth of a new baby or witnessing the death of a family member or friend (Broughton & Lawrence, 1993; McClellan, 1998). Importantly however, these situations also often cause relapses and this occurs generally in cases where stress has been involved.

Cost

Broughton and Lawrence (1993) and Murchie (1984) all found that the expense involved in buying cigarettes was an incentive to quit smoking. However at the same time, tax increases imposed by government to raise the price of cigarettes have been shown to have minimal impact on reducing Māori smoking rates (Holdaway, 1999; Reid & Pouwhare, 1991).

Quitting Methods

This section described the preparations smokers made prior to quitting. This is followed by quitting methods which were put into practice once smokers ceased smoking completely.

Across several studies numerous methods, often used in combination, were found to be helpful in preparing to quit smoking. These included reducing smoking first, visiting a hypnotist, reading literature on smoking and quitting, and registering with a quit smoking programme (Broughton & Lawrence, 1993; Glover, 2000; McClellan, 1998; Williams, 1999).

Where the smoker was ready to cease smoking for some this process involved stopping smoking cold turkey and without any health services or aids (McClellan, 1998). Others used nicotine replacement therapy (NRT) patches and gum to wean off the nicotine levels and/or took part in a quit smoking programme which provided quit coaching, counselling or support, terms often used simultaneously (BRC Marketing and Social Research & Te

Pumanawa Hauora, 2000; Broughton & Lawrence, 1993; McClellan, 1998; Williams, 1999).

Often success at quitting was linked to the amount and type of support that a person trying to quit received or had access to. A discussion of several quit smoking cessation programmes presented later in this chapter identify the barriers to quitting which these programmes address.

Maintaining quit status

Quitting smoking was not as difficult as actually staying quit and lifestyle changes were necessary for ex-smokers to maintain their quit smoking status. Maintaining cessation involved a longer timeframe, sometimes a lifetime of change for those who were successful at staying quit.

Changes to regular routines were imperative. To lessen the desire to smoke quitters found alternatives to smoking such as drinking lots of water, chewing gum, making one's home or car smokefree, and avoiding smoking situations such as pubs and partying. Factors like drinking tea instead of coffee, to combat old triggers and familiar habits, reduced the urge to smoke (Glover, 2000; McClellan, 1998; Williams, 1999).

A common finding in several studies was that women were often concerned about gaining weight (Broughton & Lawrence, 1993; Glover, 2000; McClellan, 1998; Williams, 1999). Smoking was known to be used as a weight control device since the nicotine in cigarettes reduced hunger. When women quit smoking the reverse occurred and as their appetites increased, food commonly became a substitute for smoking. Women often took up exercise to reduce weight concerns and to avoid the temptation to return to smoking. As well, exercise was used as a form of stress relief to help maintain quit status. Particularly for those who participated in quit smoking programmes, lifestyle changes were encouraged by quit coaches and counsellors (BRC Marketing and Social Research & Te Pumanawa Hauora, 2000).

Social factors either influenced or inhibited quitting success (Glover, 2000; McClellan, 1998; Williams, 1999). Helpful support included support from family members, partners, work colleagues, friends and smoking cessation professionals. Those who did

not live with other smokers were more successful at remaining quit from smoking. As well quitting alongside others, particularly ex-smokers, provided invaluable social support.

Factors which were barriers to quitting success involved being around other smokers including spouses, living with smokers, family members, friends and especially smokers who smoked in smokefree areas (Broughton & Lawrence, 1993; Glover, 2000; McClellan, 1998). Those who continued to smoke and who had close relationships with a person who quit often felt threatened. Unfortunately it was also found that those who had never smoked were sometimes unhelpful and were unaware of the difficulties smokers faced during quitting, which often undermined quit attempts.

The Effects of Quitting

Quitters often experience both positive and negative consequences from quitting. Positive experiences include improved self-esteem, having more money available, increased energy levels, improved sleeping patterns, the ceasing of other bad habits such as drinking too much coffee or alcohol, an improved sense of smell and taste and improved health (Glover, 2000; McClellan, 1998).

While the influence of the positive consequences which ex-smokers experience after quitting are a key factor in supporting and maintaining their quit smoking status, in turn the severity of the negative consequences experienced often serve as barriers to staying quit. Negative experiences can include gaining weight and having to cope with stressful situations utilising methods other than smoking. As well it is not uncommon for an ex-smoker's health to deteriorate (Broughton & Lawrence, 1993; Glover, 2000; McClellan, 1998). Health problems however, largely due to the chemical changes taking place within a person's body following nicotine withdrawal are generally temporary and tend to be more severe in the early stages of quitting.

Perhaps the most common negative consequence which ex-smokers face is the social alienation experienced from quitting (Glover, 2000; McClellan, 1998). Quitters often feel cut off from friends, family and workmates who continued to smoke. Given that the practice of smoking among Māori was often seen as normal and accepted, this made quitting especially difficult.

Relapse

Relapse is where one or more cigarettes are smoked, tempting or leading to a return to smoking. Smoking, quitting and relapse therefore involves a cycle. Research (BRC Marketing and Social Research & Te Pumanawa Hauora, 2000; Glover, 2000) shows that remaining quit from smoking often takes several attempts and that relapse is more common among those who quit unaided.

Many of the negative experiences, referred to earlier, often led to relapse. Factors identified in several studies included being exposed to smoking, drinking alcohol, weight gain and boredom while the most common factor noted was stress (Broughton & Lawrence, 1993; Glover, 2000; Reid & Pouwhare, 1991).

Significantly, men have greater success at quitting compared to women (Reid & Pouwhare, 1991). Men tend to smoke for the positive aspects alone. However when women try to quit they have to change their smoking habits in twice as many instances, namely, they have to refrain from smoking not only in positive situations, such as smoking for enjoyment during social occasions, but also in negative situations, such as to reduce stress or loneliness. Given this, research shows that Māori female quitting rates are the lowest among all other groups of smokers, including men and those in the higher socio-economic groups (Klemp, et al, 1998; Reid & Pouwhare, 1991).

Policies and Government Initiatives that Support Quitting

Largely in response to the build up to the Smokefree Environments Act (1990) and developments which occurred once the act became law, from the 1990s onward tobacco control activities gained momentum. This section looks at tobacco control activities from the 1990s to 2002, which supported quitting.

The Smokefree Environments Act 1990

The Smokefree Environments Bill was introduced to Parliament in May 1990. Support for the bill involved many years of research and lobbying from non-government groups. However, the bill did not receive overwhelming approval and despite extensive lobbying

against the bill, particularly from within the tobacco industry, the bill was passed only 3 months later in August 1990 (Thomson & Wilson, 1997).

Several developments took place following the implementation of the Act. All tobacco advertising and sponsorship was removed and to dismiss the strong messages by which advertising had been able to entice young people to smoke, the Health Sponsorship Council (HSC) was established. The HSC promoted a clear no smoking message to young people by including non-smoking personalities, such as sports people and musicians, as role models and by promoting their smokefree/auahi kore brand at numerous activities including sports and cultural events (Cancer Society, 2000).

The legislation also highlighted the impact of passive smoking and the benefits to the health of both smokers, non-smokers and especially children of not smoking indoors. Following its inception however, several writers noted a major shortcoming of the Act. The Act placed bans on smoking in offices, impacting on white collar workers whereas a significant number of Māori were employed in non-office/blue collar type occupations and in the total NZ population, 32% of blue collar workers were smokers. Similar comments made by Glover (2000) and Blewden, Waa, Spinola, & Moewaka Barnes (1997c) recommended that the smokefree legislation should be amended and extended to include all work areas, increasing the potential of the Act to reduce Māori smoking prevalence. Importantly, advances saw the Act amended many times since it was first introduced.

Smokefree/Auahi Kore Organisations

The 1990s saw the establishment of several key organisations which aimed to promote a smokefree message. Such groups included Aparangi Tautoko Auahi Kore (ATAK, the Māori Smokefree Coalition, a political advocacy and lobby group) and Te Hotu Manawa Māori (THMM, the Māori arm of the National Heart Foundation). In line with this, many hui were held with the aim of reducing smoking levels and smoking uptake among Māori.

Noho Marae Smoking Cessation Programme (NMSCP)

Significantly, in 1992 the first NMSCP took place at a marae in Taranaki (Glover, 2000). The NMSCP was based on the programme, Kati Te Kai Toru, which had been developed by several Māori women who had quit smoking. The marae-based programme was later shared with other Māori community workers and was provided in other parts of the country where the programme was able to be adapted to local hapū and iwi needs. This programme was a major advance for its time given that subsequent smoking cessation programmes which targetted Māori did not come to fruition until much later in the 1990s.

The programme, which targetted Māori men and women, included counselling and support and removed many of the barriers to quitting. Involving a 5-7 day residential stay on a marae the programme removed the normality of smoking within the marae setting, even if only for a short period of time. For the participants, keeping the programme costs to a minimum reduced cost issues while quitting alongside others took away the social isolation which quitters often experience. Glover's (2000) study showed that the quit rates at follow-up among those who participated in the Noho Marae Smoking Cessation Programme (NMSCP) were 35%, in comparison to 14% for the unaided quitters.

Initiatives Targetting Māori

Further measures which were working towards a smokefree Aotearoa/New Zealand took place in the late 1990s. A report published by the Public Health Group (1998) provided the framework which guided the purchasing of national smoking cessation programmes for Māori. This led to the implementation in 1999 of the Aukati Kai Paipa 2000 (AKP 2000) smoking cessation programme.

In 1999 tobacco control received the largest proportion of funding across the Health Funding Authority's public health areas. Within the five year plan for 1999 to 2003 (Health Funding Authority, 1999) funding was allocated towards the continuation of several initiatives which had begun under earlier government policy (Ministry of Health, 1996; Public Health Group, 1998). Key interventions which aimed to support and facilitate quitting included an evaluation of the impact of tax increases on low income earners and Māori, the subsidisation of NRT, an 0800 smoking cessation telephone

helpline which extended the pilot Quitline programme, a mass media campaign and the running of smoking cessation contests in regions with high Māori populations and among low-income groups together with a national competition. Each of these interventions are described and discussed further later in this chapter.

Government Strategies

Several overarching documents identified the government's plans for future Māori health and tobacco control strategies.

In the New Zealand Health Strategy (Ministry of Health, 2000b) reducing smoking was one of thirteen population health objectives identified while smoking cessation was included among the eight Māori health priority areas. The strategy emphasised that morbidity and mortality rates due to smoking could be significantly reduced through the use of preventative approaches.

Released as a discussion document, He Korowai Oranga, The Māori Health Strategy (Ministry of Health, 2001) provided the framework from which objectives specific to Māori health were to be actioned. With "whanau ora" as the key focus of the strategy, the document acknowledged that Māori and government both had a role to play in improving Māori health. The availability of services appropriate to Māori and access issues including cost, the quality of the services available, and the provision of culturally appropriate services were factors which District Health Boards were required to address.

The Ministry of Health's Māori Health Action Plan 2002-2005, Draft (2002) detailed how the Government intended to implement He Korowai Oranga (Ministry of Health, 2001). The action plan supported Māori-led community development, Māori participation in the health sector and the implementation of high quality and effective services for Māori.

Key Initiatives

Government funded quit smoking programmes and anti-smoking health promotions are initiated through government policies and depending on the political climate (funding, popularity, identified high need) are often further developed under the auspices of

subsequent government policies. The next section described several key initiatives which either began or were further developed as a result of several government policies (Ministry of Health, 1996; Public Health Group, 1998; Health Funding Authority, 1999).

Key initiatives would be developed from these policies:

- Tobacco taxation
- The Aukati Kai Paipa 2000 programme which later became Aukati Kai Paipa
- Quitline and Subsidised NRT
- It's About Whanau
- Quit and Win and
- Hospital and Health Services.

Tobacco Taxation

It was timely that the Health Funding Authority (1999) intended to evaluate the effects of tax increases as views on the impact of raising the price of tobacco products as a result of tax increases varied. In a media release, Annette King, the Minister of Health (2000) perceived tobacco taxation as "one of the most effective means of encouraging people to quit smoking, or at least to cut down".

In contrast several writers suggested that raising the cost of cigarettes, rather than reducing the number of Māori smokers, instead placed additional financial burden on the families of smokers (Blewden, Waa, Spinola, & Moewaka Barnes, 1997b; Holdaway, 1999; Reid & Pouwhare, 1991). As well, others noted that price increases caused smokers to switch to cheaper brands of cigarettes or tobacco which often had a higher nicotine content (Glover, 1996; Thomson, O'Dea, Wilson, Reid & Howden-Chapman 2000). Consequently Thomson, et al (2000) recommended that the provision of support for smokers to quit, run in conjunction with tax increases was likely to have a greater impact on Māori than tax increases alone.

Aukati Kai Paipa 2000 (AKP 2000) and Aukati Kai Paipa (AKP)

In 1999 the AKP 2000 smoking cessation programme was piloted and delivered by 7 Māori health provider organisations across the country. The free programme included quit coaching and the option to use NRT patches and gum. An evaluation of the AKP

2000 pilot programme showed that most participants who enrolled in the programme had never used NRT before (BRC Marketing and Social Research & Te Pumanawa Hauora, 2000). NRT products were relatively new to New Zealand, were expensive and there had been some controversy in relation to NRT products. One concern had involved NRT as being viewed as simply replacing one form of nicotine addiction with another while an additional concern was in relation to the safety of NRT use among pregnant mothers. Researchers recommended that NRT should not be used by pregnant women without first seeking medical advice. It was also suggested that comprehensive studies should be undertaken to address concerns about NRT (BRC Marketing and Social Research & Te Pumanawa Hauora, 2001).

The AKP 2000 pilot evaluation identified that the programme had removed several barriers to quitting including cost, access and location issues and had been particularly successful in encouraging a "hard to reach" group, including low income earners and heavy smokers, to participate in the programme (BRC Marketing and Social Research & Te Pumanawa Hauora, 2001). The free service targetted Māori women and their whanau. Participants were supported by quit coaches, who were Māori. Often the programme was delivered in a holistic Māori health service setting as well as other settings given that service delivery was relatively flexible to cater for client needs. Participants in the programme felt that the support of the quit coaches and the availability of the NRT patches and gum, were extremely beneficial in helping them to quit smoking. As well, participants were given the option of individual and/or group sessions. The ability to access the programme as a whanau as well as the option to quit alongside others during group sessions removed the difficulties in quitting alone.

Among the programme's participants the quit rate was found to be 23% at 12 months which compared favourably with a comparative study of Māori women who had quit smoking, but were not part of the AKP 2000 programme, and who had a quit rate of 12.5% at 12 months. More than 3200 Māori women and their whanau participated in the AKP 2000 programme (BRC Social Research and Marketing and Te Pumanawa Hauora, 2001).

Further to the HFA's five year plan (1999) the contracts of the 7 original Māori health providers of the pilot programme were extended and a further 28 providers were also

contracted to deliver the programme. The name of the programme became shortened to Aukati Kai Paipa (AKP). Given the programme's extension the number of Māori staff and health providers able to provide a smoking cessation service increased tremendously. Importantly, Whiti Ora Health Services, a Māori health provider which operates under the banner of Te Runanga O Raukawa were successful in receiving a contract to become one of the providers in the extended AKP programme with service delivery covering the entire Ngāti Raukawa region.

Quitline

First piloted in the Waikato and Bay of Plenty regions in 1998, the Quitline service provided a free 24 hour phone line where counsellors offered advice and support with the aim of increasing smokers' motivation and assisting in their attempts to quit smoking. Quitline later became a national programme. In late 2000, NRT subsidised by the government was added to the service. Following this development it was found that 84% of all callers had called Quitline specifically in response to the NRT subsidy becoming available (Ministry of Health, 2001a).

In November 2001 Quitline received 4015 calls and in December 2001, 2373 calls were received. For both November and December 55% of all callers were female. In November just over 20% of all callers were Māori, while in December just under 18% of all callers had identified as Māori[4] (The Quit Group, 2002).

Notably, several teething problems were experienced particularly when the programme first became national (Wilson, 2000). Problems included callers often having to wait to receive their NRT products and as well service delivery procedures were forced to change several times as too little time was given to allow Quitline to employ the additional staff necessary to adequately run the programme, particularly in terms of providing support and advice to callers. The popularity of the programme was completed underestimated, mainly by the government (Wilson, 2000).

[4] The decline in calls during December were closely aligned to financial stress and demands of the Christmas period.

Given the demand for the programme however, the success of Quitline should not be understated. Key barriers to quitting which the programme addressed were access and cost issues. The free 0800 helpline was available 24 hours and was well-advertised. As well the evidence was clear that the affordability of the subsidised NRT products had encouraged high service usage.

It's About Whanau

The mass media advertising campaign, It's About Whanau, was launched in August 2001. The advertisements featured stories of Māori who had given up smoking and who sought to act as role models for their whanau and other Māori (The Quit Group, 2001a). A barrier to quitting which the campaign sought to remove was the perceived normality of smoking among the whanau and as well the campaign stressed that smoking affected the entire whanau and that the issues were about more than the smoker alone. Promotion of the Quitline programme, included in the It's About Whanau advertisements, saw an increase in the number of calls received from Māori (The Quit Group, 2001a).

Quit and Win

The Quit and Win competition was piloted in Hawkes Bay. The competition was open to people aged 18 years and over and encouraged participants to quit smoking for the month in which the competition was held. Participants needed to have been regular smokers to enter the competition. Follow-up at 12 months showed that 40% of the pilot participants had remained quit. Due to its success, the competition was later extended to other regions including Manawatu, Wanganui, Taranaki and Gisborne (Lambert, 2002).

To promote the competition, Public Health Units, generally hospital-based organisations, for each region appointed local co-ordinators. Within the MidCentral Health region (Palmerston North Hospital), information about the competition was distributed widely among key Māori and community groups (Kimura, 2002).

Initially radio stations played on the controversy expressed by the public in regards to the competition, where it was felt that some entrants might revert back to smoking once the competition was over. In response, the organisers of the competition and other health and smoking cessation workers disputed these negative statements. Research (BRC

Marketing and Social Research & Te Pumanawa Hauora, 2000; Glover, 2002) showed that it generally took smokers several attempts to quit. If the competition encouraged smokers to give up either for the first time or as a subsequent attempt, then the competition would have served it's purpose. Unfortunately at the time of writing, the extent of Māori participation in the competition at local and national levels was not yet known.

Hospital and Health Services

In 2001 the Health and Hospital Services smoking cessation programme was implemented. Later named Quit for Our Kids, the programme was based at 9 hospitals throughout the North and South Island and targetted both parents/caregivers who were patients and parents/caregivers of children who were patients, to stop smoking. Quit coaches provided counselling and support to clients who were able to receive up to 8 weeks of NRT supplies. The free service aimed to raise awareness within the hospital as well as in the community (The Quit Group, 2001b).

MidCentral Health was successful in November 2000 in receiving a contract to provide the programme. Two part-time staff, both ex-nurses, were appointed as quit coaches to deliver the programme (MidCentral Health, 2001). Both quit coaches attended the intensive training modules which were developed for the programme.

A key focus of the service was that given the client's or the parents/caregivers reason for their stay or their child's stay in hospital, the effect of smoking on health was likely to be evident. This was likely to be especially so for the parents/caregivers of children who had suffered from respiratory problems and other smoking related illnesses.

A National Māori Tobacco Control Strategy

Priorities identified at the National Auahi Kore Conference held in 2001 included the implementation of quality control and evaluation mechanisms for all Māori service delivery and training, strengthened co-ordination and standardisation of service delivery and training in relation to health promotion and smoking cessation and also by Māori, for Māori research on issues relating to Māori tobacco control. It was envisaged that these priorities would be used to develop the foundation for a National Māori Tobacco Control

Strategy. Development of the strategy was to be a key focus for the next two years among Māori leaders whose work involved smoking cessation and health promotion. The strategy aimed to co-ordinate and develop core initiatives for Māori (Health Sponsorship Council, Te Hotu Manawa Māori, & Aparangi Tautoko Auahi Kore, 2001).

The development and implementation of a national Māori tobacco control strategy should prove beneficial. As well as recognising and encompassing the many conference issues identified the strategy had the potential to improve the targetting of funding and the co-ordination of service delivery throughout the country.

The next section in this chapter provides statistical evidence which identifies high smoking rates among Māori and especially for Māori women including women of Ngāti Raukawa.

Statistics on Smoking

An AC Nielsen survey undertaken in 1996, showed that 26% of those who took part identified as smokers while the results of the 1996 census found that 23.7% of all adults aged 15 and over said that they were smokers (Cancer Society, 2000). Hence the number of smokers identified in both studies were relatively similar.

The high smoking rates among Māori are evident in smoking statistics. Māori are twice as likely to smoke compared to the rest of the New Zealand population.

Table 1: *Cigarette smoking prevalence, 15 years of age and over, by ethnicity and sex, 1996* [5]

Ethnic group	Smoking prevalence		
	all	male	female
NZ European	21	22	20
NZ Māori	44	40	47

In the censuses for 1976 and 1981, the smoking rates among Māori women were more than double the rates for non-Māori women. While the 1996 census showed a slight increase for non-Māori women, the rates for Māori women remained high (Cancer Society, 2000).

[5] Table 1: Source, Cancer Society, 2000.

Table 2: *Cigarette smoking prevalence for non-Mäori and Mäori females aged 20 to 35, 1976, 1981, 1996*[6]

Census year	Ethnicity	
	non-Māori	Māori
1976	28	66
1981	32	65
1996	37	54

Although the figures suggest a decline in smoking prevalence among Māori women from 1981 to 1996, this decline was largely due to smoking-related deaths as well as the small percentage of those who had quit smoking. Significantly, the statistics for Māori women have not improved to the same extent as for Māori men (Cancer Society, 2000).

In the 1996 Census, 21,624 people identified as belonging to Ngāti Raukawa (Statistics New Zealand, 1999). These figures included all those who identified as having an affiliation to Ngāti Raukawa regardless of where they lived. Where respondents identified as belonging to more than one iwi they were included in the profiles for each or all of the iwi which they identified as belonging to.

Table 3: *Smoking Status of Ngāti Raukawa and Māori, 1996*[7]

Ethnic group	Smoking prevalence		
	Smoker	Ex-smoker	Never smoked
Ngāti Raukawa	40	20	40
All Māori	42	18	40

The figures identified for Ngāti Raukawa were not dissimilar to the smoking rates of other iwi. The high number of smokers among Ngāti Raukawa women resembled the statistics found for women of other iwi. Likewise more women of Ngāti Raukawa were smokers compared to Ngāti Raukawa men and there were more smokers in the younger age groups (Statistics New Zealand, 1999). These statistics had severe implications for Māori health as shown in the next section of this chapter.

[6] Table 2: Source, Cancer Society, 2000.
[7] Table 3: Source, Statistics New Zealand, 1999.

The Impact of Smoking on Māori Health

The literature identified that over the last 40 years there have been health gains for Māori in population size and life expectancy. However premature morbidity and mortality rates among Māori, largely affected by smoking, remained a significant health issue (National Health Committee, 1998; Te Puni Kokiri, 1998). Reducing smoking uptake and increasing the numbers quitting has the potential to see major improvements in Māori health. Smoking is the single biggest modifiable health risk factor.

Among Māori adults tobacco-related deaths were often the result of circulatory diseases (such as heart attacks, strokes, aneurysm), cancers and respiratory diseases and from 1989 to 1993, just under one third of all Māori deaths (437 out of 1417) were due to cigarette smoking (Laugesen & Clements, 1998; O'Donoghue, Howden-Chapman, & Woodward, 2000). It was predicted that 8,000 Māori were likely to die from smoking related illnesses within the next 20 years unless smoking among Māori was reduced (Laugesen & Clements, 1998).

Besides the impact of smoking on Māori adults, smoking has also been the cause of a high number of deaths among older Māori. Given the standing of Māori elders as "the repositories of much customary knowledge, skills and wisdom" (Reid & Pouwhare, 1991, p. 33) the loss of kaumatua and kuia, often before their time, represented a significant loss in terms of maintaining traditional Māori knowledge and values. Indeed, as stated by Reid and Pouwhare (1991, p. 33) "tobacco steals them from us earlier than necessary". This was further reiterated by the Health Funding Authority (1999, p. 11) which stated that "given the value that Māori society places in kaumatua, the impact of premature death from tobacco was particularly severe relative to other cultures where the role of the elderly was not as strongly defined".

The effects of passive smoking which impact particularly on the health of children, continued to be ignored by Māori. Babies are especially affected by smoking given the high rates of smoking during pregnancy among Māori women (National Health Committee, 1998). Tobacco-related deaths and illnesses among Māori infants include sudden infant death syndrome (SIDS) and premature or low birthweight. In addition, Māori children and youth whose parents smoked commonly suffer from asthma, glue ear and respiratory. Maternal smoking, teenage pregnancy, bed sharing, and having Māori

parents are high risk factors which impact on the health of young Māori infants (National Health Committee, 1998; Te Puni Kokiri, 2000).

Illness and death among Māori women as a result of tobacco-related diseases gives cause for considerable concern. Māori women are at least three times more likely to die of coronary heart disease and respiratory diseases compared to non-Māori women (Broughton & Lawrence, 1993). In 1996 the number of deaths among Māori women from lung cancer were four times that of non-Māori women and alongside this Māori women had the highest rate of lung cancer around the world (Glover, 1996).

Despite the overwhelming implications of smoking, the findings of the 1996/1997 New Zealand Health Survey showed that those Māori who smoke are generally unaware of the impact which smoking has on their health (Te Puni Kokiri, 2000). Consequently Reid & Pouwhare (1991, p. 30) suggested that smoking is "the major health challenge facing Māori".

Two women of Ngāti Raukawa, Selby and Devonshire wrote about their health concerns with regard to smoking on the marae and among their respective hapū. Selby (1999) referred to the poor health among many of her hapū, Ngāti Pareraukawa, including those who suffered from asthma and other smoking related illnesses. Selby (1999, p. 16) noted that "while ... many marae are now smokefree, we sit in our meetings amidst clouds of smoke and as yet are unable to take that step towards a smokefree marae". Devonshire (1999) referred to the detrimental effect which drugs, tobacco addiction and alcohol have had on her hapū, Ngāti Manomano and hoped that the situation would improve. Both writers indicated that smoking was a health issue for their hapū, that smoking impacted not only on current but also on future generations, and that the consequences of passive smoking and the benefits of smokefree marae were yet to be fully understood.

Conclusion

This literature review identified the broad context in which smoking and quitting smoking takes place and looks at the barriers and supports for those wanting to quit smoking.

The reasons for high smoking prevalence among Māori women are attributable to many complex factors which in turn act as strong barriers to quitting. These factors include high smoking uptake by adolescent Māori, early addiction and the habit of smoking, socio-economic influences, tobacco advertising, peer pressure and peer influences. As well, smoking by Māori women is influenced by social situations and social settings which trigger smoking. Recognising that Māori women tend to smoke in both positive and negative situations is important to understanding their smoking habits. The marae has a key influence on smoking given its perception as normal and part of the socialising ritual. The barriers identified in implementing smokefree marae reinforces the acceptance of smoking among Māori and maintains high smoking prevalence on the marae.

Factors that support or influence quitting included concerns for health, influence or pressure from others, social disapproval and a feeling of responsibility to others. A significant event or a number of minor events and the cost of tobacco products also had an influence on quitting.

Numerous methods were found to be helpful in preparing to quit smoking. Quitting smoking involved either stopping cold turkey, or the utilisation of NRT products and/or enrolling in a quit smoking programme. Success at quitting was shown to be related to the amount and type of support that a person trying to quit had access to.

Maintaining quit status was achieved by changing old behaviours. Among those who took part in smoking cessation programmes, lifestyle changes such as taking up regular exercise were encouraged to reduce the concerns about weight gain which was common among quitters. As well staying quit was either influenced or inhibited by helpful and unhelpful social support.

Either positive and negative consequences or both, were often experienced by quitters. Smoking, quitting and relapse involved a cycle. A return to smoking was largely influenced by being around other smokers, weight gain and high stress situations.

The next section in this review looked at tobacco control developments from the 1990s onward. This included the Smokefree Environments Act (1990), anti-smoking promotions, quit smoking programmes and services.

The following tables identify key tobacco control activities which were initiated to address the barriers to quitting smoking and which provide support for those wanting to quit and which also aimed to reduce smoking uptake among adolescents.

Table 4: *Barriers to Quitting*

Tobacco Control Activities	SF promotions	SF legislation	NMSCP	AKP 2000 and AKP	Quitline	HHS
Barriers to quitting						
High adolescent smoking	X	X				
Early habit and addiction			X	X	X	
Low socio-economics			X	X	X	
Tobacco advertising	X	X				
Peer pressure	X		X	X	X	
Social situations and settings	X	X	X	X	X	X
Lifestyle habits	X	X	X	X	X	X

Table 5: *Support for Quitting*

Tobacco Control Activities	SF promotions	SF legislation	NMSCP	AKP 2000 and AKP	Quitline	HHS
Support for quitting						
Targetting - youth, Māori, women, pregnant women and whanau; parents	X	X	X	X	X	X
Positive SF message	X	X				
Access issues removed			X	X	X	
Programme and product cost issues removed/reduced			X	X	X	X
Group support			X	X		
Social situations and settings challenged	X	X	X	X	X	X
Changing lifestyle habits encouraged	X	X	X	X	X	X

The national statistics for smoking show high smoking prevalence across the New Zealand population. However twice as many Māori are smokers compared to the rest of the New Zealand population. Added to this, the smoking rates among Māori women are more than double the rates for non-Māori women. The high number of smokers among

Ngāti Raukawa women resemble the statistics for women of other iwi with more women who smoke in comparison to men, and more smokers in the younger age groups.

A review of the impact of smoking on Māori health identified the effect of smoking on Māori mortality and morbidity rates. The number of Māori elderly who suffered from smoking related illnesses and premature death represented a significant loss in terms of the traditional Māori knowledge and values held by Māori elderly and which was also lost. In addition to this, exposure to smoking had significant consequences for the health of Māori children and the implications of smoking for Māori women are extreme. Tobacco is a significant preventable cause of illness and death among Māori.

The next chapter in this thesis outlines the methodology and the research journey.

CHAPTER THREE

Research Methods

Introduction

Detailed aspects of the research methodology and the processes which took place in undertaking this research are provided in this chapter. A qualitative research approach using kaupapa Māori and Māori-centred research methods were used in this research to record the experiences of 6 women who had tried to quit smoking and to identify the barriers and supports the women experienced during quitting.

This chapter starts with a discussion of quantitative and qualitative research approaches and the influence of critical theory before looking at the impact of western colonisation and western research on Māori society. A positive resurgence within Māori communities has also impacted on research leading to a range of approaches that are inclusive of a Māori worldview being developed. These approaches are discussed in the context of this research.

The particular approaches used in this research have been challenging for me as a researcher and therefore the research journey undertaken includes the sample, the interviews, ethical considerations and the data analysis and some of the critical issues that have been considered.

Quantitative and Qualitative Research

The benefits of both qualitative and quantitative approaches to research have been noted by several writers including Boulton (1999), Davidson and Tolich (1999), M. Durie[8] (1996) and Rice and Ezzy (1999). Qualitative research is flexible, subjective and accepts multiple realities (Davidson & Tolich, 1999). This interpretative approach provides

[8] M. Durie and A. Durie have both been referred to in this chapter and their initials are shown for this reason.

depth by looking at the meanings behind events, situations, and social systems. For this reason however, qualitative research has sometimes been viewed as less reliable or valid. Quantitative, objective research, on the other hand is synonymous with statistics and finite understandings. It provides breadth and deals with categories, order and often scientific logic. Critique around quantitative research is generally that it is a reductionist approach that assumes situations can be looked at in parts and dealt with in isolation unlike qualitative research which views each of the parts as making up the whole.

At times researchers employ components of both qualitative and quantitative methods in their work. For example, qualitative data can be used to explain the results and meanings behind statistical data. The decision to lean towards a qualitative or a quantitative research approach is often influenced by the research question and the methods which will be most effective in order to answer that question. When comparing qualitative and quantitative research Rice and Ezzy (1999, p. 3) infer that the "difference ... is not simply in the subject of study, statistics compared to meaning. Rather, the difference is in the method of going about the study".

Qualitative approaches have tended to be looked at more favourably by Māori partly as this aligns more with traditional Māori oral approaches to research. Methods used in qualitative research can include techniques such as in-depth interviews, direct observation, document analysis, ethnography, focus groups and narrative analysis. In attempting to align with a Māori worldview, qualitative research is useful in that it allows the researcher to understand people's actions and experiences from their perspective (Rice & Ezzy, 1999).

Qualitative research methods have been used to collect and analyse the data of this study thereby enabling the participants to tell their stories. Patton (1990, p. 18) suggests that the utilisation of qualitative research methods provides information which has "depth, detail and individual meaning". This research involved in-depth, face to face interviews providing in-depth data which could then be analysed against the literature, on anti-smoking government strategies and smokefree legislation and, other studies.

Critical Theory

When undertaking any qualitative study, the theory that underpins the study being conducted should be identified. Rice and Ezzy (1999, p. 11) define theory as "a set of propositions about relationships between various concepts. Different theoretical frameworks direct attention to different aspects of a phenomenon". Good qualitative research relies on a mix of prudent research as well as some researcher insight in terms of determining the theory and methodology which will give the best results for the study.

Critical theory links to qualitative research and Māori methodologies in that it entails a deeper understanding of meanings and interpretations. Several Māori writers have included components of critical theory together with a Māori worldview in their writings (Irwin, 1992; G. Smith, 1997; Walker, 1984; Walsh-Tapiata, 1997). This theory is accepted by many Māori largely because it is able to sit within a Māori framework and has underpinnings that align with kaupapa Māori theory.

Within critical theory there are four sub-theories, the theory of false consciousness, the theory of crisis, the theory of education and the theory of transformative action. Much research on Māori has previously been to their disadvantage perpetuating negative outcomes for Māori. This has led Māori to have a false view or sense of themselves, the theory of false consciousness (Fay, 1987).

In the context of this thesis the critical theory framework helped to underpin how the research was carried out. The women in this study all somewhat blindly started smoking and the reasons for this are traversed both in the literature chapter as well as the data results chapter. This state of false consciousness was perpetuated by low self image and negative messages reinforced even by close whanau members.

Aligned to the theory of crisis, somewhere in their smoking history the research participants became aware of the impact of smoking on both themselves and their whanau. Faced with such a crisis the women chose a variety of quit smoking methods to stop smoking. The stories told by these women talk about the considerable changes that occurred in their lives when they quit smoking.

The theory of education is where the oppressed become enlightened. For Māori this offers opportunities to work towards improving their circumstances and to create their own social change. The final phase of critical theory, transformative action involves identifying societal factors which need changing and the development of strategies for change so that social transformation within the group or society can take place.

Critical theory aligns with the methodologies used in this study and ensures that positive processes and outcomes occur. Transformative action has included empowering the research participants, Māori women, my hapū, iwi, Māori, and myself in terms of the research process. Kaupapa Māori research, which stems from critical theory, is discussed later in this chapter.

Colonial History and Development

Māori like other indigenous peoples always had ways of researching and gathering information prior to being colonised. Western research traditions however were completely different and contributed to the colonisation process in terms of their detrimental effect on indigenous people (Bevan-Brown, 1998; M. Durie, 1996; L. Smith, 1986[9]). According to Linda Smith (1986, p. 8) "research was a small but important part of the colonisation process because it concerned defining knowledge" that was acceptable or otherwise by the coloniser.

Linda Smith (1999, p. 1) also notes that as part of the colonisation process significant issues included the means by which knowledge was "collected, classified and then represented in various ways back to the west, and then, through the eyes of the west, back to those who have been colonised". These ideas are supported by many other Māori researchers and academics (A. Durie, 1998; M. Durie, 1996; Glover, 2002; Royal, 1993; Stokes, 1985; Te Awekotuku, 1991).

Colonists without regard for cultural protocols extracted knowledge and information from Māori and then used this information to exert power and control (A. Durie, 1998; L. Smith, 1999; Stokes, 1985; Te Awekotuku, 1991). Western ideologies and values

[9] Linda Mead has also written work using her married name and is therefore occasionally cited as L. Smith. Her husband, Graham Smith is also cited in this thesis.

prevailed. The researcher (the coloniser, non-Māori) came to be viewed as the "expert" which engendered distrust among the researched (the colonised, Māori). This distrust continues today.

Western research generally favoured either an objective or subjective research approach. The dichotomies encapsulated within these approaches to research have formed the basis of much of the critique from Māori of western research methodologies. Linda Smith (1999, p. 30) explained that the "universal" stance, often taken by western researchers, assumed that there were "fundamental characteristics and values which all human subjects and societies share". Embedded within this so-called "objective" approach, western (or non-indigenous) peoples were considered as the standard or benchmark. Jackson (1998, p. 73) noted that Europeans "postulated as the norm, everything which occurred in western European society". Research findings portrayed Māori as inferior, a feeling which was conveyed to both Māori and non-Māori.

In contrast and in line with a subjective approach, traditional Māori knowledge accepted multiple realities and differences across groups (e.g. Māori and non-Māori) as well as differences within groups. The traditional tribal social structure reflected nuances that were distinct to each tribe (Te Awekotuku, 1991). To view Māori as homogenous meant that internal cultural differences were not recognised. Diverse realities among Māori people have become even greater in contemporary Māori society. The subjective, qualitative approaches to research align more closely to traditional Māori methodologies (Walsh-Tapiata, 1997).

Resurgence of Māori Culture and its Influence on Research

Māori research methodologies have evolved in conjunction with significant events within Māori society, prior to and during the Māori renaissance. The effects of colonisation for Māori were similar to those amongst other colonised indigenous peoples, a "loss of culture, loss of land, loss of voice, loss of population, loss of dignity, loss of health and well-being" (M. Durie, 2002, p. 3).

Rural-urban migration meant that Māori were faced with the prospect of either assimilating into the Pakeha world or living a double life in the "dual world of

biculturalism"[10] (Walker, 1990, p. 198). As Māori adjusted to an urban world where Pakeha practices were predominant, increased political awareness eventually led Māori to question Pakeha dominance and Māori oppression. Activist groups such as Nga Tamatoa and the Māori land rights movement also brought Māori grievances to the attention of the media and the general public. This of course culminated in the Māori Land March in 1975.

Nineteen seventy five was also the year that the Treaty of Waitangi Act became law leading to the establishment of the Waitangi Tribunal. The Tribunal served to highlight the long-term injustices which Māori had suffered as a result of the Crown's failure to meet it's Treaty obligations to Māori (M. Durie, 1998). In relation to research the Waitangi Tribunal gave "a very concrete focus for recovering and/or representing Māori versions of our colonial history and of situating the impact of colonialism in our own world views and value systems" (Mead, 1996, p. 176).

The early 1980s saw the development of kohanga reo (language learning nests) around the country. According to Graham Smith (1997, p. 453) it was around this time that the term "kaupapa Māori" started being used "politically" as an avenue for Māori "conscientisation and resistance" especially in relation to education and schooling. Since then the term "kaupapa Māori" has become "portable" so that its application is now much wider and is used to describe many areas, including research, where Māori are attempting to reassert themselves.

It has been suggested that the period 1984 to 1994 represented a "time of immense change in the country as a whole but for Māori it was a time when many wanted to move beyond looking at the negative indices in Māori society to focusing on positive solutions" (Walsh-Tapiata, 1997, p. 28). The first international conference on the cultural and intellectual property rights of indigenous peoples was held in 1993 in Whakatane. The Mataatua Declaration which came out of the conference sought to reaffirm the ownership by indigenous peoples of cultural property rights. Such developments were reflective of worldwide changes for indigenous people. In 1993 the Draft Declaration on the Rights of Indigenous People was presented to the United

[10] Biculturalism is defined in the Oxford dictionary as "combining two cultures, especially Māori and Pakeha'.

Nations as was the Declaration on the Health and Survival of Indigenous People, in 2002. Both recognised cultural and intellectual property rights and were "as much about development as restoration" (M. Durie, 2002, p. 7).

For Māori, reclaiming themselves was and still is a crucial part of the decolonisation process (L. Smith, 1999). As part of this process, Māori also voiced their resentment of western research and continued to seek redress for the injustices experienced at the hands of non-Māori researchers. Within research this has led to the development of Māori methodological approaches.

Methodological Approaches With Māori Research

Māori have endeavoured to rediscover traditional Māori ways of researching as a foundation for developing research frameworks which are also appropriate for Māori within a contemporary context. As part of this process Māori have acknowledged that there are components of western research which can be useful and can be adapted to meet Māori research needs.

As a result, the development of Māori and other indigenous methodologies has seen a blending of both western methodologies and indigenous practices that accept multiple worldviews (M. Durie, 2002; L. Smith, 1998). This process places Māori concerns and worldviews at the centre and involves an understanding of knowledge, theory and research from a Māori perspective. This stance has allowed Māori to legitimise Māori knowledge as being as important as any other knowledge. This aligns well with the worldviews of other indigenous groups and contributes to a push internationally to validate indigenous knowledge. In turn, global, political and philosophical changes have contributed towards the validation of a Māori worldview.

Typically then Māori research is based on a Māori worldview, which acknowledges the past, the present, the future and the influence of these on the Māori position. Māori research methodologies as with other indigenous and also western research methodologies continue to evolve as a range of different research contexts occur.

Cunningham (1998) has provided a framework that identifies and characterises research based on the level of Māori involvement and control. He has identified research as:

- Research not involving Māori
- Research involving Māori
- Māori Centred Research
- Kaupapa Māori Research

Philosophical approaches to research will fall somewhere within this continuum, from research not involving Māori (ranging from no or limited inclusion of Māori in the process) to research premised on kaupapa Māori philosophies (involving full participation and control by Māori). Within the broad framework of Māori research, researchers may lean more towards one stance or the other. Interestingly the phases may also depict the power relations for Māori evident in any one research project. Often the methodologies used may also overlap.

Cunningham's framework (1998) was primarily constructed to assist the Foundation of Research, Science and Technology (FoRST). However this framework is also useful in allowing other researchers and academics to locate research somewhere on the continuum and to then consider both the understandings that come with that type of research as well as the impact that the research will have on the Māori knowledge base and Māori development. As with western research, within each type of research that Cunningham has identified there are several layers which are continually being reworked and developed. Given this there has been some criticism among Māori that the framework is perhaps too simplistic and that more in-depth discussion may be required.

As noted earlier, the realities in which Māori live are diverse and due consideration must be given to this in research which involves Māori and in terms of the knowledge one is seeking. As Mason Durie (1995, p. 1) states "there is no one Māori reality" and while there are factors which are common among Māori, there are also vast differences in terms of Māori lifestyles. Any attempt to describe Māori as a single entity disregards the internal differences which exist especially given that intra-ethnic (internal) diversity and disparity is greater at this time than ever before (Cunningham, 2000). Bevan-Brown (1998, p. 234) also reiterated this message when she stated, that "Māori research must focus on Māori in all their diverse realities. What is of importance and concern to a person living in a rural situation and identifying strongly with their tribal heritage may differ considerably from a second person living in central Auckland, unaware of and

unconcerned about any tribal affiliations they might have". The range of research types which Cunningham (1998) identified are therefore essential to enable the inclusion of Māori who may sit within these differing Māori realities.

As with diverse Māori realities, there will be a diversity of opinion among the research community over the category in which a particular piece of research fits. The location of the research is largely influenced by the research question, the experiences of the researcher, the researched and other end-users of research. Each will locate the research based on their own perspective of what they believe constitutes Māori research.

Research not involving Māori is research where Māori are not included in the sample and where data concerning Māori is not deemed relevant. This pertains to research whereby the results are considered to have no impact on Māori. Examples include research in quantum chemistry or volcanology (Cunningham, 1998).

Research involving Māori will include Māori as participants and/or as members of a research team. In this type of research, the research processes are more likely to have been developed well before Māori are consulted. Māori researchers working on this type of project are unlikely to have a leading role but will generally have been employed to research Māori communities. Although the research may involve Māori, the project will not be based solely on Māori processes and while the research may include the collection of Māori data through statistics and interviews, the analysis however, will not "produce Māori knowledge - it will produce mainstream knowledge of Māori" (Cunningham, 1998, p. 397). Thus the overriding factor is that the research must primarily meet mainstream needs.

Māori-centred research acknowledges the diversity of research methods (both Māori and non-Māori/western). This method places Māori people and their experiences at the centre of the research activity. Cunningham (1998) like Mason Durie (1996; 1997), suggested that in Māori-centred research Māori were typically involved throughout the research process and at all levels, as participants, researchers, and analysts. The researchers will have an interactive, responsive role and the values which permeate the research will be cultural. Māori-centred research is not value-free. Following the collection of Māori data, a Māori analysis will be applied, and Māori knowledge will be

the result. Importantly, in Māori-centred research the researcher will have dual accountabilities to both mainstream and Māori. However, the expectations of different stakeholders need not be conflicting as long as those that are involved are aware of the differences.

As with other research methodologies, within a kaupapa Māori research approach there are layers. Kaupapa Māori research may be characterised by the extent to which Māori are able to control the research (Cunningham, 1998). The research process including the research priorities and methods will be determined by a Māori researcher or researchers. Māori will be actively involved in all stages of the research and a key focus will be Māori development and the advancement of Māori knowledge.

Kaupapa Māori research derives out of critical theory, hence Graham Smith (1997, p. 491) describes kaupapa Māori theory as "an intervention and transformative strategy which responds to a range of Māori crises". Principles of kaupapa Māori research originally derived from principles relevant to the development of kura kaupapa Māori. These principles are:

- tino raNgātiratanga which relates to self-determination whereby Māori are in control and are able to make decisions and choices for themselves
- taonga tuku iho acknowledges the importance of Māori language, knowledge, culture, values and their survival
- ako Māori recognises the need for culturally appropriate teaching and learning strategies. Smith suggests that while the pedagogies of other cultures may be utilised, Māori must be able to influence the process by incorporating cross cultural methods without devaluing Māori cultural values
- kia piki ake i nga raruraru o te kainga aims to provide cultural support mechanisms to reduce the effects of the socio-economic position of Māori
- whanau emphasises the significance of the extended family as a support structure which has a collective responsibility to each individual member of the whanau and
- kaupapa or the collective philosophy embraces kaupapa Māori initiatives through a common vision and common goals.

Graham Smith (1997) seeks to validate and legitimise kaupapa Māori and Māori ways of doing things. However he also notes that his aim is not to add to the history of

oppression by suggesting that kaupapa Māori philosophies are superior to that of other cultures.

In addition Bishop (1996; 1998) emphasises the importance of "whakawhanaungatanga" and refers to the development of relationships with all who are involved in the research, as a means of establishing a "whanau of interest". As well, Bishop (1998) felt that Māori researchers should be totally committed to the research, "physically, ethically, morally and spiritually and not just as a 'researcher' concerned with methodology".

Mead (1996) suggests the following principles in kaupapa Māori research are:

- whakapapa which embraces genealogical ties and refers to the connection Māori have to all people and to all things.
- te reo acknowledges Māori language as paramount to understanding and expressing Māori worldviews, culture and values
- tikanga Māori is about observing customary practices and obligations
- raNgātiratanga involves Māori having control in decision making.
- whanau provides a support structure which has inbuilt responsibilities and obligations, similar to Bishop's (1998) concept of whakawhanaungatanga. In kaupapa Māori research, the "whanau" principle is significant as a way of organising research, and "connecting with communities and maintaining relationships" (Mead, 1996, p. 218).

Irwin (1994) sees kaupapa Māori research as research which is "culturally safe" and includes the involvement of mentors in the research process to protect both the researcher and those being researched. The study should also be "culturally relevant" and should therefore both value and adhere to Māori principles and practices (Irwin, 1994).

Consequently, Johnston's perspective perhaps sums up the view of many Māori researchers. For Johnston (1998, p. 356) "kaupapa Māori theory, practice and research ... is an approach that incorporates Māori conceptions of our position in Aotearoa, our experiences, history, social relationships and more importantly, our explanations of these positions". Kaupapa Māori research "confirms Māori norms as positive and valid" (Johnston, 1998, p. 356)

Compared to "research involving Māori", "kaupapa Māori research" represents the other end of Cunningham's (1998) framework not only in regards to Māori control and involvement in all facets of the research process but also in terms of the determination by Māori to reclaim Māori history and thereby themselves. While perspectives on what denotes as kaupapa Māori research can vary there are also several common themes. These include the reclaiming of Māori philosophies, an acknowledgement of Māori worldviews, practices and protocols, the significance of the whanau (both whakapapa and kaupapa-based), Māori self-determination, Māori control of the research process and the pursuit for positive Māori development.

A blend of kaupapa Māori research and Māori-centred research principles are utilised in this study.

The Research Perspective Utilised in this Thesis

The term which seems to best describe my research approach is that coined by Boulton (1999, p. 31) who describes the work involved in researching and writing her own Masters thesis as "a Māori research perspective". Boulton (1999) referred to the dual accountabilities which Māori academics experience where it is necessary to meet the university's requirements and at the same time our obligations to the participants. This can present a challenge whereby Māori researchers must endeavour to combine university and hence mainstream research standards and controls alongside Māori research protocols.

Unlike Boulton's work which was largely evaluative, this thesis comes from a policy perspective and therefore looks at policies, legislation and programmes and how these impacted on smoking and quitting among Māori women, whanau, hapū and iwi. The methodologies employed in this research combine Māori centred and kaupapa Māori philosophies and methods. Both philosophies, grounded on basic Māori principles, provide Māori researchers with the opportunity to effectively contribute to Māori development and as stated by Doublett (1997, p. 33) "the value of Māori research lies in its capacity to foster the unique cultural identity of Māori".

Key concepts

Mason Durie (1996, p. 6) identified three key concepts as central to Māori-centred research. They were "whakapiki tangata (enablement or empowerment), whakaurunga (integration), and Mana Māori (Māori control)". These concepts were useful in that they allowed me to illustrate several of the key underpinnings involved in my research, not only from a Māori -centred research perspective but also encompassing kaupapa Māori methodologies and methods.

Whakapiki tangata - Enablement or empowerment

The concept of whakapiki tangata seeks to empower Māori so that Māori are better able to enhance or improve the Māori position (Bishop, 1998; Cunningham, 1998; M. Durie, 1996; Gifford, 1999; Irwin, 1994; Mead, 1996). Although the smoking rates for Māori women are among the highest known in the world very few studies, let alone qualitative studies, have focussed solely on Māori women and smoking. Due to this and given the high smoking rates among the women in my hapū and iwi, the purpose of my research was to capture a sense of the experiences of 6 women of the same hapū (Ngāti Pikiahu-Waewae) and iwi (Ngāti Raukawa) as myself, by looking at the barriers and supports experienced during quitting. Through this study I sought to empower the women as well as my hapū, iwi and Māori in general. Aligned to transformative action strategies this was achieved by extending the knowledge base about Māori women and smoking and by contributing to the lack of information currently available to influence future policies and strategies which support quitting at all levels, namely hapū, iwi and Māori.

My whakapapa links enabled me to recruit the hapū and iwi members who participated in this study. I was an "insider" (Selby, 1996, p. 62). This carried with it the advantage of being a known face to the participants or in the situation where one participant was nominated by a whanaunga my credibility was endorsed by that of the nominator. In either case this enabled a relationship of trust between the participants and myself and in line with Bishop's (1998) concept of "whakawhanaungatanga" a relationship building process evolved.

Gifford (1999, p. 66) suggested that in research which involved whanau, hapū and iwi, the accountabilities involved were "principally to ensure that the research remained focused on the improvement of Māori well-being and to ensure that the processes used to

carry out the research are culturally safe and appropriate". This was consistent with suggestions made by Irwin (1994) and others.

In the initial stages I was horrified at the suggestion by my supervisors of having a hapū/iwi focussed topic. I was acutely aware of my conflicting roles, namely my position as an "insider", that I was of the same hapū and iwi as the participants, and of my role as a researcher based within a mainstream institution especially given that distrust of research and researchers among many Māori, including some members of my hapū, still exists. In addition, even though it was intended that my research would benefit both my hapū and iwi I still felt that primarily the benefits of this research would be for me personally as I would obtain my Masters degree. Selby (1996, p. 49) described similar concerns whereby she "humbly accepted" her participants involvement in her study with the knowledge that she would greatly benefit from their input.

It was largely due to the fact that I felt it might be difficult to find 4-6 women from my hapū who had quit smoking that the study sample was extended to also include women of the same iwi as myself. I was embarking on this research at a time when anti-smoking promotions and programmes, including media campaigns and the national Quitline programme, which targetted Māori were just beginning to take off and as a result within te ao Māori and within my hapū as well, there was a strong sense that anti-smoking campaigns were an attack on the "rights" of smokers. From both my work and personal experiences I was well aware that the impact of anti-smoking promotions were not unlike advertising; slow, subtle and often unconscious. I was therefore not surprised at the initial negative reactions from within and outside of my hapū to the campaigns. However, across the country, Māori and the New Zealand population as a whole, were gradually changing their smoking habits, for example by smoking outdoors. Often this occurred without realisation of the impact that the nationwide anti-smoking campaigns and promotions were actually having. My assumption is that those who eventually agreed to participate in this study did so initially because of whakapapa links but also because each of us envision a better, healthier future for our hapū and iwi. With this research I hoped that we would be empowered and grow in terms of upskilling ourselves through our relationship within this research process and that we might also be "better positioned to take control of our own health" (M. Durie, 1996, p.6).

To enable and empower the women who participated in this research and to ensure that culturally appropriate research processes were employed I ensured that each participant had a clear understanding of the research project, what their participation in this research would involve and my obligations to them both as a whanaunga and as a researcher. The women were informed that the purpose of my research was to record their experiences and that they could ask questions about the study at any time, before, during and after the interview. Further background to the study was provided both verbally and in writing initially via the information sheet (Appendix A). The interviews, which were kanohi ki te kanohi (face to face) were held at a place and time chosen by each of the participants. Some chose to be interviewed in their homes and others in their workplace. I explained that the consent forms (Appendix B) were for my records and to meet Massey's ethical requirements and would not be seen by anyone else. All of the participants agreed to be tape recorded and were informed that they would be sent the edited interview transcripts during which time they could add, delete and/or change any information.

The participants were assured that every attempt would be made to preserve their integrity and that of their hapū and iwi. I was mindful that the research should empower the participants. Given the small sample size and the fact that the women were of the same hapū and iwi as myself it was not possible to guarantee anonymity in regards to the interview taking place although they could choose to remain confidential. Three of the 6 participants chose this option and therefore chose pseudonyms for themselves. It became clear that there were definite links between my need to protect the participants, in terms of my hapū and iwi responsibilities, as well as meeting my obligations as a Massey University researcher and in meeting the ethical requirements of the Massey University Human Ethics Committee (MUHEC).

The length of time spent with the participants varied from 1 to 2 hours to a full day or evening. This was due to the fact that my hapū and iwi relationship to the participants meant that there was an expectation that time would also be spent talking about other matters concerning our whanau, hapū and iwi. This occurred regardless of the venue for the interviews. In line with Irwin's (1994) description of culturally safe practices, every attempt was made to adhere to Māori practices and protocols. This process definitely allows for the "wealth of information" and knowledge that is gained over and above the actual interview (Walsh-Tapiata, 1997, p. 172). During the interviews I allowed each

participant to dictate the amount of time I spent in their company. It was indeed a privilege to listen to the stories and taonga (treasures) which the women were willing to share.

Whakaurunga - Integration

The term whakaurunga is used to describe research which encompasses a holistic Māori worldview where both traditional and contemporary issues are studied and identified (M. Durie, 1996; Mead, 1996). The literature reviewed for this study illustrated the Māori experience, from the past to the present, providing a broad picture of the context in which smoking and quitting among Māori women takes place. This was paramount in order to fully understand the circumstances around Māori women and their high smoking rates and thus to identify the barriers and supports for quitting. This also provided a foundation on which to look specifically at issues for Māori women within my hapū and iwi.

Mason Durie (1996, p. 6) proposes that within this integrated approach, research must acknowledge the "complex interactions" which exist. Thus I was mindful not only of the relationships between the past and the present but also of my existence both as an individual and as part of a collective, namely my whanau, hapū and iwi. Throughout the research I was appreciative of where I came from, of my identity, my turangawaewae (place of belonging) especially given that as an insider and not dissimilar to other qualitative researchers, I am a part of the community I am researching (Rice & Ezzy, 1999).

Classic examples of the traditional (or the past) and the contemporary (the present) in terms of the research processes used were evident whereby the interviews with participants were kanohi ki te kanohi while outside of the interviews contact was maintained largely by email and phone. Time and distance prevented us from carrying out all contact via the face to face approach traditionally favoured by Māori. Possibly due to my whakapapa links and relationship with the participants the integration of both traditional and modern methods of communication were acceptable and were practiced without undermining Māori values (G. Smith, 1997).

Mana Māori - Māori control

The concept of Mana Māori is related to tino raNgātiratanga and Māori self determination and refers to research which is controlled and directed by Māori (Cunningham, 1998; M. Durie, 1996; Mead, 1996; G. Smith, 1997). The processes utilised in this research were developed in consultation with my supervisors and extended support people. From the outset I had intended to focus my study on Māori women thus I was especially pleased to have two Māori women, appointed by the School of Sociology, Social Policy and Social Work, as my supervisors. As the research topic developed and with strong advice from my supervisors to write about my own hapū and iwi, it was an added benefit that both my supervisors were of the same iwi (Ngāti Raukawa) as myself. My work colleagues were also a constant source of advice and support throughout this research as we are all working in the area of Māori health research and Māori development. In the final year of my thesis another Māori women and work colleague was appointed as one of my supervisors due to the unavailability of one of the Ngāti Raukawa supervisors. In every essence mana Māori was maintained.

Several writers (Bishop, 1998; Boulton, 1999; Glover, 2000; Irwin, 1994; Mead, 1996; Selby, 1996; G. Smith, 1997) emphasised the significance of whanau support structures for Māori researchers, both whakapapa and kaupapa-based. My support people, namely my supervisors and work colleagues, have guided me throughout this research. The participants of my hapū and iwi have also shared in the research process. While I was cognisant of my obligations to Massey University, as much as possible this research was determined by Māori, for Māori and with Māori. I have attempted to attain standards suggested by Mason Durie (1996, p. 7) whereby he proposed that the "mana Māori" principle "enforces Māori initiative and drive in (health) research and rejects attitudes of superiority that in the past have resulted in Māori being regarded simply as passive subjects". Hence factors appropriate to critical theory, kaupapa Māori theory, and in addition principles central to qualitative research, kaupapa Māori and Māori centred research, were fundamental to this study.

The Research Journey

The experience gained in undertaking this research was invaluable for me as a researcher and the unplanned inclusion of factors specific to two other marae were an additional

bonus. This section looks at the research journey in relation to the sample, the interviews, the ethical considerations and the data analysis methods used in this study.

The Sample

The sample for this study were 5 women of the same hapū (Ngāti Pikiahu-Waewae) and iwi (Ngāti Raukawa) as myself who had tried to quit smoking in the past 12 months. Although the study involved interviewing a small number of participants Rice and Ezzy (1999, p. 47) comment, that for qualitative studies "the number of participants is less important than the richness of the data".

Participant selection for this study involved purposeful sampling which according to Patton (1990) allows for in-depth study around a research topic. Similarly, Rice and Ezzy (1999:43) note that purposive sampling "aims to select information-rich cases for in-depth study to examine meanings, interpretations, processes and theory". My supervisors had suggested seeking participants who were "talkers" and who would be good to interview. Ideally then the participants needed to comprise Māori women who would be comfortable with sharing their stories.

Participants for the study were recruited by using a snowball approach. Whanau and hapū members told me of two women of my hapū who had recently tried to quit smoking and who might be suitable study participants. Both agreed to participate in this study. It was the intention that participants would "snowball" from there (Patton, 1990).

I had spoken to two people who I knew well, both are of Ngāti Raukawa descent and both were working in smoking cessation programmes, in the hope that they might be able to act as intermediaries by making copies of my information sheet available to potential participants. The name of a whanaunga who had voiced her interest in taking part in the study was passed on to me. Once I contacted her she agreed to participate in the study. Although this women was the only participant that was not from my hapū she had links to other neighbouring marae and she was also from Ngāti Raukawa.

The final two participants that I approached were two women of my hapū that I knew had given up smoking but had both recently returned to smoking. At first they were

somewhat reluctant to be interviewed. I assured them that their experiences were just as important and valuable as their smoking relapse described the experiences of many women. Both agreed to be interviewed.

During early discussion with my supervisors we had felt that it might be interesting to interview participants across a range of different age groups (e.g. rangatahi, pakeke, and kuia) and different living situations (e.g. to include some women who lived in urban areas and some who lived in rural areas). This was an attempt to ascertain whether the range of Māori women had similar or different experiences in their attempts to quit smoking.

The participants in this study however did not comprise the broad range initially anticipated though the data gathered met the objective of this thesis, to record the experiences of women who had tried to quit smoking. A fuller description of the participants profiles are included in the data results chapter. In summary, their ages ranged from 25 to 39 years. Time spent at secondary school varied from 3 to 5 years and most of the women held tertiary qualifications. All were employed in reasonably well-paid jobs, ranging from administration to teaching and one of the women lived in a rural area with others living in urban areas.

Three of the six participants interviewed chose to be identified. I recalled Selby's (1996) experience where a participant had withdrawn from her study due to concerns about who would have access to her story and also because the other participants had all agreed to be identified. I accepted the decisions of those participants who did not wish to be named without questioning their reasons. Pseudonyms were therefore used where appropriate.

Across the participants there was some variation in terms of marae involvement and attendance. Two of the participants in particular live at least 2 hours drive from the marae that they have the closest affiliation to and generally only visit the marae on certain occasions such as tangi. Through whakapapa each of the 6 participants have links to my own particular marae, however 2 of the participants were both more actively involved in other Marae which they also whakapapa to. This variance meant that the participants stories related to at least 3 different marae and hapū.

The Interviews

The interviews sought to gain an understanding of the participants experiences and to help understand the nature of the issues around smoking and the barriers and supports for quitting. The interview schedule (Appendix C) was semi-structured and included both open-ended and closed questions. The schedule covered several key areas: smoking history, educational background, employment background, the environment in which the participants' quitting attempts had taken place including the support or otherwise of friends, work colleagues and whanau and the participants' aspirations for whanau, hapū and iwi in terms of smoking. The closed questions were related to smoking history and smoking levels. These questions were also repeated later in the interview schedule in the form of open ended questions so that the participants were able to provide more detail if they wished.

From earlier reading of the literature (Broughton & Lawrence, 1993; McGee, et al, 1995; Klemp, et al, 1998; Te Puni Kokiri, 2000) it was indicated that socio-economic circumstances were a significant contributor to the smoking habits of women, and especially Māori women. To assess whether these factors held true for women of my hapū and iwi, questions concerning education and employment were therefore included in the interview guide.

I was interviewed by one of my supervisors, as a pilot to the interview guide. This offered me a valuable opportunity to practice the questions and the use of the technology. During this session my supervisor advised me to be well-prepared for each interview by becoming comfortable with the questions and familiar with the order of the questions as well as testing the tape recorder, the volume and making sure that I had enough tapes before I set off for each interview. Following the pilot the decision was made to change the order of some of the questions to improve the flow and to ensure that the interview schedule would serve "to guide the interview but not to restrict it" (Selby, 1996, p. 59). It was also decided to include my interview as a part of the study.

Initial contact to arrange the interviews was made with the participants by phone and email. Only one of the participants lived locally. All 5 participants used email regularly and none saw this method of communication as impersonal although I also knew each of

the participants reasonably well. Due to the busy work and personal lives of the participants communicating by email was far easier especially given that several times interview dates needed to be changed due to tangi and other unexpected circumstances. It is taken as a given among Māori that appointments such as the interviews for my study are secondary to other matters, including hui and tangi, which arise. Māori researchers must accept changes at short notice. Two participants chose to be interviewed at their workplace, while the three other women opted to be interviewed in their homes.

Prior to the interviews all participants were mailed copies of the information sheet. Before each interview I went through the information sheet and consent form with the participants who were then asked to sign the consent form. During the interviews I followed the interview schedule. This ensured a consistent collection of data. However the open-ended nature of the interviews also allowed the flow and content of the interviews to be shaped by the participants.

My supervisors had advised me to let the participants talk and "tell their story" so that the experiences of the women might be described in as much detail as they were willing to contribute. The interview times varied from to 1 to 2 hours. Two of the interviews which were much shorter than the others were likely because I knew the participants reasonably well and I did not realise until later that some answers to questions were not teased out as much as they could have been because either the participants or myself, possibly presumed that the answers or responses did not need to be stated. This is no doubt due to the close relationship which I shared with the participants and in this instance my insider position might be considered as a disadvantage. Occasional prompting was used where a participant was slow to respond or seemed unsure of the question. At other times participants would unknowingly answer several questions at once. Tape recording the interviews proved invaluable as few handwritten notes were taken.

Rice and Ezzy (1999, p. 68) noted a key advantage in relation to in-depth interviewing is that "people generally find the experience rewarding". The interviews provided an opportunity for the participants to talk about their experiences. For those four who had remained smokefree the opportunity to share in a major achievement in their lives was noted. For the two who had returned to smoking, the interview encouraged them both to think about trying to quit again sometime in the near future.

One of the limitations of in-depth interviewing is the "investment of time and energy" which is required (Rice & Ezzy, 1999, p. 68). As previously stated a considerable time was spent with each participant. The entire process was much bigger than the interview itself. I had travelled to interview four of the five participants since only one of the participants lived locally. In all instances we shared a meal or coffee. Additional time was also spent with the participants outside of the interview "catching up". The amount of time spent in each participant's company was expected given my role as a Māori researcher and my insider connection to the participants as being of the same hapū and iwi and myself.

I transcribed the interviews myself and although this was time consuming this proved beneficial in several ways. Listening to the interviews a second time reminded me of the manner in which questions had been answered. For example, when a participant had been whakama, shy or nervous. I was also familiar with the names, places, hapū and marae referred to by the participants, a situation that may not have been the case if another person had transcribed the tapes.

The edited transcripts were sent to the participants to check and make deletions or additions, and then returned. The process of transcribing interviews and forwarding these to participants for editing can be time consuming. In other studies (Stewart, 1999) the final transcripts ended up being quite different from the actual interviews which took place. Despite my concerns about the possibility of any changes to the transcripts being made this proved unfounded as the transcripts were returned with no changes required.

Ethical Considerations

The ethical issues considered were due to my responsibilities as a Māori, a researcher, and as an "insider" whose participants were of the same hapū and iwi as myself and as a student from Massey undertaking a Masters thesis. To meet the University's requirements, ethical approval was sought from the Massey University Human Ethics Committee (MUHEC) and was eventually given subject to minor changes to the information sheet.

Role of the researcher

Massey's ethical standards required that I made it clear to participants that during the interviews my primary role was as a researcher and a student. This was imperative given that the participants were of the same hapū and iwi as myself. I explained at the outset that the research would contribute to an academic qualification.

Information sheet and Informed consent

The information sheet gave a full explanation of the research objectives and was posted to the participants. Any questions were addressed prior to the interview when I again went through the information sheet and also the consent form with the participants who were then asked to sign the consent form. The participants were advised that their participation in the research was totally voluntary and that they could withdraw at any stage from the project. As well, they could ask questions at any time before, during or after the interview.

Anonymity and confidentiality

Anonymity could not be guaranteed in terms of the actual interview taking place due to the small and specific study sample. Every attempt, however, was made to keep the participants' identities confidential where they requested.

Reducing potential harm

All of the participants agreed to have the interview tape recorded and were informed that they could stop the tape or withdraw from being interviewed at any time. While initially some of the participants seemed somewhat distracted at the sight of the tape recorder as the interviews progressed they soon relaxed. The contact details of my supervisors and myself were included in the information sheet so that participants were able to contact either my supervisors or myself if they had any queries with regards to this research.

Access to and ownership of the data

Care was taken to ensure that the data was stored securely in a locked cabinet at Te Pūmanawa Hauora, Te Putahi a Toi, Massey University. Access to the data was denied to anyone except my supervisors and myself. My work computer was protected by an access code. Tapes were returned to the participants once the study was completed and all participants received a summary of the study findings. The final thesis report was

made available through the libraries at Massey University, Te Wananga O Raukawa, the School of Sociology, Social Policy and Social Work, Massey University and from myself.

Data Results, Analysis and Discussion

To organise the data I cut and pasted by computer, the participants transcripts for each question into separate files. Throughout this process the commonalities and the differences in the data information gathered were identified. The final section in the data results were specific to Ngāti Raukawa marae, hapū and iwi. While several issues were described earlier in the data results, this information was also included in the final section and emphasised the influence of key factors which impacted on smoking and quitting within a social and cultural environment. The prominence of addressing hapū, marae and iwi issues is a unique aspect of this thesis.

The analysis and discussion chapter looked at key factors identified in this study and compared the stories of the women against the literature. The barriers and supports for quitting, many of which are unique to these Ngāti Raukawa women, are discussed.

Conclusion

This chapter outlined the research methodology and the processes which took place in undertaking this research. The methodology encompassed qualitative research, critical theory and kaupapa Māori theory together with kaupapa Māori and Māori-centred research principles to record the experiences of 6 women who had tried to quit smoking and to identify the barriers and supports they experienced during quitting

The benefits of both quantitative and qualitative research approaches were noted. Qualitative methods were utilised in this study to collect and analyse the data which involved in-depth interviews.

Critical theory was aligned to qualitative research and Māori methodologies in its application to this study in looking at reasons for smoking and quitting smoking among Māori women and in identifying the barriers and supports the women experienced during

quitting. Critical theory ensured that positive processes and outcomes occurred in the research journey.

The research journey highlights many of the considerations that had to be taken into account in order to undertake this piece of research. In addition to the empowering of those who participated in the study it was a powerful learning experience for me as the researcher. The narrative approach which allowed these women to share their stories including their dreams of a smokefree whanau, hapū and iwi is presented in the next chapter and presents the information rich data described as core to the research methodologies utilised.

CHAPTER FOUR

Data Results

Introduction

This research records the experiences of 6 Ngāti Pikiahu-Waewae and Ngāti Raukawa women who have travelled the quit smoking journey. The data results offer an opportunity for the voices of the participants to come alive and provides evidence around the issues of smoking and quitting smoking for Māori women and identifies the barriers and supports which the participants experienced during quitting.

Following a description of the participants profiles the data looks firstly at key factors which infuenced the women in this study to become smokers followed by key factors which supported and influenced the participants in their decision to quit.

The processes around quitting began with the preparations made by the participants prior to quitting. The supports that enabled the participants to cease smoking completely are described as are the changes that they put in place in order to maintain their quit status. For those who were unable to remain quit issues that contributed to their relapse are highlighted.

The final section of this chapter looks at the participants views of the supports and barriers to stopping smoking within the context of their whanau, hapū, marae and iwi of Ngāti Raukawa. Opinions were expressed around the participants' awareness of the support systems in place, including the programmes and services available in Ngāti Raukawa. The participants were asked to comment on developments within Ngāti Raukawa which had supported them personally to quit smoking and that also had impacted on the iwi overall.

Participants Profiles

Koea is aged 32. She attended secondary school for four years and then went on to tertiary education. She has a teaching background. Koea lives in the city with two other non-smokers. Her strongest affiliation is to Te Tikanga Marae and because she lives at least 2 hours drive from Te Tikanga she sometimes finds it difficult to return to the marae but generally attends tangi several times a year. At the time of the interview Koea had been quit smoking for 1 year.

Tui is aged 30. She attended secondary school for three years. Her work has involved mainly customer services and administration. Tui lives in the city and lives alone. Her strongest affiliation is to Te Tikanga Marae, and although the marae is at least 2 hours drive from her home she regularly attends tangi. At the time of the interview Tui had recently returned to smoking.

Nicola is 25. She attended secondary school for five years and has a teaching background. Nicola lives in Taihape and lives mostly alone. Her strongest affiliation is to Whitikaupeka Marae ki Moawhango. She lives 30 minutes drive from Whitikaupeka and is actively involved in marae activities together with marae, hapū and iwi development. Nicola also has close whakapapa links to Te Tikanga Marae. Nicola had been quit smoking for 3 years at the time of the interview.

Weka is 33 years old and she attended secondary school for 3 years and Polytechnic for 1 year. Her work has involved mainly customer services and administration and she currently works for a large organisation in the city. Weka lives alone in a small town. Her strongest affiliation is to Te Tikanga Marae. She lives 30 minutes drive from the marae and is actively involved in marae activities. Weka had recently returned to smoking at the time of the interview.

Tracey is aged 39 years. She attended secondary school for 5 years. She spent many years working with Child, Youth and Family (CYF) and is currently a social worker for Te Runanga O Raukawa. Tracey lives with her husband (a smoker) and her children in Foxton. Her strongest affiliation is to Poutu Marae, Shannon, and she is actively

involved in marae, hapū and iwi activities. Tracey had been quit smoking for 1 year at the time of the interview.

Sharon is 39 years old and she attended secondary school for 4 years. She has undertaken tertiary studies and works as a researcher at Massey University. Sharon lives mostly alone as her teenage daughter is at boarding school and her son lives overseas. Her strongest affiliation is to Te Tikanga Marae. She lives 40 minutes drive from the marae, is actively involved in marae activities and has a keen interest in marae, hapū and iwi development. At the time of the interview Sharon had been quit smoking for 6 months.

Across the participants there was some variation in terms of marae involvement and attendance. Koea and Tui, who live at least 2 hours drive from Te Tikanga Marae generally visited the marae only on certain occasions such as tangi. However Nicola, Weka, Tracey and Sharon were each involved in marae and hapū activities on a regular basis.

Through whakapapa each of the 6 participants have links to Te Tikanga Marae, however 2 of the participants, Tracey and Nicola were both more actively involved with other marae, Poutu ki Shannon and Whitikaupeka ki Moawhango, which they also whakapapa to. The women's stories therefore are in relation to at least 3 different marae and hapū.

At the time of the interviews 4 of the participants, Koea, Nicola, Tracey and Sharon, had been quit smoking for more than 6 months, while 2 participants, Tui and Weka had both recently returned to smoking.

Influences on Smoking

During the period 1981 to 1989 the women in this study were introduced to smoking and then went on to become regular smokers. The participants discuss what led them to take up smoking and the significant barriers experienced during quitting.

Initiation to smoking

Peer pressure played a key role in the participants initiation to smoking. The women did not describe peer pressure as being coerced to smoke but rather as being influenced by what their peers were doing. Smoking initiation and experimenting with smoking occurred largely due to the fact that the participants had grown up in an environment where smoking was predominant among their friends, parents and whanau.

Tui, Nicola, Koea, and Weka, were introduced to smoking while at school, starting in their early teen years from as young as age 12.

The first time smoking, trying it out, was when someone had a smoke and I might've done that two or three times in Form 1 and Form 2[11] *(Nicola).*

Their smoking continued at secondary school and generally involved associating with other smokers. As teenagers many of the participants had perceived smoking as a grown-up thing to do especially given that older whanau members were also smoking.

It [smoking] was purely social because that's where everyone was. At school it was cool. I smoked every day, building the addiction (Nicola).

At school it was cool to sneak around and smoke. ... My brothers and cousins and that would give me smokes and it was just the in thing (Koea).

Sharon and Tracey, unlike the other participants, had not smoked in their early teen years and during their school years.

I didn't get into smoking at school ... I wasn't interested (Sharon).

My mates didn't smoke and a lot of them were Pakeha. I wasn't interested in smoking, absolutely not interested (Tracey).

[11] The participants quotes are shown in italics.

Tracey perceived that the smokers at school were more likely to be Māori and that because she socialised less with Māori she was less likely to be around other smokers.

When Sharon and Tracey did begin smoking they both indicated that they tended to socialise with other smokers and both viewed their smoking during those times as an "adult" activity. Tracey did not take up smoking until she was in her early 20s when she not only left home but also her hometown. Sharon began smoking after she had finished school and had left home at age 18. Both saw their initiation to smoking as a step towards "adulthood" and to being independent.

I think it was the freedom ... it was just a new world and that world involved smoking, drinking, socialising (Tracey).

After I left home I was around lots of other smokers (Sharon).

For Koea, having two parents who smoked made smoking appear normal. Koea was the only women in this study who mentioned easy access to cigarettes by sneaking them from her parents cigarettes and because they were relatively inexpensive.

I was pinching smokes from 13, mum and dad's smokes (Koea).

Everyone used to buy Mild 10s. It was just in. We'd go and pinch the milk money ... then go and buy Mild 10s and then puff on those (Koea).

Notably, in the 1980s there was no restriction on age to purchase cigarettes.

Smoking regularly

Each of the participants quickly became regular smokers, smoking on a daily basis. Koea, Nicola, Tui and Weka perceived themselves to be regular smokers by age 15. Sharon and Tracey started smoking at 18 and 22 respectively, but they both became regular smokers almost immediately.

The number of years smoked ranged from 9 to 17 years[12]. This smoking history is relatively high considering that ages of the participants ranged from 25 to 39 years old at the time of the interviews.

The participants were asked to identify their smoking levels, ranging from a "heavy" smoker (20 or more cigarettes per day) to a "low" smoker (less than 5 cigarettes per day). Two of the participants considered themselves to be heavy smokers, 3 were medium smokers and 1 considered herself as a low smoker. Given that often smokers will underestimate their level of smoking perhaps this was the case for the participants in this study although importantly each of the women noted that their smoking levels tended to vary in different situations.

I was a low smoker daily, I smoked about 5 a day. I would smoke 20 smokes when I was out drinking. I would've been a medium to heavy smoker when I was socialising (Tui).

Consequently particular social settings triggered the participants inclination to smoke and the amount they smoked. The women felt that they tended to smoke more when at the marae, at work and when drinking alcohol and socialising.

Each of the participants were involved in marae activities to varying degrees and all emphasised that the marae was a key setting where they felt the desire to smoke. Smoking was definitely considered a large part of the social scene as during hui and tangi there were always lots of smokers. Smoking at the marae was seen as a way in which to relieve stress. Smoke time was also seen as "break time" and often during hui and in between working in the kitchen and to reduce boredom. Smoking at the marae also provided a chance to catch up on all the gossip.

In kapa haka there were a lot of smokers. Have a break, have a smoke (Tracey).

[12] The total number of years smoked was based on the participants age at the time of the interview, minus the age at which the participants had started smoking regularly and less any time off smoking, for previous quit attempts and for Tracey and Sharon time off during pregnancies.

There's a joke at our marae that the main paepae is out the back, because when everyone's sitting out there having a smoke that's when all the gossip's going on. I used to think that was funny (Sharon).

The statement made by Sharon suggested a change in her attitude had occurred towards smoking on the marae. She was ashamed that she and so many others had taken smoking at the marae for granted. The influence to smoke and the habit of smoking was so strong at the marae that Koea considered the marae as one place where there was no point in thinking about quitting.

I was just smoking non-stop. High stress situations around lots of people. Everyone smoked just everywhere. I didn't even try and give up smoking then (Koea).

For the participants, their experiences on the marae showed how within the same social setting, smoking is often used to enhance both a positive situation, for instance having a chat and catching up with whanau, and to reduce a negative or stressful situation, for example having time out from working in the kitchen and/or during tangi. It is largely because Māori women tend to smoke for both the positive and negative affects of smoking and often within the same setting, which makes quitting particularly difficult.

Another setting where the participants tended to smoke a lot and often, was their workplace, alongside workmates and to reduce work stress.

Tracey described her previous job, prior to working for the Runanga,[13] as involving significant work pressures where she smoked regularly during her working day.

I think smoking enabled me to get through the mahi that I had at that time and it was all that pressure stuff, that stress relief. Smoking was one of the only pleasures that I had (Tracey).

[13] Te Runanga O Raukawa has offices in Feilding, Otaki and Levin and provides several services including health and social services. These services are available within Ngati Raukawa ki Te Tonga. The key target group for Te Runanga are the hapü and the affiliated iwi of Ngati Raukawa iwi.

In times of stress the women tended to smoke more and used smoking as a stimulant to get through a difficult situation or task.

The third trigger the participants identified as perpetuating their smoking was when drinking alcohol and socialising. Tui stated that she did not smoke at work but that for her and her work colleagues, drinking alcohol, socialising and smoking went hand in hand.

On the other hand both Sharon and Tracey smoked when they were at home alone. Sharon had been a single parent while Tracey and her partner had lived apart for sometime because their jobs meant that they were living in different cities.

I think smoking was my friend ... because I was at home a lot by myself with a young child (Sharon).

Interestingly in these situations other smokers were not present to tempt them to smoke. Instead, both used smoking as company to reduce a negative situation and to compensate for being alone.

Factors that Supported Quitting

Between 1999 and 2001 the participants began to think about quitting smoking. The context for quitting was considerably different in comparison to the 1980s when each of these women first became smokers due to the growth in support for quitting.

Key factors which had encouraged the women to quit included: influences at work, children and rangatahi, personal health, the loss of whanau members due to smoking, the policy at Te Wananga O Raukawa, cost and the Quitline programme.

Influences at work

The Smokefree Environments Act (1990) and its amendments together with anti-smoking promotions have had a huge effect on where people are permitted to smoke and where they feel comfortable smoking, notably the workplace is one such area. The main

influences within the workplace to quit smoking identified by the participants were the public's perception and their own of smoking as being bad.

Nicola, is a school teacher and while at the time of the interview the grounds at Nicola's school were not completely smokefree, a designated smoking area had recently been put in place. This was a small shed which necessitated a long walk during the limited break times.

There are some [smokers] but you don't see it in your working environment. They have to go out to the garage. You never see it (Nicola).

The ostracising of smokers often to unfriendly spaces or places has had a big part to play in encouraging smokers to think about quitting.

For Tracey, a change in jobs created a change in her smoking habits.

When I came to Te Runanga, a number of stresses were relieved. I didn't have the same kind of work pressures as my old job (Tracey).

Her new roles also made her see that as a descendant of Ngāti Raukawa and a staff member of Te Runanga O Raukawa she was an example for others of Ngāti Raukawa.

Children and rangatahi

Tracey's desire to be a good role model for both her children and other rangatahi then motivated her to think about quitting.

I thought about what mentoring meant and if I was going to be doing the korero, standing in front of rangatahi, I actually needed to be a good role model ... but I was a smoker! (Tracey).

Although Nicola is a school teacher she did not indicate that "children" had had any direct influence on her reasons for quitting smoking. It is possible that this may have been because Nicola had already been quit smoking for some time prior to the interview.

Personal health

Several of the women in this study were conscious of the effect of smoking on their personal health. None of the women identified a specific health concern but commented that smoking was bad for their health in general.

Loss of whanau members due to smoking

The participants were acutely aware of the impact that smoking had had on their whanau as most had had whanau members who had been smokers and who had died from cancer.

My mother died of cancer and all my aunties died of cancer. A major thing was nursing mum, through watching her die ... and dad he was just surviving on smoking cigarettes ... I knew it was killing him (Koea)

The death of Nicola's grandfather was the first time she considered giving up smoking. However it was not until another whanau member became ill with lung cancer that Nicola actually quit again.

Te Wananga o Raukawa policy

Nicola was the only participant who was a student at Te Wananga o Raukawa[14] at the time of the interviews. When Nicola first enrolled at Te Wananga she was still smoking. She referred to the high number of students who were smokers at that time and how the idea of banning smoking within the campus grounds was mooted.

It [the policy] was being talked about in my first year. In that time we [smokers] were all in the centre of the place. The smoking was rampant. We smoked in most places outside of the buildings. Then that got pushed out. First of all they nominated a zone and you started to notice the stinky smokers go to that area. It made you stand out, separate, and you could see who smoked. They were always talking about it [the policy] in classes, classes would be debating it. Then we had a survey with questions like, would

[14] Te Wananga o Raukawa, an initiative of Te Atiawa, Ngati Raukawa and Ngati Toa Rangatira iwi, provides tertiary education courses from its main campus in Otaki alongside the delivery of its education programmes at marae. Interestingly, the three marae identified by the participants, Whitikaupeka ki

you come back if the Wananga was totally non-smoking, would that stop you from learning at Te Wananga and those sorts of things. So there was a lot of talk before it happened. Then they made the decision, put the panui out and said right next year when we [Te Wananga] start it's going to be no smoking. When you smoke you go out on the road (Nicola).

The smokefree policy and a specific Ngāti Raukawa initiative, Te Ohaki, once put in place meant that those who continued to smoke would have to walk to the front gate.

The Wananga was making it harder to smoke, you had to go somewhere and that was a nuisance. So the hub of the place, the social things became non-smoking. So you wouldn't want to go for a smoke because you're missing what's going on. There's still the diehards that need to go out there but it became another chore (Nicola).

This new measure caused many Te Wananga students to either quit smoking, think about quitting or at least cut down their smoking. Nicola also indicated that Te Wananga had promoted healthy lifestyles during this time. She was also aware that smoking cessation workers together with subsidised NRT products were available to students.

Cost

Some of the participants, indicated that cost had caused them to give up smoking. In contrast to earlier comments which Koea had shared indicating that during her adolescent years cigarettes were relatively cheap, by the year 2000 the expense of cigarettes and the embarrassment of borrowing money to purchase cigarettes had caused her much anguish and influenced her to quit smoking.

I stopped working and it got to the point where I was having to borrow money until I'd get my pay and I'd have to borrow money to buy smokes and I thought no way (Koea).

Moawhango, Te Tikanga ki Tokorangi, and Poutu ki Shannon are all involved in delivering Te Wananga programmes at these marae, commonly known as marae-based studies.

The Quitline programme

Only one participant had taken advantage of the free Quitline service. Weka, had been encouraged to ring the Quitline programme after she had seen the free programme advertised on television.

I rang the Quitline but it took ages. I had to ring back again. They were very busy at the time so they told me to ring back again (Weka).

It took some time before Weka was able to speak to a quit advisor and there was a delay in receiving the vouchers which were necessary to claim the subsidised NRT products from a chemist.

Quitting Methods

Once the decision to quit had been made, the women then began to make preparations to quit. All of the participants started by cutting down on the number of cigarettes they smoked prior to quitting. A few participants read literature about quitting smoking. As noted earlier Weka enrolled in the Quitline programme while Tracey accessed the support of the smoking cessation workers within her workplace who were delivering the AKP programme.

The quitting methods employed by the women varied. Tui, Koea and Nicola all quit smoking cold turkey, that is, without any services or aids. Two of the participants, Weka and Sharon, used NRT products to help them to quit smoking. Weka obtained subsidised NRT patches through the Quitline programme while Sharon purchased NRT patches directly from the chemist. Although Tracey had enlisted the support of the AKP workers within her workplace she chose not to utilise the subsidised NRT products which were also available as part of the AKP programme. Since nicotine replacement products had only recently been introduced in New Zealand this may be partly the reason for its low utilisation among the participants. As well there have been some concerns that NRT replaces one form of nicotine addiction with another and this may have affected Tracey's decision not to use NRT products. She commented that she was aware of some people who had relapsed when using the patches rather than going cold turkey.

Maintaining quit status

After quitting the participants found that they needed to make changes in their lifestyles in order to support them to stay quit. These changes included avoiding certain triggers and cues like socialising with other smokers at the marae and at work. Substitutes had to be put in place.

To combat old habits of drinking alcohol and smoking several participants stopped going to the pub. Some replaced drinking coffee with drinking tea instead. When trying to quit smoking any reminder of old smoking habits made quitting more difficult hence simple factors like switching to tea aided quitting by removing old and familiar patterns.

I've got a new taste for tea because I never drank tea when I smoked but now I don't mind the odd cup of tea (Tracey).

Chewing gum, drinking lots of water, eating an apple and keeping busy were other substitutes for smoking. All of the women took up regular exercise for a number of reasons, as an alternative to smoking, to keep busy, as a form of stress relief and largely to counteract fears about gaining weight. Koea and Tracey joined the gym while Tui, Nicola, Weka and Sharon went for walks as often as possible.

I didn't want to put on weight and what I'm doing is exercise and again I'm just trying to change my habits, like joining a gym (Tracey).

I've been going to the gym ... so I haven't put on weight since I gave up smoking (Koea).

Since gaining weight after quitting smoking is a common cause for relapse among women, exercise and healthy eating were essential for these participants to avoid the temptation to return to smoking. While joining a gym is often expensive and beyond the reach of most Māori women, Tracey and Koea found becoming members of a gym reduced their fears particularly about weight gain. Koea's workplace promoted healthy lifestyles and contributed a $100 subsidy towards employees healthy activities. This money paid for Koea's gym subscription.

Helpful and unhelpful social support

During their attempt at quitting smoking the participants identified both positive and negative responses from those they socialised with.

In the household

Koea shared a home with her flatmates who were non-smokers while three of the other participants, Tui, Weka and Sharon, lived mostly alone. These participants were therefore not influenced to smoke by having other smokers living in the same household.

Tracey was the only participant in this study who lived with another smoker, her partner. He was not ready to give up smoking. This can create tension in the household.

My husband was saying, don't think I'm going to give up. He became defensive. I'm ... working on the smokefree car, even the amount of smokes he has. But I'm not giving him any pressure (Tracey).

Tracey's children felt her biggest test would be when she socialised with her friends who were also smokers.

When I was giving up, my children weren't as encouraging and supportive as I felt they could have been ... For the first 6 months they were like that and thought I'd smoke when I went out. They probably thought I was going to slip up (Tracey).

Tracey's home was not completely smokefree however she was working slowly to introduce changes.

Our lounge is smokefree but the rest of the house isn't. I keep encouraging my husband to smoke outside ... I think he's now seeing that I am serious about giving up smoking (Tracey).

Given that none of the other participants lived with smokers each of them did not have to contend with others to make their homes smokefree. All of the participants received

support from friends who accepted that smoking was no longer permitted inside the house.

The friends are actually really cool cause they're quite happy to be outside and have a smoke (Tui).

Friends

The study participants tried not to mix with other smokers however given the high smoking prevalence of Māori, for each of the participants this proved difficult. Nicola said that up until recently all of her friends had previously been smokers. Her perception of smoking among Māori as normal was evident in her comment.

All my friends, everyone I associated with smoked, because I associate with Māori and they smoke (Nicola).

Tracey also indicated that she started smoking after she left school because while she was at school her friends were not Māori. Therefore for these two participants they obviously saw a connection with smoking and Māori.

Koea found her friends who were smokers were unsupportive. Their comments often involved teasing. Those friends who were most supportive were those who had also recently given up smoking. For Nicola this included members of her hapū who were also students at Te Wananga.

Whanau

Each of the participants came from families where smoking prevalence was high. This included members of both their immediate and their extended whanau. Nicola mentioned that while her mother smoked her father had never been a smoker. She did not see her mother quitting anytime in the near future.

She's going for a gold medal (Nicola).

Koea was whakama when discussing the number of smokers within her immediate whanau. Three of her four brothers and sisters were currently smoking.

Whanau members who were most helpful were those who had also quit smoking. Tracey viewed her cousin who had given up smoking as an important role model for her.

One of my cousins has been smokefree about 3 or 4 years now and so I've been exposed to people that've given up (Tracey).

Workmates

Within their workplace both Weka and Tracey referred to the availability of smoking cessation programmes in encouraging them and other workmates to quit. Weka had joined the Quitline programme along with some of her work colleagues. Tracey had enlisted the support of the AKP quit coaches within her workplace.

Tui described her workmates as social smokers who rarely smoked within the work environment. Nicola indicated that smokers were generally not seen at work while Koea noted that there were only a few smokers within her work environment due to the healthy lifestyles promotion.

They're social smokers most of them. ... None of us smoke at work (Tui).

There are some but you don't see it in your working environment (Nicola).

Most don't smoke, the majority. They're quite health conscious (Koea).

It appeared then that the growth in implementing and enforcing smokefree areas, together with the availability of free smoking cessation programmes, had provided crucial support for these women enabling them to quit and maintain their quit status alongside others in their workplace.

Quitting with others

Having the support of others during quitting was also invaluable at the marae.

There were 6 of us and 4 of us had some association with the Wananga. So it was our lifestyle. We'd go to the pa and we'd be trying not to smoke again. That was helpful, that we sort of made this pact to do it and support each other (Nicola).

Non-smokers

Weka and Koea commented on the support they received from non-smokers but Tracey suggested that often non-smokers do not understand how difficult it is to quit.

They have difficulty in comprehending. They say if you want to give up you'll just give up (Tracey).

Across each of the relationships discussed helpful and unhelpful social support seemed to have been largely dependent on where other people were in terms of their own views and attitudes towards smoking. A major barrier to quitting appeared to have come mostly from others who continued to smoke.

The positive and negative consequences of quitting

The women also experienced both positive and negative consequences after quitting smoking. The benefits of quitting included improved sleeping patterns, an improved sense of smell and taste and being able to stop bad habits such as drinking too much coffee. They also found they had more money available and Koea and Nicola indicated that they used this extra money as an incentive to stay quit.

Money was a huge other thing in the decision that helped me make it (Koea).

I used the extra money to reward myself, to buy more clothes (Nicola).

Several of the participants felt that their health had improved as a result of quitting smoking. A negative consequence of quitting however is that it is not uncommon for an ex-smoker's health to deteriorate particularly during the early stages of quitting. Consequently even after quitting Nicola was still subject to what is commonly known as "smoker's cough" and thus indicated that she still suffered from having been a smoker.

I don't cough as much, but I still feel the effects of it [smoking] (Nicola).

Koea on the other hand felt that her overall health had improved and that her energy levels had increased since she had given up smoking.

Tracey and Koea believed that their self-esteem had improved as a result of quitting smoking. Tracey felt that her confidence had grown and that she would be a useful role model for others trying to quit, especially her whanau.

I've always been confident and outgoing but I actually think it [quitting smoking] enhanced my self-esteem, my confidence ..... I can be seen as a resource, primarily for my whanau cause they can link in to me and that's really important (Tracey).

Negative consequences which the participants identified included weight gain and a deterioration in health. These have been already discussed earlier.

Some of the participants indicated that they became irritable and that they had difficulty coping with stressful situations.

I was demanding with my partner, unbearable, 6 months of turmoil (Tracey).

When I got into stressful situations I didn't know how to handle it, cause all I knew was light up a smoke and then puff on it ... but I didn't know how to handle stress. That's when I started at the gym too, that's the only way I could handle it (Koea).

Many of the participants felt alienated and missed the social side of smoking. Staying quit meant that they needed to avoid smoking situations. Nicola recalled her experiences during quitting whilst at Te Wananga.

There were times at the Wananga when you could hear everyone laughing and you'd miss that because it's an icebreaker, it's a social thing. That's anywhere because usually they're not working and they're relaxed (Nicola).

Relapse

Prior to being interviewed each of the participants had made several attempts to give up smoking. This ranged from as many as 2 to 7 times. At the time of the interview Tracey, Koea, Nicola and Sharon had been quit smoking for more than 6 months.

Tui and Weka however had both recently returned to smoking. Success at quitting was often related to the length of time a person had smoked, namely their smoking history, and their smoking level. Tui and Weka had begun smoking as teenagers. Their smoking levels had varied from 5 to 13 cigarettes a day.

Weka had tried to quit smoking many times, however Tui had tried to quit only once prior to her last attempt. Throughout all of their quit attempts the length of time Weka and Tui were able to remain quit had varied from 2 weeks to about 3 months. These two women were somewhat apprehensive about participating in this study but were assured that their experiences were just as valuable as the other participants given that returning to smoking was common among Māori women.

The negative consequences experienced, noted earlier, all had the potential to see each of the participants relapse. However Tui believed that no particularly negative experience had led her to relapse and Weka indicated that her relapse may have been due to her not using the NRT patches for the recommended time of 12 weeks.

Both Tui and Weka offered few comments during this part of the interview. This may have been the result of the disappointment they felt in not being able to stay quit. Both indicated that they were thinking about giving up smoking again.

Ngāti Raukawa

The Current Situation

Although only three of the six participants, were living within the Ngāti Raukawa rohe at the time of the interview five of the participants were conscious of the anti-smoking activities that were taking place within Ngāti Raukawa and suggested that these developments were having an impact on Ngāti Raukawa hapū and marae.

Sharon, Tracey and Koea were aware of the AKP programme which was being offered by Te Runanga o Raukawa. As noted earlier, Tracey as an employee of the Runanga had enlisted the support of the smoking cessation workers for this programme when she had quit smoking. Koea had heard from members of her hapū that the two Runanga workers had attended the annual Ngāti Raukawa touch event and that as a result many of the iwi had been encouraged to join the programme.

The Aukati programme is now being provided by Te Runanga and is being offered in the Feilding area and that's a new service for the area (Sharon).

There's been lots of promotion because they [the two Ngāti Raukawa workers] have put a lot of energy into the promotion and they have a high profile in the rohe between them anyway and they're always consistently promoting that kaupapa (Tracey).

I heard all about the quit smoking [at the Runanga] and they're starting into things. Like when the touch happened, I heard about that, and how supportive ... lots of people put their names down to give up smoking (Koea).

Between the participants they talked of the Quit and Win competition offered by MidCentral Health (Palmerston North Hospital) and of a Ngāti Raukawa whanaunga who was involved in this work. They also referred to an iwi member who worked for Te Hotu Manawa Māori and several other whanaunga who were involved in anti-smoking work and suggested that the numbers involved in this work were growing.

For Nicola the changes at Te Wananga o Raukawa had been extremely helpful in supporting her and others of her hapū to quit smoking. She referred to this many times throughout the interview.

When I was at the Wananga they made that change of policy. That was really good because there were a few of us that wanted to give up and it helped. So it made it easier for us to not smoke (Nicola).

Sharon also knew of the Wananga activities, referring to the efforts made before introducing the Ohaki policy to Te Wananga where the students were discussing the idea of quitting smoking before the policy was put in place.

I've seen a presentation about Te Ohaki and I'm aware that prior to the Ohaki policy that a quit coach had been to Te Wananga and had talked to some students then. A cousin of mine had enrolled in the quit smoking programme at that time (Sharon).

Nicola and others of her hapū who were fellow students at Te Wananga had quit as a group and found that designating the smoking area to the front gate had removed the temptation to smoke. This smoking area however was not without some controversy. Some found the sight of the smokers at the Wananga gate somewhat embarrassing. Tracey commented on this not realising that the gate was the "designated" smoking area.

I see the smokers at the front gate and it's not good. Dare I say they need a designated area. The staunch ones are still smoking (Tracey).

Tracey was the only participant who had sought the support of the AKP workers at Te Runanga. Nicola had been strongly influenced to quit smoking by Te Ohaki at Te Wananga. The other women in the study may have been encouraged to quit smoking although indirectly, because of Ngāti Raukawa activities, as five of the six women were cognisant of the promotions and the support that was available to assist within the iwi.

Aspirations for the future of Ngāti Raukawa

One women was unaware of activities which were happening within Ngāti Raukawa itself however she thought that things were likely to improve because of the support that was available nationally, particularly in terms of the Quitline programme. She felt that anti-smoking promotions were likely to have an impact on Ngāti Raukawa smoking rates.

Tracey commented at length about future smoking within Ngāti Raukawa.

There've been a few whanau that have returned home and I think that change has come about partly due to Whakatipuranga Rua Mano[15] *and their learning ... In terms of our unhealthiness and the stats that is evidence too ... All these contributing factors, I didn't want to be part of those stats. I now want to be seen differently (Tracey).*

I think there'll be a considerable reduction in smokers. It probably comes about through our lines of work, and in our children and our families and how long we actually want to be around. Ideally I want to be living until I'm 80, 90 plus rather than Mum, 62 and Dad, 59. They were too young. As we become more conscious and if we want leaders of tomorrow then we need to be putting some things in place to ensure that that happens and that our own children maintain being smokefree. ... I do have a sense of hope that it [smoking among the iwi] will reduce. I think people are actually at a point where they want to give up smoking and they just need that extra awhi to give them a hand (Tracey).

Tracey obviously believed that the education she has received about smoking and its negative impact on Māori, Māori women and Ngāti Raukawa has strongly affected her. In addition initiatives like Whakatipuranga Rua Mano have been instrumental as an iwi initiative in developing and supporting change.

Hapū and Marae

The Current Situation

As noted earlier, while all 6 of the participants had whakapapa connections to Ngāti Pikiahu-Waewae, 2 were more actively involved with other hapū and marae. Therefore the participants comments referred to 3 different marae, Te Tikanga Marae ki Tokorangi, Poutu ki Shannon, and Whitikaupeka ki Moawhango.

Differing views were expressed in terms of seeing the marae as a good and bad place to quit smoking. For Koea, avoiding the marae (Te Tikanga) was essential for her to stay quit although she was embarrassed in stating this. Both Weka and Sharon also found it

[15] Whakatupuranga Rua Mano, Generation 2000, aimed to prepare Te Atiawa, Ngati Raukawa and Ngati Toa Rangatira iwi for the year 2000 and was initiated during the 1970s. Strategies included a focus on education alongside hapü and iwi development.

difficult not to smoke at the marae and during the early quitting period they both deeply resented being at the marae for that reason.

Association's the main thing, I don't go to the pa ... I suppose for me I needed to stay away. Like what I said ...it was my main time smoking, going to all the hui ... I know people think I'm being a snob and stuff but I actually had to stay away to break the cycle (Koea).

For me the hardest place not to smoke was the marae. I think it's because of the stress ... especially when a hui gets rowdy. It was a memorable moment the first time I got through a marae meeting without a smoke. It was a struggle (Sharon).

Nicola found the support of others at Whitikaupeka Marae, who were quitting at the same time, particularly advantageous. She noted that the desire to smoke at the marae was lessened by having the support of others and by not being subjected to those who continued to smoke. She was proud to be part of a group who were contributing to removing the perception of smoking on the marae as normal.

We'd turn up at the marae and someone would say aren't you smoking and then we started to know and we were able to support each other. The people that were humbug or thinking about giving up didn't smoke in front of you, they'd turn away or at the next hui you'd notice someone else had given up. It is that support thing that makes you keep going (Nicola).

The participants identified that there were many smokers at their marae but most notably they felt there were a lot of women who smoked.

Heaps of them smoke, heaps of our women smoke (Koea).

There's more women smoking than men (Tui).

Weka and Tracey suggested that the high smoking among women was probably due to social factors.

We've got a lot of smokers. More women. Don't know why, might be the social side, going outside and talking (Weka).

It's mostly the women ... I think part of that are the stresses that we have as wahine, whanau life responsibilities. The smoking is some way of escaping that and also just having that social contact with other wahine, a common bond dare I say (Tracey).

At Te Tikanga Marae, Tui, Sharon and Weka felt that fewer teenagers were smoking. In contrast, at Poutu Marae, Tracey felt that there were a lot of young people who were taking up smoking, including young women.

I think it's the kotiro that are starting ... the teenagers (Tracey).

Given that there were less young people taking up smoking at Te Tikanga Marae, those identified as most likely to be smoking were older and appeared to be mostly those aged between 25 to 40.

I think it's those aged 25-40 ... about 75% of those who are in the kitchen really (Sharon).

I think the one's that are smoking now, even though they want to give up they haven't done it. Most of the one's around the 30s and 40s are still smoking (Weka).

Nicola at Whitikaupeka indicated that the continuing smokers tended to be those over 40 and who possibly had a long history of smoking. Tracey felt that at Poutu there were still a number of smokers across many age groups.

I think the smokers are getting younger and the late 20s and 30s. There's a huge number around my own age group, the late 30s. I think it's our age group still smoking (Tracey).

Aspirations for Hapū and Marae

Since Tracey had indicated that at Poutu smoking was occurring across many age groups she felt there were many developments which still needed to take place. Tracey was hopeful that she would be seen as a positive role model for her hapū in the future.

There are those that are still asking if I'm smokefree and I think if I can just reinforce that to them and if I can maintain my own smokefree status I think that'll assist them (Tracey).

Tui, Weka, Sharon and Koea all saw the potential for positive changes happening at Te Tikanga and felt that the influence of Te Wananga o Raukawa on their hapū and other hapū had been considerable.

I think that Te Wananga has been a positive influence ... even though there's still some Wananga students who are smokers. You can see it slowly progressing ... the groups of smokers aren't so big anymore (Sharon).

At Whitikaupeka Marae those aged 30 to 40 were among those quitting and again it was suggested that this is the age group studying with Te Wananga o Raukawa. If the Wananga continues marae based studies Nicola felt that reductions in the number of smokers could continue.

With fewer young people taking up smoking Tui, Weka and Koea could see a decline in smoking especially among future generations of Ngāti Pikiahu-Waewae.

Sharon expressed some disappointment that many of those who had quit smoking were coming back to the marae less and less.

Unfortunately some of the ones that I know that have quit hardly ever come home [to the marae]. They come home maybe once or twice a year. It took me a while to realise that the ones that aren't smoking don't come home very much (Sharon).

This aligns with the participants comments about avoiding the marae when they were attempting to quit. It may be that hapū members are still avoiding the marae in order to quit smoking and to stay quit.

Some marae rather than going totally smokefree have attempted to implement smokefree areas, however this has not been without some difficulty.

At my husband's marae ... literally we had to wait for that [older] generation to die. Now we have our cousins who are in their 40s and we are able to enforce that policy but sadly we had to wait for those older ones to pass on (Tracey).

Koea saw the potential for change at Te Tikanga in introducing smokefree areas starting with the kitchen.

The dream is that it would be lovely if [the marae] became smokefree, but actually I reckon it could be. That new kitchen, they can make that smokefree. Yeh make the new building smokefree, definitely (Koea).

Sharon in fact commented that Te Tikanga was already smokefree but cringed when she described the events of how that came about.

At one of several hui involving the re-drafting of our Marae charter a clause had been included to make all buildings totally smokefree. When the fact that this decision had been made was announced at a subsequent hui those who had not been present at the previous hui opposed the idea. If we'd done a count it was almost equal of those who were for smokefree buildings and those who weren't. Those people who I think were against it [making the buildings smokefree] would understand about not smoking in schools, but it's become such a norm with our people that you can smoke at the marae. The idea [of making the buildings smokefree] was seen as inflicting the wishes of a small few on others, particularly the views of our kuia and kaumatua who smoked as well as manuhiri. This situation held up the registering of our Marae charter for several years until eventually the Trustees made the decision that the charter would be registered regardless with the [smokefree] clause included (Sharon).

So Sharon's comments substantiate that Te Tikanga is smokefree in its charter, but Koea's comments obviously highlight that the marae is not smokefree in practice and therefore there is still some way to go.

At Whitikaupeka, Nicola felt that making the wharepuni smokefree was a start.

The wharepuni, you don't smoke in there any more, they used to. As far as the dining room and the kitchen goes they're still smoking in there (Nicola).

Significantly however none of the participants were confident enough to suggest that making the marae completely smokefree was likely to happen anytime soon.

Conclusion

The stories of the participants described their experiences and views around smoking and quitting.

Key factors which had influenced the participants to take up smoking included starting smoking at a young age, peer pressure peer influences, habit and addiction, social situations and settings and smoking to enhance positive and to reduce negative situations. In turn these influences were significant barriers to quitting.

Smoking initiation and experimenting with smoking was strongly linked to growing up in an environment where smoking was predominant alongside the perception of smoking as an adult activity. Each of the participants quickly became regular smokers, smoking on a daily basis.

All 6 participants were influenced to smoke and to smoke more in settings which largely involved the company of other smokers, including the marae, at work, and when drinking alcohol. At the same time at least 2 of the participants indicated that when they were alone smoking was seen as company. All of the participants indicated that they had smoked for both positive and negative reasons and often within the same social settings.

Factors which influenced the women to quit smoking included influences at work, children and rangatahi, personal health, the loss of whanau members due to smoking-related illnesses, the Wananga o Raukawa policy, cost and the Quitline programme.

In preparing to quit each of the participants reduced their smoking levels prior to quitting. Once the participants were ready to stop smoking completely three of the

women quit smoking cold turkey and without the support of any services or aids. One participant enlisted the ongoing support of the AKP workers, another used the subsidised NRT products offered through the Quitline programme, while one participant accessed NRT from the chemist.

To maintain their quit status the participants changed their old habits around smoking. Both positive and negative responses were received from those the participants socialised with. In the early stages of quitting being able to avoid situations where there were lots of smokers removed the craving for the participants.

At the time of the interviews 2 of the 6 participants had returned to smoking though they could not think of any obvious causes for their return to smoking.

Almost all of the participants were aware of the anti-smoking activities that were taking place within Ngāti Raukawa to support quitting. References were made to Te Runanga o Raukawa, the AKP programme and Te Wananga o Raukawa's non-smoking policy.

For several of the participants the marae had not been a positive place to be while attempting to quit smoking. The large number of smokers, the temptation to return to smoking and the habit of smoking within the marae setting were significant barriers incurred during the quitting experience.

In contrast having the support of others who were also quitting at the marae presented a completely different experience for another participant. Influenced by the Wananga policy, this participant was proud to be involved with others who were contributing to a reduction in smoking on the marae.

Across the three marae smoking prevalence remained high particularly among women. However a positive development suggested was that at both Te Tikanga and Whitikaupeka Marae there were less young people smoking. For both marae Te Wananga o Raukawa had played a key part in reducing the number of smokers. At Poutu Marae however there were still many smokers across all age groups which suggested that further developments still needed to take place.

There was reluctance from all of the participants to consider their marae becoming totally smokefree.

The next chapter presents an analysis and discussion of key factors identified in this thesis.

CHAPTER FIVE

Analysis and Discussion

Introduction

This chapter analyses and discusses key factors identified in the literature and data results and looks at issues around smoking and quitting and identifies the barriers and supports for those trying to quit. The first section in this chapter begins with an analysis of key factors which transpired during the 1980s and discusses factors which influenced the participants to become smokers. Following on from this, factors that supported and influenced quitting are discussed. As well as integrating factors relevant to Ngāti Raukawa marae, hapū and iwi, factors specific to marae, hapū and iwi are also discussed at the end of the chapter with an emphasis around smoking and the barriers to quitting within a cultural context.

Influences on Smoking

Factors which have influenced high smoking prevalence among Māori are long-term and complex. Influences included taking up smoking at a young age, peer pressure, tobacco advertising, habit and addiction, socio-economics, social situations and smoking to enhance positive and to reduce negative situations. The extent and influence of each of these factors are significant barriers to quitting.

Initiation to smoking

In the 1980s, it was within the historical context of high smoking prevalence among Māori that the participants in this study first took up smoking. While an awareness of the impact particularly of passive smoking seemed to influence a change in attitude toward smoking among non-Māori, political and national activities appeared to have had no noticeable effect on Māori (Thomson & Wilson, 1997).

Four of the participants had experimented with cigarettes from as young as 12. Broughton & Lawrence (1993) also indicated that smoking uptake often began both as an experiment and a new experience. These four women tended to associate with other smokers at school, in contrast to Tracey who did not take up smoking until after leaving school. Tracey commented that the smokers at her school were more likely to be Māori and that as she socialised less with Māori she was less likely to be around other smokers. This highlighted her perception of the normality of smoking among Māori. Similarly Broughton & Lawrence (1993) found those participants who took up smoking at school had friends who were smokers, however non-smokers were more likely to have friends who were also non-smokers.

Each of the women indicated that their introduction to smoking had generally involved being influenced by what their peers were doing, rather than being pressured or coerced to smoke. Other research (Reid & Pouwhare, 1991) suggested that both peer pressure and peer influences were common reasons for smoking initiation among young Māori.

The participants perceived smoking as a grown-up thing to do with smoking commonly viewed as an adult activity. In line with this, Reid and Pouwhare (1991) indicated that smoking appealed to young people because of its association with maturity, independence and that this was also linked to targetted advertising.

While several of the research participants indicated that either one or both parents had been smokers few participants suggested that their parents had a direct influence on their taking up smoking. While parental smoking was shown in other studies (Glover, 2000; Reid & Pouwhare, 1991) to have a significant impact on smoking uptake by young people, this study indicated that the influence of parental smoking appeared to be less prominent.

The ability of the participants to access cigarettes as young adolescents was made easier not only by being around other smokers but was also due to the low cost of cigarettes at that time. Added to this, Thomson and Wilson (1997) suggested that legislation enacted in 1988 which made the sale of tobacco products to anyone under 16 years of age an offence was never actively enforced.

Tracey and Sharon took up smoking at age 18 and 22. Both women identified that their initiation to smoking was largely linked to their close association with other smokers, particularly after leaving home and having developed a newfound independence. Similarly, socialising with other smokers was found to be a strong predictor of taking up smoking and continuing to smoke, across several studies (BRC Marketing and Social Research & Te Pūmanawa Hauora, 2000; Broughton & Lawrence, 1993).

Smoking regularly

Regular smoking for several of the participants was largely attributed to having started smoking at a young age. Other research (Glover, 2000) had similar findings with most Māori women considering themselves to have been smoking regularly between the ages of 15 and 20.

Each of the participants in this study had a long history of smoking with the number of years smoked varying from 9 to 17 years. Māori women were known to smoke longer compared to non-Māori women and the literature indicated that Māori women often smoked from between 17 to 20 years (Broughton & Lawrence, 1993).

The participants indicated that they smoked between 5 to 20 cigarettes per day. Other studies identified that often Māori smokers consumed between 10 to 20 cigarettes per day (Glover, 2000; Reid & Pouwhare, 1991). Although the smoking levels of the participants in this study were slightly lower compared to other studies, similarly other research has found that smokers often under-estimated the amount they smoked, sometimes by about a third (Glover, 2000; Reid & Pouwhare, 1991).

Four of the 6 participants in this study were smoking regularly prior to completing secondary school, none had left secondary school early and after leaving high school all of the women, at various stages in their lives, went on to tertiary education. In contrast, the literature (Klemp, et al, 1998) noted that among Māori women becoming a regular smoker at a young age was generally associated with leaving school early and was often linked to having lower levels of education. Thus in contrast to other studies, in this study the educational backgrounds of the women in this study had not prevented them from becoming smokers.

Each of the women in this study worked in relatively good jobs and received adequate incomes. Unlike other studies (Klemp, et al, 1998) low socioeconomic status was not seen as a contributing factor to the smoking habits of these women. In addition, although the literature (Klemp, et al, 1998) showed close links between economic stress and smoking none of the women in this study indicated that they had smoked due to financial stress.

The tendency among the participants to smoke for both the positive and negative affects of smoking was evident. The literature found that unlike other groups of smokers, when Māori women tried quitting they had to change their smoking habits in twice as many instances (Glover, 2000). Particularly in settings, such as the marae and work, where smoking was undertaken for both the positive and negative effects, quitting smoking was thus made all the more difficult.

The participants experiences also linked to Glover's (2000) findings which showed a strong relationship between smoking, drinking alcohol and social occasions. The combination of smoking and drinking alcohol, and drinking coffee as well, often took place because the user experienced twice the effect, the pleasure, by having them both together (Glover, 2000).

Smoking at work among the participants was largely due to working alongside other smokers as well as to lessen stress levels. Smoking was commonly used as a stimulant to cope with difficult situations and to keep motivated. This was supported by Reid and Pouwhare (1991).

Tracey and Sharon smoked when they were at home alone, using smoking as company to reduce a negative situation and a feeling of loneliness. Broughton and Lawrence (1993) suggested that Māori women living alone used smoking as their friend. None of the other four participants mentioned smoking for this reason, even though each of them had also lived mostly on their own. Klemp, et al (1998) showed that women who were single, separated or divorced were among those most likely to be smokers. Similarly this study suggested that living alone was likely to have a key influence on smoking among Māori women.

The marae was highlighted by the participants as a setting in which smoking was a large part of the social scene. Sadly research (Reid & Pouwhare, 1991) showed that the likelihood of becoming regular smokers was higher among those who regularly participated in hapū and iwi activities because smoking was common on these occasions. The participants stated that at the marae they smoked for the positive aspects such as catching up with whanau and also to reduce negative situations such as to alleviate stress or during tangi. All of these factors certainly exacerbated the level of smoking on the marae.

Factors that supported quitting

The research participants all began smoking in the 1980s. Factors which influenced the women to quit, from 1999 to early 2000, occurred alongside an increase in tobacco control developments that supported quitting. Key factors included: influences at work, children and rangatahi, personal health, the loss of whanau members due to smoking, the Wananga o Raukawa policy, the cost of cigarettes and the Quitline programme. These influences were similar to the literature however the Wananga policy was a specific Ngāti Raukawa initiative.

The Smokefree Environments Act (1990) and its amendments together with anti-smoking promotions had an influence on where people were able to smoke. The participants in this study indicated that a key influence to quit smoking was the public's view and their own of smoking as being bad. This was linked to the anti-social stigma towards smoking which occurred both in their work environments and among the general public.

For Tracey, the stress levels she experienced in her previous job reduced when she changed jobs. As well her new position as an employee of an iwi organisation gave her new incentives to quit smoking. She was keen to become an example for Ngāti Raukawa and hoped to be a role model for both her children and other rangatahi. Research (McClellan, 1998) shows that ex-smokers serve as useful role models in supporting those who wanted to quit.

Passive smoking identified that the health risks of smoking were not confined only to those who smoked, but also to others around them including children (National Health

Committee, 1998). Nicola, a school teacher referred to the designated smoking area which had been established within the school grounds. As intended by anti-smoking groups, the relegation of smokers to unfriendly places encouraged some smokers to think about giving up smoking. All schools had access to anti-smoking material as early as the 1980s (Thomson & Wilson, 1997), however it was not until the mid to late 1990s that smokefree areas were introduced to most schools.

When Nicola first became a student at Te Wananga o Raukawa[16] she was still smoking. She indicated that there were many students who were smokers at that time. Extensive discussions around banning smoking within the campus grounds took place, eventually leading to the "Ohaki" policy, making the grounds completely smokefree. The Wananga policy is discussed further later in this chapter.

Similar to other research (McClellan, 1998) most of the participants in this study did not identify a specific health concern but indicated that their wanting to quit smoking was more due to an acknowledgement that smoking was detrimental to their overall health. None of the participants indicated that they had received medical advice to quit smoking, in comparison to other studies which found that smokers often quit for this reason (Broughton & Lawrence, 1993; Glover, 2000). Concerns were raised however at the high numbers within their whanau who had died from smoking related illnesses.

Another factor that supported the study participants in their decision to think about giving up smoking were the increases in the price of cigarettes. While several studies (Broughton & Lawrence, 1993; Murchie, 1984) have also identified that the cost of tobacco products can influence smokers to think about quitting, others (Holdaway, 1999; Reid & Pouwhare, 1991) found that price increases had little effect on lowering Māori smoking rates.

Weka indicated that the Quitline advertisements alongside anti-smoking promotions had influenced her to think about quitting. The Quitline service, as noted in the literature

[16] Te Wananga o Raukawa and Te Ohaki were both initiatives of Ngati Raukawa and affiliated iwi, namely Te Atiawa and Ngati Toa Rangatira.

(Ministry of Health, 2001a), provided subsidised NRT together with a free helpline phone service and was promoted extensively.

Quitting methods

The women in this study used a range of methods to support them during their preparations to quit smoking. Each of the participants tried to reduce their smoking prior to quitting. A few read literature about quitting smoking, one enrolled in the Quitline programme and another accessed the support of the AKP smoking cessation workers within her workplace. This aligns with the literature, (Glover, 2000; McClellan, 1998) which shows that numerous methods when used in conjunction with each other were helpful in preparing to quit. In contrast to the literature (McClellan, 1998) however none of the participants had visited a hypnotist. This may have been due to the perceived cost involved.

Once the participants ceased smoking, their chosen method of quitting was put into practice. Two of the participants used NRT products to help them quit smoking, one accessed subsidised NRT patches and gum through the Quitline, while another purchased NRT patches directly from the chemist. Although Tracey enlisted the support of the AKP workers in her workplace, she declined to utilise the subsidised NRT products which were also available as part of the AKP programme.

Notably three participants chose to quit cold turkey and without any health services or aids. However it has been found that Māori tend to under utilise health services and products due to barriers including access and cost (BRC Marketing and Social Research & Te Pumanawa Hauora, 2001; National Health Committee, 1998). Hence it was with the aim of removing these barriers that quit smoking programmes, including AKP and Quitline were made available and included either free or subsidised NRT products.

Maintaining quit status

The participants needed to make changes in their lifestyles in order to remain quit. For the participants this included avoiding certain triggers and cues and replacing the habit of smoking with alternatives. Several of the participants stopped drinking coffee and began

drinking tea instead. As with coffee there was a strong association with drinking alcohol and smoking hence many of the women in this study avoided going to the pub. Other substitutes for smoking included chewing gum, drinking lots of water, eating an apple and keeping busy. These alternatives are similar to those cited in the literature (Glover, 2000; McClellan, 1998).

One factor that is gender specific with smoking is that women commonly used smoking to control their weight (Broughton & Lawrence, 1993). Consequently several of the participants were worried about gaining weight after quitting. Exercise therefore became an important part of the women's lifestyles with exercise offering an alternative to smoking, as a means of keeping them busy, as a form of stress relief, but more importantly to combat concerns about putting on weight. Exercise and healthy eating were essential to avoid the temptation to return to smoking.

Helpful and unhelpful social support

During their attempt at quitting smoking the participants received both helpful and unhelpful support from those they socialised with and this was similar to the literature (Glover, 2000; McClellan, 1998; Williams, 1999). Throughout this study it was evident that giving up smoking altered the relationships the participants had with others. A significant barrier to quitting mostly involved those who continued to smoke.

Within the household, not living with smokers made quitting easier. Four of the participants were fortunate in that they were not influenced or tempted to smoke by having other smokers living in the same household. Likewise Glover (2000) found that those who did not live with other smokers had greater success at quitting. Sharon and Tracey however noted that prior to quitting when they were at home alone they had tended to smoke more.

One participant found that initially there was little support within her household for quitting. Tracey's partner was a smoker and as he was not interested in giving up smoking he became defensive. Glover (2000) also found that continuing smokers who had a close relationship with another person who had quit smoking often felt threatened.

As well, Tracey's children doubted that she would be able to stay quit mainly because the friends she tended to associate with were smokers. Although these negative influences within the home were potential barriers to quitting and to staying quit, Tracey was able to maintain her quit status.

Making one's home smokefree supported quitting by removing the habit of smoking within the home environment and also acknowledged the implications of passive smoking for others, including non-smokers and especially children. Tracey's home was not completely smokefree however in an effort to slowly introduce changes she made the lounge in her home smokefree. The other participants all made their homes smokefree. Other research (Glover, 2000) showed that often quitters made their homes smokefree. Interestingly all of the participants indicated that when friends visited they accepted without question that smoking was no longer permitted inside the house.

The relationships ex-smokers had with friends who continued to smoke changed after quitting smoking. This was because the participants endeavoured not to socialise with other smokers especially during the early stages of quitting. One participant indicated that her friends who were smokers were unsupportive and that their comments had involved put-downs and enticements for her to return to smoking. Those friends who offered the most support tended to be those who had also recently quit smoking. For Nicola this included members of her hapū who were also fellow students at Te Wananga o Raukawa. McClellan (1998) noted that during quitting, having the encouragement of friends made quitting easier.

For the women in this study smoking prevalence within both their immediate and extended families was high. Similarly Broughton and Lawrence (1993) identified that when many of the quitter's family members were smokers major barriers were experienced in that the temptation to smoke was constantly around the person trying to quit. Tracey saw her cousin who had quit smoking as an important role model for her and this positive support from a non-smoking whanau member made the quitting experience easier.

Within their work environments two of the participants referred to the influence of smoking cessation programmes in encouraging themselves and several of their work colleagues to quit smoking. Weka, alongside some of her workmates, had enrolled in the Quitline programme while Tracey had enlisted the support of the AKP quit coaches within her workplace, as did several of her work colleagues.

Tui described her workmates as social smokers who rarely smoked within the work environment. Similarly Koea noted that there were few smokers within her workplace. For each of the participants having smokefree environments in the workplace reduced the number of smokers at work and placed continuing smokers out of view, diminishing the urge to smoke.

Quitting alongside others has been shown to provide invaluable support for those attempting to quit smoking. Both the participants and the literature (Glover, 2000) identified that quitting with others provides a ready support group and removes the social alienation which quitters often experience especially since prior to quitting they generally associated with other smokers.

Similarly the participants and the literature (McClellan, 1998) suggested that those who never smoked were at times unhelpful and were unaware of the difficulties smokers faced during quitting. This often undermined quit attempts.

The positive and negative consequences of quitting

The participants referred to several personal gains they had experienced and which had supported them to stay quit. Positive experiences included improved sleeping patterns, a better sense of smell and taste, the stopping of other bad habits such as drinking too much coffee, improved health, increased energy levels and improved self-esteem. Many of the participants also indicated that after quitting smoking they found that they had more money available and had used this as an incentive to remain quit. The positive experiences identified by the participants reinforce the findings of other studies (McClellan, 1998).

As well, similar to the literature (McClellan, 1998) the women in this study encountered several negative experiences after giving up smoking. While gaining weight had caused some concerns, as noted earlier in this chapter each of the participants were able to reduce their worries to a large extent by exercising regularly. Several of the participants felt that they had become irritable and had difficulty coping in stressful situations. In such instances exercise became a useful way in which to reduce stress levels. Almost all of the participants felt socially cut off and missed the social side of smoking. Nicola suggested that her health still suffered from having been a smoker however as Glover (2000) indicated this is generally a short term situation which tends to be more extreme during the early stages of quitting.

Glover (2000) showed that the extent of the negative consequences experienced after quitting can often lead to relapse.

Relapse

At the time of the interviews 4 of the women had been quit from smoking for more than 6 months, while two of the women had both recently returned to smoking. McClellan (1998) showed that a significant event or sometimes a series of minor events often caused relapse whereby the ex-smoker's inability to cope led them to return to smoking to relieve stress. However neither of these two participants believed that any particularly negative experience nor any significant event had led them to relapse.

Hence there were no overwhelming circumstances which caused these two women to relapse and which set them apart from the other 4 participants who had been able to remain quit. However one believed that her relapse may have been due to her not using the NRT patches for the recommended time of 12 weeks. The other participant was unable to give any indication as to what had caused her to return to smoking, although notably she had quit cold turkey and studies (BRC Marketing and Social Research & Te Pumanawa Hauora, 2000; Glover, 2000) have shown that the tendency to relapse is higher among those who quit unaided.

As other studies have shown (BRC Marketing and Social Research & Te Pumanawa Hauora, 2000) smoking, quitting and relapse often involves a cycle and this certainly appeared to be the case for the two participants in this study who were already contemplating giving up smoking again.

Ngāti Raukawa

The participants suggested that anti-smoking activities that were taking place within Ngāti Raukawa had impacted not only on them personally but also within the iwi and Ngāti Raukawa hapū and marae.

Several participants referred to Te Runanga o Raukawa, including the availability of the AKP quit smoking programme and the active role the Runanga had taken in anti-smoking promotions at sports events. Although this had encouraged many of the iwi to join the quit smoking programme only one participant in this study had actively sought the support of the AKP workers at Te Runanga. Notably low utilisation of this service was not typical nationally (BRC Marketing and Social Research & Te Pumanawa Hauora, 2001).

One of the women suggested that her increased awareness of the issues around smoking had been influenced by her role as an employee of Te Runanga and that iwi initiatives like Whakatupuranga Rua Mano had been instrumental in developing changes within the iwi. The participants also referred to iwi members who were involved in anti-smoking work both within and outside of the Runanga. It was suggested that the numbers involved in this work were growing.

The initiative of Te Wananga o Raukawa in implementing the Ohaki policy had been particularly supportive in encouraging Nicola and others of her hapū to quit smoking. Several of the other participants had referred to the Wananga activities. The slow introduction of the policy to Te Wananga was similar to the processes which Masters (2000) had referred to in her study. Policies need to be gradually introduced to be successful and the extensive consultation process which had taken place within the Wananga had contributed to the buy-in and acceptance of the policy by the students prior to its implementation.

The Ohaki policy sought to reduce smoking prevalence by promoting a smokefree campus, forcing smokers to smoke away off the campus grounds and highlighting the implications of passive smoking. Requiring smokers to smoke at the front gate and in full public view was part of the "shame" process which made smokers feel guilty, while having to walk some distance to smoke made smoking more difficult. Thus opportunities for a quick smoke break decreased. As intended, this policy saw a reduction in smoking among Te Wananga students and also supported others to think about quitting or to cut down their smoking. This iwi initiative was also influential at whanau and hapū levels.

It was timely that iwi activities had been developed to combat the high smoking prevalence evident within Ngāti Raukawa (Statistics New Zealand, 1999). This sits well alongside the vision of many Ngāti Raukawa descendants that as an iwi we are best suited to improve our own health. The high rates of morbidity and mortality due to smoking among older Māori has particularly severe consequences for hapū and iwi. The premature loss of kaumatua and kuia means that as hapū and iwi we lose much of the mana that goes with having our elders among us and especially on the marae. Hence I have often heard others make comments such as "the paepae is getting younger and younger". Although this is partly due to a gap in terms of knowledge of te reo among some of our elderly, the small number of kaumatua and kuia who stand on many of our marae can be excruciatingly painful.

Ngā Hapū, Ngā Marae

During quitting many of the women in this study had not considered the marae as supportive of quitting with some finding it necessary to avoid the marae in order to maintain their quit smoking status. Several participants even stated that especially during the early quitting period they had resented being at the marae because the temptation to smoke was so strong.

One of the participants however, who had strong alliances to Whitikaupeka Marae said that having the support of others also trying to quit was an advantage. She was pleased to be part of a group who were helping to remove the normality of smoking on the marae.

All of the participants identified that within their hapū and marae there were many smokers, mostly women, and this was mainly attributed to social factors. Against the high number of smokers, significantly at Te Tikanga Marae the participants observed a decline in smoking uptake among the younger generation. In contrast at Poutu Marae, the one participant with strong alliances to Poutu felt that there were a lot of young people who were taking up smoking, including young women.

At Te Tikanga, those most likely to be smoking were older and appeared to be mainly those in the 25 to 40 year age group. At Whitikaupeka it was suggested that the continuing smokers were mainly those over 40. These women were likely to have a long history of smoking and were therefore likely to have difficulty quitting.

The extent of smoking indicated across all age groups at Poutu showed that many developments still needed to take place. The participant hoped that she would be seen as a useful role model for her hapū and marae.

Those from Te Tikanga also saw the potential for progress at their marae. It was felt that the influence of Te Wananga o Raukawa on their hapū and other hapū in reducing smoking had been considerable.

At Whitikaupeka Marae those quitting were mostly aged 30 to 40. It was indicated that these quitters were representative of the age group studying with Te Wananga o Raukawa. It was hoped that further reductions in smoking would occur if the Wananga continued its marae based studies programme.

With less young people taking up smoking participants had visions of a reduction in smoking particularly among future generations of Ngāti Pikiahu-Waewae. At the same time however there were some concerns that many of those who had quit smoking were coming back to the marae less and less. Similar to the experiences of those participants who chose not to visit the marae when they were trying to quit it is possible that hapū members are continuing to avoid the marae in order to stay quit. This represents enormous costs in cultural terms of absenting oneself from the marae, including loss of identity, self-esteem and whakawhanaungatanga.

In terms of implementing smokefree policies at marae, some felt that rather than going totally smokefree that smokefree areas might need to be introduced slowly, although even this could be with some difficulty. While one participant commented that Te Tikanga was already smokefree other participants were not aware of this. The practice at the marae is not always consistent with the policy and therefore further work needs to occur in order for smokefree marae to become a reality.

Conclusions

The pattern observed in the literature was also seen in the research data which evolved from the participants stories. However several unique and challenging aspects were identified.

Parental smoking did not appear to have as big an influence on the participants smoking habits compared to other studies.

Each of the participants were reasonably well educated and as regular smokers were receiving adequate incomes. Unlike other studies low socioeconomic status was not a factor which contributed to the smoking habits of these women.

Difficulties in reducing Māori smoking rates were further exacerbated due to the tendency of Māori women to smoke for both the positive and negative effects particularly at the marae and work.

Social disapproval and public attitudes were shown as factors which supported the research participants decisions to think about quitting. In addition the influence of the smokefree legislation within the participants workplace had led to positive results in supporting these participants to quit and to maintain their quit status.

Up until recently Māori have tended to underutilise health services and products. However the introduction of quit smoking programmes including Quitline and AKP together with increased access to NRT aimed to address low utilisation issues by developing programmes which targetted Māori and removing barriers including cost and

access issues. Even so, several of the women in this study had chosen to quit cold turkey and without any health services or aids and it appears that high utilisation of smoking cessation services and products at a national level had not yet occurred within Ngāti Raukawa.

To stay quit significant lifestyle changes needed to occur and the participants attempted to avoid smokers and going to places where there were lots of smokers. This was difficult for Māori given the predominance of smoking on the marae and within their social environment.

Helpful social support for the participants had included non-smoking whanau members and quitting alongside others. Barriers to quitting for these women included the high number of immediate and extended whanau members who continued to smoke. Since quitting has the potential to affect relationships with other smokers the quitter can at times feel alienated.

The long history of smoking among Māori and the extent of the circumstances which have contributed to high smoking rates each have the potential to lead to a return to smoking.

Barriers to reducing smoking at the marae including the high number of women who continue to smoke has been shown to have serious implications throughout our history given the key roles that Māori women play on the marae. In addition smoking for both the positive and negative effects increases the level of smoking within the marae setting and makes quitting at the marae extremely difficult.

Against some of the positive changes which have occurred at iwi, hapū and marae levels to support quitting and to reduce smoking uptake particularly due to the influence of the Wananga policy, progress remains slow given that the barriers to quitting within this same cultural context are overwhelming. The challenges for Ngāti Raukawa marae, hapū and iwi are significant and are noted in the following chapter.

CHAPTER SIX

Conclusions

Introduction

This study set out to record the experiences of 6 Ngāti Pikiahu-Waewae and Ngāti Raukawa women who had tried to quit smoking. This objective was achieved by undertaking in-depth qualitative interviews which identified issues around smoking and quitting within the participants daily lives, namely at work, home and in other social situations and compare these with other studies. A key focus of this study was to identify the supports and the barriers for quitting smoking within the marae, hapū and iwi environments of the research participants. The richness of the qualitative information gathered contributed to the development of knowledge needed to address high smoking prevalence among the women of my hapū and iwi.

The methodologies employed in this research evolved out of critical theory, kaupapa Māori and Māori-centred research and are discussed in relation to the research journey. The limitations of this research and suggestions for further research are provided. Recent developments which have taken place as a result of amendments to the smokefree legislation are identified.

Recommendations and their implications for national policies are followed by recommendations for possible changes at Ngāti Raukawa iwi, hapū and marae levels are also presented. These recommendations might also be useful for other Māori.

Key Findings

This study identified factors that play a critical part in the smoking and quitting habits of Māori women.

The impact of social factors

Social factors play a key role in influencing smoking uptake and regular smoking. The history of smoking among Māori has instilled the habit of smoking as a social and cultural norm. Alongside this young Māori women are the highest at risk group of becoming smokers.

As young adolescents associating with other smokers at school increases the likelihood of taking up smoking and continuing to smoke. Smoking appeals to young people because of its association with maturity, independence and this is also linked to targetted advertising. Tobacco control policies need to focus more strongly on reducing smoking uptake among youth. This could be achieved by removing the messages which make smoking appealing to young people, in line with the work of the HSC which promotes a clear no smoking message by including non-smoking high profile personalities, such as sports people and musicians, as role models.

A key factor which encourages smoking is the desire to belong and be part of the in-crowd. Besides school, peer influences to smoke continue at work and in other social situations. The government needs to work with schools to discourage smoking. Given that young people are susceptible to peer pressure to start smoking, education programmes in schools provide an important avenue in which to teach young students to resist social pressures to smoke.

Within the home, smoking can be influenced by parental smoking. In contrast to the literature however, for the participants in this study parental smoking appeared to be less prominent in influencing smoking. However strategies which support parents not to smoke would remove the negative role modelling.

Social situations in which smoking commonly occurs trigger the urge to smoke and to smoke more. The three main settings where the participants were inclined to smoke were the marae, work and when drinking alcohol and socialising. Other studies supported this.

Social factors can also support smokers to quit. An awareness of passive smoking and the smokefree legislation have been effective in changing attitudes among the general

public towards smoking so much so that social disapproval of smoking has the ability to influence smokers to think about quitting. In this study this was most apparent within the participants work environments.

The conflicting influences which can occur were clearly demonstrated by the mix of helpful and unhelpful social support which the participants experienced during quitting and within the same social settings. Support for quitting in the home included not living with smokers, having a partner who had quit, wanting to be a role model for children and having a smokefree home. On the other hand barriers to quitting included living with smokers, having a partner who smokes and having a home which was not smokefree. Smokefree homes should be encouraged and alongside this further research which looks at the influences of factors within the home are recommended.

Throughout the quitting period having to avoid smokers and smoking situations was a major barrier to quitting and made staying quit extremely difficult. The extent by which social factors are able to influence smoking and quitting suggest that tobacco control activities need to continue to focus on encouraging social situations where there are more non-smokers than smokers.

Implications of smoking for health

Smoking has ramifications for the health not only of the smoker but also for whanau, hapū and iwi. Non-smokers, especially Māori children are highly susceptible to the implications of passive smoking given the predominance of smoking among Māori.

The tendency of Māori adolescents to experiment with smoking at a young age leads to early addiction. The stories of the participants were similar to other research findings with most Māori women considering themselves to have been regular smokers between the ages of 15 and 20. Policies must recognise that smoking is an addiction and needs to be treated as such in terms of addressing the problem.

As well, Māori women often smoke longer than non-Māori and tend to smoke more cigarettes on a daily basis. The research participants had smoked from 9 to 17 years. While the participants suggested that their smoking levels were relatively low other

studies (Glover, 2000) show that smokers often under-estimate the amount they smoke, sometimes by about a third.

The issues are further compounded due to the fact that most Māori women smoke for both the positive and negative aspects of smoking. In this research this had a major influence on high smoking rates and was a significant barrier to quitting. When Māori women try to quit smoking they have to change their smoking habits in twice as many instances, particularly at the marae and work, where smoking is undertaken for both its positive and negative effects, quitting is thus made all the more difficult.

Funding for smoking cessation programmes and services need to be long-term. As well, programmes and services need to be long-term and intensive to have any significant impact on reducing smoking rates.

Other studies (Mclellan, 1998) showed that around age 30 and over smokers will often begin to consider or notice the implications of smoking on their health. However, quitting due to health reasons was not a key factor which had influenced quitting for these women. Despite this, given the smoking histories of the women in this study, the likelihood that they will experience significant smoking related health issues later in life are increased. Tobacco control activities need to continue raising an awareness of the impact of smoking on health. Information should also be provided which emphasises the health benefits of quitting and which shows that a smoker's health can be improved once they have quit, regardless of age or smoking history.

Socio-economics

Previous studies (Klemp, et al, 1998) have shown that higher rates of smoking are co-related with lower socio-economic status. Becoming a regular smoker at a young age was generally associated with leaving school early and was often linked to having lower levels of education. In contrast however, given the educational backgrounds of the participants in this study, staying at school longer and attaining higher educational qualifications did not necessarily have as strong an influence on preventing or reducing smoking as other studies have suggested.

The research participants worked in reasonably well-paid jobs and received adequate incomes. A key factor however was that many of the participants lived alone and links between economic stress, living alone and smoking prevalence were evident in other studies. Previous research has also shown that the risks of smoking uptake are increased among women who lack economic security, have low self-confidence, and who may be single, separated or divorced. This study therefore indicates that possibly other factors, particularly the impact of economic, social and cultural factors, had a far greater influence on smoking uptake among the participants compared to educational factors. The need for further research in this area is validated. The implications of socio-economics also suggest that tobacco control activities should focus on providing programmes which aid in developing skills to cope with stress and anxiety. Self-assertiveness programmes to improve low self-confidence would also be beneficial.

Government policies

Government policies including smokefree legislation have been supportive in influencing quitting. While each of the women in this study identified a number of reasons which caused them to quit smoking, the influence of the Smokefree Environments Act (1990) figured strongly.

In the 1980s each of the participants were smoking regularly. Since that time, smokefree legislation has been responsible for the removal of tobacco advertising and sponsorship. The work of the HSC, established as a result of the Smokefree Environments Act (1990), has the potential to dismiss the strong messages by which previous advertising had been able to entice young people to smoke.

The ability of the research participants to access cigarettes as young adolescents was made easier not only by being around other smokers but was also due to the low cost of cigarettes. In the mid 1980s significant tobacco tax increases led to raising the price of tobacco products, as well as increasing the government's health funding pool. By the late 1990s the increasingly high cost of cigarettes influenced several of the study participants to quit smoking. Other studies have suggested that alongside tax increases, support programmes for quitters need to be made available if increasing the cost of cigarettes is to have any impact in reducing smoking rates. This suggestion is warranted given the tendency of Māori women to relapse.

Further to legislation enacted in 1988 which saw age restrictions placed on cigarettes, this same measure was reinforced in subsequent legislation in 1997 in the Smokefree Amendment Bill. While this might be seen as a positive step to reducing the sale of cigarettes to those under 18 years of age, especially given that retailers are required to take reasonable steps to check age, research showed that this legislation was difficult to enforce. Whether this move will have any real benefits is yet unknown. Monitoring and research to assess the impact of age restrictions in terms of reducing smoking uptake among young people and to assess the level of adherence to the legislation among retailers is recommended.

The smokefree legislation has also led to an increase in designated smoking areas, an increase in smokefree workplaces, alongside again further public acknowledgement of the issues around passive smoking.

Developments within the education environment have also been influenced by the smokefree legislation. Several measures had impacted on the participants. Change had been effected through the designation of smoking areas in schools. While schools had had access to anti-smoking information from as early as the 1980s, smokefree areas were not implemented until the 1990s suggesting that the smokefree legislation and an increase in smokefree promotions had been effective in encouraging teaching staff to become receptive. As well the initiative of Te Wananga o Raukawa in implementing the Te Ohaki policy also reduced the normality of smoking. Smokefree environments can help smokers to quit and stay quit. This also encourages continuing smokers to reduce their smoking levels. Health promotions need to provide strong, clear and continual messages about the broad impact of passive smoking; encouraging changes in attitudes.

Government policies from the late 1990s to 2002 led to further developments. The implementation and availability of programmes such as AKP 2000, Quitline's subsidised NRT programme and the later initiation of the Hospital and Health Services programme represented significant attempts by government in conjunction with health workers and smokefree organisations, to reduce Māori smoking rates by supporting and facilitating quitting. As well each of these programmes saw an increase in access to NRT products.

The AKP programme targetted Māori women and their whanau and Māori were also a key target group for the Quitline programme. Both programmes included NRT products. In contrast to high national usage however several of the participants had not used these services or products even though cost issues had either been removed or substantially reduced. Importantly unaided quitting, like cold turkey, has high failure rates compared to other quitting methods (Glover, 2000). As noted earlier, low health service utilisation and low health product usage may be influenced by issues including access, cost and location and although the AKP programme in particular had attempted to remove many of these issues this appeared to have had little impact in encouraging some of the women in this study to make use of the products and services available. This is a really critical issue if we are going to look at quitting for Māori and Māori women in particular and is worthy of further research into the low utilisation issues.

The controversies around NRT suggest that further research should be undertaken especially as a key benefit of NRT use is that withdrawal symptoms are reduced and therefore NRT may be particularly helpful for long-term heavy smokers.

Changing lifestyles

Aligned to the theory of crisis, the research participants became aware of the impact of smoking on both themselves and their whanau. As a consequence the women chose a variety of methods to quit smoking. For the participants considerable changes occurred in their lives once they quit smoking.

For the participants maintaining their quit status was achieved by changing old behaviours. The women identified that they needed to avoid triggers which influenced their smoking habits. They also had to employ alternatives to smoking. Key barriers which affected the participants were the need to avoid other smokers as well as the need to exercise regularly to reduce concerns about weight gain. This and other studies (Reid & Pouwhare, 1991) suggest that Māori women care more about looks and less about health. The gym membership fees of one of the participants was subsidised by her workplace. Possibly run in conjunction with a smoking cessation programme and to reduce weight concerns, gym membership at a reduced rate would be particularly helpful for those who would otherwise be unable to afford to join a gym.

The positive consequences of quitting included improved self-esteem, the ceasing of other bad habits, improved health, more money available and the potential to become role models for others. A useful support strategy would be to promote the benefits of quitting as incentives to quit rather than continually focusing on the negative.

Relapse, the cycle

Often the difficulties in maintaining lifestyle changes necessary to stay quit are responsible for a return to smoking. Success at quitting among Māori women is hindered due to the fact that Māori women have a long history of smoking and are therefore likely to experience severe withdrawal symptoms. Relapse is strongly aligned to the negative consequences of quitting. This can include having to avoid other smokers and smoking situations, the feeling of social alienation, health deterioration and weight gain. For the two participants in this study that relapsed there were no extenuating circumstances which caused them to return to smoking, although one indicated that she had not used the NRT products for the recommended time suggesting the importance of ongoing contact with Quitline advisors to reinforce correct NRT usage. The other participant had quit cold turkey and as noted earlier, unaided quitters have a higher tendency to relapse.

Smoking is not simply for pleasure. There is overwhelming evidence that Māori women smoke to cope with the stress of daily life. Quitters often find that they are unable to deal with stress after quitting smoking. Thus a significant event or a number of minor events has been shown to lead to a return to smoking to reduce stress. Anti-smoking advertising often portrays smoking as due to ignorance and selfishness and attempts to influence smokers to quit on moral grounds. Such strategies have the potential to backfire and may contribute further to low self-esteem. To stay quit, quitters need to be in a good space otherwise the potential to relapse is high.

Smoking, quitting and relapse involves a cycle and often smokers need to make several attempts at quitting before they are able to stay quit. Importantly however changes in attitudes towards smoking can occur even among smokers who are unsuccessful at staying quit. Positive benefits can include a reduction in smoking, an awareness of not smoking around others and plans to try quitting again.

Ngāti Raukawa Iwi, Hapū and Marae

The participants experiences were reflective of the literature, however factors which impacted on smoking and quitting within Ngāti Raukawa hapū, marae and iwi settings were exacerbated given that in these instances cultural influences combined with other environmental factors to bring about high smoking rates. At the same time this study also showed that there is the potential to reduce smoking rates within these same settings although this will require a concerted effort from hapū, marae and iwi. What is required is a change in policy and behaviour across the whole community.

Cultural factors which influence and maintain high smoking rates include peer influences and the predominance of smoking among Māori and particularly Māori women. This has led to the normality and acceptance of smoking on the marae so that smoking for many years has been very much perceived as a social and cultural norm within the hapū and marae of the research participants. This is a sad reflection of our Māori communities and therefore to reduce the barriers to quitting it is imperative that marae attempt to address this issue by removing the normality of smoking on the marae. We need to provide a cultural and social climate which promotes positive Māori messages about being smokefree.

Hapū and iwi policies should target youth to decrease smoking uptake among the younger generation. This could include involving key figures, such as the HSC's auahi kore role models, in Ngāti Raukawa hapū and iwi activities.

Smoking habits which include smoking for both the positive and negatives aspects and within the marae setting compounded the difficulties in quitting for these women. Alongside this is our long history of smoking. Quitters and those contemplating quitting need to have the support of other quitters who can serve as useful role models. Marae and hapū should target women and young girls.

In encouraging Māori women to quit we should not contribute to their already low self-esteem. Skills are needed to build up self-esteem and confidence alongside quitting and giving up smoking should be promoted in a non-judgmental manner.

The risks of smoking are higher among those actively involved in hapū and iwi activities. For the women in this study having to avoid the marae to stay quit had a significant effect on the marae which was not necessarily recovered after quitting. Lifestyle changes can involve avoiding the marae because of its influence in triggering smoking and the temptation to smoke given that smokers are predominant. This has major ramifications for marae in that quitters may not be keen to return to the marae for fear of relapse.

Children become particularly susceptible to the effects of passive smoking when they are at marae as they are around so many smokers. Clear messages about passive smoking and the broad implications of smoking for the hapū need to be continually reinforced. Marae need to keep working towards implementing smokefree areas and eventually totally smokefree marae.

A marae education and support programme similar to the Noho Marae programme developed and initiated by Ngāti Raukawa iwi and specific to the needs of Ngāti Raukawa marae and hapū could prove extremely useful. A database could be established in conjunction with this programme. Social support is key and this programme could provide continual support for those wanting to quit and would also reduce the social alienation that is often inherent with quitting. This programme could be piloted and then offered at other Ngāti Raukawa marae, each time evaluating and monitoring the programme so that we end up with a complete package which is totally suited and appropriate to Ngāti Raukawa hapū and iwi. This programme could be run in conjunction with services already available, such as the AKP programme and hence could involve working alongside members of Ngāti Raukawa already working and experienced in this area.

To see a reduction in smoking rates, to support quitting and to reduce the barriers to quitting on the marae the momentum should come from within marae, hapū and iwi. Hapū and iwi initiatives have the potential to influence change and are more likely to be accepted. As shown during the development of Te Wananga o Raukawa's policy, to be successful changes and initiatives need to be implemented gradually. Given the effects that smoking has had on hapū and iwi the benefits of quitting should be promoted as a

way of strengthening and empowering Ngāti Raukawa hapū, marae and iwi. Aligned to critical theory the change has to come from within in order for there to be change in communities.

The Research Journey

The lessons learned in undertaking this research were invaluable for me as a researcher. Initially I was reluctant to focus this study on my marae and hapū as I felt that negative things about my marae might come to the fore and I did not want to draw attention to this. I have learnt during this research journey that often we have to face or admit to the bad things before we can move on to strategies for change and solutions.

In this study it was important to be clear about the values and experiences that I brought into this thesis. I am a Māori researcher based within an academic mainstream institution. As well I am a Māori women with active whanau, hapū and iwi links. It was inevitable that my background influenced this research. I was aware of my conflicting roles and my position as an insider and of the same hapū and iwi as the participants. I also began this research at a time when national anti-smoking promotions and programmes were on the increase and among Māori and including within my hapū, there was a strong feeling that anti-smoking strategies were an attack on the "rights" of smokers.

The participants in this study did not comprise a range of different age groups and lifestyles as originally anticipated. Instead the participants profiles were very similar. However, the data gathered met the thesis objective in enabling the experiences of 6 Māori women, including myself, who had tried to quit smoking to be recorded. The unplanned inclusion of two other marae in this study were an additional bonus given that my original intention had been to focus this study on my hapū, Ngāti Pikiahu-Waewae and Te Tikanga Marae alone.

There were delays in undertaking the interviews due to a combination of finding it difficult to get participants, a feeling of nervousness on the part of the researcher and the need to travel, not earlier envisaged. Several times interview dates were changed due to

unexpected circumstances. Appointments like the interviews for my study are secondary in the Māori context, to tangi and other hui which can occur at short notice.

The time spent with the participants was much longer than the interviews. My hapū and iwi relationship to the participants involved an expectation that additional time would be spent discussing other matters concerning whanau, hapū and iwi. Every attempt was made to ensure that the research practices were culturally safe. The participants dictated the amount of time I spent in their company.

It was not until I embarked on this thesis that it became obvious that I was far more used to report writing than narratives. This was reflected in the way I tended to draft chapters in report format, a habit I was unaware of until my supervisors pointed this out. In this sense my supervisors suggested that this was a new area in qualitative research for me and hence presented me with another challenge.

Given the nature of this research this study was approached using principles consistent with a Māori worldview. Factors appropriate to critical theory, kaupapa Māori theory, and as well principles central to qualitative research, kaupapa Māori and Māori centred research were fundamental to this study and were used as a means of approaching the research and in achieving the research objectives. My learnings in terms of critical theory and kaupapa Māori research were also increased as in my employment I have mainly been involved in research which leans toward a Māori-centred focus. Importantly however, one research process is not inferior to the other, they are just different.

Both critical theory and kaupapa Māori theory involved the empowerment of my whanau, hapū, iwi and myself as a Māori women of Ngāti Pikiahu Waewae and as a researcher. As part of the reciprocal exercise members of my hapū and iwi were empowered through their involvement as participants in this research and by giving them the opportunity to tell their stories. I was honoured at the privilege of listening to the stories and taonga (treasures) which they were willing to share.

High smoking prevalence among Māori recognises the struggle that Māori women, whanau, hapū and iwi have endured and acknowledges the structural inequalities inherent within society. The theory of false consciousness is evident in the low self-esteem which

many Māori women have of themselves, and where there is an expectation that because they are Māori women they will be smokers. The theory of crisis recognised the impact of smoking including negative statistics, poor health and the loss of whanau members among the participants. The theory of education involved growth, recognised the potential for change through increased awareness, and enabled the women to quit smoking due to the influences of other people, smokefree legislation and the availability of services and products to aid during quitting. As well, critical and kaupapa Māori theories accounted for decisions made by Ngāti Raukawa iwi to improve this situation by implementing initiatives to combat high smoking rates. This process involved educating Ngāti Raukawa iwi and recognised that change was possible through transformative action.

Transformative action also included empowering the research participants, Māori women, my hapū, iwi, Māori and myself in terms of the research processes, findings and recommendations. This study extends the knowledge base about Māori women and smoking and contributes to the lack of information currently available to influence future policies and strategies at all levels, namely, hapū, marae, iwi and Māori.

I am personally empowered by this research in infinite ways. Strengthening my relationship with the participants, increasing my knowledge, broadening my skills as a Māori researcher and improving my academic qualifications are just a few of the benefits, as well as finishing this thesis when there were times when I really thought it would not happen.

In terms of my self-development I have found a compelling need to improve my level of te reo. My belief is that without confidence in te reo, as Māori we may be inclined to miss the crux of Māori concepts and ways of being. It's like having branches on a tree without the roots, the base or the foundation. To quit and stay quit I need to repair the walls of my house and I believe that a key area that needs improving in my life involves developing my reo. This in turn will also contribute to improving my self-esteem.

Limitations of this Research

The findings of this study were not intended to be generalisable. Due to the small sample involved, the participants were not expected to be representative of all Māori women of Ngāti Pikiahu-Waewae and Ngāti Raukawa. What the research participants conveyed was a sense of their world, both in the mainstream and in a cultural context, and their experiences and the issues around smoking and quitting within these contexts.

The size of the study sample may also have limitations in that this research may not provide a true indication of the knowledge, awareness and utilisation of Ngāti Raukawa services such as the AKP programme. It could also be suggested that the perspectives of those of Ngāti Raukawa involved in anti-smoking would have been useful to this study. Significantly this study offers new knowledge which can be used to provide support and to address the barriers to quitting within the rohe of Ngāti Raukawa.

Suggestions for further research

The findings of this study suggest that additional research should be undertaken which looks at risk factors for smoking and the links to social, economic and cultural influences.

Research which looks at the controversies around NRT safety is imperative. Since NRT has the potential to reduce withdrawal symptoms, a common problem which Māori women face given their smoking habits, further studies which look into the safety or otherwise of NRT are recommended.

Monitoring and research to assess the impact of legislative age restrictions in terms of reducing smoking uptake among young people and to assess the level of adherence to the legislation among retailers is also suggested.

It would be useful to undertake a longitudinal study at each of the marae and hapū involved in this study. This would give a picture of the developments, including key barriers and supports which have occurred since the fieldwork for this study was undertaken and would provide the opportunity to record these developments.

This research was undertaken at a time when numerous tobacco control activities at national and iwi level were still in the early stages. Further research is recommended to assess the current level of utilisation among Ngāti Raukawa hapū and iwi as well as to identify hapū and iwi opinions of the support systems smoking cessation services and products presently available.

It would also be interesting to interview members of Ngāti Raukawa involved in smokefree work to gain their perspectives of the Ngāti Raukawa position and to assess their views in regards to implementing a hapū and iwi database. A larger scale study would also be useful to corroborate or otherwise the findings of this study. It would also be particularly useful to interview those involved in the Te Ohaki policy at Te Wananga and to gauge any new developments at both Te Wananga and within the broader Ngāti Raukawa iwi, hapū and marae settings.

Combined this research would provide useful information to develop strategies for change at Ngāti Raukawa hapū and iwi levels including the development of a Ngāti Raukawa marae-based smoking cessation programme.

New Developments

Since undertaking this research there have been further developments in the smokefree legislation.

In 1997 an amendment banned the sale of tobacco products to anyone under 18 years of age and required retailers to take all reasonable steps to check age. Although this legislation has been difficult to enforce, from 10 December 2003 it became an offence to sell tobacco products to anyone under 18.

Reducing the social approval of tobacco use is one of the main provisions of the Smokefree Amendment Act 2003. All indoor workplaces will become completely smokefree from 10 December 2004. The amendment applies only to internal areas however.

Triggers to smoke when socialising and drinking alcohol will be somewhat reduced following the ban on smoking indoors in hospitality venues including bars, cafes and restaurants scheduled to take place from 10 December 2004.

The Smokefree Amendment Act 2003 places greater restrictions on schools and childcare centres. Both schools and childcare centres including kohanga reo and kura kaupapa Māori, became completely smokefree indoors and outdoors from 1 January 2004. The Amendment aims to prevent children in schools and pre-schools from being influenced by having other smokers around them.

Marae are not included in the new legislation although they may be affected in certain situations if the marae has a paid employee, has an indoor restaurant or licensed premises, and when the marae is used as a kohanga reo or kura kaupapa.

Further to advances in the legislation two significant tobacco control strategies have also been developed since I first began this study, namely the Tobacco Control Research Strategy for New Zealand (2003) and the National Māori Tobacco Control Strategy 2003-2007 (2003).

Recommendations for National policies

The findings of this study identified several implications for policies. While a number of recommendations have been included in this chapter, key areas for national policies presented here. The overall focus should be to reduce the numbers taking up smoking and increase the numbers quitting. Messages need to be continually reinforced and ongoing.

Social factors imply that tobacco control policies should target youth to reduce smoking uptake among young people as well as focus on encouraging social situations where there are more non-smokers than smokers.

Health issues suggest that policies should recognise smoking as an addiction and provide the necessary support systems to deal with this addiction. A continuation of previous

health promotions is recommended and should include information which emphasises the health benefits of quitting regardless of age or smoking history.

Socio-economic factors indicate that national policies should focus on providing programmes which aid in developing skills to cope with stress and anxiety as well as self-assertiveness programmes to improve low self-confidence.

Government policies imply that tobacco control activities should provide comprehensive support services to quitters including the continuation of stage-matching interventions such as the AKP programme. The smokefree legislation should be supported by education, enforcement and ongoing media campaigns.

Changing lifestyle issues suggest that tobacco control policies should promote the benefits of quitting as incentives to quit. Smoking cessation programmes could promote group exercise activities as part of the programme and this could include gym membership at a reduced rate.

Relapse issues indicate that tobacco control policies should involve promotion and advertising which focuses on the benefits of quitting rather than adding to low self-esteem and encouraging ex-smokers to stay quit. Tobacco control activities need to be continual to keep reinforcing the benefits of quitting.

Recommendations for Ngāti Raukawa Iwi, Hapū and Marae

Ngāti Raukawa iwi initiatives have been responsible for some shifts in attitudes towards smoking among Ngāti Raukawa hapū and marae. Throughout this study several factors were identified which can support quitting at marae, hapū and iwi levels. Morbidity and mortality rates due to smoking can be reduced. Key factors are recommended here as having the potential to influence a reduction in smoking and an increase in quitting.

Changes must be introduced gradually and must be initiated at grass roots level. Starting off in small steps could involve increasing smokefree areas and working towards totally smokefree marae.

At the same time as rangatahi are encouraged to participate in marae, hapū and iwi activities to strengthen their knowledge of tikanga and their identities, we are also teaching them to smoke. To decrease smoking uptake among the younger generation we must remove the normality of smoking on the marae.

To reduce the numbers smoking extensive social support is crucial. A Noho Marae Smoking Cessation Programme tailored to meet the needs of Ngāti Raukawa has the potential to meet this need. Women should be a key target group for this programme. The benefits of quitting should be promoted as a way of strengthening and empowering Ngāti Raukawa hapū, marae and iwi.

Conclusion

An awareness of the issues around smoking does not necessarily lead to giving up or refraining from smoking. The factors which influence Māori women to smoke are overwhelming and the changes required to quit and stay quit can seem insurmountable. Unless all four corners of the house are in balance giving up smoking and staying quit is difficult. For many Māori women smoking can seem like an escape from the harsh realities of the world, a form of comfort.

For long term heavy smokers even after quitting the urge to smoke often never goes away. Although in many public settings the situation in the last 10 years has changed considerably so that smokers have become ostracised and this is likely to increase given recent and pending legislative developments, unfortunately at most marae the situation is often reversed and for Māori, the normality of smoking continues the cycle. However this study has shown that within Ngāti Raukawa marae, hapū and iwi there is also the potential for change.

My daughter used the following whakatauki to describe an art piece she recently designed. It seemed appropriate to include this whakatauki and her description here.

E kore au e ngaro, he kakano i ruia mai i Rangiatea

Although much may be lost, the seeds of Rangiatea remain

It is the land and my whakapapa which maintains my turangawaewae, my identity. It is permanent, stable and will continue through nga kakano, the seeds, my nephews, and in future generations of Ngāti Pikiahu-Waewae as we stand at our marae, Te Tikanga, on the land which is ours, ki Tokorangi.

As Māori women just as we have perpetuated high smoking rates on the marae we are also in a position to make changes in reducing smoking especially among our younger female generations. The challenge will be for the women of my hapū, Ngāti Pikiahu-Waewae and Ngāti Raukawa iwi, including myself, to work towards improving ourselves, learning new skills and restoring our identity as a positive smokefree people.

Appendices

Appendix One: Information Sheet

Quitting Smoking: The Experiences of Mäori Women

INFORMATION SHEET

Who is the researcher?
My name is Sharon Taite and I am of Ngäti Pikiahu-Waewae hapü and Ngäti Raukawa and Ngäti Tuwharetoa iwi. My supervisors are Wheturangi Walsh-Tapiata and Rachael Selby, both of Ngäti Raukawa. The information from the research will be used for my Masters thesis.

How can I be contacted?
Sharon Taite
Ph (06) 3505799 ext 2540
Te Pumanawa Hauora
Massey University
Private Bag 11 222
Palmerston North

How can my supervisors be contacted?

Wheturangi Walsh-Tapiata
Ph (06) 3505799 ext 2836
Rachael Selby
Ph (06) 3505799 ext 2831

School of Sociology,
Social Policy and Social Work
Massey University
Private Bag 11 222
Palmerston North

What is this study about?
The smoking rates for Mäori women are among the highest known in the world. At the time of the 1996 Census, 41% of Ngäti Raukawa were currently smoking. For all age groups under 55 years, Ngäti Raukawa women were more likely to smoke than Ngäti Raukawa men. This is a study to record the experiences of Ngäti Raukawa women who have tried to quit smoking in the past 12 months.

What will you have to do?
I will ask you to answer some questions about your experiences while attempting to quit smoking. The interview will cover areas such as how long you have been a smoker, your social and educational background, and your aspirations for the future of your whanau, hapü and iwi.

This will involve one individual interview lasting up to two hours. Interviews can be at your own home or somewhere else convenient to you, and at a suitable time for you. Given the sensitive nature of some questions there is the potential you might become upset. If this occurs I will stop the interview and offer names of individuals or organisations who can offer assistance.

During the interview I will take handwritten notes, and if you agree I would like to tape the interview. The interview tapes will then be transcribed by me. You will be sent copies of the edited transcripts to check and make deletions or additions, and then return the transcript to me. Once the study is completed, I will mail you a summary of the research findings and inform you of where copies of the Masters thesis can be found.

How were you selected?
I would like you to participate in this study because you are of the same hapü (Ngäti Pikiahu-Waewae) and/or iwi (Ngäti Raukawa) as myself, and I am aware that you have tried to quit smoking in the past 12 months. Your name has been provided through whanau, hapü and iwi networks.

What are the benefits of the research?
Information from this research will help identify what has been helpful and what are the barriers for Ngäti Raukawa women wanting to quit smoking. I will use the information from this study initially for a Masters thesis report and later I may also use this information to write journal articles and/or to present at hui/conferences.

How will confidentiality and anonymity be protected?
If you choose, every attempt will be made to keep your identity confidential. I will use the information collected in such a manner that you will not be identified unless you wish to be. Should you wish to keep your identity confidential I will ask you to choose a pseudonym for yourself. However, given the small and specific study sample, participants need to be aware that confidentiality can not be entirely guaranteed.

What will happen to the data on completion of the project?
All data will be stored in a locked cabinet at Te Pümanawa Hauora, Te Putahi a Toi, Massey University. Access to the data will be denied to anyone except myself and my thesis supervisors. Tapes from your interview will be returned to you at completion of my

Masters thesis, however I may utilise information from this research to write journal articles and/or to present at hui/conferences.

If you take part in this study, you

- can refuse to answer any questions or stop at any time
- can ask any questions about the study
- can withdraw from the study at any time
- can provide information on the understanding that your name will not be used unless you give permission to the researcher
- will be given a summary of the findings of the study when it is concluded

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/119.

Appendix Two: Consent Form

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Quitting Smoking: The Experiences of Mäori Women

CONSENT FORM

Please read the following carefully:

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

I agree that the information I provide may be used by the researcher initially for a Masters thesis report and may later be utilised to write further publications and/or to present at hui/conferences.

Signed: .....

Name: .....

Address: .....

.....

Date: .....

Appendix Three: Interview Schedule

THESIS OBJECTIVES: To record the **experiences** of 4-6 Ngäti Pikiahu-Waewae and/or Ngäti Raukawa women **who have tried to quit smoking in the past 12 months.** Main interest is in hearing participants experiences about the support and influences around them (from friends, workmates, whanau, hapü and iwi) when they were trying to quit.

QUESTIONS FOR PARTICIPANTS - 2 hour interviews
At first contact, verify with participants that they have either quit smoking or tried to quit smoking in the past 12 months

---

PART ONE - PARTICIPANT TO COMPLETE:

Participant details
Name _____
Address _____
_____
_____
Phone _____
Date of birth _____
Marae _____
Hapü _____
Iwi _____

Number of years as a regular smoker

Current Age		
Age began regular smoking		Subtract
Time off smoking in previous quit attempts		Subtract
Total years smoked		Equals

Smoking level
About how many cigarettes do you think you smoke/d per day?
Would you rate yourself as a low, medium or heavy smoker?

Have you ever tried to cut down on smoking in the past? Yes or No
How many times?

Have you ever tried to quit smoking in the past? Yes or No
How many times?
How long were you quit for? Add details (years) to table above

PART TWO - INTERVIEW QUESTIONS - PARTICIPANT TO RECEIVE COPY. These questions to guide but not limit the interview.

Educational background
Tell me about your education

Employment status
Are you working at the moment. Tell me about it.

Smoking history - You and smoking
When did you have your first cigarette?
Tell me about you as a smoker, your smoking history.

IF NOT SMOKING - How long have you been quit smoking? What influenced you to stop smoking?

IF CURRENTLY SMOKING - Do you know why you started smoking again? Did something happen? Do you think you will try to give up smoking again? Why or why not? What is your reason for this?

Social influences on smoking
Have the people around you had any effect on your trying to give up smoking, i.e. were they supportive, unsupportive, etc. In what way? (e.g. smokefree whare or waka)
- **Your household**, the people that you live with
- **Friends**
- **Whanau**, other than those you live with
- **Workmates**
- **Other support** - Did anybody try to stop smoking with you?
- **Non-smokers**

Ngäti Raukawa
What's happening in your iwi with attitudes to smoking and quitting smoking?
Are you aware of any programmes/services that Ngäti Raukawa provides to encourage quitting smoking or to promote a smokefree message?

Hapû
Tell me about the smokers and smoking in your hapü

What are your aspirations for the future for your whanau/hapû/iwi?
Do you see your whanau/hapû/iwi being smokefree within the next 5 years?

Advice to others
What advice would you give to others who are thinking about quitting smoking?

PART THREE - INTERVIEWER CHECKLIST - AT END
CIRCLE OR NOTE ANSWERS IF PARTICIPANT HAS MENTIONED ANY OF THE FOLLOWING DURING THE INTERVIEW?

What made you decide to quit smoking?
(a) health reasons, e.g. you became ill, medical advice, you wanted to look after your health, lack of physical energy
(b) influence/pressure from friends, smoking socially unacceptable
(c) influence/pressure from workmates, smoking socially unacceptable
(d) a friend or workmate gave up smoking
(e) whanau influences, e.g. a relative gave up smoking
(f) hapü influences
(g) iwi influences
(h) cost of cigarettes
(i) children
(j) other - note details

Maintaining cessation
What methods (if any) did you to help you in trying to stay quit
(a) walking or taking up regular exercise
(b) chewing gum
(c) drinking lots of water
(d) changing living environments, e.g. establishing a smokefree home or waka
(e) reading quit smoking literature
(f) other - note details

Personal gains from quitting smoking - the good things?
Have you experienced any of the following:
(a) more money available
(b) improved self-esteem
(c) improved sense of smell/taste
(d) increased energy levels
(e) improved sleeping patterns
(f) improved health
(g) other - note details

Negative consequences from quitting smoking - not so good?
Have you experienced any bad changes or negative consequences from quitting smoking:
(a) gained weight
(b) find it hard to cope with stressful/difficult situations
(c) had to avoid friends/whanau who smoke
(d) had to avoid smoking situations, e.g. the pub, the marae
(e) felt alienated or socially cut off (i.e. given that so many Mäori smoke)
(e) health temporarily deteriorated
(f) other - note details

Bibliography

Agency for Health Care Policy and Research. (1996). The Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guideline. *JAMA Journal of the American Medical Association, 275*(16), 1270-1280.

Aparangi Tautoko Auahi Kore. (2001, September). New Zealand Quitline one of the busiest in the world. *He Panui,* 1.

Aparangi Tautoko Auahi Kore. (2003). National Māori Tobacco Control Strategy 2003-2007. Wellington: Aparangi Tautoko Auahi Kore.

Batenburg, M., & Reinken, J. (1990). The relationship between sickness absence from work and pattern of cigarette smoking. *New Zealand Medical Journal, 103*(802), 11–13

Bevan-Brown, J. (1998). By Māori, for Māori, about Māori – is that enough? In Te Pūmanawa Hauora (Eds.), *Te Oru Rangahau Māori Research Conference* (pp. 231–246). Palmerston North: School of Māori Studies, Massey University.

Bishop, R. (1996). *Whakawhanaungatanga: Collaborative research stories.* Palmerston North: The Dunmore Press Ltd.

Bishop, R. (1998). Whakawhānaungatanga+ as a research process. In Te Pūmanawa Hauora (Eds.), *Te Oru Rangahau Māori Research Conference* (pp. 133–138). Palmerston North: School of Māori Studies, Massey University.

Blewden, M., Waa, A., Spinola, C., & Moewaka Barnes, H. (1997). *An overview of smokefree/tobacco control practice in Aotearoa New Zealand. Literature review.* Auckland: Alcohol and Public Health Research Unit and Whariki, Faculty of Medicine and Health Sciences, University of Auckland.

Blewden, M., Waa, A., Spinola, C., & Moewaka Barnes, H. (1997a). *Background to smoking in Aotearoa New Zealand. Literature review.* Auckland: Alcohol and Public Health Research Unit and Whariki, Faculty of Medicine and Health Sciences, University of Auckland.

Blewden, M., Waa, A., Spinola, C., & Moewaka Barnes, H. (1997b). *Māori smokefree: History of tobacco use: Background facts and figures. Literature review.* Auckland: Alcohol and Public Health Research Unit and Whariki, Faculty of Medicine and Health Sciences, University of Auckland.

Blewden, M., Waa, A., Spinola, C., & Moewaka Barnes, H. (1997c). *Māori smokefree: Models of health: Provision of tobacco/smokefree programmes for Māori. Evaluating public health programmes that provide for Māori. Literature review.*

Auckland: Alcohol and Public Health Research Unit and Whariki, Faculty of Medicine and Health Sciences, University of Auckland.

Borman, B., Wilson, N., & Mailing, C. (1999). Socio-demographic characteristics of New Zealand smokers: Results from the 1996 census. *New Zealand Medical Journal, 112*(1101), 460–463.

Boulton, A. (1999) *Tangata ora, tangata toa: An evaluation of a Māori men's well-being programme. Unpublished master's thesis*, Victoria University, Wellington, NZ.

BRC Marketing and Social Research & Te Pūmanawa Hauora. (2000). *Aukati kai paipa 2000: Evaluation report.* Wellington: BRC Marketing and Social Research.

BRC Marketing and Social Research & Te Pūmanawa Hauora. (2001). *Aukati kai paipa 2000: Evaluation report.* Wellington: BRC Marketing and Social Research.

BRC Marketing and Social Research & Te Pūmanawa Hauora. (2002), *Evaluation of culturally appropriate smoking cessation programme for Māori women and their Whānau: Aukati kai paipa 2000.* Wellington: BRC Marketing and Social Research.

BRC Marketing and Social Research & Te Pūmanawa Hauora. (2002a). *Appendices: Evaluation of culturally appropriate smoking cessation programme for Māori women and their Whānau. Aukati kai paipa 2000.* Wellington: BRC Marketing and Social Research.

Broughton, J. (1996). *Puffing up a storm: Volume 1. Kapai te torori.* Dunedin: The Ngai Tahu Māori Health Research Unit, The Department of Preventive and Social Medicine, University of Otago.

Broughton, J., & Lawrence, M. (1993). *Ngā wahine Māori me te kai paipa. Māori women and smoking.* Dunedin: The Department of Preventive and Social Medicine, University of Otago.

Brown, S. L., & Owen, N. (1992). Self-help smoking cessation materials. *Australian Journal of Public Health, 16*(2), 188–191.

Cancer Society of New Zealand. (2000). *Tobacco statistics 2000.* Wellington: Cancer Society of New Zealand Inc.

Chetwynd, J., Coope, P., Brodie, R., & Wells, E. (1988). Impact of cigarette advertising on aggregate demand for cigarettes in New Zealand. *British Journal of Addiction, 83*(4), 409–14.

Cowan, S. (2000). *Addressing smoking in pregnancy.* Christchurch: Family Education Services.

Cram, F. (1995). *Ethics and cross-cultural research.* Auckland: Department of Psychology, University of Auckland.

Cunningham, C. (1998). A framework for addressing Māori knowledge in research, science and technology. In Te Pūmanawa Hauora (Eds.), *Te Oru Rangahau Māori Research Conference* (pp. 394-405). Palmerston North: School of Māori Studies, Massey University.

Cunningham, C. (2000). *Health and disability services for older Māori.* Palmerston North: Te Pūmanawa Hauora, School of Māori Studies, Massey University.

Dalzell, R., & Gibbs, C. (1997). *Smoke cignals: The message after twenty years. Light up, light out: No ifs, just butts. A longitudinal study (1977-1997) of the behaviour, attitude and knowledge of College of Education student teachers with respect to cigarette smoking.* Palmerston North: College of Education, Massey University.

Davidson, C., & Tolich, M. (Eds.). (1999). *Social science research in New Zealand: Many paths to understanding.* Auckland: Pearson Education.

Department of Health and Human Services. (1986). *The health consequences of involuntary smoking: A report of the Surgeon General.* Maryland: Department of Health and Human Services, Public Health Service.

Department of Statistics. (1983). *New Zealand census of population and dwellings 1981: Bulletin on cigarette smoking.* Wellington: Department of Statistics.

Devonshire, M. (1999). Taumata-o-te-ra-Marae. *Te Ukaipo, 1*, 19–26.

Dickson, N., Sporle, A., & Rimene, C. (2000). Pregnancies among New Zealand teenagers: Trends, current status and international comparisons. *New Zealand Medical Journal, 113*(1112), 241-245.

Doublett, S. J.(1997). *Family volence among Māori: Research issues and guidelines,* A Health Research Council Summer Studentship Report.

Durie, A. (1998). Me tipu ake te pono: Māori research, ethicality and development. In Te Pūmanawa Hauora (Eds.), *Te Oru Rangahau Māori Research Conference* (pp. 257–263). Palmerston North: School of Māori Studies, Massey University.

Durie, M. (1994). *Whaiora Māori Health Development.* Auckland: Oxford University Press.

Durie, M. (1995). *Matatini Māori: Diverse Māori realities.* Palmerston North: Te Pūmanawa Hauora, Department of Māori Studies, Massey University.

Durie, M. (1996, September). *Characteristics of Māori health research.* Paper presented at the Hui Whakapiripiri, Hongoeka, NZ..

Durie, M. (1997, July). *Identity, access and Māori advancement.* Paper presented at New Zealand Agricultural Economics Society (NZAES) Conference, Auckland, NZ.

Durie, M. (1998). *Whaiora Māori Health Development* (2nd ed.). Auckland: Oxford University Press.

Durie, M. (1998a). *Te mana, te kawanatanga: The politics of Māori self-determination.* Auckland: Oxford University Press.

Durie, M. (2002, September). *Health research in New Zealand: Science, mātauranga Māori, and the generation of new knowledge* (Ian Prior Oration). Paper presented to the Australian Epidemiological Association, Wellington, NZ.

Easton, B. (1995). Smoking in New Zealand: A census investigation. Australian *Journal of Public Health, 19*(2), 125–129.

Fay, B. (1987). *Critical social science: Liberation and its limits.* Cambridge: Polity Press.

Flay, B. (1987). Mass media and smoking cessation: A critical review. *American Journal of Public Health, 77*(2), 153–160.

Ford, D., Scragg, R., Weir, J., & Gaiser, J. (1995). A national survey of cigarette smoking in fourth-form school children in New Zealand. *New Zealand Medical Journal, 108*(1011), 454–457.

Gardiner, C., Taylor, C., & Roberts, L. (1961). *Smoking habits of school children: A survey of the smoking habits of New Zealand school children.* Wellington: Department of Health.

Gifford, H. (1999). *A case study of Whānau Ora, a Māori health promotion model (A service developed by Te Oranganui Iwi Health Authority Trust (Inc.) Whanganui).* Unpublished master's thesis, University of Otago, Dunedin, NZ.

Glover, M. (1995). Mobilising an indigenous population: Reducing Māori smoking. In K. Slama (Ed.), *Tobacco and health* (pp. 907-909). New York: Plenum Press.

Glover, M. (1996). New tobacco policy fails Māori women. *Broadsheet,* 211, 41–44.

Glover, M. (2000). *The effectiveness of a noho marae smoking cessation intervention: Utilising a kaupapa Māori methodology.* Unpublished doctoral thesis, University of Auckland, Auckland, NZ.

Glover, M. (2002). *A literature review and commentary on the use of a kaupapa Māori approach within a doctoral study of Māori smoking cessation.* Auckland: Applied Behavioural Science, University of Auckland.

Graham, H., & Der, G. (1999). Influences on women's smoking status: The contribution of socioeconomic status in adolescence and adulthood. *European Journal of Public Health, 9*(2), 137–141.

Harrison, R., Chetwynd, J., & Brodie, R. (1989). The impact of advertising on tobacco consumption: A reply to Jackson and Ekelund. *British Journal of Addiction, 84*(11):1251–1254.

Hay, D., & Foster, F. (1984). Intercensal trends in cigarette smoking in New Zealand: 1: Age, sex and ethnic status. *New Zealand Medical Journal, 97*, 283–285.

Health Funding Authority. (1991, July). *Guidelines for smoking cessation.* Wellington: National Advisory Committee on Health and Disability.

Health Funding Authority. (1999). *Toward a tobacco-free New Zealand: A five-year plan for HFA funding for tobacco control (1999-2003).* Wellington: Public Health Group, Health Funding Authority.

Health Research Council. (2000, October). Many Māori Smokers Want to Cut Down. *HRC Newsletter*, 7.

Health Sponsorship Council, Te Hotu Manawa Māori, & Aparangi Tautoko Auahi Kore (2001). *Conference Proceedings from the National Auahi Kore Hui 2001: E tu, are we making a difference.* Wellington: Health Sponsorship Council, Te Hotu Manawa Māori, & Aparangi Tautoko Auahi Kore.

Hillrice, V., Templin, T., Fox, D., Jarosz, P., Mullin, M., Seiggreen, M., & Lepczyk, M. (1996). Social context variables as predictors of smoking cessation. *Tobacco Control, 5*(4), 280–285.

Holdaway, R. (1999). Smoking - a taxing issue. *PHA News, 11*(6), 1–3.

Hotere, A. (1998, December). Exploring kaupapa Māori research. *HRC Newsletter*, 9–10.

Irwin, K. (1992). Towards theories of Māori feminism. In R. Du Plessis et al (Eds.), *Feminist voices: Womens Studies texts for Aotearoa/New Zealand* (pp. 1–21). Auckland: Oxford University Press.

Irwin, K. (1994). Māori research methods and processes: An exploration. *Sites, 28*, 25-43.

Jackson, M. (1996). Māori Health Research and Te Tiriti o Waitangi. In Te Ropu Rangahau Hauora a Eru Pomare; (Ed.). *Hui whakapiripiri: A hui to discuss strategic directions for Māori health research* (pp. 8-10). Wellington: University of Otago.

Jackson, M. (1998). Research and the Colonisation of Māori Knowledge. In Te Pūmanawa Hauora (Eds.), *Te Oru Rangahau Māori Research Conference* (pp. 70–78). Palmerston North: School of Māori Studies, Massey University.

Jackson, M. & Fukofoka, J. (2001, December). Editorial. *Auahi Kore News, Panui Whanui*, 15, 2.

Jahnke, H., & Taiapa, J. (1999). Māori research. In C. Davidson & M. Tolich (Eds.), *Social science research in New Zealand: Many paths to understanding* (pp. 39–50). Auckland: Pearson Education.

Jha, P., & Chaloupka, F. J. (2000). The economics of global tobacco control. *British Medical Journal, 321*, 358–361.

Joe, M. (1991). Up in smoke. *Broadsheet, 190*, 20–22.

Johnston, P. (1998). This is not just another story: A journey to discover what counts as research. In Te Pūmanawa Hauora (Eds.), *Te Oru Rangahau Māori Research Conference* (pp. 354–363). Palmerston North: School of Māori Studies, Massey University.

Kapoor, S. (1980). *Smoking and health: Policymaking structure and process. An analysis of the policymaking structure and process within the Department of Health concerned with the issue of smoking and health* (Research paper 2/3) Wellington: New Zealand Institute of Public Administration.

Kawachi, I., Pearce, N., & Jackson, R. (1989). Deaths from lung cancer and ischaemic heart disease due to passive smoking in New Zealand. *New Zealand Medical Journal, 102*(871), 337–340.

Kimura, S. (2002, April). Quit and Win in the MidCentral region. *Smokelink,* 15, 3.

King, D., Smith, A., & Salter, D. (1983). Mortality attributable to smoking in New Zealand. *New Zealand Medical Journal, 96*, 195–199.

Klemp, P., Roberts, M. C., Stansfield, S., Klemp, J. A., & Harding, E. (1998). Factors associated with smoking and the reasons for stopping in Māori and Europeans: A comparative study. *New Zealand Medical Journal, 111*(1064), 148–150.

Lambert, J. (2002, April). Stop smoking contest offers travels. *Smokelink,* 15, 3.

Laugesen, M. (1996). *Tobacco statistics 1996.* Wellington: Cancer Society of New Zealand and the Ministry of Health.

Laugesen, M. (1996a). *The big kill continues: The human cost of smoking in New Zealand in the 1990s.* Wellington: Cancer Society of New Zealand.

Laugesen, M., & Clements, M. (1998). *Cigarette smoking mortality among Māori, 1954-2028.* Wellington: Health New Zealand.

Laugesen, M., & Swinburn, B. (1999). New Zealand's tobacco control programme 1985-1998. *Tobacco Control, 9*, 155–162.

Masters, B. (2000). *Researching the process of auahi kore for marae.* Wellington: Health Sponsorship Council.

Mataatua Tribes. (1993, June). *The Mataatua Declaration on cultural property rights of Indigenous Peoples.* Presented at the First International Conference on the Cultural and Intellectual Property Rights of Indigenous Peoples, Whakatane.

McClellan, V. (1998). *A life-cycle approach: Factors influencing decisions to quit smoking.* Wellington: Centre for Research, Evaluation Services and Social Assessment.

McGee, R., Williams, S., & Stanton, W. (1995). Smoking among New Zealand adolescents, 1960-83. *New Zealand Medical Journal, 108*(995), 85–87.

Mead, L. (1996). *Ngā aho o te kakahu mātauranga: The multiple layers of struggle by Māori in education.* Unpublished doctoral thesis, University of Auckland, Auckland, NZ.

MidCentral Health. (2001, June). Smoking cessation contract. *Health Promotion,* 23, 4.

Minister of Health, (2000, May). Increase in excise on tobacco products. *The Dominion.*

Ministry of Health. (1996). *Progress on health outcomes.* Wellington: Ministry of Health.

Ministry of Health. (1998). *Progress on health outcome targets: The state of the public health in New Zealand 1998.* Wellington: Ministry of Health.

Ministry of Health. (1999). *Our health, our future: Hauora pakari, koiora roa: The health of New Zealanders 1999.* Wellington: Ministry of Health.

Ministry of Health. (2000). *Social inequalities in health: New Zealand 1999.* Wellington: Ministry of Health.

Ministry of Health. (2000a). *The New Zealand Health Strategy. Discussion document.* Wellington: Ministry of Health.

Ministry of Health. (2000b). *The New Zealand Health Strategy.* Wellington: Ministry of Health.

Ministry of Health. (2001). *He korowai oranga: Māori Health Strategy. Discussion document.* Wellington: Ministry of Health.

Ministry of Health. (2001a). *Tobacco Facts 2001.* Retrieved 28 May 2001 from http://www.moh.govt.nz/moh.nsf/ea6005dc347e7bd44c2566a40079ae6f/2da018a2eb73c257cc256bc600076cb5/$FILE/Tobacco_Facts_2001.pdf

Ministry of Health. (2002). *The Māori Health Action Plan 2002-2005. Draft.* Wellington: Ministry of Health.

Ministry of Women's Affairs. (1990). *Women and smoking* (Policy discussion paper no. 2). Wellington: Ministry of Women's Affairs.

Ministry of Women's Affairs. (2001, November). *Status of women in New Zealand: Fifth report to the United Nations Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW)* (Draft). Wellington: Ministry of Women's Affairs.

Ministry of Women's Affairs. (2001a). *The Women's Health Strategy. Discussion document.* Wellington: Ministry of Women's Affairs.

Mitchell, D. (1983). A comparison of high school student's smoking behaviour in 1968 and 1981. *New Zealand Medical Journal, 96*, 534–536.

Murchie, E. (1984). *Rapuora: Health and Māori women.* Wellington: Māori Womens Welfare League.

National Advisory Committee on Health and Disability. (1999). *Guidelines for smoking cessation.* Wellington: National Advisory Committee on Health and Disability.

National Health Committee. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health. A report from the National Advisory Committee on Health and Disability.* Wellington: National Health Committee.

National Research Bureau. (1999) *Attitudes towards environmental smoke.* Public attitude research report prepared for the Ministry of Health. Wellington: National Research Bureau.

Nicther, M., Nicther, M., Vuckovic, N., Quintero, G., & Ritenbaugh, C. (1997). Smoking experimentation and initiation among adolescent girls: Qualitative and quantitative finds. *Tobacco Control, 6*, 285–295.

O'Donoghue, B., Howden-Chapman, P., & Woodward, A. (2000). Why Do Australians Live Longer Than New Zealanders? *Health Education and Behaviour, 27*(3), 307–316.

Oei, T., Brasch, P., & Silva, P. (1984). The prevalence of smoking among Dunedin nine-year olds. *New Zealand Medical Journal, 97*, 528–531.

Patton, M. (1990). *Qualitative evaluation and research methods.* Newbury Park, CA: Sage Publications.

Pearce, N., Davis, P., Smith, A., & Foster, F. (1985). Social class, ethnic group, and male mortality in New Zealand, 1974-8. *Journal of Epidemiological Community Health, 39*, 9–14.

Peto, D., Lopez, J., & Boreham, J. (1994). *Mortality from smoking in developed countries.* Oxford: Oxford University Press.

Pomare, E., & de Boer, G. (1988). *Hauora: Māori standards of health: A study of the years 1970-1984.* Wellington: Te Rōpū Rangahau Hauora a Eru Pomare.

Pomare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., & Watene-Haydon, N. (1995). *Hauora: Māori standards of health III. A study of the years 1970-1991.* Wellington: Te Rōpū Rangahau Hauora a Eru Pomare.

Prochaska, J., & DiClemente, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: Theory, Research and Practice *19*(3), 276–288.

Public Health Commission. (1994). *Our health, our future. Hauora Pakari, Koira Roa: The state of the public health in New Zealand 1994.* Wellington: Public Health Commission.

Public Health Group. (1998). *Smoking cessation pilot programmes for Māori: Purchasing framework.* Wellington: Health Funding Authority/PHARMAC Steering Group.

Quit Group. (2000, July/August). Quitline expands. *Quit News,* 7, 1.

Quit Group. (2001a). *It's about whanau.* Retrieved November 9, 2001, from http://www.quit.co.nz/page.php3?p=64&fp=70.

Quit Group. (2001b). *Quit for our kids, he tohu aroha.* Retrieved November 9, 2001, from http://www.quit.co.nz/page.php3?p=50&fp=69.

Quit Group. (2002, May). Quitline statistics for November and December. *Hono Mai,* 2.

Reid, P., & Pouwhare, R. (1991). *Te-Taonga-mai-Tawhiti: The-gift-from-a-distant-place.* Auckland: Niho Taniwha.

Rice, P., & Ezzy, D. (1999). *Qualitative research methods: A health focus.* Melbourne: Oxford University Press.

Royal, T. (1993). *Te haurapa: An introduction to researching tribal histories and traditions* (2nd ed.). Wellington: Bridget Williams Books Limited and Historical Branch, Department of Internal Affairs.

Selby, R. (1996). *A study of the factors which contribute to success for Māori women in tertiary education.* Unpublished master's thesis, Massey University, Palmerston North, NZ.

Selby, R. (1999). Tararua is my mountain. *Te Ukaipo, 1,* 9-18.

Smith, G. (1997). *The development of kaupapa Māori: Theory and praxis.* Unpublished doctoral thesis. Auckland: University of Auckland, , N.Z.

Smith, L. (1986). *Te rapunga i te Ao Marama: The search for the world of light.* Auckland: University of Auckland.

Smith, L. (1995, February). *Towards kaupapa Māori research.* Paper presented at the Matawhanui Māori University Teachers Conference. Palmerston North: Massey University.

Smith, L. (1996). Kaupapa Māori health research. In Te Ropu Rangahau Hauora a Eru Pomare; (Ed.). *Hui whakapiripiri: A hui to discuss strategic directions for Māori health research* (pp. 14–13). Wellington: University of Otago.

Smith, L. (1998). Towards the new millenium: International issues and projects in indigenous research. In Te Pūmanawa Hauora (Eds.), *Te Oru Rangahau Māori Research Conference* (pp. 12–31). Palmerston North: School of Māori Studies, Massey University.

Smith, L. (1999). *Decolonizing methodologies: Research and indigenous peoples.* Dunedin: University of Otago Press.

Smith, A., & Pearce, N. (1984). Determinants of differences in mortality between New Zealand Māoris and non-Māoris aged 15-64. *New Zealand Medical Journal, 97*,101–108.

Smokefree Coalition. (2000). *Secondhand tobacco smoke: The facts.* Wellington: Smokefree Coalition.

Statistics New Zealand & Ministry of Health. (1993). *A picture of Māori health.* Wellington: Statistics New Zealand & Ministry of Health.

Statistics New Zealand. (1996). *Census of population and dwellings.* Wellington: Statistics New Zealand.

Statistics New Zealand. (1999). *Ngāti Raukawa* Wellington: Statistics New Zealand.

Stewart, K. (1999). *Critical incident stress management within secondary schools in Aotearoa New Zealand.* Research report for the Master of Social Work Applied degree, Massey University, Palmerston North, NZ.

Stokes, E. (1985). *Māori research and development. A discussion paper.* Wellington: National Research Advisory Council, Social Services Committee.

Swinburn, B. (2000, May). *Why we need more resources for tobacco control.* Paper presented at "$x Million Plan for Tobacco Control" Conference held at Pipitea Marae, Wellington, NZ.

Te Awekotuku, N. (1991). *He tikanga whakaaro: Research ethics in the Māori Community. A discussion paper.* Wellington: Ministry of Māori Affairs.

Te Hotu Manawa Māori. (2001, December). Auahi kore Conference, 11-12 October 2001, Te Papa Tongarewa. *Auahi Kore News, Panui Whanui*, 15, 1.

Te Puni Kokiri. (1998). *Progress towards closing social and economic gaps between Māori and non-Māori. A report to the Minister of Māori Affairs.* Wellington: Te Puni Kokiri.

Te Puni Kokiri. (2000). *Tikanga oranga hauora.* Wellington: Te Puni Kokiri.

Te Wānanga O Raukawa. (1999). *Te Ukaipo* (Vol. 1). Otaki: Te Wānanga O Raukawa.

Thomson, G. (2001). A smokefree agency: How to fund and run a continuously effective New Zealand tobacco control programme. *PHA News*, *14*(4), 1–3.

Thomson, G., O'Dea, D., Wilson, N., Reid, P., & Howden-Chapman, P. (2000). *The financial effects of tobacco tax increases on Māori and low-income households.* Wellington: Department of Public Health, Wellington School of Medicine and University of Otago.

Thomson, G., & Wilson, N. (1997). *Resource document: A brief history of tobacco control in New Zealand.* Wellington: Australasian Faculty of Public Health and Medicine (N.Z.).

Thomson, S. (2000, May). *Breaking through the New Zealand women's tobacco epidemic*. Paper presented at "$x Million Plan for Tobacco Control" Conference held at Pipitea Marae, Wellington, NZ.

Tobacco Control Research Strategy Steering Group. (2003). A Tobacco Control Research Strategy for New Zealand. Wellington: Allen & Clarke, Policy and Regulatory Specialists Ltd.

Toxic Substances Board. (1989). *Health or tobacco: An end to tobacco advertising and promotion.* Wellington: Department of Health.

Turrell, G. & Battistutta, D. (2000). Social determinants of smoking among parents with infants. *Australian and New Zealand Journal of Public Health, 26*(1), 30–37.

VandenBerg, M. (1995). Smoking during pregnancy and post neonatal death. *New Zealand Medical Journal 98*, 1075–1078.

Walker, R. (1990). *Ka whawhai tonu matou: Struggle without end.* Auckland: Penguin Books.

Walsh-Tapiata, W. (1997). *Raukawa Social Services origins and future reflections.* Unpublished master's thesis, Massey University, Palmerston North, NZ.

Whitlock, G., MacMahon, S., Vander Hoorn, S., Davis, P., Jackson, R., & Norton, R. (1997). Socioeconomic distribution of smoking in a population of 10 529 New Zealanders. *New Zealand Medical Journal, 110*(1051), 327–330.

Williams, N. (1999). *Me mutu te kaipaipa: Facilitating participation by Māori women in smoking cessation programmes.* Unpublished master's research proposal, Massey University, Palmerston North, NZ.

Wilson, N. (2000). *Brief evaluation of the pilot phase of the Nicotine Patches and Gum Subsidisation programme.* Wellington: Health Funding Authority.

World Health Organisation. (1992). *Women and Tobacco.* Geneva: World Health Organisation.

Young, J. & Ward, J. (1998). Improving smoking cessation advice in Australian general practice: What do GPs suggest is needed? *Australian and New Zealand Journal of Public Health, 22*(7), 777–780.