



## Māori challenges and crown responsibilities: Māori policymaker ideas on smokefree policy options

Heather Gifford, Kiri Parata, George Thomson

### Abstract

**Aim** To determine obstacles/opportunities within policy processes, for smokefree interventions appropriate to Māori. In particular, to explore Māori policymakers' ideas on how to achieve progress on smokefree homes, cars and community property.

**Methods** Documents and interviews with 16 senior Māori officials and Members of Parliament, and nine interviews in two case studies, were used to explore Māori policymakers' ideas for (i) Progress, within relevant policy processes, on smoking in homes, cars and community property; (ii) Particular interventions that the interviewees felt were most and least effective, practical, sustainable, politically feasible or desirable in some way; (iii) The context, and obstacles and opportunities for such interventions. The case studies were of a Māori health service and a group of Māori District Health Board managers.

**Results** Several key themes emerged from the research including, (i) children as drivers for change, (ii) strong national and local indigenous leadership needed for change, (iii) delivering smokefree messages as part of wider healthy living approaches, (iv) targeting of the messages for greatest impact for Māori, (v) need for a Māori approach, not a general approach, (vi) central and local government having a significant role in the prevention of tobacco harm, (vii) ideas on how tobacco tax revenue should be spent on tobacco control, and (viii) the rights of children to smokefree environments.

**Conclusions** Results indicate that indigenous specific approaches and indigenous leadership are critical for Māori tobacco-free advances. Harnessing indigenous values and principles related to health, family and children was the preferred method of these Māori policymakers for delivering social marketing messages.

Smoking in homes is a crucial factor in starting smoking and quitting.<sup>1-5</sup> For New Zealand youth, the relative risk of Māori children reporting smoking inside their homes has been increasing.<sup>6</sup> Substantial immediate gains in preventable mortality and morbidity are possible by reducing exposure to secondhand smoke (SHS) in homes and cars, particularly from the reduction of the exposure to children.<sup>7-11</sup> There is clear evidence of higher exposure to SHS in homes and cars for Māori children.<sup>6,12</sup>

When Year 10 students were asked in 2008 if there was smoking in their homes, 36% of Māori students reported smoking in the home, compared to 18% for European/other students.<sup>6</sup> These figures had decreased significantly since 2001, when 48% of Māori students reported smoking in the home, compared to 27% for European/other students. Exposure may be compounded for Māori by over representation in low socioeconomic groupings; for students in the three most

socioeconomically deprived deciles of schools in 2008, 31% reported smoking in the home.<sup>6</sup>

Māori children are also exposed to SHS in cars at a higher rate. When asked in 2006 if someone had smoked while they were travelling in cars or vans in previous seven days, 43% of Māori Year 10 students reported exposure, compared to 22% of European/other students.<sup>13</sup>

One option for addressing the problem of tobacco smoking, and specifically the widespread exposure to secondhand smoke, is through policy approaches. At present, information is lacking on New Zealand stakeholders' attitudes and responses to policies on reducing the exposure of children to smoking behaviour and to SHS, and on the optimal avenues for introducing such policies. Little work has been done on the processes for new tobacco policies, or on health policy processes in groups such as iwi (tribal groups). Research on Māori and Pacific health decisionmakers' views is rare,<sup>14</sup> and in-depth research about any Māori and NZ Pacific decisionmakers is uncommon.<sup>15,16</sup> We found no published research on their views about smoking.

The aim of the research was to determine obstacles and opportunities within policy processes, for smokefree interventions appropriate to Māori. In particular, to explore Māori policymakers' ideas on how to achieve progress on smokefree homes, cars and community property.

## Methods

This research reports on the results of interviews conducted with senior Māori officials and Members of Parliament, and interviews with members of two case studies; one of a tribal health provider organisation, and the second, a formal collective of senior Māori policymakers employed by district health boards.

The criteria for interviewee selection included being a Māori policymaker (senior central government officials or ex-officials, or a Member of Parliament), closeness to processes relevant to tobacco control, and ability to articulate information. The sample was selected using purposeful sampling, including the use of reputational snowball recruitment methods.<sup>17</sup> An advisory group of senior Māori researchers, including those with policy and tobacco control expertise, identified an initial list of 28 potential interviewees and four potential case study groups; this list was used to approach potential participants. Māori researchers conducted all components of the research, including formulating the interview schedule, collecting and analysing data.

The case study sites were selected as formal Māori collectives with an interest in Māori tobacco control, as accessible within the research timeframe, and as having the ability to influence policy at a local and or national level. One case study was a medium size Māori primary healthcare provider employing approximately 20 employees and servicing approximately 4000 clients. Six interviews were undertaken with the staff and tribal elders, who are affiliated with the provider and the governance of the organisation.

The second case study site was the group of senior Māori officials of the twenty one district health boards, who meet regularly as a formal collective to discuss key national health issues for Māori. Initially it was suggested that a focus group approach would be undertaken with the collective. However, it was considered by the group that individual interviews should be conducted with key people to represent the view of the collective. Three interviews were undertaken with members of the second case study site. The opportunity to be involved in the research was well supported by both case study groups.

A semi-structured interview format was created based on a comprehensive literature review of Māori policymaking and tobacco control, and was added to as the interviews progressed. The same interview schedule was used for both policymaker and case study interviews.

Open-ended questions were used to find:

- General ideas on how to achieve progress on smoking in homes, cars and community property;
- Particular interventions that the interviewees felt were most and least effective, practical, sustainable, politically feasible or desirable in some way; and
- The context, and obstacles and opportunities for such interventions.

The interviews were not conducted to find the extent of the policymakers' knowledge, but their ideas and beliefs.

The interviews were conducted on the basis of confidentiality, with the results to be anonymous. All data collection occurred between May 2008 and March 2009. Ethics permission for the study was obtained through the University of Otago ethics process.

The data was examined for patterns and themes, and then all the material identified that relates to the patterns identified was gathered.<sup>18</sup> The use of semi-structured interviews, with some open questions, allowed for template analysis to identify themes. Template analysis is the coding of material within hierarchic groups, some based on the set questions.<sup>19</sup> The selection of themes was discussed by the research team and advisory group, and compared to those in the literature available.

## Results

Sixteen policymaker interviews were conducted, with 3 politicians and 13 officials/ex-officials. Including the case studies, a total of 25 interviews were completed.

Several key themes emerged from the research including, children as drivers for change, strong national and local indigenous leadership needed for change, delivering smokefree messages as part of wider healthy living approaches, targeting of the messages for greatest impact for Māori, central and local government having a significant role in the prevention of tobacco harm, tobacco tax revenue being spent on tobacco control, and the rights of children to smokefree environments.

**The context for changes around tobacco and Māori**—There was general agreement that tobacco smoking is highly addictive and requires support and intervention from many, including whānau. Almost all participants believed that most smokers have a desire to kick the addiction, but find it difficult to do so:

...It's got to be more addictive than heroin because you look around society, when you're working in Wellington and you're walking down Lambton Quay (Central Business District) and you see seriously intelligent people standing out in the wind and the rain...and there is all of this public shame but they still do it.

Participant responses were varied on the issue of normalisation of tobacco within New Zealand and in particular within Māori culture. Some felt very strongly that smoking was still a normalised part of some sections of the Māori population, while others believed that tobacco smoking was now an unaccepted part of Māori society. One interviewee said.

...The product [tobacco] within Māoridom was seen as a normal cultural activity, now it's not and I think we have to get to a point where we denormalise it.

The majority of participants believed that children have a fundamental right to be free not only from secondhand smoke but also from the role modelling of adults smoking. One person stated that it is the role of whānau (extended family) to ensure their tamariki (children) are safe.

...Yes, children's rights are greater [than adults]. Children have a right to a safe environment and it's the adult's responsibility to ensure this.

Some made the comparison with alcohol policy.

...So if I want to smoke, more power to me, but I also need to be conscious of the impact that has on other people ... we [government] certainly do that subtly and also quite explicitly around our drinking behaviour. So you get to holiday periods and suddenly you get bombarded on TV with a whole lot of ads around drink driving, wearing your seat belts, not speeding. So we're linking our choice or our decision to have a drink with the impact that it might have on other people once we do that.

**The need for Māori approaches**—All participants argued that general population approaches (i.e. addressed to the whole population, Māori and non- Māori) are not the best way to support Māori to reduce smoking. While the goals for reduction may be the same across the whole population, the approaches need to take into account the specific social, political, historical and cultural differences for Māori. Most went on to say that Māori can make change if the message comes from someone they identify with, and many believed that a whānau-focused approach is more effective for Māori than a focus on the individual. One participant spoke of the need to ensure our legislative responses are meeting the needs of all groups within the wider population.

...You need to have a policy that is flexible enough to be able to respond to which ever group needs to use it. So it's ... like – got this kete [basket], got all these tools in it, this particular community can take that kete and go, [but] I want [just] those 3 tools, the rest I don't need to use. And government needs to do that, because it needs to meet the needs of it's entire population and it can't take out one brush or one policy for everyone.

**The range of solutions**—The majority of participants interviewed said that children hold the key to making change within Māori households; largely as a motivator for quit behaviour. Participants described a duty and obligation to tamariki/children. They said that almost all whānau /families understood the negative role modelling of smoking, and that was often a sufficient motive for them to quit. Some interviewees felt it might be too late with the older generation, but educating our young ones and using children as “agents for change” was the best way forward.

...My mother only gave up smoking once the mokopuna [grandchildren] arrived, it was that easy, she knew it was wrong and didn't want to harm them.

Other participants discussed a wider intergenerational approach.

...If there's a whānau focus, ... there is a sense of intergenerational responsibility and obligation to take care. Particularly for those of us who are in mid adult years, where we are both caring for children but we are in the process of caring for our Kuia [??] and kaumātua [leaders] too. Our health matters. Their health is dependant on our health, therefore there is that responsibility for getting that message through.

Many participants believed that Māori leadership at a national, local, community and whānau level was fundamental to making change with Māori smoking rates. Almost all those interviewed agreed that Māori need to take ownership of the situation. They generally advocated starting locally with leaders within a whānau or hapū, and the need for them to lead by example, despite the problems with this approach.

...Unfortunately many of the respected people on a marae[meeting house] or within a whānau are smokers. It can be difficult to change behaviours and implement rules around smoking if iwi leaders are smokers themselves .... who's going to tell a respected Kaumātua what to do?

There was also some debate about the role of individual responsibility for behaviour change (and sometimes the guilt attached for individuals who don't change) and the

role of government or wider structural change. While most saw the use of whānau /families in social marketing campaigns as positive and educative, a few saw it as unhelpful for those unable or unwilling to quit, due to a range of pressing and immediate social and economic challenges.

...It's a bit like the cervical screening ads that were very guilt laden, you have to do it for your family. So what if you don't? Does that mean you're bad, that you have let down your family?

... [Government] needs to be particularly careful around the assumptions of personal responsibility. Because while it is true everyone does have personal responsibilities for their own health and wellbeing, the process of colonisation and the systemic racism that still exists in both the health and the legal system mean that there are particular barriers to getting access to ... information [for] Māori. ... [And] if those systemic failures aren't recognised, the message does not get through.

A number of participants talked about the over-use of the same messages in smokefree campaigns. They spoke of a need to move away from the specific focus of being smokefree, and wrapping it up in a broader healthy lifestyle approach, such as the Healthy Eating Healthy Action campaign, (a national public health campaign to reduce obesity).

...They are sick of it [smokefree messages]. We had a recent Māori golf tournament and people said they are sick to death of the same old smokefree messages. It's been that way for 10 years now, it's gone stale.

When discussing a particular after-school and holiday programme in the Hutt Valley, another interviewee said:

...The kids come together, they're off the streets and out of trouble, they learn a number of things about being healthy, and smokefree messages might be part of that... it's kaupapa Māori, it's about who we are and the kids like it and get it.

All participants agreed that the government has a significant role in the prevention of tobacco harm. All agreed that a portion of tobacco tax revenue should be spent on tobacco control.

...There should be a hypothecated/tied tax regime. There's a billion dollar tax take per year... and just \$40 million out of the billion dollar tax take [is being invested in tobacco control], your math quite easily says this is not right.

Some believed that a blanket approach, such as legislation to ban tobacco products from Aotearoa/New Zealand, was the best idea and believed this could be done within a five year period:

...The only obstacle is lack of political will. If we had the courage today to pass a piece of legislation to ban the manufacture and sale of tobacco in Aotearoa, tomorrow there would be none [tobacco].

Others wished to see local body councils taking a stronger leadership role, for example by introducing smokefree bylaws for playgrounds and sports fields. While some participants identified that it would be difficult to enforce, the promotion of smokefree environments concept and the discussion it would raise was seen as useful. Some interviewees spoke of their own experiences introducing smokefree policies on their marae; this was generally positive but took some time to be adopted.

Other participants thought that it would be inappropriate for a Council to impose rules on Māori-owned land or resources such as urupa or Marae; they felt strongly that such changes needed to be owned by the people involved.

## Discussion

**The findings**—Māori policymakers interviewed called for a strong interventionist role for central and local government in reducing disparities in tobacco smoke exposure. This is not surprising, when considered alongside a Treaty of Waitangi framework that holds government accountable for ensuring that Māori experience at least the same level of health as that of the wider population. There was clearly some opinion that the emphasis needs to move from constraining the individual to constraining the market, through managing the supply of tobacco. And that political will (other than that being demonstrated by some Māori members of government),<sup>20</sup> is currently lacking in this area.

Māori leadership at all levels was considered critical to leading change. This included taking ownership of the situation, role modelling positive behaviours, and helping design tobacco control interventions in collaboration with tobacco control experts. The implicit Treaty agreement with government could be: share authority and appropriate levels of resources with Māori groups for the purpose of tobacco-free change, and Māori leadership within government and within tribal structures will be responsible for change.

One of the challenges that currently exists in engaging Māori leadership in tobacco resistance work is that many of the leaders smoke; this should not be an impediment to action. Tobacco resistance can take many forms, including policy level interventions and the creation of smoke free environments. This work does not require the advocate to be smokefree themselves but does require a commitment to a smokefree Aotearoa for future generations; a concept that the majority of Māori leadership may support.

The theme of children as a motivator of quitting has been found in research of smokers' quit reasons.<sup>21</sup> There is some evidence from the USA (with Latinos v whites) that ethnicity can be a factor in the extent to which smokers quit as an example to children.<sup>22</sup> That Māori policymakers stressed the birth of children and grandchildren as a strong catalyst for quit behaviour, suggests that there is potential for advocacy *through* such policymakers for additional relevant quit support.

There was a strong theme that the rights of children clearly outweigh the individual rights of adults to smoke in privately owned spaces, for instance homes and cars, and that adults have a duty of care to protect children from harm. However there was no one clear view on how best to achieve changes in the area of smokefree environments around children. Some thought that the changes needed to be at a more structural level where the manufacture and supply of tobacco was limited, others called for a comprehensive approach requiring a "suite of programmes and responses" needing to be put in place, others said that we should not legislate for a smoking ban in cars, as people should be supported to make changes and choices for themselves in their private spaces.

While this research did not show a consensus on approaches for increasing smokefree environments for children, other New Zealand research does indicate strong Māori public and smoker support for a legislative framework banning smoking in cars with children.<sup>23–25</sup>

**Policy implications**—A total ban on tobacco products within New Zealand, an approach receiving increasing support by Māori tobacco control advocates and Māori policy makers over the past five years,<sup>20</sup> was supported by some of the Māori policy makers interviewed in this research. While a total ban may be unachievable in the near future, there is an onus on government to show that their alternatives are effective in reducing disparities for Māori.

Māori tobacco control should be a high priority for government, including a distinctive indigenous controlled approach to reducing disparities in outcomes. Approaches need to take into account the specific social, political, historical and cultural differences for Māori. Greater funding for various targeted programmes should come from tobacco tax revenue, and should be reflective of the health significance of high rates of smoking for Māori.

The call by interviewees, for a move towards a broader wellness approach for smokefree marketing to Māori, indicates an avenue to be considered when social marketing and health education messages are reviewed.

**Limitations**—While the search for themes used validated qualitative approaches which were conducted rigorously, the thematic selection from the data by another research group might be quite different. The small sample size means that the results from the study are not indicative of the opinion of all Māori policy makers; additional research is needed to explore the issues raised more widely. We note that contrasting Māori policy makers' views with non-Māori policy makers' would cast further light on approaches to policymaking.

## Conclusions

The results indicate that Māori policymakers consider indigenous specific approaches and indigenous leadership critical for Māori tobacco-free advances. In addition, the research supports a strong role for central and local government to reduce disparities in tobacco smoke exposure. Funding for interventions could come from dedicated tobacco tax, and the mandate to act on behalf of children is provided through human rights frameworks. Harnessing indigenous values and principles related to health, family and children provides an impetus to change smoking behaviours, and was the preferred method of these Māori policymakers for delivering social marketing messages.

**Competing interests:** The authors have undertaken tobacco control work for health sector agencies.

Author information: Heather Gifford, Whakauae Research Services, Whanganui; Kiri Parata, Whakauae Research Services, Whanganui; George Thomson, Senior Research Fellow, Department of Public Health, University of Otago, Wellington

**Acknowledgments:** The Health Research Council of New Zealand provided funding for this Project. We also thank our interviewees for their contributions of time and ideas.

**Correspondence:** George Thomson, Department of Public Health, Te Tari Hauora Tūmatanui, University of Otago, Box 7343 Wellington South, New Zealand. Fax: +64 (0)4 3895319; email: [george.thomson@otago.ac.nz](mailto:george.thomson@otago.ac.nz)

## References:

1. Darling H, Reeder A. Is exposure to secondhand tobacco smoke in the home related to daily smoking among youth? *Aust N Z J Public Health*. 2003;27:655-6.
2. Borland R, Yong HH, Cummings KM, et al. Determinants and consequences of smoke-free homes: findings from the International Tobacco Control (ITC) Four Country Survey. *Tob Control*. 2006;15 Suppl 3:iii42-50.
3. Proescholdbell RJ, Chassin L, MacKinnon DP. Home smoking restrictions and adolescent smoking. *Nicotine Tob Res*. 2000;2:159-67.
4. Scragg R, Laugesen M, Robinson E. Parental smoking and related behaviours influence adolescent tobacco smoking: results from the 2001 New Zealand national survey of 4th form students. *N Z Med J*. 2003;116:U707.
5. Wakefield M, Chaloupka F, Kaufman N, et al. Effect of restrictions on smoking at home, at school, and in public places on teenage smoking: cross sectional study. *BMJ*. 2000;321:333-7.
6. Paynter J. National Year 10 ASH Snapshot Survey, 1999-2008: Trends in tobacco use by students aged 14-15 years [Report for the Ministry of Health, Health Sponsorship Council and Action on Smoking and Health]. Auckland: ASH New Zealand; 2009.
7. Woodward A, Laugesen M. Morbidity attributable to second hand cigarette smoke in New Zealand. Wellington: Ministry of Health; 2001.  
[http://www.moh.govt.nz/moh.nsf/0/ad594d5c5231e7ecc256a5c007d0f91/\\$FILE/MorbidityAttributableToSecondHandCigaretteSmoke.pdf](http://www.moh.govt.nz/moh.nsf/0/ad594d5c5231e7ecc256a5c007d0f91/$FILE/MorbidityAttributableToSecondHandCigaretteSmoke.pdf)
8. Woodward A, Laugesen M. How many deaths are caused by second hand smoke? *Tob Control*. 2001;10:385-8.
9. Sherrill D, Martinez F, Lebowitz M, et al. Longitudinal effects of passive smoking on pulmonary function in New Zealand children. *Am Rev Respir Dis*. 1992;145:1136-41.
10. Robertson J, Pattemore PK, Ford RP. The effect of maternal smoking on admission to hospital in infancy. *N Z Med J*. 1993;106:476-7.
11. Mitchell E, Tuohy P, Brunt J, et al. Risk factors for sudden infant death syndrome following the prevention campaign in New Zealand: a prospective study. *Pediatrics*. 1997;100:835-40.
12. Thomson G, Wilson N, Howden-Chapman P. Smoky homes: A review of the exposure and effects of secondhand smoke in New Zealand homes. *NZ Med J*. 2005;118:U1404.
13. McDuff I. 2006 HSC Year 10 In-depth Survey. Wellington: Health Sponsorship Council; July 2007.
14. Boulton A, Simonsen K, Walker T, et al. Indigenous participation in the 'new' New Zealand health structure. *J Health Serv Res Policy*. 2004;9 Suppl 2:35-40.
15. Johnston PMG. Enabling, encouraging or empowering? : Maori members on school boards of trustees. Access : *Critical Perspectives on Cultural and Policy Studies in Education*, 1992; v11 n2:p1-17 1992;11:1-17.
16. Salmond G. Native forests and the treaty. *Maruia*. 1992;Winter 13-22.
17. Farquharson K. A Different Kind of Snowball: Identifying Key Policy Makers. *International Journal of Social Research Methodology*. 2005;8:345-53.
18. Aronson J. A Pragmatic View of Thematic Analysis. *The Qualitative Report*. 1994;2.  
<http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html>
19. King A. Template analysis. In: Symon G, Cassell C, eds. *Qualitative methods and analysis in organizational research: A practical guide*. London: Cassell; 1998:14-36.
20. Gifford H, Bradbrook S. Recent actions by Māori politicians and health advocates for a tobacco-free Aotearoa/New Zealand, A brief review (Occasional Paper 2009/1). Wellington: Whakauae Research Services; Te Reo Mārama; Health Promotion and Public Health Policy Research Unit (HePPRU) University of Otago; 2009.  
<http://www.uow.otago.ac.nz/academic/dph/research/HIRP/Tobacco/Maori%20tobacco%20control%20review%20-%20Occasional%20Paper%20Feb%202009.pdf>

21. McCaul KD, Hockemeyer JR, Johnson RJ, et al. Motivation to quit using cigarettes: a review. *Addict Behav.* 2006;31:42-56.
22. Perez-Stable EJ, Marin G, Posner SF. Ethnic comparison of attitudes and beliefs about cigarette smoking. *J Gen Intern Med.* 1998;13:167-74.
23. Thomson G, Weerasekera D, Wilson N. New Zealand smokers' attitudes to smokefree cars containing preschool children: very high support across all sociodemographic groups. *NZ Med J.* 2009;122:84-6. 7th August.
24. Health Sponsorship Council. Topline results: 2008 Health and Lifestyles Survey Wellington: Health Sponsorship Council; March 2009.
25. Thomson G, Weerasekera D, Wilson N. New Zealand smokers' attitudes to smokefree cars containing preschool children: very high support across all sociodemographic groups. *N Z Med J.* 2009;122:84-6.