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SMOKING, NOT OUR TIKANGA:  
AN ANALYSIS OF MĀORI IDENTITY AND SMOKING BEHAVIOUR

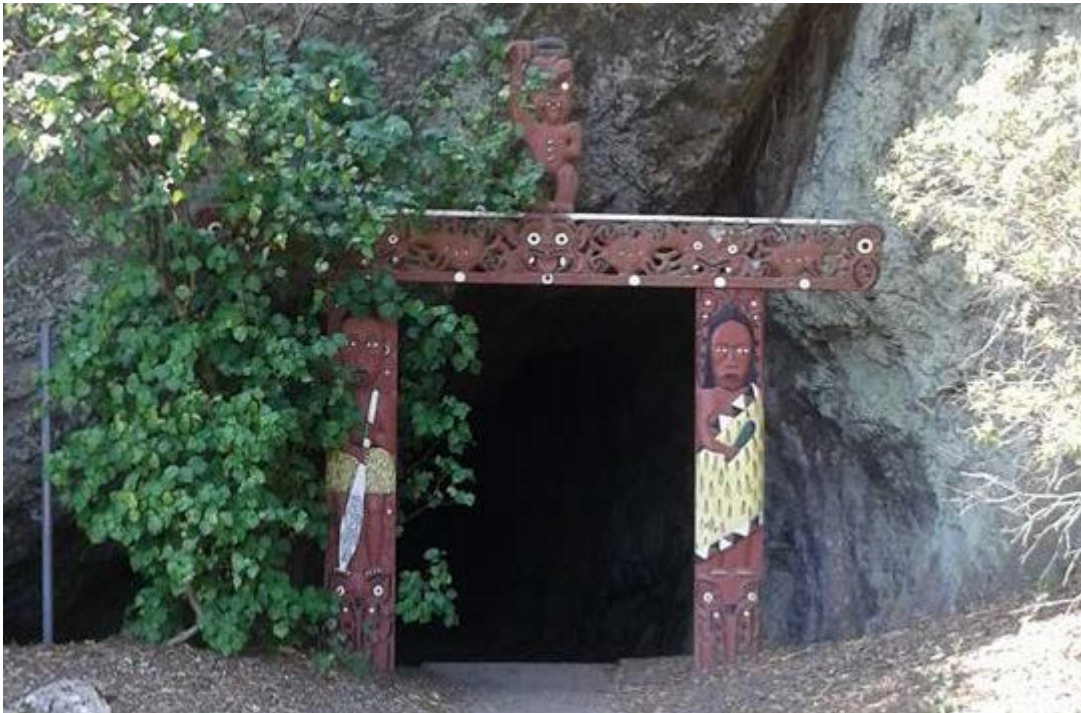
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## Abstract

Māori, the indigenous peoples of Aotearoa (New Zealand), have the highest national smoking prevalence of any ethnic group. Decades of research has focused on understanding the underlying mechanisms of Māori smoking behaviour. Despite this research, smoking prevalence for Māori remains markedly high. This thesis explores Māori smoking behaviour through an analysis of Māori identity. Undertaking a Kaupapa Māori positioning, I present two studies with the intention of decolonising Māori smoking research and acknowledging Māori aspirations to reduce tobacco harms and become auahi kore (smoke free). In my first study I present a qualitative media analysis which investigates the representations of Māori who smoke in national media. This study highlighted four central themes; deficit-style representation, strengths-based representation, historical recognition and cultural dissociation. I found that a causal link between ‘being Māori’ and smoking is commonly implied through negative representations of Māori who smoke. However, evidence of an alternative narrative emerged which dissociated aspects of ‘being Māori’ from smoking behaviour. Building on these findings I present a second paper, which quantitatively tested speculated links between Māori identity and culture, as well as experiences with discrimination, with smoking status on a national sample of Māori ( $N = 557$ ). This study used the Multi-Dimensional Model of Māori Identity and Cultural Engagement (MMM-ICE2) to test aspects of Māori identity. We found no evidence linking Māori identity and smoking with one exception through the measure of ‘Perceived Appearance’. This unexpected finding reflects on how other people’s external evaluations of Māori may influence their smoking behaviour. Together these studies show support for distinguishing Māori identity from Māori smoking behaviour. The results of these studies are perhaps best encapsulated by the novel kaupapa formed in this thesis; ‘Smoking, Not Our Tikanga’.

Kō Mātiti te maunga  
Kō Waioweka te awa  
Kō Ōpeke te marae  
Kō Ira te whare tipuna  
Kō Te Kurapare te whare kai  
Kō Ngāti Ira te hapū  
Kō Whakatōhea te iwi



Muriwai (2015).

“I ora te tuatara ka patu ki waho”

*“A problem is solved by continuing to find solutions”.*

(Māori whakataukī/proverb)

## Ngā mihi

I am humbled and incredibly grateful towards everybody who made this opportunity a reality. In this past year I have learned intensively what it means to be an indigenous Kaupapa Māori researcher. Firstly I'd like to thank Tobacco Research Control Tūranga for selecting me for the Masters Scholarship which has made my research possible. This support has helped me kick start my aspirations to contribute towards Māori health and decolonising research.

I would also like to thank Associate Professor Chris Sibley for being an excellent and supportive supervisor. Being a part of the New Zealand Attitudes and Values Study (NZAVS) has enabled me to learn beyond what I initially conceptualised as Psychology and I have made so many life-long friends and connections. I am especially grateful to Chris for encouraging my independence and creativity as an indigenous student from my 2<sup>nd</sup> year at University until now. It is not only his encouragement but his passion for justice and meaningful outcomes for my people which inspire me to continue down this path.

I am indebted to my whānau for the sacrifices made in supporting me through my studies. To my mum especially, thank you for your hard work and for role modelling excellence. I would also like to thank my sisters Angie and Esme and my nephews for their positive and loving presence in my life. I'd like to also thank my father whose journey as an indigenous man in Aotearoa underpins my passion for bringing awareness to the struggles of our people.

Inclusive of my whānau are my wonderful friends and colleagues who continue to provide me with the stability and support to get me through my studies. I'd like to thank Jade Le Grice, Shiloh Groot, Lara Greaves, Yanshu Huang and Lucy Cowie for your support as my Tuākana. I value your hard work and input, your successes continue to inspire me. I'd also like to acknowledge my fellow Masters cohort, especially Karishma Beach, for enduring this and our many years of study together to get where we are today.

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It is with my utmost gratitude I present you all with my Masters Thesis.

## Organisation of Thesis

This Masters thesis takes a mixed methodology approach towards exploring Māori identity and smoking behaviour. I have explored this topic with two distinct research papers, each of these is presented in full. Aligning myself with a Kaupapa Māori positioning, this thesis captures the dynamic nature of smoking behaviour with some novel and unexpected conclusions. Te Reo Māori is used throughout this thesis, definitions are provided in text and in the Glossary.

Chapter One offers an introduction to my research. In chapter one I provide an overview of a Māori history of tobacco smoking. This chapter reflects on the historical implications which bare significant influence on the legacy of Māori smoking today. By drawing attention to the origins of Māori tobacco consumption I hope to illustrate the complexities of Aotearoa's smoking epidemic.

Chapter Two offers an outline of decolonising smoking research, an introduction towards the Kaupapa Māori positioning I take and the tools I use to undertake this research. Certainly, chapter two contextualises my research as Māori centred. Using my skills as an indigenous researcher I explore some reasoning for why this thesis is explicitly Māori and reflect on recent developments in Māori research which make this thesis possible.

Chapter Three contains the stand alone paper entitled "*Smoking – Not Our Tikanga: The misrepresentation of Māori and Smoking in national media.*" This paper was published in MAI Journal on the 16<sup>th</sup> June 2016. The first paper forms the foundations for the subsequent quantitative study following later in the thesis.

Chapter Four contains my second paper entitled "*Looking Like a Smoker a Smokescreen to Racism? Māori Perceived Appearance linked to Smoking Status.*" This paper was submitted to Ethnicity and Health on February 24<sup>th</sup> 2016. This empirical study analyses smoking status at two levels and yields some unexpected findings.

Finally, Chapter Five brings my two papers together in a discussion. I address some of the limitations of my studies and reflect on what they have added to the field. I offer some thoughts on my journey with this research and some directions for future study on Māori smoking cessation and facilitating the re-establishment of an auahi kore future for Māori.

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## Glossary

Aotearoa	New Zealand
Aroha	Love and respect
Auahi Kore	Smoke Free
Aukati Kaipapa	Māori smoking cessation programme developed in 1998
Hapū	Sub-tribe
Iwi	Tribe
Kanohi ki te kanohi	Face to face, in person
Kaupapa	Matter for discussion, agenda, project, concept, initiative, issue
Kaupapa Māori	The conceptualisation of Māori knowledge, a Māori framework
Kōrero	To speak, have a discussion
Mahi	Work
Mana	Strength, respect, pride
Manaakitanga	Hospitality, kindness, generosity, support
Māori	The indigenous people of New Zealand
Mātauranga Māori	Māori knowledge/perspectives, originating from Māori ancestors
Pākehā	‘Other’, referring to British/European New Zealanders
Rangatahi	Youth
Rangatira	Chief, leader
Tapu	Sacred, untouchable
Tangata Whenua	People of the land, Indigenous people
Te Tiriti o Waitangi	The Treaty of Waitangi
Tikanga	Protocol, customs, culture
Tino Rangatiratanga	Self-governance
Tupeka	Tobacco
Tupeka Kore	Tobacco Free
Tūranga	To stand, also refers to Tūranga Tobacco Control Research
Tūrangawaewae	Place to stand, place of belonging through whakapapa
Te Ao Māori	The Māori World
Wāhine	Women (wahine, singular)
Whakapapa	Ancestry/Genealogy
Whakataukī	Māori proverb
Whānau	Family, inclusive of extended family

## **CHAPTER ONE**

This chapter encapsulates the opening of my thesis. I firstly present my General Introduction which outlines my rationale for this research. From here I delve into a detailed Māori history of smoking in Aotearoa to provide context for the research.

## General Introduction

Aotearoa, land of the long white cloud, is overcast with disproportionately high rates of tobacco smoking and related illness for Māori, the indigenous peoples. Māori comprise approximately 15% of the population (Statistics New Zealand, 2013) yet present prolifically across negative social and health outcomes. For the past nine years Māori smoking has remained around the 38% mark and during this time the national average has decreased from 20% to 17% (Ministry of Health, 2015). Māori who smoke are often contrasted against Pākehā (who have a national smoking prevalence of 15%), Pacific Islanders (25%), and Asian peoples (6%; Ministry of Health, 2015). When comparing across ethnic groups it is important to recognise that different peoples do not share equitable privileges and positions in society. The unequal health status of Māori has often been considered the cause, rather than the consequence of experiencing a colonised reality.

The findings of Māori smoking research remain inconclusive. Thus far empirical research has focused on Māori socioeconomic inequities (for example: Barnett, Moon, & Kearns, 2004; Barnett, Pearce & Moon, 2005; Blakely, Fawcett, Hunt, & Wilson, 2006), role-modelling, tobacco advertising (Ford, Scragg, Weir, & Gaiser, 1995) and even 'being Māori' itself as driving influences behind Māori smoking behaviour (for example, Broughton 1996; Klemp, Robertson, Stansfield, Klemp, & Harding, 1998; Mitchell, 1983; Olson, 1993). Auahi kore (smoke free) initiatives continue to gain momentum in support of Māori aspirations to quit smoking. Despite this, narratives speculating a link between Māori identity and smoking appear to give a common sense understanding of why it is that Māori people smoke. This narrative has been constructed by lay people, health professionals and the media, yet has received minimal recognition in research. Blaming Māori for their smoking behaviours is a deductive way to address New Zealand's smoking epidemic. This way of thinking overlooks the contexts in which colonised peoples live and negotiate their realities.

To challenge this narrative of Māori smoking behaviour I am faced with two questions: How can we explore *Māori* smoking behaviour from a *Māori* perspective? And further how do we explore Māori smoking behaviour in the context of inequitable, systemic conditions which position Māori against the struggles of a colonised reality?

Being Māori and experiencing smoking cessation myself, this research is personal to me and my whānau. Though I have an awareness of meaningful and sustainable ways to quit smoking I am also aware that the heterogeneity of Māori realities means a singular approach cannot be applied as a 'one size fits all' to reduce tobacco harms among our peoples. Reflecting on this topic I came across an important division between what I conceptualise as that which is *identity* and that which is *behaviour*. Being indigenous is an identity, whereas smoking is a behaviour. Behaviours and expressions of the self are often linked to identity which left me with a dilemma when understanding that many who identify as Māori also exhibit the highest rates of measurable smoking behaviour in the country.

So why is it problematic to link identity and negative behaviours? Through my research and life experiences I became aware that smoking can indeed be an important facet of identity and powerful crutch for many. However, there is danger in assuming smoking as an identity. When smoking is seen as a part of one's identity it presents the individual as the source of smoking, rather than the cumulative pressures and experiences which can trigger one to smoke. Looking beyond the individual, as is crucial in my research, associating smoking with Māori identity is problematic as it overlooks the potent influence of colonisation and couples *being Māori* and *doing Māori culture* with smoking behaviour. Knowing smoking was not a part of Māori experience until colonisation, I find it imperative for me to establish this distinction through my Masters thesis.

Prior to 1980 Māori were not recognised by the Government as a distinct group within the smoking population with specific cultural needs and aspirations for smoking cessation and reducing tobacco harms (Kapoor, 1980 cited in Thomson & Wilson, 1997). The two decades following this saw increased attention cast on Māori smoking rates. This era could have provided support for Māori to uphold tino rangatiratanga (self-governance) through legislative recognition of our unique health objectives. Instead, attempts to control smoking produced surmountable reductions in smoking rates for everyone *but* Māori (Thomson & Wilson, 1997; Reid & Pouwhare, 1991). The Government approach was pitched from an economic perspective, whereby tax was added to make smoking more expensive which appeared only to make Māori turn to cheaper ‘roll your own’ alternatives (Glover, 1995). It is only very recently that Māori aspirations have been legally considered and supported with the Māori Select Affairs Committee’s 2010 report: *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*.

Researchers have spent the past few decades untangling the interwoven realities of Māori in order to provide effective support to reduce tobacco harms for Māori. Leading this movement researchers such as Associate Professors Papaarangi Reid and Marewa Glover have presented a Māori-centred approach which has eventuated in significant shifts in both the conceptualisation and active response to Māori smoking (for example, Quitline’s auahi kore services, Aukati KaiPaipa counselling services, Glover’s WERO Challenge). Indeed, this pro-active approach has integrated community groups, academic institutions, Non-Government Organisations and Government in supporting and recognising Māori kaupapa (agenda/initiative) presented *for* and *by* Māori. The efforts of these researchers and groups have significantly propelled Māori smoking cessation interventions towards practical and responsive therapy. Intervention programmes such as WERO have provided meaningful ways to help Māori to address smoking in appropriate and transformative settings which allow for

both contemporary and traditional conceptualisations of Māori health to be explored. In this sense both mātauranga Māori (Māori knowledge/perspectives inherited from Māori ancestors) and modern Māori understandings can be shared in a healing format that keeps Māori identities and cultures safe. Māori tobacco research has prioritised Māori and our diversity by paying homage to the damages introduced and enforced by New Zealand's colonial context, though further expansion on this is needed to explore the continuing trends of Māori smoking behaviour today.

Many have contributed meaningful kōrero and action in this evolving field of Māori health research. In this thesis I will explore Māori smoking behaviour using qualitative and quantitative methodologies. Using our most valuable and transformative indigenous research approach, I conduct this thesis from a Kaupapa Māori positioning. First I present a qualitative analysis of Māori and smoking from a sample of national media to guide my study. I follow this with empirical data using the New Zealand Attitudes and Values Study to explore and untangle the speculated link between Māori identity and Māori smoking. With the help of statistical modelling I explore Māori identity and culture using the Multi-Dimensional Model of Māori Identity and Cultural Engagement (MMM-ICE2, Houkamau & Sibley, 2015<sub>a</sub>). This empirical tool has contributed to emerging health and identity research with some particularly propelling findings (see: New Zealand Attitudes and Values Study, 2016).

The thesis is centred on the appropriative kaupapa shared in the title: *Smoking, Not Our Tikanga*. This kaupapa was formed during the writing of my first paper. With permission from the Health Promotion Agency New Zealand this kaupapa is a play on the distinguished health promotion campaign 'Smoking Not Our Future' launched nationwide in 2010. After forming this kaupapa I became aware of a campaign which Te Ara Hā Ora ran in 2014 named 'Tobacco, Not Our Tikanga'. I also express my gratitude to Te Ara Hā Ora for approving the

‘Smoking, Not Our Tikanga’ kaupapa. I use this kaupapa as the basis of my thesis to reiterate a narrative which disassociates Māori identity and culture with smoking behaviours. It is a decolonising kaupapa which actively resists the simplistic and victim-blaming narratives Māori have been subject to in colonial discourse. I also broadly position the thesis within what the Māori Select Affairs Committee (2010) coined as ‘kaupapa tupeka kore’ (a tobacco free project). Though I conduct this research with an aspiration for Māori to someday return to being an auahi kore people, I will let the research speak for itself.

My thesis begins with a Māori history of tobacco smoking in Aotearoa. Through this I illuminate how smoking is part of a much larger colonial context Māori are positioned within. I title this a *Māori history* as I narrate this from Māori and decolonising perspective. I will also address the fairly recent legislative attention Māori smoking behaviour has had and the implications for current smoking cessation interventions.

### ***A Māori History of Smoking in Aotearoa***

Most sources suggest that tobacco was first introduced to Aotearoa in 1769 when Captain Cook first embarked on land (Reid & Pouwhare, 1991; Smokefree Coalition, 2015; Smokefree Organisation, 2015). Documented evidence detailing tobacco introduction remains unclear and often unaddressed in research specifically on the history of smoking in Aotearoa (Ministry of Health, 2013; Thomson & Wilson, 1997). Several, if not all, Māori narratives indicate that smoking was not present in Aotearoa until the arrival of the British (Reid & Pouwhare, 1991). One Ngāi Tahu Māori account remains the most prominent origin story of tobacco in Aotearoa. Reid and Pouwhare (1991) speculate that Captain Cook himself almost became the first tobacco-related death in Aotearoa when he arrived in Te Wai Pounamu and Te Ihutakaru (Ngāi Tahu) suspected he was an atua (demon) who should be killed (Cook, 2013; Karetu, 1990 cited in Reid and Pouwhare, 1991). To determine Cook was



human Te Ihutakaru decided it was necessary to throw water at the Captain while he was smoking a pipe. It is understood that after this encounter tobacco became a vital currency in the earliest stages of colonisation (Reid & Pouwhare, 1991).

With the turn of tobacco as one of three main sources of exchange (the others being alcohol and muskets) Māori began consuming tobacco at markedly high and unregulated rates. Tobacco is one of the most problematic forms of currency to have entered Aotearoa and is highly entangled with the ‘unethical transactions’ of the British in the Te Tiriti o Waitangi, signed in 1840 (Reid & Pouwhare, 1991; Turia, 2013). By the 1890s both Māori and Pākehā began to speculate on the unusually high consumption of tangata whenua (people of the land) who were dubbed ‘the heaviest smokers’ (Reid & Pouwhare, 1991; Cook, 2013). In 1899 a Māori newspaper *Te Puke ki Hikurangi* noted the unregulated nature of tobacco consumption among Māori meant usage was characterised very differently to the way Pākehā smoked (cited in Cook, 2013). This difference speaks to the legislative differences inherited by Pākehā from their countries of origin who had established legal and moral regulations for tobacco consumption. Māori, on the other hand, had not conceptualised the poisonous harms associated with tobacco. As tobacco is sourced from a plant, Māori recognised it as a new product to cultivate and provide for whānau (Reid & Powhare, 1991). Because of this, consumption of tobacco was rife among Māori men, women and children and Pākehā colonisers often captured this in their paintings and photography of Māori right through to the early 20<sup>th</sup> century (Reid & Pouwhare, 1991). Producing this image of Māori set up the conditions under which Māori smoking was normalised and understood as a ‘Māori problem’

In the late 19<sup>th</sup> and early 20<sup>th</sup> century New Zealand became pro-active in legislating tobacco control policies and rallying anti-tobacco groups. In 1883 the Anti-Nicotine Society formed and successfully aided in the outlawing of selling cigarettes to those under 16 years of

age through the 1903 Juvenile Smoking Suppression Act (Thomson & Wilson, 1997; Thompson, 1994). Despite this promising start to tobacco control, public health did not see tobacco as a national problem and only allocated 'smoking' in relation to the Māori Councils Act 1900 which was supposed to specifically target Māori smoking as well as alcohol behaviours and cleanliness (Maclean, 1964, cited in Thomson & Wilson, 1997 p. 9). Unfortunately the Māori Councils Act was massively underfunded leading to prioritisation of issues other than smoking (Cook, 2013). Independent iwi made some decisions about prohibiting tobacco smoking in tapu places and some rangatira such as Rua Kenana (Tuhoe) banned tobacco outright from their communities (Cook, 2013).

In the early to mid-20<sup>th</sup> century trends in Māori female smoking became distinctly high. While the 1920s presented a global phenomenon of increased female smoking coinciding with suffragette movements, figures were as high as 70% for smoking among Māori women (Cook, 2013; Reid & Pouwhare, 1991; Thomson & Wilson, 1997). Reid and Pouwhare (1991) suggest that today's high rates of smoking for wāhine Māori can be attributed to the initial stages of Māori tobacco consumption. Māori women are said to have smoked as much as or in excess of the Pākehā males who introduced tobacco to Aotearoa (Broughton, 1996; Reid & Pouwhare, 1991). Other authors have linked this prominent trend stretching into the 1960s-1980s where women globally smoked a lot more in an increasingly liberal society (Johnston, 2009). It is likely this latter period remains influential in today's wāhine Māori smoking trends, though the issue of high smoking prevalence appears to stem directly from encounters drawn from the first colonial contact.

The World War periods saw decreased moral opposition to smoking which facilitated its normalisation throughout society in Aotearoa (Cook, 2013; Reid & Pouwhare, 1991). During the wars soldiers were supplied with free cigarettes and the manufacturing of tailor-

made (rather than hand-rolled) cigarettes increased exponentially (Reid & Pouwhare, 1991). Using tobacco as an ordinary means of dealing with stress became engrained in this time. By 1953 the National Tobacco Company boasted New Zealanders as ‘the heaviest smokers in the world’ (Johnston, 2009, p.15) which helped grow an industry of New Zealand-made tobacco to cover the growing global smoking population. Before this time New Zealand tobacco had been poorly received internationally, leading the Government to eventually retract funding it as a leading export (Johnston, 2009). Johnston (2009) also notes that local manufacturing did continue for local consumption and that media appeal pulled through by making cigarettes relevant to New Zealand sports (for example, sponsoring the All Blacks), a tactic still seen to attract Māori customers today (Ford et al., 1995; Reid & Pouwhare, 1991).

Throughout the 1960s-1980s Māori smoking routinely featured in new health research, though culturally specific interventions were not considered at the time (Johnston, 2009; Thomson & Wilson, 1997). In the absence of aspirations to improve Māori realities the inclusion of Māori in smoking research seemed pragmatic and self-serving to the researchers funded in this area (many of whom were not Māori). In 1972 it was noted that Māori women had the highest female lung cancer rate in the world, reflecting the grossly exuberant rates of female Māori smoking (Thomson & Wilson, 1997). Despite this obvious disparity Māori women were not adequately addressed by any health promotion media or any tailored cessation interventions. A system lacking in visibility and relevance for Māori has carried through in exacerbated levels of smoking prevalence today.

Until 1980 Māori were not recognised by the Government as a distinct group within the smoking population with specific cultural needs and aspirations. Around the 1980s many continued to speculate that Māori were the greatest tobacco consumers in the Western industrialised world (Gifford & Bradbrook, 2009). As aforementioned, studies started to

focus on Māori smoking behaviour but consistently depicted a deficit narrative with many even sourcing 'high cultural identity' as a significant correlate to being a Māori smoker (Mitchell, 1983). Cultural shaming became implicit in research conducted on Māori who smoke. By 1993 the International Agency for Research on Cancer noted that Māori men and women had the highest incidence of tobacco-related lung cancer in the entire world (Thomson & Wilson, 1997). Dire statistics like this lead researchers and Government to distinguish that Māori were both ethnically and culturally different from all other groups in Aotearoa in relation to smoking behaviours (Thomson & Wilson, 1997). As it took two centuries to distinguish this, the legacy of Māori smoking behaviour remains strong across communities today (Reid & Pouwhare, 1991).

### ***The current state of Māori Smoking***

Statistics indicate that smoking trends for Māori in the 21<sup>st</sup> century continue to be of concern. Smoking rates over the past 15 years have reported figures as high as 39.3% of Māori males and 48.3% of Māori females, the latter being three times higher than that of their non-Māori female counterpart (Ministry of Health, 2011). Of young wāhine Māori 47.1% reported smoking in 2009 which was 34% more than their non-Māori female counterpart in the 15-19 years old age bracket (Ministry of Health 2011). Such high statistics are often referred to as 'disparities' due to their outlying nature in representing the Māori population as markedly different to 'non-Māori'. While this is statistically accurate, this framing still posits Māori as failing against a norm which is essentially defined by *not being Māori*.

In 2010 the Māori Affairs Select Committee (MASC) presented a report to the House of Representatives titled '*Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*'. Alongside a host of recommendations, the report specifically outlined the need for support for 'Māori and Māori women'. This included the accelerated

progression of the 'Wai 844' claim to the Waitangi Tribunal which, to the best of available knowledge, has not been addressed or settled as yet. Specifically, the report calls for 'equitable funding' for Māori centred initiatives to support Māori smoking cessation. Fundamentally, the MASC establish three recommendations for Kauapapa Māori centred action which includes Māori at all levels of planning, policy, interventions and community events. Significantly, they put forward a 'kaupapa tupeka kore' (tobacco free project/agenda) which is undertaken in this thesis. Blakely, Thomson, Wilson, Edwards and Gifford (2010) noted that the recommendations fall under four categories: done or in progress, do now, develop policy options in 2011 and develop an overall social marketing plan.

Following the MASC report the New Zealand Parliament responded to the recommendations made recognising how tobacco use affects Māori communities (NZ Parliament, 2011). In this, the Government agreed and committed to consideration of all 42 recommendations which highlighted imminent actions required for accelerating Māori smoking cessation. Of note is the Government's response to the recommendation concerning Wai 844 which is reported as 'independent of Government'. The report notes 'the Government already provides funding for Māori health initiatives to eliminate [and] reduce smoking among Māori and will continue to do so (NZ Parliament, 2011, p.15). While this response is supportive, it foreshadows the lack of momentum in regards to this particular issue which has followed through to today. In terms of inclusion, the Government responded that 'Terms of reference for a new national Māori tobacco control service are under development, including participation in policy development'; this echoes the lack of inclusion Māori had experienced until this point (NZ Parliament, 2011, p.19).

Perhaps the most important innovation from MASC and the Government's response is the collective goal of a Smoke Free 2025. This goal essentially aspires to lower smoking

prevalence to under 5% by 2025. The NZ Parliament noted in their report that although Smoke Free 2025 was an ‘aspirational goal’ no specific time frame has been put forward until the MASC report. The NZ Parliament makes extensive comment on this time frame, noting that this proposition should have ‘stretch’, be ‘realistic’, ‘cost-effectively achievable.’ Also noting that “The Government therefore proposes to undertake further detailed work to determine the optimal set of specific mid-term targets to ensure progress is made” (NZ Parliament, 2011, p.5). Such a commitment cannot be understated. Partial to the Smoke Free 2025 goal is the commitment to halving smoking prevalence by 2015. At the time of writing this thesis, this mid-term target has not been achieved for Māori and other New Zealanders.

This is where the majority of the current mahi (work) stands from a legal and political perspective; however Māori-centred initiatives have been gaining momentum. Both with and without Government funding, self-determined Māori cessation programmes have become rapidly innovative in order to best serve Māori who are attempting to quit smoking. Many researchers, Smokefree groups and politicians have speculated that Smoke Free 2025 is unrealistic for Māori in the context of a past which has ignored (and continues to do little towards) Māori aspirations (Bootham, 2016). Tobacco industries also claim the 2025 goal cannot be achieved – an idea which is in their interest as benefactors of New Zealand’s smoking epidemic (Action on Smoking and Health, 2012). Current interventions appear to be working for Māori by, at the very least, encouraging much greater quit-smoking attempts (Cook, 2013). The Ministry of Health (2013) has promoted smoking cessation with the slogan “Quit for yourself, your whānau, your friends and your pocket”. Initiatives such as Quitline’s auahi kore services, Aukati KaiPaipa (a kanohi ki te kanohi or face-to-face counselling service), and the recent innovation of the WERO challenge, are evidence of excellent Māori-centred kaupapa which foster a journey towards smoking cessation.

Together, researchers and Māori-centred organisations have provided rich pathways towards Māori smoking cessation.

Despite the rapid increase in excellent Māori kaupapa overall rates of change are developing very slowly. It is my hope with this thesis that increased understanding around this topic will provide support towards an auahi kore future for Māori. By identifying and decreasing stigmas associated with Māori smoking behaviour I acknowledge the mana (respect) and tino rangatiratanga of Māori who smoke and Māori who are supporting Māori to quit. It is important in this research to foster manaakitanga (support and kindness) and aroha (respect and love) for our tangata whenua. While it is imperative to focus on smoking cessation, it is also important to take consideration of the complex interweaving of internal and external pressures which may contribute to Māori smoking prevalence today.

In a recent turn of events, academics and people working towards auahi kore for Māori have come together to criticise the Government's 'inadequate' attempts at supporting Māori smoking cessation. Colleagues from ASPIRE 2025 at The University of Otago (among others) released a letter, published in the New Zealand Medical Journal, outlining the shortcomings of Government actions in response to the Māori Affairs Select Committee's (MASC) enquiry into tobacco in 2010. A takeaway from this letter is that less than 20% of the recommendations stated by the MASC have been fully implemented. Such a low rate of response does not align realistically with the Government's imposition of MASC's proposed 'Smokefree 2025'. It would seem that not enough is being done by the Government to recognise Māori needs. As such, these developments highlight the urgency of accelerating Māori smoking cessation which is the priority and imperative research presented in this thesis.

## **Summary**

Though Māori aspirations have largely been ignored throughout Aotearoa's tobacco history, there is a promising future ahead. The introduction of smoking to Aotearoa comes with the broader implications of colonisation. The colonial remnants inherited by Māori continue to exacerbate Aotearoa's tobacco epidemic. Moving forward, this thesis is motivated by a greater need for Māori research to help advance an understanding of Māori and smoking. The purpose of this research is to address the continuing struggle in decreasing Māori smoking prevalence and potentially help accelerate Māori smoking cessation.



### **Bridging Statement**

In the previous chapter I have exhibited a Māori history of tobacco smoking in Aotearoa. The scarcity of this documented history parallels the research and literature on Māori and smoking. As indigenous peoples, Māori have long been subjects of medical and health research without necessarily being involved in the processes and decisions which contribute to the public representation of Māori health. Māori share this commonality of misrepresentation and exclusion with other indigenous peoples worldwide. In recent times, indigenous peoples who smoke have been focused on in greater detail with diverse analyses and conclusions drawn about the unique experiences of indigenous smoking behaviour. It appears that tobacco consumption among indigenous peoples is highly dependent on their varying experiences with colonisation. Tobacco can be considered a colonising tool. When exchanging tobacco with colonisers many indigenous peoples did not inherit the moral, legal and health understandings related to tobacco harm that Pākehā possessed. In order to understand where Māori sit within the indigenous tobacco smoking experience it is important to review some of the research. In the next chapter I present a brief history of indigenous smoking research and introduce a decolonising, Kaupapa Māori research agenda.

## CHAPTER TWO

The following chapter positions Māori within global indigenous smoking research. I introduce why it is important to decolonise smoking research and draw on my epistemological positioning as a Kaupapa Māori researcher. This chapter concludes with an introduction to the quantitative Māori tool I use in my second study to analyse Māori identity and culture.

## **Decolonising Smoking Research**

As with most psychological and health research on a global scale, indigenous peoples have long been subject to a colonising research agenda. This chapter outlines the fundamental importance of decolonising smoking research to honour Māori realities and address Māori health from an appropriate and culturally safe perspective. I will briefly review some of the international literature before delving into my own positioning as a Kaupapa Māori researcher. Explicitly stated, this thesis adheres to a decolonising research agenda and can be considered as a contribution toward ‘kaupapa tupeka kore’ (Māori Select Affairs Committee, 2010). Through the end of this chapter I will introduce the Multi-Dimensional Model of Māori Identity and Cultural Engagement.

### ***A Brief History of Indigenous Smoking Research***

The extant literature on indigenous smoking research largely focuses on smoking cessation interventions stemming from the medical sciences. Indigenous Australians and Native Americans make up the majority of peoples studied throughout this limited literature, though examples from nations such as Fiji, India, New Zealand and Norway also feature. A general consensus is held supporting the idea that indigenous cultural needs have thus far not been met and are essential for future smoking cessation interventions (for example, Carson, Brinn, Peters, Veale, Esterman, & Smith, 2012; DiGiacomo, Davidson, Abbott, Davison, Moore & Thompson, 2011; Heath, Panaretto, Manassis, Larkins, Malouf, Reilly, & Elston, 2006). Few studies report that indigenous peoples do not need culturally tailored support due to overarching factors such as socioeconomic status (Subramanian, Smith & Subramanyam, 2006), or susceptibility to risk taking (Spein, Sexton, & Kvernmo, 2004) though the data in these studies is correlational.

A clear and unifying aspect among indigenous smoking research is the resistance, rejection or ambivalence towards mainstream attempts to target indigenous smokers. Bond and colleagues' (2012) study on Aboriginal and Torres Strait Islander ex-smokers suggested that indigenous peoples were largely distrusting of mainstream quit smoking services. They describe this positioning of Aboriginal and Torres Strait Islanders as a 'social practice' of resistance inspired by the need for a self-defined indigenous space to be created within smoking cessation (Bond, Brough, Spurling, & Hayman, 2012). New Zealand studies have suggested that a combination of mainstream and indigenous targeted campaigns are most effective to cater to the diverse needs of Māori in Aotearoa (for example: Grigg, Waa & Bradbrook, 2008; Wilson, Grigg, Graham & Cameron, 2005). In their comparison of indigenous smokers, Bramley and colleagues (2005) pointed out that smoking disparities between Māori and other New Zealanders were much more pronounced than those experienced by Alaskan Native Americans compared to their non-indigenous counterparts. This is perhaps a reflection of New Zealand's very recent history of colonisation.

Echoing the creation of indigenous histories from a non-indigenous perspective, some research on indigenous smoking has perpetuated harmful social narratives about native smokers by excluding indigenous researchers and/or methodologies. The idea of outsiders observing indigenous populations as research subjects is not new, yet is increasingly counter-productive for the authentic representation of indigenous realities. Clough and colleagues (2009) provided useful insight into the self-determined approaches towards smoking cessation used by rural Indigenous Australians of the Northern Territory. Despite their research they entitled their paper 'The gap in tobacco use between *remote Indigenous Australian communities* and *the Australian population* can be closed', such framing can be considered irresponsible and inconsiderate as this others indigenous Australians from being a part of 'the Australian population' (emphasis added, Clough, Robertson, & MacLaren, 2009).

These studies illustrate a need for indigenous research to be conducted by and for indigenous peoples. In doing this researchers can meet the imperative of de-stigmatising and honouring diverse tangata whenua across the globe.

### ***Kaupapa Māori Research***

Kaupapa Māori research encompasses a broad indigenous epistemological standpoint managed and directed by Māori researchers and our collaborators. First conceptualised in the mid-1980s by Graham Hingangaroa Smith, the approach has come to encompass a huge variety of disciplines and interdisciplinary study to focus on self-determination and meaningful engagement with Māori realities. Following Moewaka Barnes' (2000) analysis, I use a Kaupapa Māori framework to centre a Māori epistemology as the default and norm from which my research is interpreted.

Referred to as 'the greatest epistemological innovation in a generation' (Borell, 2015) Kaupapa Māori enables a transformative and open approach to research which incorporates the best of all available epistemologies and tools seen as useful to the researcher. Kaupapa Māori encapsulates my research in what Linda Tuhiwai-Smith refers to as a 'social project', which weaves together Māori aspirations and mātauranga whilst embodying 'the vantage point of the colonised' (Tuhiwai-Smith, 1999, p.1-191). What this means is that I undertake this research using my knowledge of Te Ao Māori (the Māori World) and my learning (and unlearning) of Western Psychology to form a Māori centred analysis. This approach prioritises Māori knowledge (both traditional mātauranga and contemporary understandings) and culture as the expert source to inform meaningful outcomes for our people. It also supports the tino rangatiratanga of the researcher in presenting decolonising research.

As a Māori researcher I am also influenced by the mahi of Associate Professor Chris Sibley and Dr Carla Houkamau who have presented an innovative approach which integrates

Western quantitative methodologies into Māori research. In a recent chapter Houkamau and Sibley (in press) suggest that collecting as many Western and Indigenous tools as possible works well for selecting appropriate ways to conduct analyses on Māori in the modern context. They also claim that qualitative and quantitative methodologies can work in a ‘complementary fashion’ for Māori research. Presenting this to a field which has been predominantly qualitative by nature, I see this approach as an exciting pathway to conduct mixed methodology Kaupapa Māori research which I present here in my Masters thesis.

### **The Multi-Dimensional Model of Māori Identity and Cultural Engagement (MMM-ICE2)**

It was Houkamau and Sibley who first created the Multi-Dimensional Model of Māori Identity and Cultural Engagement in 2010 with the most recent revised edition published in 2014 (Houkamau & Sibley, 2010; Houkamau & Sibley, 2014). The model is public domain, self-report and contains seven dimensions. The dimensions were created using Exploratory Factor Analysis from items generated by broader literature and qualitative interviews. The MMM-ICE2 serves the purpose of quantitatively analysing the self-concept of Māori in the context of the ‘social world’ (Houkamau & Sibley, 2010, p.12).

The quantitative model is the first of its kind in psychological identity research and has produced several meaningful and novel findings about Māori identity and wellbeing. Topics using this model range from differences in wellbeing, (Houkamau & Sibley, 2011), home ownership (Houkamau & Sibley, 2015<sub>b</sub>), identity profiles (Greaves, Houkamau, & Sibley, 2015) and psychological wellbeing (Muriwai, Houkamau & Sibley, 2015). As a fairly recent tool built to measure Māori identity, the MMM-ICE2 shows clear potential for

understanding the complexities of Māori realities and has important use in guiding how we conceptualise some of the struggles Māori face.

The Multi-Dimensional Model of Māori Identity and Cultural Engagement (MMM-ICE2) currently contains seven factors (Houkamau & Sibley, 2015<sub>b</sub>). These factors are Group Membership Evaluation (GME), Cultural Efficacy and Active Identity Engagement (CEAIE), Interdependent Self-Concept (ISC), Spirituality (S), Socio-Political Consciousness (SPC), Authenticity Beliefs (AB) and Perceived Appearance (PA). A detailed summary of these factors is provided in Table 2 of the Appendix. In short, these factors broadly cover belongingness as Māori (GME, ISC), involvement with Te Ao Māori (CEAIE, Spirituality) and internal (AB, SPC) and external (PA) markers of Māori identity. The updated version is used in this current paper. The most recent addition to the MMM-ICE2 is the Perceived Appearance factor which has revealed unique information about the heterogeneity of Māori peoples – particularly those of mixed European and Māori ethnicity.

The MMM-ICE2 is predictive of a range of outcomes making it an appropriate tool to be used on the diverse, heterogeneous population of people who identify as Māori. Commonly in research on Māori simply ‘being Māori’ is implied as causal for a number of social and health afflictions. Through looking at different aspects of Māori identity with the MMM-ICE2 researchers are able to conduct detailed research which links specific factors to specific outcomes. In many cases the MMM-ICE2 has been used to show how aspects of ‘being Māori’ are protective factors which provide indigenous resilience (e.g. Muriwai, Houkamau & Sibley, 2015). In other cases it shows how specific parts of ‘being Māori’, such as one’s appearance are unfairly used against Māori, indicating institutionalised racism (Houkamau & Sibley, 2015<sub>b</sub>).

## Summary

It is important for indigenous researchers to decolonise research in order to honour the realities of our peoples. As a Kaupapa Māori researcher I am able to weave through qualitative and quantitative methodologies to provide detailed and complementary analyses. In my research I use the MMM-ICE2. This tool recognises a variety of expressions of 'being Māori', as perceived and reported by different Māori peoples. Used in conjunction with rich qualitative research the MMM-ICE2 is a decolonising tool by recognising the real experiences reported by self-identifying Māori throughout Aotearoa. Using my culmination of tools and skills I endeavour to offer alternative narrative to a field which typically explores Māori health in disparate ways.



## **Bridging Statement**

Bringing together qualitative and quantitative methodologies, this Masters thesis is both an exploration and showcase of the developments in Kaupapa Māori research on Māori health. I hope to acknowledge that it is with gratitude I unite two forms of analysis to provide a psychological examination of how Māori identity and culture may or may not be related to smoking behaviour. This study grew from an intuition I had about the victim-blaming discourse used to explain Māori smoking prevalence. In order to explore my intuition that Māori culture and identity had been problematically linked with smoking behaviour I had to investigate a prominent source of dominant colonial discourse which I found in national media. Through a qualitative ethnographic content analysis I explore how Māori who smoke are represented by journalism in Aotearoa. This first study is presented in full in the following chapter.

### CHAPTER THREE

Chapter Three consists of the published paper entitled ‘Smoking, Not Our Tikanga: Exploring representations of Māori smoking in national media’. This paper was submitted to MAI Journal on January 14<sup>th</sup> 2016 and published on the 16<sup>th</sup> of June 2016. The paper was written with input from second author Associate Professor Marewa Glover from the School of Public Health, College of Health, Massey University. As this is a stand-alone paper there are a few instances of repetition when reviewing relevant literature presented earlier in this thesis. This paper is presented in its published form. To reflect the views of my co-author, readers may observe the change of pronouns from ‘I’, to ‘we’. This paper forms the basis of my subsequent study in Chapter 4.

## **SMOKING, NOT OUR TIKANGA:**

### **Exploring Representations of Māori and smoking in national media**

Emerald Muriwai\*

Marewa Glover†

#### **Abstract**

Māori, the Indigenous peoples of Aotearoa New Zealand, continue to present with disproportionately high smoking prevalence. Investigating the impact of recent media representations of Māori who smoke may increase understanding of the cumulative pressures that maintain Māori smoking. This study aimed to explore representations of Māori and smoking through examining a sample of online media from 2010 to 2015 on this topic. We identified four key themes in reporting: strengths- based representation, deficit- style representation, historical recognition, and cultural dissociation. Acknowledging the history of Māori as a tupeka kore people prior to colonisation, we found that some media representations of Māori who smoke may pose an obstacle for Māori aspirations to be smoke-free. In contrast, we also found examples of positive representation expressed almost exclusively from Māori perspectives. Our analysis suggests that separating Māori tikanga from smoking is imperative in recognising Māori resilience against tobacco and working towards a future in which Māori can be smoke- free.

#### **Keywords**

Māori, tobacco, tupeka, smoking, media, representation

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## Introduction

Researchers say history predisposes Māori to having higher rates of smoking than other ethnic groups in New Zealand and this is passed from parents to children like a contagious disease. (Johnston & Singh, 2014, para. 9)

You've got a cultural norm and a contagion . . . of smoking transmission. (Blakely, as quoted in Johnston & Singh, 2014, para. 12)

News media in Aotearoa New Zealand (hereafter referred to as New Zealand) have an enduring record of disparaging and victim blaming Māori people and their culture for their afflictions. The opening quotation exemplifies how news media frame narratives that source Māori and their culture as causal of smoking, rather than acknowledging the contexts in which Māori live (Nichter, 2003). In New Zealand, Māori have disproportionately higher smoking prevalence at 38% compared with a national average of 17% (Ministry of Health, 2015)—a disparity that has existed since the start of the nation's smoking epidemic in the mid- 1800s (Trainor, 2008). It was not until recently that Māori were recognised by media and the government as having distinct ambitions to reverse the harms caused by tobacco (Public Health Commission, 1994). Developments towards decreasing Māori smoking prevalence have provided opportunities to transform tobacco from colonising Māori future potential (Reid & Pouwhare, 1991); however, progress in this area is slow. We present an analysis of the different representations of Māori who smoke across national media. We discuss the ways in which some media illustrations (strengths- based representations) support Māori resilience while others (deficit representations) problematically display a causal link between aspects of Māori identity and culture with smoking.

### *A Māori History of Smoking in New Zealand*

Prior to colonisation Māori had no relationship with smoking or tobacco (Reid & Pouwhare, 1991). Several Māori narratives claim that tobacco was introduced to New Zealand with the arrival of the British (Reid & Pouwhare, 1991). One Ngāi Tahu tribal story recounts that when Captain Cook arrived, Te Ihutakaru (a Ngāi Tahu warrior) suspected that Cook was not human because smoke was rising from him (Cook, 2013; Karetu, as cited in Reid & Pouwhare, 1991). To determine whether Cook was human and therefore could be slain, Te Ihutakaru doused him with water while he was smoking a pipe. It is understood that after this encounter tobacco became a vital currency in the earliest stages of colonisation (Reid & Pouwhare, 1991).

Māori experiences with tobacco are entwined with markedly different understandings of tobacco regulation and a historical absence of Māori involvement in decision making about health policy, legislation and the research agenda. As early as 1899 the Māori newspaper *Te Puke ki Hikurangi* (as cited in Cook, 2013) noted that the unregulated nature of tobacco consumption among Māori meant usage was characterised very differently from the way Pākehā smoked. Māori did not have any tikanga surrounding tobacco prior to colonisation. In the early 20th century, Māori women smoked as much as Māori men, and children also consumed tobacco (Reid & Pouwhare, 1991). By contrast, Western cultures limited smoking by Pākehā women until the 1920s–1930s, when the “emancipatory politics” surrounding women’s right to vote across Britain and the United States emerged (Johnston, 2009, pp. 7–9). At this time some speculated that Māori had the highest smoking prevalence in the Western industrialised world (Gifford & Bradbrook, 2009).

Looking beyond typical determinants of Māori smoking, such as accessibility to tobacco and levels of social deprivation, current research and practice takes a “multi-

pronged” approach in understanding and working with Māori who smoke (Blakely et al., 2010; SHORE and Whāriki Research Centre, 2014). Over the second half of the 20th century non- Māori smoking prevalence declined. Māori smoking rates, however, reduced from 60% in 1976 to 50% by 1991 and slowly declined by only a further 2% to 48% by 1998 (Trainor, 2008). Support for cessation was not funded by the government until 2000, when it established a national freephone smoking cessation service (Quitline) and a “for Māori by Māori” stop smoking pilot programme—Aukati KaiPaipa. Support to help Māori stop smoking has remained an essential component of the tobacco control programme, which also includes taxation on smoking and social marketing (Apārangi Tautoko Auahi Kore—Māori Smokefree Coalition, 2003).

Developments towards Māori smoking cessation have emerged from the “landmark” report by the Māori Affairs Select Committee’s (MASC, 2010) Inquiry into the Tobacco Industry in Aotearoa and the Consequences of Tobacco Use for Māori. In response, the government agreed to an “aspirational” goal to reduce smoking to 5% or below by 2025 (New Zealand Government, 2011). This commitment included reducing Māori smoking prevalence “proportionately”. Recently, Ball and colleagues (2016) suggested that the government’s response to Māori smoking has been “inadequate” in addressing several of the recommendations put forward by the MASC and their collaborators. Several Māori- led initiatives outline and practise culturally appropriate interventions to support Māori who smoke towards an auahi kore and tupeka kore future (see Gifford & Bradbrook, 2009; Muriwai, 2016, pp. 10–14). As it seems, national media also have the potential to facilitate the achievement of this goal.

### *Representations and misrepresentations of Māori in the Media*

News media in New Zealand continue to play a role in creating representations of Māori that are widely recognised as legitimate (Moewaka Barnes et al., 2012; Nairn et al., 2012; Rankine, Moewaka Barnes, Borell, Nairn, & McCreanor, 2014; Wall, 1997). Some of these are penned by journalists (or organisations) from a strengths-based perspective; at other times, a deficit framing towards Māori is employed. Several studies recognise that current media undermine Māori aspirations by echoing stereotypes of Māori that have been engrained from the first point of contact with settler society (Moewaka Barnes, Taiapa, Borell, & McCreanor, 2013; Rankine & McCreanor, 2004; Stuart, 2002). Māori are consistently contrasted with Pākehā in media news coverage, reasserting the premise that the two groups enjoy equal positions in society—a notion that is simply untrue (Gregory et al., 2011). Research highlights that non- Māori media consumers are able to identify that reporting on Māori regularly features negative identifying factors (Gregory et al., 2011) that are rarely particularised in news items about Pākehā. Comparisons between Māori and Pākehā appear to have become defining aspects of hegemonic colonial discourse, overwriting the uniqueness of Māori realities.

Problematic misrepresentations of Māori appear to be exacerbated by Pākehā journalism. In their recent review, Rankine and colleagues (2014) noted that Pākehā journalists published significantly more columns about Māori issues in daily news media than Māori journalists. This discrepancy is an example of how Pākehā perspectives are validated through regular consumption by readers across the nation. When concerned with representing Māori people, some non- Māori authors appear to be pragmatic, self- serving, self- preserving and even fundamentally “anti- Māori” in some instances (Matheson, 2007; Moewaka Barnes

et al., 2012; Phelan, 2009). It is possible that non- Māori utilise what McCreanor and Nairn (2002) term “interpretive repertoires” that victim blame “the poor health status of Māori as a function of being Māori [emphasis added]” (p. 5). Victim blaming Māori for their smoking is in sharp contrast with the work by researchers who use Māori culture and identity as a strengths- based foundation to encourage Māori to quit smoking (for example, Glover et al., 2013; Grigg, Waa, & Bradbrook, 2008; Wilson, Grigg, Graham, & Cameron, 2005).

Despite an established field of research on effective mass media and social marketing campaigns for discouraging Indigenous people from smoking (for example, Grigg et al., 2008; Wilson et al., 2005), media in New Zealand appear to present a pattern of anti- Māori instead of anti- smoking content. Evidence suggests that attitudes produced by the media, health professionals and laypeople can have a profound effect on the health and wellbeing of Māori (Moewaka Barnes et al., 2012; Moewaka Barnes et al., 2013). For Māori, it is crucial that the influences of social stressors and colonial trauma are addressed in understanding the struggles Māori face (Selby, 2005). Use of the words “normal”, “norm” and “culture” to describe Māori smoking can “pigeonhole” Māori (Nichter, 2003) as the source of their smoking, which is implausible when recognising the role of tobacco as a colonising tool. The stark difference between Māori- driven approaches to combating smoking and the structurally embedded deficit discourse around Māori health in the media deserves investigation. Could it be that the intended and unintended effects of strengths- based versus deficit- based discourse, on balance, nullify a reduction in Māori smoking?

### ***Overview of the study: Decolonising Māori and Smoking in the Media***

Our analysis investigates whether there is a need for “alternative media narratives” (Te Rōpū Whāriki, 2014) to represent Māori more effectively to reduce Māori smoking. In



line with previous studies, we explore how current media coverage may pose an obstacle towards Māori aspirations (Nairn et al., 2011) or otherwise facilitate support to ending tobacco smoking harm. We also explore speculated links (Trainor, 2008) between Māori culture and identity with smoking. We investigate the national media as a “political antagonist” (Phelan, 2009) that focuses on maintaining an opposing, binary discourse of Māori versus Pākehā instead of presenting positive Māori narratives and contributing towards equitable achievement of the Smokefree 2025 goal for Māori. We undertake this analysis from a kaupapa Māori positioning. Our approach is embedded in decolonisation through asking whose voice, language and perspective can be held accountable for the dominant and shared representation(s) of Māori who smoke present in national media (Moewaka Barnes, 2011, p.137). This study investigates a novel kaupapa, “Smoking, Not Our Tikanga”, to challenge the idea that Māori culture and smoking culture are related.

## **Method**

### ***Sampling procedure***

Data were drawn from theoretical sampling of open access news media articles published online over the past five years. Theoretical sampling, a process that uses a broad sample to develop theory (Altheide, Coyle, DeVriese, & Schneider, 2008), was used to inform our key search terms. A search was entered into the generic Google search engine and the Google News application using the key term combinations “Maori”, “Māori” and “smoke”, and “smoking” and “tobacco”. To narrow the search, preliminary boundaries were set whereby either the title had to contain the key terms “Maori”/“Māori” and “smoke”/“smoking”/“tobacco” or the article had to feature a spotlight on Māori by mentioning them at a minimum of twice per article. We chose to cover a recent five- year period to test whether stereotypes echoed since colonial contact continued in modern- day

coverage of Māori who smoke. To reflect this focus we also entered “2010”, “2011”, “2012”, “2014” and “2015” into the search criteria.

Forty- six articles were used in the final sample after omissions were made for articles that did not fit our criteria. All were written and published on nationally hosted websites. We also identified the “type” of article at two levels of analysis. Level 1 assessed the regional reach of articles sampled. There were significantly more articles that reached a national audience than those with a regional readership. At a second level of analysis we recognised that the majority of articles were included in general publications covering a variety of topics, followed by Māori- specific publications and medically oriented publications. Most articles in our sample provided author names, though some remained unspecified, leaving us to attribute certain articles to organisations rather than to the individual(s) who wrote them. A full summary of our data is available online (Tūranga, 2016).

### ***Analytic Approach***

A sample of online media articles about Māori and smoking were analysed using ethnographic content analysis (ECA). This method simultaneously allows us to analyse the social construction of reality through mediatisation (Stocchetti & Kukkonen, 2011) and reflexively interpret the illustration of “common sense” in media representations of Māori people who smoke (Altheide, 1996). Using ECA, we recognise the “polysemic” nature (Macnamara, 2005) of our data, which have been written by and for a variety of media consumers throughout New Zealand. In more recent developments to this approach, “immersion” in the research space and context has become a key element of ethnographic analysis—in other words, the authors need to be deeply familiar with the symbolic representations communicated by the data they are studying (Altheide et al., 2008). We recognise this method as compatible with a kaupapa Māori positioning within this research. Ethnographic

content analysis centralises on an understanding of comparison and contrast, which is especially familiar for kaupapa Māori researchers enmeshed in disciplines that previously positioned Māori as subject rather than author. Furthermore, an ethnographic analysis has been employed to focus on the discursive content of our data; in doing this, we avoid the rigidity of quantifying our sample (Altheide, 1996).

### ***Coding***

Following the extant literature on Māori in the media (for example, Hodgetts, Masters, & Robertson, 2004; Moewaka Barnes et al., 2012; Phelan, 2009; Rankine et al., 2011; Wall, 1997) and Māori smoking (for example, Glover, 2005; Glover & Cowie, 2010; Glover, Nosa, Watson, & Paynter, 2010), a thematic coding schedule was developed as shown in Table 1. The coding schedule contained the following items: statistical frequency, neutral statistics, Māori responsibility, Māori strengths, deficit statistics, Māori victim blaming, Māori cultural shaming, historical recognition and cultural dissociation. Many of these items overlapped across the data and were thus collated into four main themes, which are elaborated further in the paper. These included strengths- based perspective, deficit perspective, historical recognition, the context of Māori and smoking and dissociation of Māori culture from smoking. Both titles and article content were analysed.

### **Results and Discussion**

We start the discussion of our analysis by acknowledging that there were some promising examples of positive representation contained in much of the media coverage on Māori and smoking. Many of the articles addressed a common reality where the disparity between Māori and non- Māori smoking rates were purposefully highlighted to emphasise the need for Māori smoking to be appropriately addressed. Disparity frameworks, however, are

not always useful. Such framing positions non- Māori as setting the standards that Māori fail to meet. Critically, we noted that many media outlets made it difficult to identify the authorship of their published articles. We found that the majority of media reports on Māori and smoking used statistical evidence throughout their coverage. One would presume a statistics- based journalism can be interpreted as neutral by nature. Our analysis suggests this may not be the case.

### ***Strengths Based Perspective of Māori People who Smoke***

Over half of the media articles sampled mentioned or presented a strengths- based perspective or framing that focused on Māori resiliency, responsibility and competency. Originally coded separately, Māori responsibilities and Māori strengths coding were collapsed into one category “Māori strengths- based perspective” because of immense overlap. Of note, instances of a strengths- based perspective were presented not by journalists themselves, but in quoting Māori community members, teachers, researchers and health professionals:

Māori approaches to Māori health issues are required. (Ahuriri, as quoted in University of Canterbury, 2015, para. 10)

The reason is because so many Māori smoke, so Māori need to lead the solutions. (Tamatea, as quoted in Waikato District Health Board, 2013, para. 12)

While initial coding was only looking for strengths- based Māori content, a closer examination revealed this perspective as accountable to the (Māori) sources quoted by journalists. This signals an impartiality or reluctance that media outlets appear to have when using their own words to report positively on Māori. Thus, the only time te reo and positive representations are reported are when Māori people or organisations are quoted directly. This

transparent use of positive Māori perspectives can, however, provide some foundational knowledge for future reporting on Māori and smoking:

Targeted at Rangatahi (Māori youth) the initiative is being piloted . . . the rangatahi will be empowered to make positive lifestyle choices and see real benefits for their physical and financial wellbeing. (MidCentral District Health Board, 2014, para. 2)

Substituting te reo Māori for a term with equivalent English meaning (“youth”) gives this article grounding, showing tautoko for te reo in mainstream media to explain unique Māori predicaments. Several studies by researchers from Te Rōpū Whāriki have illustrated that use of te reo in media coverage is rare and when it does occur it is unaccompanied by support for readers to learn te reo Māori. This example is important as “rangatahi” is never substituted for its English equivalent throughout this article.

The Minister [Hon. Tariana Turia] described Matariki as the perfect time to quit smoking . . . Matariki occurs in mid- June each year when the cluster of stars known as the Pleiades or Seven Sisters appears in the night sky. For Māori this was a time of new beginnings. (Wylie, 2012, paras. 5–7)

This example dedicates space to defining a crucial concept from te ao Māori. The article does not assume prior knowledge of this Māori concept, though it is unclear who the target audience for this media is. This attention to detail of Māori knowledge and customs clarifies and normalises Māori in a positive way.

### ***Deficit Representations of Māori who smoke***

A small number of the articles presented a deficit- style perspective of Māori smoking. Relatively lower prevalence of this view combines the coding of victim blaming, cultural shaming and deficit statistics (where the latter were used as framing). Deficit

representations signal a concerning reality whereby Māori are blamed for their smoking prevalence and also seen as unable to quit. Language was a prolific indicator of these deficit-style representations. For example, a recent article titled “Smoking among Maori Girls Stubbornly High [emphasis added]” begins with “It appears Maori girls are refusing to give up smoking [emphasis added], and adult role models are being blamed [emphasis added]” (Radio New Zealand, 2015). The language exemplified here sets up the conditions in which Māori smoking is seen as unchangeable and a matter of choice simultaneously. Indeed, titles alone can run this risk of introducing a deficit perspective by victim blaming Māori early on: “Tobacco still a *ticking time bomb* [emphasis added] for Māori and Pacific” (Te Ara Hā Ora, 2014), “Multi- pronged *attack on Māori smoking* [emphasis added] gives hope for future” (McMillan, 2013) and “*Māori women pay the price* [emphasis added] for their high addiction rate” (Johnston, 2010). These titles signal a fatalistic theme that is echoed in the following:

Nearly half of Maori mothers giving birth are smokers, dooming Maori to continued poor health. (O’Sullivan, 2014, para. 1)

This quotation from O’Sullivan (2014) illustrates media placing blame for the continued disproportionately poor health among Māori on pregnant Māori women who smoke. In this way, Māori smoking, which is a dynamic and multifaceted issue, is rewritten into a simplified narrative of a recalcitrant people. Such language construes Māori as worthy of victim blaming and further emphasises a representation of Māori as “other” and stigmatised. Language such as this also positions Māori tobacco control initiatives for Māori as intangible or destined for failure by refusing to acknowledge that such initiatives exist nationwide.

Tauranga Girls’ College principal Pauline Cowens says . . . the issue needs to be addressed at home and not just at school . . . She says at school they have Maori

councillors for the Maori students but they prefer to work with individual students rather than targeted groups. “We work with the individual girls who are putting their health at risk.” (Taylor, 2012, paras. 7–11)

Stewart [Ngatai] says Maori youth smoking is so high because so many of their own family members smoke. De- normalising smoking amongst Maori is a good start. (Taylor, 2012, paras. 16–19)

This regional media article presents a deficit style representation of Māori using deductive reasoning and language. The article sources two professionals, one Pākehā and one Māori, to voice their opinions about solutions to Māori youth smoking. The beginning of the quotation relays information provided by a Pākehā school principal whose position empowers her to say that despite Māori interventions being accessible she prefers working with young female Māori smokers as individuals (as if individuals can be devoid of ethnicity), whom she depicts as responsible for “putting their health at risk”. This illustrates an interesting display of Pākehā ownership over Māori realities. In contrast, the Māori perspective of Western Bay of Plenty Smokefree Coalition chairperson Stewart Ngatai counters this perspective by acknowledging the social pressure to smoke experienced by Māori youth where there are high smoking rates among their whānau members. This article ends with a quotation from Ngatai on “de- normalisation of smoking culture” among Māori, elaborated on later in this study.

A consultant at charitable trust Te Reo Marama, which advocates tobacco resistance for Maori, Shane Bradbrook says . . . Now smoking is seen as normal within the Māori community . . . He says to prevent smoking, “we need to get rid of the tobacco industry” . . . “[We] need to challenge the government to make sure that the supportive health promotion programmes that there are, [are] Māori specific quit

programmes that assist our people to quit.” He says it is up to Māori to get smoking out of the community, and Māori need to change their cultural behaviours. (Hickland, 2010, paras. 21–27)

This excerpt presents a manipulation of a Māori perspective into an anti- Māori and deficit- style framing. The excerpt opens by introducing Shane Bradbrook (who was the director of Te Reo Marama) and following what he has to say about smoking with a statement written by the author positioning smoking as a “norm” within “the Māori community”. The author homogenises Māori as “one community” sharing one “norm”, which is incongruent with the diverse reality of the various communities who identify as Māori. Preluding the statement that “Māori need to change their cultural behaviours”, Bradbrook is quoted as acknowledging the increased need for government support for Māori- specific health promotion and quit programmes, and this is followed by the author’s own interpretation of what this means. The author indicates that Māori “cultural behaviours” are the source of blame for Māori smoking when in fact they are being suggested as a remedy and protective factor supporting reducing Māori smoking. This can be viewed as an example of both misrepresentation and misinterpretation as the author has used the direct quotations from Māori against Māori aspirations for tupeka kore. We consider this kind of journalism to be problematic.

### ***Historical Recognition, the context of Māori and Smoking***

Only a small fraction of articles recognised how the history of colonisation has affected Māori smoking prevalence. Tariana Turia (2013) referred to the introduction and imposition of tobacco on Māori as an “unethical transaction”. It is plausible to consider tobacco a colonising tool used in the process of subduing and oppressing Māori.

Acknowledging the history of Indigenous peoples can be aligned with a commitment to



decolonisation and recognising Māori peoples' colonised realities. This was done in a variety of ways across the few articles that recognised how history plays a role in Māori smoking:

She says the current state of Māori health is a product of inequalities fostered in the settlement and colonisation of Aotearoa New Zealand, perpetuated in prevailing social structures. Statistics New Zealand figures from 2010–2012 show that Māori could expect to live seven years less than non- Māori. (University of Canterbury, 2015, para. 3)

Although reference is made to another quotation in this excerpt, there is an attempt to validate a historical perspective. The statistics chosen to validate such a perspective are centred around mortality and death rather than being smoking specific, which overlooked an opportunity to discuss tobacco harms. Instead, the authors reinforce a negative deficit- style perspective framing Māori as “doomed” by the effects of smoking, regardless of its historical origin:

The authors comment: “Maori policymakers interviewed called for a strong interventionist role for central and local government in reducing disparities in tobacco . . . This is not surprising, when considered alongside a Treaty of Waitangi framework that holds government accountable for ensuring that Maori experience at least the same level of health as the wider population”. (McMillan, 2010, paras. 7–8).

This article is the only one that quotes a reference to Te Tiriti o Waitangi, which would have seeming importance in addressing a disparity as wide as smoking by ethnicity in New Zealand. The inclusion of this in a news publication aimed at medical doctors recognises that these health professionals should be aware of the explicit parallels between health disparities and obligations to support Māori to “at least the same level of health” of non- Māori under Te Tiriti o Waitangi. The article explicitly positions empirical science

alongside national history. However, since this is only mentioned once in our sample, we cannot generalise that this kind of recognition is common in media on Māori and smoking. A lack of historical recognition contributes to the silencing of perspectives that ground Māori smoking in a historical and colonised context, which is so often recognised in research across Māori health.

### *Dissociating Māori Culture and Smoking Culture*

We were interested in exploring the distinctions between Māori culture/tikanga and smoking in this analysis. Dissociation appeared in a handful of articles analysed. In the remaining articles, the idea that Māori culture and identity and smoking are causally linked was often implied. The lack of representation of perspectives that disassociate the two reveals how deep this association may be. Those who did mention a disassociation of Māori culture from smoking were often quoting directly from Māori sources:

Zoe Hawke, Kaiwhakahaere (manager) of Te Ara Hā Ora . . . said the statistics are a reminder of how far Aotearoa has come with its smoking status . . . “Tobacco is not for our whānau, not for our tamariki, it wasn’t our history and it will not be our future”. (Te Ara Hā Ora, 2014, paras. 4–7)

Mr Elers took issue [with Māori being associated with smoking] . . . “it is being singled out that that is the Maori norm, that’s how Maori are.” (Deane, 2013, paras. 4–5)

It’s really about people understanding that tobacco is not part of the Maori tradition. (Bradbrook, as quoted in Theunissen, 2010, para. 11)

The excerpts selected here show variation on the same imperative—that smoking and Māori culture (and identity) are not essentially linked. These excerpts emphasise a need for

“culture” itself to be defined more purposefully, something that has been labelled as fundamental in research that involves ethnicity and culture with smoking prevalence (Nichter, 2003; Unger et al., 2003). In our analysis Māori culture represents tikanga and identifying one’s ethnicity as Māori, which is a separate concept from the social norms around smoking (often misleadingly referred to as “smoking culture”). Because this distinction has not been made, the media are able to continue a deficit style of reporting that blames Māori for disproportionately high smoking rates and legitimises unequal health status:

East coast iwi Ngati Kahungungu is advocating not just to make its maraes smoke-free places, but also tobacco-free, as part of a movement to disassociate Māori culture from smoking. (Theunissen, 2010, para. 1)

Ms Glover believes that if this happens, it could turn round a culture where smoking has been normal, and make quitting normal instead. (Te Manu Kohiri, 2013, para. 6)

In some instances Māori sources were not quoted directly; instead, their perspectives were paraphrased. The first example from Theunissen (2010) explicitly outlines Ngāti Kahungungu’s kaupapa. The second example from Te Manu Kohiri (author unspecified) is more ambiguous through the use of the word “normal”. As mentioned earlier, comments on Māori “norms” run a risk of overlooking how the remnants of colonisation affect Māori experiences. In this case, substituting the word “prevalent” may change the framing of what may be misinterpreted and paraphrased as a cultural Māori norm.

### ***Implications for Māori Smoking Cessation***

We aimed to explore representations of Māori and smoking in a sample of recently published online news media. We found competing themes that show support or otherwise belittle Māori people who smoke. To our knowledge, the study is the first of its kind to

explore representations of Māori who smoke in a sample of national news media. While we explored a variety of representations, there were some examples that call for further work in constructing alternative media narratives surrounding Māori who smoke. Themes we identified as historical recognition and cultural dissociation could provide a good starting point for media to play a more facilitative role in understanding Māori smoking prevalence. While it is important to recognise and report health disparities between Māori and non-Māori, we think that the framing of these needs attention. Framing of Māori and smoking in the media (and health research) may be more useful when the potential Māori have to reduce tobacco smoking harm is recognised.

This study is not without its limitations. We have presented an analysis of a small sample of online news media. Future research should look at larger national samples; an analysis of change through decades of media representation of Māori who smoke could be of future interest. The key search terms generated for this study could also be expanded in future studies to include kupu Māori (for example, “tupeka kore” and “auahi kore”). As well as this, news media representation could be compared with health promotion advertising and media releases surrounding Māori smokers. Language used by decision makers who fund tobacco control programmes for Māori should also be investigated. If the media are reflecting negative narratives of Māori and smoking, there is certainly a risk that those with political and monetary influence may be reluctant to support Māori-led initiatives to reduce tobacco harm.

### ***Smoking, Not Our Tikanga***

Tobacco has colonised Māori health since its introduction to New Zealand. It is possible that the ways in which Māori who smoke are represented may contribute to the initiation and maintenance of smoking among Māori. Through our research, we emphasise

that blame has been misplaced when sourcing Māori culture and identity as the reason Māori smoke at high prevalence. Ethnicity and culture are not appropriate targets for modification as a strategy to change smoking prevalence. If Māori identity and culture are implicated as causal of smoking, stopping smoking by association becomes immutable and starting smoking becomes inevitable. This proposition discourages Māori self-efficacy to stop smoking and may also encourage a fatalistic helplessness that obstructs Māori from reducing tobacco harm (Glover et al., 2010).

There are numerous social and health determinants contributing to the disproportionately higher smoking prevalence among Māori. We propose that the role the media plays in constructing health narratives may be another contributor to the uptake and maintenance of Māori smoking. We recommend that future news media update their standards to ensure Māori potential to reduce tobacco harm is recognised. With permission from the Health Promotion Agency (previously known as the Health Sponsorship Council) and Te Ara Hā Ora, the authors stand by our kaupapa “Smoking, Not Our Tikanga”—a play on the original motto of Smokefree New Zealand’s “Smoking Not Our Future” (SNOF). Further research on this kaupapa is warranted to further distinguish Māori tikanga, Māori identity and Māori culture from smoking.

## **Conclusion**

Research on representations of Māori who smoke is essential for understanding how to facilitate more rapid reduction in tobacco harm for Māori. Our analysis reveals some important themes in representation that may play a role in obstructing and facilitating Māori tobacco control aspirations. The way in which news media frame Māori may impact on initiation and maintenance of Māori smoking. If we are able to better represent Māori who

smoke in news media, there is potential for tupeka kore to be accelerated. By adopting the kaupapa “Smoking, Not Our Tikanga” we hope to contribute to decolonising Māori smoking and contribute towards the better health of Māori peoples.

## **Bridging Statement**

This first paper explored representations of Māori who smoke using a novel ethnographic content analysis on a sample of national media. A variety of representations of Māori who smoke were identified, some showed support for Māori smoking cessation while others inhibited this. Ultimately, the aim of this research was achieved insofar that evidence for distinguishing Māori identity and culture as separate from smoking behaviour was present. Though this theme, coined 'Cultural Dissociation', was only present in a few articles, its absence highlights that Māori identity and culture are often synonymously linked with smoking behaviour. This paper points out the problems with this association, particularly in the case of causation – being Māori is unchangeable and if being Māori is causal of smoking then auahi kore cannot be achieved. Following through with the kaupapa 'Smoking, Not Our Tikanga' the second study quantitatively explores the speculated link between Māori identity and culture with smoking status among a national sample of Māori participants.

## CHAPTER FOUR

The following chapter consists of the submitted paper entitled '*Looking Like a Smoker, a Smokescreen to Racism? Māori Perceived Appearance linked to Smoking Status*'. This paper was submitted to Ethnicity and Health on February 24<sup>th</sup>, 2016. The paper was written with supervision from Associate Professor Chris Sibley from the School of Psychology, The University of Auckland and advisor Dr Carla Houkamau from the Department of International Business and Management, The University of Auckland. This paper is presented in full, with adjustment to Table numbers as per the Appendix of this thesis. Again, the readers will note a change in pronouns from 'I' to 'we', to reflect the co-authorship of this paper.



**LOOKING LIKE A SMOKER, A SMOKESCREEN TO RACISM?  
MĀORI PERCEIVED APPEARANCE LINKED TO SMOKING STATUS**

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**Abstract:**

Māori, the indigenous peoples of Aotearoa (New Zealand), continue to exhibit the highest rate of smoking of any ethnic group in the nation. Clarifying the present day factors which perpetuate Māori smoking has become matter of some urgency. We investigate links between Māori identity, demographic factors, and discrimination experiences with smoking status in a national probability sample of self-identified Māori ( $N = 557$ ). Our results suggest that core aspects of Māori identity and cultural engagement were *not* linked with smoking. However, the extent to which participants felt they were perceived as prototypically Māori (measured as Perceived Appearance) was reliably associated with smoking. The effect of Perceived Appearance held when adjusting for perceived experiences of discrimination and other standard demographic indicators. Our analysis indicates that simply appearing more visibly Māori is associated with increased likelihood of smoking, which may reflect how Māori negotiate the larger systemic forces of racism present in New Zealand society.

Keywords: Māori, Smoking, Tobacco, Perceived Appearance, Prototypicality

## Introduction

“If left unchecked tobacco will continue to limit Māori development and colonise our future potential” (Reid & Pouwhare, 1991).

Māori are the largest tobacco consumers in Aotearoa, New Zealand. Well over a third of Māori (38%) report regular smoking behaviour (Ministry of Health 2015; Statistics New Zealand, 2013) compared to an average smoking prevalence of 25% for Pacific peoples, 15% for Europeans/Others and 6% for Asian peoples (Ministry of Health, 2015). When broken down by gender the Ministry of Health (2015) found that 34% of Māori males and 42% of Māori females report regular smoking behaviour. Current smoking statistics highlight that mainstream approaches in the health sector are not working for Māori.

While studies continue to report that smoking rates are declining globally, this positive message is tempered by variance in smoking status between ethnic groups (Centers for Disease Control and Prevention, 2014; World Health Organisation, 2015). Rates of smoking are not declining equally across ethnic groups. So far reports of a declining smoking epidemic has failed to acknowledge that as general smoking rates decrease, the gap between the marginalised and the mainstream increases in parallel (Barnett, Pearce & Moon, 2005).

Māori have presented with prolifically high rates of smoking since first contact with Pākehā/New Zealand Europeans (Cook, 2013; Reid & Powhare, 1991). Once introduced, tobacco became a main source of trade and exchange. There is no evidence to suggest that Pākehā informed Māori of the harms surrounding tobacco use despite legal and moral tobacco regulations being commonplace across Western nations at this time (Broughton, 1996; Te Puke ki Hikurangi, cited in Cook, 2013). For this reason, many have come to conceptualise the imposition of tobacco upon Māori as an ‘unethical transaction’ (Turia, 2013) which has lasting effects today. Māori did not smoke tobacco until Pākehā contact and

colonisation (Reid & Powhare, 1991). It would seem this vital fact continues to be significantly overlooked in understanding Māori smoking status today.

Researchers have strived to find solutions for reducing Māori smoking for the past few decades and despite these considerable efforts (for example, Barnett et al., 2005; Blakely, Fawcett, Hunt & Wilson, 2006), Māori smoking remains a prevalent health issue. In order to broaden our understanding of the mechanisms which underpin Māori smoking behaviour, we test an empirical model using measures of Māori identity and experiences of discrimination. Specifically, the current study examines the theory that Māori identity and culture are related to smoking status. This association has been a matter of speculation throughout some health literature and media discourse. In their analysis, Muriwai and Glover (2016) found support for a deficit narrative which implies a link between ‘being Māori’ with smoking. Through this study we quantitatively explore whether or not Māori identity and culture are related to Māori smoking status, as others have previously speculated.

### ***Understandings of Māori Smoking***

Many explanations for higher rates of among Māori have been proffered. Ford and colleagues (1995) speculated that decreased health knowledge, greater exposure to tobacco advertising in televised sports and parental role-modelling could help explain but could not fundamentally account for why Māori consume tobacco at such a high rate.

Historically, the most common explanations for Māori smoking status have centred on socioeconomic factors (for example, Barnett et al., 2005; Klemp et al., 1998). A recent national report on Māori smoking suggests that those living in the most deprived areas are 3.5 times more likely to smoke than those living in the least deprived areas (Ministry of Health, 2014). The important association between socioeconomic factors with Māori smoking status clearly holds some validity as the most consistently reported ‘reason’ for why Māori smoking

status is so high. However, despite this longstanding and repetitive narrative, efforts to adequately address Māori smoking are not reflected in the lack of decline in smoking status among Māori, relative to the rest of Aotearoa.

Though empirical research has largely pointed to socioeconomic factors to understand the derivatives of Māori smoking behaviour, some researchers have linked Māori identity with smoking. Mitchell (1983) has suggested higher levels of smoking among Māori is associated with ‘higher cultural identity as Māori’ (Mitchell, 1983, p.535). The baseline of this conclusion came from measuring student’s knowledge of marae, iwi and hui attendance as the definition of ‘Māori cultural identity’. Similarly, in a comparison between Māori and Pākehā, Klemp and colleagues (1998) measured ‘Maoridom’ as a significant correlate to Māori smoking. In 1996, Broughton speculated that smoking ‘may have been part of [Māori] cultural identity’ (cited in Trainor, 2008, p.9). Olson (1993) furthers this perspective with their claim that smoking may be a function of group membership for ‘enculturated Māori’. In our view, these conclusions are incomplete. Not only do they place the cause of smoking “within Māori” individuals (i.e. blame smokers for their own behaviour). They fail to consider the socio-economic and historical context in which smoking occurs.

### ***Identity and smoking***

Research has highlighted the importance of defining smoking as a behavioural outcome stemming from a variety of social determinants for different groups. Currently, statistical data collected in New Zealand defines smoking as ‘active smoking behaviour, the intentional inhalation of tobacco smoke by a smoker’ (Statistics New Zealand, 2015). Such a definition supports the idea that smoking is a behaviour but also posits ‘smoker’ as an identity. Some researchers have reported that a smoking identity can assist smoking cessation (van den Putte , Yzer, Willemsen, & de Bruijn, 2009) while many others have illustrated that

measuring smoking identity alone is insufficient for smoking cessation (Ridner , Walker, Hart & Myers, 2010) as many people who smoke do not identify as smokers (see: Choi, Choi & Rifon, 2010; Falomir & Invernizzi, 1999). Understanding smoking as a behavioural outcome means tobacco consumers are not defined by their habits and that smoking can be seen as a dynamic process with a number of factors contributing to commencement and continuation of smoking.

It is important to acknowledge that some people who smoke often adopt ‘being a smoker’ as their identity and ‘smoking culture’ as their way of negotiating, surviving and finding meaning in the world (for example: Hoek, Maubach, Stevenson, Gendall & Edwards, 2013; Young & Banwell, 1993). However, when smoking is seen as a part of one’s identity it can present the individual as the source of smoking rather than acknowledging the cumulative pressures and experiences which may trigger one to smoke. Thus, associating smoking with Māori identity can be problematic as it overlooks the potent influence of colonisation and couples being Māori with being someone who smokes. To victim-blame the recipients of colonisation as the source of their colonial misfortune is fundamentally irresponsible, misrepresentative and obstructive of Māori aspirations for smoking cessation.

Enmeshing Māori identity with smoking appears to be current practice within New Zealand media. Muriwai and Glover (2016) identified four major themes in online media about Māori who smoke: deficit narratives, strengths-based narratives, historical recognition and cultural dissociation. The authors illustrate that deficit narratives blame Māori as the source of their unequal health status. In their analysis, the authors state that Māori do not share equitable social positions or privileges with non-Māori, making deficit narratives both misrepresentative and antagonising. Nonetheless, Muriwai and Glover (2016) also noted that some authors occasionally recognised the historical significance of colonisation on Māori

smoking. Through the paper Muriwai and Glover (2016) formed the kaupapa (concept) ‘*Smoking, Not Our Tikanga*’ (Smoking, Not Our Culture). This kaupapa iterates active resistance to linking any aspect of Māori identity and culture with smoking behaviour; we enter this study in support of this.

### ***Discrimination and Smoking***

Research suggests that smoking may be viewed as a behavioural response to experiences with different types of discrimination. Discrimination is closely linked with several unchangeable aspects of the self, such as gender, age, sexuality, ethnicity and so forth. In a study on ‘embodied discrimination’ Zucker and Landry (2007) found that experiences with sexism were firmly related to smoking for weight control among women. Ryan and colleagues (2009) suggested that higher smoking prevalence among lesbian, gay and bisexual peoples could be explained by homophobia. Northern American research has suggested gender-based discrimination from police and businesses could predict smoking among Black and Latino men (Wiehe, Aalsma, Liu, & Fortenberry, 2010). These different examples illustrate how different forms of discrimination can predict smoking status and influence smoking behaviour for a variety of tobacco consumers.

Emergent research notes that smoking behaviour may be linked to specific ethnic groups through experiences of ethnic and racial discrimination. Some studies have suggested this relationship to be direct, with tobacco consumers reporting higher levels of perceived ethnic/racial discrimination (Chae, Takeuchi, Barbeau, Bennett, Lindsey & Krieger, 2008), unfair treatment (Guthrie, Young, Williams, Boyd & Kinter, 2002) and racial harassment (Bennett, Wolin, Robinson, Fowler & Edwards, 2004). Paradies’ (2006) review of indigenous Australian health research found that racism related stress (but not racism alone) was predictive of smoking behaviour across several studies. The inconclusiveness of ethnic

discrimination literature suggests that tools used to measure this type of discrimination may not fully encapsulate institutional and internalised racism (Wiehe et al., 2010). However, it is critical to note that this literature importantly conceptualises smoking as a behavioural response to ethnic-based stressors.

### *Overview of the present study*

We undertake this study using empirical tools designed specifically for and by Māori (Houkamau & Sibley, 2010; Houkamau & Sibley, 2015<sub>a</sub>). Following from Muriwai and Glover (2016), we statistically assess the possible links between Māori identity and cultural engagement with smoking status in a national probability sample of Māori. To do this we use the Multi-Dimensional Model of Māori Identity and Cultural Engagement (MMM-ICE2; Houkamau & Sibley, 2015<sub>a</sub>). This self-report questionnaire has a robust record of predicting important health and social outcomes for Māori (see: New Zealand Attitudes and Values Study, 2016). In conducting this research we hope to contribute to the acceleration of Māori smoking cessation.

We present a two-step logistic regression model assessing the extent to which (if at all) Māori culture and identity are related to smoking status and whether discrimination is also predictive of smoking for Māori. Using a national probability sample we surveyed self-identifying Māori across New Zealand. We test for the likelihood of smoking (coded as 1) versus not smoking (coded as 0) based on two steps of analysis which address Māori culture and identity as well as broader demographic, health and discrimination-related factors which may predict Māori smoking behaviour.

In our initial test of factors relating to Māori smoking status we present an Identity Model using the MMM-ICE2 (Houkamau & Sibley, 2015<sub>a</sub>). This model assesses broad facets of Māori identity including Group Membership Evaluation, Cultural Efficacy, Spirituality,



Interdependent Self Concept, Socio-Political Consciousness, Authenticity Beliefs and Perceived Appearance. We utilise Muriwai and Glover's (2016) kaupapa 'Smoking, Not Our Tikanga' for our hypothesis. As much as one may formally predict a null hypothesis, we did *not predict* significant associations between the seven factors of the MMM-ICE2 and Māori smoking status. In other words, we hypothesized that Māori identity and cultural engagement would be unrelated to whether or not one smoked.

Moreover, following the literature on smoking amongst ethnic minorities, we test a Discrimination Model at the second step of our analysis. As reviewed earlier, research indicates discrimination is connected to smoking and so we test this using a New Zealand sample. At this step we test for perceived ethnic discrimination predicting Māori smoking status with a range of covariates. This model continues to test all measured aspects of the MMM-ICE2 whilst controlling for typically associated demographic predictors of smoking status such as levels of deprivation and employment status. We hypothesise that perceived discrimination will be significantly associated with Māori smoking status. As we continue to use the MMM-ICE2 in the second model we again, do not expect to detect statistically significant associations between aspects of Māori culture and identity with Māori smoking status.

## **Method**

### ***Participants***

We analysed data from 557 self-identified Māori participants (356 Female, 201 Male) who completed the NZAVS Māori Focus questionnaire and provided complete data for the measures of interest here. The majority of participants reported that they did not smoke. A statistical breakdown of mean scores between Māori who smoke and Māori who do not smoke is provided in Table 3.

Participants ranged in age from 18 to 69 years and roughly two thirds were employed. As well as this, participants ranged in levels of deprivation with the majority being on the upper end of the scale which ranged from 1-10 (1 being low deprivation, 10 being high deprivation) as indexed by The NZ Deprivation Index. Nearly 20% of participants lived in an area with a deprivation value of 10.

Additional family-related demographics of participants were measured. A majority of participants were parents and most had a partner. Participants were nearly as likely to have a Māori Mother as a Māori Father, though fewer participants had both a Māori Mother and Māori Father.

### ***Sampling Procedure***

Participants were part of the holistic sample for Time 4 of the New Zealand Attitudes and Values Study ( $N=12,183$ ). This phase of the NZAVS included a booster sample aimed specifically at recruiting Māori participants (Frame 5 of the Time 4 NZAVS). To recruit Māori into the sample 9,000 people were randomly selected from those who indicated on the 2012 Electoral Roll that they were of Māori ethnicity (ethnic affiliation as Māori is listed on the roll, but other ethnic affiliations are not). A total of 690 Māori participants responded to this booster sample.

To efficiently test this target demographic group, questions specifically designed for Māori were administered for these participants amongst the general Time 4 Questionnaire. We had a response rate of 7.78%, compared to the main (full random probability) sample frames used in the NZAVS which give responses rates of approximately 16%. The lead researcher and primary point of contact for this sample frame was of Māori descent, and was introduced to participants in the cover letter by listing Iwi affiliations. The questionnaire was similar in format and content to the standard NZAVS questionnaire, with the exception that it

included approximately 2 pages of questions revised specifically to assess aspects of identity and wellbeing specifically for Māori.

### ***Questionnaire Measures***

Our outcome variable was measured with the simple Yes/No question “Do you smoke?” This is consistent with current measurement of smoking statistics by the Ministry of Health (Ministry of Health, 2014).

Participants completed the revised Multi-Dimensional Model of Māori Identity and Cultural Engagement (MMM-ICE2, Houkamau & Sibley, 2015<sub>a</sub>). This scale includes all seven factors: Group Membership Evaluation (GME), Cultural Efficacy and Active Identity Engagement (CEAIE), Interdependent Self-Concept (ISC), Spirituality, Socio-Political Consciousness (SPC), Authenticity Beliefs (AB) and Perceived Appearance (PA). We summarise definitions of these factors in Table 2.

Participant’s experiences of Perceived Discrimination were assessed using a single item developed for the New Zealand Attitudes and Values Study. The item asked participants to respond to the statement: *‘Feel that I am often discriminated against because of my ethnicity.’* Participant responses were measured on a Likert scale from 1 (Strongly Disagree) through to 7 (Strongly Agree).

In the final analysis we also included some demographic, health and family related covariates. We asked participants to disclose their gender, employment status, religious status, parental status, partner status. As well as this we asked participants whether their mother or father was Māori. We also created an interaction term for those whose parents were both Māori (‘Māori Parents’), fewer participants reported two Māori parents than those who had either a Māori mother or Māori father. Additionally we asked participant’s their age ( $M =$

44.8,  $SD = 12.5$ , ranging 18-69 years), and derived a New Zealand Deprivation score based on the participant's location, detailed below.

We measured levels of deprivation of participants' immediate neighborhood using the New Zealand Deprivation Index (Atkinson, Salmond, & Crampton, 2014). New Zealand is unusual in having rich census information about each area unit/neighborhood of the country available for research purposes. The 2014 New Zealand Deprivation Index (Atkinson et al., 2014) uses aggregate census information about the residents of each meshblock to assign a decile-rank index from 1 (most affluent) to 10 (most impoverished) to each meshblock unit. The current sample had an above average deprivation score ( $M = 6.68$ ,  $SD = 2.77$ ).

We also included one health related variable, the Kessler 6 measure of Psychological Distress (Kessler, Andrews, Colpe, Hiripi, Mroczek, Normand, Walters, & Zaslavsky, 2002). This measure is considered appropriate for use in the New Zealand context (Krynen, Osborne, Duck, Houkamau, & Sibley, 2013). The Kessler-6 measures self-reports of non-specific psychological distress. We asked participants to respond to the item stem 'during the last 30 days, how often did you feel...' and then rate six items (e.g. 'nervous' 'hopeless') on a scale from 0 (none of the time) to 4 (all of the time). Low ratings are equivocal to lower levels of psychological distress, our sample exhibited generally low levels ( $M = .91$ ,  $SD = .80$ ).

### ***Overview of analyses***

Our model was tested using logistic regression analyses to predict smoking status answering the question "Do you smoke?" (1 = yes, 0 = no). We adopted a p-value of  $<.01$  for statistical significance.

At step 1 of the analysis, our Identity model, we included the seven MMM-ICE2 subscale scores as predictors of smoking status. This allowed us to assess the associations between these seven broad indicators of Māori identity and culture and smoking.

At step 2, our Discrimination model, we included Perceived Discrimination as the predictor of smoking status. Additional to this we included the MMM-ICE2 again as well as a wide range of demographic, health and family related covariates which might be related to smoking status among Māori. The inclusion of these covariates was informed by previous smoking research.

## Results

The results of our logistic regression model are presented in Table 4. As reported, at step one of our Identity Model we predicted no significant relationship between smoking status and all seven factors of the MMM-ICE2. Contrary to our prediction one measure, Perceived Appearance, played a significant role in uniquely predicting smoking status among Māori. The association between Perceived Appearance and increased likelihood of smoking was the only significant factor from the MMM-ICE2 associated with smoking status ( $b = .181, se = .056, z = 3.224, p = .001$ ). The Odds Ratio of 1.198 in our initial Identity Model suggest that for every one unit increase in the Perceived Appearance subscale (ranked from 1-7) Māori were 1.2 times more likely to smoke. On the other hand, these initial results suggest for every one unit decrease in Perceived Appearance Māori were .83 times less likely to smoke.

At step two of our analyses we tested our Discrimination Model adjusting for a complete set of demographic, health, family-related factors. The complete MMM-ICE2 remained in this model to test for any differences. Contrary to our hypothesis, Perceived Discrimination did not predict smoking status among Māori ( $b = .011, se = .062, z = .182, p$

=.856). Thus, a discrimination effect could not be supported. However, even when adjusting for our full range of covariates the Perceived Appearance effect remained significantly predictive of Māori smoking status ( $b = 0.222$ ,  $se = .071$ ,  $z = 3.110$ ,  $p = .002$ ). The Odds Ratio of 1.25 in our full logistic regression model indicates that for each one unit increase in the Perceived Appearance subscale Māori were 1.25 times more likely to smoke and for every one unit decrease in Perceived Appearance Māori were .80 times less likely to smoke.

As anticipated, increased likelihood of smoking was highlighted through other important demographic and health-related covariates. Living in a more deprived area was associated with increased likelihood of smoking ( $b = .151$ ,  $se = .046$ ,  $z = 3.306$ ,  $p = .001$ ). Differences in mean levels of deprivation for Māori who smoked ( $M = 7.76$ ) versus Māori who do not smoke ( $M = 6.22$ ) illustrate that Māori generally live in areas which rank high in levels of deprivation (measured on a scale of 1-10) and those in especially deprived areas are more likely to smoke. Experiencing higher levels of psychological distress was also associated with increased likelihood of smoking ( $b = .284$ ,  $se = .131$ ,  $z = 2.167$ ,  $p = .030$ ). Again, differences in mean scores of psychological distress (measured on a scale of 0-4) show marked differences between Māori who smoke ( $M = 1.14$ ) and Māori who do not smoke ( $M = .82$ ).

Contrary to some Māori health literature, which has emphasised intergenerational transmission of smoking in the past, having a Māori father, a Māori mother, or Māori parents (the interaction term) was not significantly related to Māori smoking status.

Factors associated with decreased likelihood of smoking were consistent with previous research. Older Māori were less likely to smoke ( $b = -.020$ ,  $se = .010$ ,  $z = -2.137$ ,  $p = .033$ ) and Māori who had partners ( $b = -.835$ ,  $se = .216$ ,  $z = -3.859$ ,  $p < .001$ ) were also less likely to smoke. Being employed was associated with a decreased likelihood of smoking ( $b =$

.436,  $se = .219$ ,  $z = -1.987$ ,  $p = .047$ ). Consequentially, being unemployed was associated with increased likelihood of smoking, highlighted by differences of mean scores of unemployment for Māori who smoke ( $M = 47.5\%$ ) versus Māori who do not smoke ( $M = 28.2\%$ ). However, these results did not account for the significant effect of Perceived Appearance predicting Māori Smoking Status.

## Discussion

Research analysing the effects of ethnic identity and discrimination on smoking behaviour has offered varied explanations as to why different people smoke. Our study analysed how Māori identity and experiences with discrimination may account for Māori smoking status. We discuss how our analysis has revealed some unexpected findings.

In this study, we initially explored the relationship between Māori identity and culture with smoking status with our Identity Model. Following Muriwai and Glover's (2016) kaupapa 'Smoking, Not Our Tikanga' we predicted no associations between Māori identity and culture with smoking status. Our first hypothesis was mostly accurate; we showed that six of the seven factors in the MMM-ICE2 were unrelated to smoking status. However, one measure, Perceived Appearance, did significantly predict Māori smoking status. This measure of Māori identity and culture is the only measure which depends on external valuations of how one is perceived as 'being Māori'.

At our second step of analyses we tested our Discrimination model which expanded on the Identity model by including Perceived Discrimination and a number of demographic, health and family related covariates. Despite a broad literature supporting the idea that discrimination and smoking are related, our second hypothesis was not supported—perceived discrimination was not significantly associated with smoking. However, the unexpected effect of Perceived Appearance predicting smoking status remained significant—even when

statistically adjusting for various other demographic predictors associated with Māori smoking (e.g. levels of deprivation, Barnett et al., 2005).

Our results contradict previous speculation about a possible link between Māori identity and smoking. Challenging the work of Mitchell (1983) we find specific evidence in our measure of Cultural Efficacy and Active Identity Engagement which refutes the conclusion that ‘higher cultural identity as Māori’ is causal of smoking. Our measures relating to group membership and belonging also repudiate previous speculation. We found that Group Membership Evaluation and Interdependent Self Concept, specifically, did not significantly predict smoking status—unlike what authors like Olson (1993) had alleged. We also found evidence that Māori Spirituality, Socio-Political Consciousness and Authenticity Beliefs were not related to smoking.

It is important to reflect on how one’s prototypicality or ‘Perceived Appearance’ as Māori can be linked to smoking. Unlike other subjective assessments of one’s Māori identity, Perceived Appearance is about how Māori are seen by other people. Similarly, Perceived Discrimination reflects on how others treat people based on their ethnicity. Research has shown that being perceived as more prototypically Māori is related to increased exposure to discrimination and systemic racism (Houkamau & Sibley, 2015<sub>b</sub>). Paradoxically, our study found no link between discrimination and smoking. This may be because reporting experiences of discrimination may be more complicated than assessing one’s prototypicality as Māori. It is possible, for example, that the increased rate of smoking in Māori may be maintained by clustering within social networks. The link between Perceived Appearance and the increased likelihood of smoking behaviour may be tapping into this underlying effect, to the extent that people who look more prototypically Māori may be more likely to be embedded in social networks of other Māori on average.



### *Limitations and Directions for Future Research*

Smoking is a dynamic behaviour which cannot be fully represented by one time point. To fully encapsulate the smoking process one would have to access information about when, why, or how Māori start, maintain and, in some cases, attempt to quit smoking. To understand such patterns of smoking behaviour one would have to design a study which follows participants from childhood, which was not a possibility within our sample. Our study focuses only on a snapshot of data which illustrate an effect which, to our knowledge, has not been explored in research in this field. Future research should investigate longitudinal patterns of Māori smoking whilst assessing the systemic conditions (i.e. racism) which appear to play a role in why it is that Māori smoke.

Discrimination is a social determinant of smoking which needs further detailed investigation (Blakely, Fawcett, Hunt, & Wilson, 2006). In our study our measure of ethnic discrimination may have been one of many alternative forms of discrimination which could have explained why Perceived Appearance emerged as the significant predictor of Māori smoking status. It is clear from our findings that external evaluations of looking visibly Māori predict smoking status. Though our measure of discrimination did not pin point how or why Perceived Appearance had this effect, further detailed analysis is required. There is evidence that discrimination towards Māori manifests in different forms. McCreanor and Nairn (2002) recognised biases from Doctors which conceptualise Māori at a deficit result in less effective healthcare. Recent research by Cormack, Harris and Stanley (2013) suggests that social ascription as Māori (versus 'passing' as non-Māori) influences how Māori negotiate health care and importantly, why many Māori have negative experiences with health service provision. There is more work to be done here in order to support Māori working towards smoking cessation.

Reflecting on the opening quote, priority research on smoking and racism is needed to avoid the colonisation of Māori future potential. External perceptions of Māori can be understood and decolonised when the systemic forces of racism in New Zealand are recognised. If simply 'looking Māori' to others is predictive of smoking then factors associated with stereotyping (based on appearance) could plausibly be related to how and why Māori smoke. Crucially, our study has confirmed that one's subjective and internal evaluations of Māori identity and culture are unrelated to whether or not Māori smoke. Future research needs to critically analyse the external factors and contexts which maintain Māori smoking prevalence.

### ***Concluding Statement***

This study explored associations between Māori identity and culture and experiences with discrimination on smoking status. To our surprise, we found that simply looking prototypically Māori was significantly predictive of whether or not one smoked. We found no support that experiences of discrimination played a role in this. Our unexpected results signalled that smoking is a dynamic process influenced by the interweaving of internal and external forces. Indeed, we think an analysis of systemic forces such as racism, is necessary in research moving forward. Importantly, we upheld the idea that 'being Māori' is distinct from smoking – supported by the kaupapa 'Smoking, Not Our Tikanga.' For Māori, smoking is *not* linked to cultural or social identity, as some have previously suggested. Though the situation is complicated, our findings emphasise that we must look beyond the typical narratives surrounding Māori who smoke. This alternative narrative offers new insight and direction for future research. Through further investigation of the broader context, it is possible to decolonise Māori future potential.

## **CHAPTER FIVE**

This chapter includes a general discussion of my papers as well as some of the limitations of my research and directions for future research. I finish with some reflexive thoughts and my conclusion of the research. This chapter concludes my Masters Thesis.

### **General Summary of the Discussion**

“Distortion of Māori social reality... has entrapped Māori people within a cultural definition which does not connect with either our oral traditions or our lived reality”.

–Linda Tuhiwai Smith (1999, p.170).

The aim of this thesis was to explore speculated links between Māori identity and smoking in Aotearoa. Through utilising a Kaupapa Māori positioning this thesis was explicitly purposeful in decolonising smoking research and abandoning some of the stigmas previously used to victim blame Māori for their smoking behaviour. Focusing on aspects of Māori identity I present two analyses which support the common theme separating aspects of ‘being Māori’ from the colonial imposition of tobacco on Māori peoples. Delving through this research I was able to form the novel kaupapa ‘Smoking, Not Our Tikanga’. This kaupapa was supported in both of my studies with evidence of alternative narratives surrounding Māori people who smoke.

My first study unveiled a media norm whereby ‘being Māori’ is often implied as causal of being someone who smokes. This study illuminated the paradox of implying this association. As mentioned in the study, if being Māori is causal of smoking then smoking cessation is implausible because ‘being Māori’ is not something that one can change. We called this kind of narrative a deficit-style representation. Juxtaposing this, there were instances of what we referred to as ‘strengths-based representation.’ Through this analysis we also found evidence for the occasional reference to the colonial determinants of Māori smoking. Presence of this kind of kōrero came under the themes ‘Historical Recognition’ and ‘Cultural Dissociation’. The latter theme explicitly supported the ‘Smoking, Not Our Tikanga’ kaupapa.

Unexpected findings from my second quantitative study presented an imminent need to focus on how being visibly perceived as Māori (Perceived Appearance) is linked to how Māori negotiate the struggles of a colonised reality. Smoking is a detrimental behaviour and is well-established as a contributor to several health inequities. Through focusing solely on Māori I was able to forego a disparity or deficit narrative by definitively dissociating aspects of Māori culture (Cultural Efficacy, Spirituality), Māori belongingness (Group Membership, Interdependent Self Concept) and internal iterations of being Māori (Authenticity Beliefs, Socio-Political Consciousness) from smoking behaviour. Results from this study revealed how feeling that you are being perceived as ‘more prototypically Māori’ was associated with increased likelihood of smoking – independent of any other previously recognised predictors (e.g. perceived discrimination, deprivation, employment).

Novel in its design, my thesis set out ambitiously to unify qualitative and quantitative methods in an exploration of what it means to be Māori and to smoke. Though both studies took very different approaches to analysing separate samples of Māori and Māori content, they come together to meet the aims of this research. The mixed methodological nature of this research has illustrated a decolonising narrative, using different tools to form one story. It is important to acknowledge that with each study some limitations did emerge. Importantly, the thesis, as a whole, presents some theoretical and practical implications which I elaborate on below.

### **Theoretical Implications**

Mixed methodology research is gaining prominence and is especially useful for Māori-centred research. My studies provide two unique analyses of Māori smoking behaviour from the same epistemological positioning. I discuss the theoretical implications of conducting this research.

### *Kaupapa Māori Research*

Māori centred research offers researchers an opportunity to validate and honour the realities of diverse Māori people. Though I did not interact directly with Māori participants in this research, careful consideration towards respectfully representing Māori was crucial to my analyses. Representation matters. Moewaka Barnes and colleagues summarise this point; “Internalising hegemonic constructions of Māori as inherently bad... ultimately limits the potential of Māori as it sets a pre- determined pathway for expectations and behaviours” (Moewaka Barnes, Taiapa, Borell & McCreanor, 2013, p.74). Clearly, there are harms associated with perpetuating colonial and deficit representations of Māori. This is something which I reflected on seriously in deconstructing what I refer to as ‘misrepresentations’ of Māori who smoke. Recognising and reproducing authentic (I hesitate to use the word ‘empowering’), Māori narratives is an important part of conducting decolonising Kaupapa Māori research. For the most part, the health research lens has provided a fatalistic focus on Māori who smoke. Through focusing on Māori, and specifically Māori identity, I add alternative narratives of Māori who smoke towards the smoke free kōrero. As my research crosses disciplinary boundaries, this alternative narrative has the potential to communicate to several Māori and non-Māori audiences that Māori smoking behaviour is not determined or maintained by core aspects of Māori identity and culture.

This research is intersectional and involved the collaboration of different Māori and non-Māori researchers, different University institutions and different Smoke Free Organisations. It is important to acknowledge that although this thesis is ultimately a representation of my analysis and perspective, I have integrated the best tools and advice I have access to as a Kaupapa Māori researcher. Absorbing a variety of knowledge sources, tools and perspectives has enabled me to conduct my studies with consideration for what

Houkamau and Sibley (in press) refer to as ‘interrelated and overarching goals’. This research adds to a decolonising agenda by offer an alternative viewpoint to those expressed and speculated in research and reality surrounding Māori who smoke. Tuhiwai Smith (1999) warns of the potential indigenous researchers encounter in conducting ‘crisis research’ to ‘solve Māori problems’ (Tuhiwai Smith, 1999, p.174). This is certainly not the intention here. Instead of providing answers for the Māori smoking ‘epidemic’, I present a kaupapa and challenge with ‘Smoking, Not Our Tikanga’ for research moving forward.

### *The Paradox of Perceived Appearance*

Realities can be determined by physical appearance. Since its early days, psychology has reported the classic effects of stereotyping across age, race, gender and so forth. For Māori, issues of racial profiling from Police, discrimination in schools and Universities and unequal treatment from health professionals are recognised iterations of racism and discrimination towards Māori. Research in this area has been rich in insight, mostly (but not exclusively) from focused qualitative study. The Multi-Dimensional Model of Māori Identity and Cultural Engagement (Houkamau & Sibley, 2015<sub>a</sub>) has provided researchers with an empirical tool to analyse diverse Māori outcomes and experiences at a national level.

My second paper is also the second paper from the MMM-ICE2 to link Perceived Appearance with an important (and yet, detrimental) life outcome that Māori experience. Houkamau and Sibley’s (2015) paper on Perceived Appearance predicting Home Ownership revealed that those who were perceived by others as more visibly Māori were less likely to own a home. Decreased likelihood of home ownership, based on one’s appearance as Māori lead the authors to conclude that there is institutional racism against Māori in New Zealand’s home lending industry. Unlike their outcome, my study focuses on a behaviour which is characteristically different from home ownership. Smoking is a health behaviour which has

been identified as a means of habit, coping and for some, survival. As illustrated throughout this thesis, different people smoke for different reasons. Individualising the smoker risks blaming them for the culmination of experiences which may have contributed to why they smoke. Māori smoke at a prolific rate compared to other ethnic groups in New Zealand. So why is it that being perceived as more visibly Māori is linked with increased likelihood of smoking?

It may appear that discrimination is the obvious contributor when outcomes are determined by the way that someone looks. And yet, our measure of Perceived Discrimination was not a significant predictor of Māori smoking in our sample. It is possible that manifestations of discrimination are experienced and interpreted in different ways among diverse people. In our sample, those who were perceived as more prototypically Māori shared the same increased likelihood of smoking even when accounting for other crucial demographic, family and health variables. Intuition would link Māori prototypicality with increased risk of exposure to discrimination in its many forms – including racism. Using our measure of Perceived (ethnic) Discrimination this was not found. This may be because experiences with discrimination are hard to quantitatively measure and capture. Discrimination is not always blatant, direct or antagonising and it is important to know this when attempting to measure its effect on marginalised peoples.

Social psychology can provide further points for speculation on what I call the ‘Perceived Appearance Paradox’. As discussed in my second paper, it is plausible that those who are perceived as more prototypically Māori may be more likely to cluster and interact with Māori like themselves. This should extend beyond whānau as we did not show evidence for parental influence on Māori smoking. The Rejection Identification Model suggests that people who experience rejection based on their ethnicity will identify more strongly and thus



cluster more for group solidarity (Giamo, Schmitt, & Outten, 2012). It makes sense to conceive of smoking as a response to rejection, discrimination, stigma and a plethora of colonial determinants and thus, investigating the effect of one's social network may be necessary in future research.

### **Practical Implications**

It was important to generate meaningful kōrero which contributes to Māori smoking cessation through this research. As tobacco smoking is a priority health issue in Aotearoa, I took serious consideration of how a social psychological analysis of identity and culture could impact on the realities of Māori who smoke. Forming the kaupapa 'Smoking, Not Our Tikanga' was an important aspect which I hope will translate into future support and initiatives for Māori attempting to quit smoking. I discuss the practical implications of this research.

### ***Māori Smoking Cessation***

A central aim of the research was to help accelerate smoking cessation and reduce tobacco harms, which I have attempted in the formation of this thesis. So far, initiatives to assist Māori to be auahi kore have received minimal Governmental support (Ball et al., 2016), however, they continue to support Māori smoking cessation and quit smoking attempts. Though auahi kore is the goal, reducing the harms of tobacco smoking and supporting Māori with any efforts leading towards this goal is imperative. Māori services created for and supported by Māori are increasingly effective. It is my ambition with the addition of 'Smoking, Not Our Tikanga' kaupapa that a Māori-centred focus can continue to be upheld in smoking cessation services and research.

The 'Smoking Not Our Tikanga' kaupapa has potential for future cessation initiatives. After forming this concept I sought permission to use it from both the Health Promotion

Agency New Zealand and Te Ara Hā Ora. Each of these groups had variations of this kaupapa through auahai kore public service branding (Smoking, Not Our Future) and a one-off workshop called 'Tobacco, Not Our Tikanga'. After initial consultation I received feedback on the willingness of these groups to hear about my research and potentially implement my findings into their mahi. This is an achievement I did not anticipate and look forward to fulfilling. Getting greater exposure for 'Smoking, Not Our Tikanga' is also beneficial to Tobacco Research Control Tūranga, who funded this thesis. Tūranga recognise themselves as 'a national programme of research to inform rapid smoking prevalence reduction'. This research plays a role in honouring the need for acceleration towards smoking cessation.

This research has reconceptualised the colonial roots of tobacco smoking in Aoteroa. By placing a priority focus on Māori I highlight the fact that Māori were an auahi people (and had an auahi kore culture) before the imposition of tobacco used in the early exchanges between Māori and Pākehā. It appears this fact has been lost in the dominance of colonial discourse over the decades. Drawing attention to this fact simply affirms that smoking is not a 'Māori thing' and is not associated with aspects of Māori identity and culture. Furthermore, tobacco has the colonial connotation of being a means of trade with no regulations imposed on such trade. No information about the harms of tobacco was translated in exchange, which is reflected in why Māori of all ages and genders smoked at high rates. For Māori, it is plausible to conclude that tobacco consumption was used without the knowledge Pākehā had about regulated use. This parallels the miscommunications of Te Tiriti o Waitangi and in this thesis I further my support for the acknowledgement of the Wai 844 claim. In terms of smoking cessation this means initiatives and recommendations should keep in mind that Māori are negotiating colonised realities and colonisation has very real run-on effects in health behaviours like smoking.

### *Limitations and Directions for Future Research*

Emergent research will certainly have some limitations which I hope I can address to further Māori smoking research and Māori research more broadly. Firstly I address my qualitative study. Aspects of media analysis using psychological tools certainly require access to resources and mātauranga which capture each detail of public discourse. As a student researcher access to a media-clipping service was not viable, reducing my sampling procedure to a smaller, refined dataset. This however, came as a benefit for the rich qualitative analysis conducted as I was able to focus more time and attention to the details of coding and deciphering different forms of discourse. As researchers such as Moewaka Barnes and Rankine have exhibited, it is possible to conduct detailed longitudinal media analysis when access to appropriate (and expensive) tools is readily available alongside support from a large interdisciplinary research team.

Further tools are needed for dealing with open-access online data. For my study, the online nature of data collection meant that search engines used (Google and Google News) may have presented some inaccuracies as they prioritised media articles based on popularity – meaning some articles may have been missed. This highlights that the purpose of data collection must be clarified. The purpose of my data was to analyse the common representations of Māori who smoke, meaning a selection of data based on popularity was appropriate however, this is certainly a consideration which should be given some attention for future researchers. As well as this, online media sources are relatively recent sources of information considered for analysis. In some cases, online media is not considered appropriate for that which is traditionally academic. The discourse provided by online sources cannot be underestimated so further attention needs to focus on representations of Māori from internet sources is necessary. With the fluctuating and infinite presence of the internet, I imagine undertaking research on such content is no easy task.

In terms of my quantitative study I am limited by lack of a longitudinal sample. This has implications over a number of domains. Data used in my second study only represents what I refer to as a 'snapshot' of Māori responses in a specific time. I cannot infer conclusions beyond this frame of time, though I do offer some kōrero which appeals to the bigger picture. As I have stated throughout this thesis, smoking is a dynamic process which involves stages of commencement, maintenance and, for some, cessation. Our study contains no details on these processes. There are intentions in place to repeat a Māori sample of the NZAVS in the coming years where testing for smoking status will occur. However, through this research it has become apparent that we may also need to extend our measures to encapsulate more dimensions of smoking – especially within the context of Smokefree 2025. Research on smoking is valuable and so I propose some future measures for inclusion in future NZAVS questionnaires.

As reviewed throughout this thesis international and national smoking research has tested for a variety of smoking-related variables. Necessary predictors such as levels of deprivation, age, gender (et cetera.) will continue to be an important facet of smoking research. In line with my findings I suggest the integration of questions which address discriminatory or adverse experiences and how these impact on health. Because smoking is prolific among Māori, questions which provide more detail on the social context of smoking may be useful. Though we have disproved a link between having Māori parents and being a Māori who smokes, there may be links which could be iterated in statements such as 'A lot of people around me smoke', 'at home more people around me smoke', 'at work more people around me smoke', 'at the marae people around me do not smoke' et cetera. In proposing these statements I realise that considered prioritisation goes into the formation of a survey which measures multiple social and health outcomes, as the NZAVS does. I suggest thus, that greater detail in Māori smoking research may be more appropriately addressed through

focused qualitative and quantitative study. It is my hope that mixed methodology approaches will provide thorough and balanced future research by continuing to address ways to reduce tobacco harms for Māori.

Future research should also address variations in forms of tobacco smoking. Evidence suggests a relationship between second hand smoking and ill health outcomes for Māori. This makes sense for further research investigating how the ways that Māori interact with one another may influence whether or not they smoke. Interest in innovative cessation technologies (such as the E-cigarette) should continue in Māori smoking research as it is important to continue to support efforts which seek to reduce the harms of tobacco on our diverse Māori population.

### ***Reflexive Thoughts***

Initially some degree of intuition, experience and observation sparked my interest in this area. As a Māori immersed in smoking environments at different points in my life, I recognised that victim-blaming and deficit representations of Māori who smoke were transmitted as common place. It is a lot easier to blame the individual than understand the culmination of experiences which colonise their potential. Having, at some point, internalised the norm that smoking was at least ‘normal’ for me as a Māori I can now recognise that internalising this very idea may be contributing towards Māori smoking prevalence. So how do I fit within my own research?

In the first instance, I am someone who recognises the colonial connotations which pepper the everyday kōrero of New Zealanders. I commonly heard excuses within my own circles which took an ‘everybody else does it’ approach towards maintaining a tobacco addiction. In addition to this was the kōrero bringing smoking into question when victim-

blaming Māori who live in particularly difficult circumstances; ‘but they can afford their smokes’. Being an urban Māori in Tamaki Makaurau, I could only understand Māori smoking through my own experiences prior to this research. It has been important to recognise that cultural stereotypes are unfair and in fact, untrue when it comes to Māori smoking.

As a Māori woman I also reflect on the future of Perceived Appearance research. It is concerning that simply looking more Māori can have a detrimental effect on one’s behaviour and outcomes. At the same time, it is understandable and I think there is a lot more to this story. Perceived Appearance measures how one thinks others perceive them as visibly Māori. As someone who self-reports low on this scale, I wonder how my appearance may have affected my ability to quit and maintain smoking cessation. Though there is obviously a relationship between Māori prototypicality and smoking, it is important to acknowledge there are people who are not seen as visibly Māori and still experience adversity across a number of domains. For this reason, I don’t want this research to be deductive or invalidating of people who fall inside and outside of the Perceived Appearance measure.

Coming into my sixth year immersed in a research environment I feel privileged to have conducted this decolonising research. This thesis certainly has some ties to my previous studies. In 2014 I undertook a study using the MMM-ICE2 which revealed that the measure of Māori Cultural Efficacy and Active Identity Engagement was positively associated with psychological resilience (Muriwai, Houkamau & Sibley, 2015). In this instance, being immersed in Māori culture proved as a protective factor which could maintain positive Māori mental health. In other words, Māori culture was linked to a positive health outcome. In this study I analysed the speculated link between Māori identity and culture with the negative health outcome of smoking. Disproving this link adds to a growing literature which suggests that Māori culture can facilitate positive Māori futures for our diverse peoples.

Identity research is important for Māori, especially in deconstructing deficit stereotypes which carve upon the mana of our people. Māori are a diverse and heterogeneous people. Evidence shows that Māori choose to identify in a number of ways, from detailed whakapapa through hapū and iwi identification to non-identification as Māori (listing Māori ancestry but not Māori ethnicity). As someone of multiracial origins I think it is important to acknowledge the unique and diverse experiences of self-identifying Māori. For many of us, access to our culture is limited and there are several obstacles imposed on our lives as a colonised people. For some, even stating Māori ethnicity can be the first step towards a decolonised reality. It is important to consider this. Though Māori identity intersects with so many other identities and ways of negotiating the world, it is the one constant which brings us together as a resilient indigenous people. Breaking the speculated link between Māori identity and negative outcomes is necessary for a decolonising future.

### **Concluding Statement**

I ora te tuatara ka patu ki waho”

*“A problem is solved by continuing to find solutions*

I conclude by reflecting on a whakataukī I introduced at the beginning of the thesis. Decades of work has offered several different solutions to the Māori smoking epidemic, yet progress with the lowering of smoking prevalence is slow. This thesis offers an alternative narrative focusing on external factors which might contribute to Māori smoking. Whether it is being misrepresented in national media or being perceived as more prototypically Māori, smoking is linked to Māori not by Maori identity and culture but by other people’s perceptions of it. I offer an alternative, decolonising narrative through this research. It is by no means ‘the’ solution, but it is ‘a’ solution which may support the de-stigmatisation and victim-blaming deficit discourse which has entrapped Māori since colonial contact.

Through this research I can affirmatively say that smoking is not linked with one's subjective sense of Māori identity and culture. My studies provide two distinct analyses of Māori smoking behaviour from the same epistemological positioning. Perceived Appearance unexpectedly played a significant role in explaining variance in Māori smoking status. I think this is a symptom of systemic racism manifested in the lives of Māori today. It is important to ensure Māori realities are honoured by Māori who share them. An auahi kore future is possible for Māori. This thesis supports the idea that smoking should be considered in the broader context in order to assess how external factors effect Māori, rather than placing the blame on us. With evidence from qualitative and quantitative exploration, I can confidently conclude that for Māori smoking, is not our tikanga.



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## Appendix

*Table 1: Coding Schedule Māori and Smoking across national media*

CODING SCHEDULE	
Statistical Frequency	The presence and frequency of statistical information used throughout articles.
Neutral Statistics	The presence of statistics presented in a neutral way, often including cross-racial statistics.
Māori Responsibility	The presence of a focus on Māori responsibility presented in a positive or neutral way.
Māori Strengths	The presence of a focus on Māori strengths, cultural resilience or similar presented in a positive or neutral way.
Deficit Statistics	The presence of negative Māori statistics presented in a negative or deficit way.
Māori Victim Blaming	The presence of a focus on victim-blaming Māori presented in a negative way.
Māori Cultural Shaming	The presence of a focus on Māori culture as negatively associated with Māori smoking.
Historical Recognition	The presence of a focus on historical recognition presented in a neutral way.
Cultural Dissociation	The presence of a focus on disassociating Māori culture from smoking presented in a positive or neutral way.

*Table 2: Construct definitions for the seven factors indexed by the MMM-ICE2*

MMM-ICE2 Factor Name	Definitions, adapted from Houkamau & Sibley (2014, 2015)
<b>Group Membership Evaluation (GME):</b>	The extent to which the individual positively evaluates their membership in the social category Māori and views their membership as Māori as a personally important or central aspect of their self-concept versus the extent to which the individual negatively evaluates their membership in the social category Māori and views their membership as Māori as peripheral or irrelevant to their self-concept.
<b>Cultural Efficacy and Active Identity Engagement (CEAIE):</b>	The extent to which the individual perceives that they have the personal resources required (i.e., the personal efficacy) to engage appropriately with other Māori in Māori social and cultural contexts versus the extent to which the individual perceives that they lack the personal resources and ability to engage appropriately with other Māori in Māori social and cultural contexts.
<b>Interdependent Self-Concept (ISC):</b>	The extent to which the concept of the self-as-Māori is defined by virtue of relationships with other Māori people versus the extent to which the concept of the self-as-Māori is viewed as being defined as solely unique and independent to the individual rather than as part of the social group.
<b>Spirituality (S):</b>	The extent to which the individual is engaged with, and has a belief in, certain Māori concepts of spirituality, including a strong connection with ancestors, Māori traditions, the sensation and experience of waahi tapu (sacred places), and a strong spiritual attachment and feeling of connectedness with the land versus the extent to which the individual is disengaged from or does not believe in Māori concepts of spirituality.
<b>Socio-Political Consciousness (SPC):</b>	The extent to which the individual perceives historical factors as being of continued importance for understanding contemporary intergroup relations between Māori and other ethnic groups in New Zealand; and how actively engaged the individual is in promoting and defending Māori rights given the context of the Treaty of Waitangi versus the extent to which the individual perceives historical factors and injustices experienced by Māori as being irrelevant in contemporary society.
<b>Authenticity Beliefs (AB):</b>	The extent to which the individual believes that to be a ‘real’ or ‘authentic’ member of the social category Māori one must display specific (stereotypical) features, knowledge and behaviour versus the extent to which the individual believes that Māori identity is fluid rather than fixed, and produced through lived experience.
<b>Perceived Appearance (PA):</b>	The extent to which people subjectively evaluate their appearance as having clear and visible features that signalling their ethnicity and ancestry as Māori (or high Māori prototypicality) versus the extent to which people evaluate their appearance as less indicative of having Māori ancestry (low Māori prototypicality).

Table 3. Descriptive Statistics of Māori who smoke versus Māori who don't smoke

	Māori who Smoke %	<i>N</i>	Māori who Don't Smoke %	<i>N</i>
Female	72.5%	116	60.7%	239
Male	27.5%	44	39.3%	155
Religious	51.2%	82	43.9%	173
Non-Religious	48.8%	78	56.1%	221
Parent	83.8%	134	87.8%	346
Non Parent	16.3%	26	12.2%	48
Partner	39.4%	63	66.2%	261
No Partner	60.6%	97	33.8%	133
Employed	52.5%	84	71.8%	283
Unemployed	47.5%	76	28.2%	111
Māori Mother	73.1%	117	70.6%	278
Māori Father	69.4%	111	62.7%	247
Māori Parent	46.9%	75	39.6%	156
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Age	43.08	12.26	45.41	12.65
NZ Deprivation Index	7.76	2.46	6.22	2.76
Psychological Distress	1.14	0.95	.82	.71
Perceived Discrimination	3.07	1.83	2.82	1.72
Group Membership Evaluation	5.79	1.07	5.70	1.11
Cultural Efficacy	4.93	1.37	4.68	1.36
Spirituality	5.42	1.41	5.15	1.43
Interdependent Self-Concept	3.98	1.31	3.70	1.37
Socio-Political Consciousness	5.16	1.33	5.02	1.49
Authenticity Beliefs	3.69	1.07	3.54	.98
Perceived Appearance	4.75	1.72	4.13	1.82

Table 4: Logistic Regression of Identity Model and Full Model Predicting Smoking Status among Māori

<b>Identity Model</b>	<b>b</b>	<b>se</b>	<b>OR</b>	<b>z</b>	<b>p</b>
Group Membership Evaluation	-.120	.120	.887	-1.000	.317
Cultural Efficacy	.095	.094	1.100	1.017	.309
Spirituality	-.006	.090	.994	-.067	.947
Interdependent Self Concept	.094	.080	1.099	1.179	.238
Socio Political Consciousness	-.032	.082	.969	-.391	.696
Authenticity Beliefs	.103	.094	1.108	1.092	.275
Perceived Appearance	.181	.056	1.198	3.224*	.001
<b>Full Model</b>					
Perceived Discrimination	.011	.062	1.011	.182	.856
Group Membership Evaluation	-.095	.153	.909	-.621	.535
Cultural Efficacy	-.011	.115	.989	-.095	.924
Spirituality	.076	.111	1.079	.688	.491
Interdependent Self Concept	.051	.098	1.053	.528	.598
Socio-Political Consciousness	-.029	.103	.972	-.277	.782
Authenticity Beliefs	.064	.112	1.034	.299	.765
Perceived Appearance	.222	.071	1.248	3.110*	.002
Gender	-.317	.234	.729	-1.356	.175
Age	-.020	.010	.980	-2.137	.033
NZ Deprivation	.151	.046	1.163	3.306*	.001
Religious	.275	.219	1.316	1.255	.209
Parent	-.139	.327	.871	-.423	.672
Partner	-.835	.216	.434	-3.859*	<.001
Employed	-.436	.219	.647	-1.987**	.047
Psychological Distress	.284	.131	1.329	2.167**	.030
Mother Māori	-.167	.541	.846	-.309	.758
Father Māori	.133	.545	1.142	.244	.807
Māori Parents	-.232	.600	.793	-.387	.699

Notes. 0 = Do Not Smoke, 1 = Smoke. \* p <.01, \*\*p <.05, N = 557.