The Impacts of Colonization on the Inequities of Smoking During Pregnancy in Aotearoa

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Introduction

Smoking during pregnancy is one of the most common preventable causes of pregnancy complications (e.g. stillbirth, intrauterine growth restriction (Rodriguez-Thompson, 2018), and infant mortality (Centers for Disease Control and Prevention, 2016), and remains a significant health issue worldwide (Glover, Nosa, Watson, & Paynter, 2010). Children born to mothers who smoked during pregnancy are at increased risk of sudden infant death syndrome (Klonoff-Cohen et al., 1995), respiratory disorders (Braillon, Bewlet, & Dubois, 2010), obesity (Oken, Levitan, & Gillman, 2008) and poor neurodevelopment (Cornelius & Day, 2009). Moreover, smoking during pregnancy has been associated with adulthood obesity, metabolic disorders and cardiovascular disease (Humphrey, Rossen, Walker, & Bullen, 2016).

Despite a decline between 2008 and 2015 (Ministry of Health, 2017), the prevalence of smoking during pregnancy in Aotearoa (original name given to New Zealand by Māori, the indigenous people of Aotearoa) remain significant, with 11.7% of all women smoking during pregnancy. Unfortunately, inequities exist between Māori and non-Māori in the burden of smoking during pregnancy, with 31.8% of all women who identified as Māori smoking during pregnancy (Ministry of Health, 2018). To understand why these inequities exist, we must have a framework for considering the factors that influence health. One such model is the rainbow model, which hypothesizes that the determinants of health of the general population are organised into rainbow-like layers of influence, with the individual placed at the center (downstream determinants), and in the periphery are general socioeconomic, cultural and environmental conditions (upstream determinants) (Dahlgren & Whitehead, 1991). The colonization of Aotearoa by Pākehā (Europeans) in the late 1700s and subsequent events marked a significant transition in the socioeconomic, cultural and environmental condition experienced by Māori (Ministry of Culture and Heritage, 2016). Put aptly by Reid and Robson (2006): “it is impossible to understand Māori health status or intervene to improve it without understanding our colonial history” (Reid & Robson, 2006).

As such, the aim of this essay is to consider the impacts of colonization on the inequities of smoking during pregnancy that exist between Māori and non-Māori. The author acknowledges that the links between Māori health and colonization are extensive, and that it would be impossible to cover all points in-depth. However, the author wants to discuss three pertinent topics in as much detail as is practicable: 1) the introduction of tobacco with colonization and its initial impact; 2) the marginalization of Māori with colonization and its links to smoking in pregnancy; and 3) why smoking cessation interventions are not effective for Māori hapū mama (pregnant mothers).

The Introduction of Tobacco with Colonization

Tūpeka (a transliteration from tobacco) was first introduced to Māori when Pākehā arrived in Aotearoa in the late 1700s. By the early 1800s, it became a standard trade item for Pākehā, who used it to pay Māori (including children) for services and resources. Moreover, when tūpeka plants became available, they were planted by Māori in the community gardens (Cook, 2013). Eventually, smoking became prevalent amongst Māori, and its use amongst Māori was not restricted by sex or age as it was with Pākehā. In the 19th century, where it was unacceptable for Pākehā wāhine (women) to smoke, Māori wāhine were often photographed or painted with smoking pipes. Māori children also smoked, but its prevalence was not known (Cook, 2013). By the mid-20th century, tūpeka and smoking had become embedded in Māori communities (Cook, 2013).
Although speculative, one interpretation of the ‘societal norms’ administered by Pākehā is the belief of their own superiority: that Pākehā wāhine are too good for ūpēka but Māori wāhine are not. It has been noted that colonization is based on dehumanizing indigenous peoples, which is dependent on the colonizers holding the belief that they are superior (Reid & Robson, 2006). The standards for smoking in wāhine set by colonizers established a difference in smoking prevalence between Māori and Pākehā wāhine that is still present today, with important ramifications as mentioned above.

The colonial beliefs about wāhine smoking and the trends that occurred subsequent to introduction of ūpēka can be viewed as the event responsible for the inequities that exist between Māori and non-Māori hapū mama that we see today.

Colonization and the Marginalization of Māori

As referred to earlier, the colonization of Aotearoa brought about significant changes to the socioeconomic, cultural and environmental conditions that Māori had previously enjoyed. Upon their arrival, Pākehā established a multitude of new systems that outlined how the acquisition and (re)distribution of resources was to occur, and to whom these resources were allocated. These systems were constructed to benefit Pākehā and afford them privileges over Māori (Reid & Robson, 2006). From the 1840s, there was a steady and marked loss of Māori land, through confiscation, Crown purchase and the Native Land Court. The loss of land led to the displacement of a significant proportion of Māori, and “deprived of their land, tribes were in many instances reduced to poverty, with no option but to live in overcrowded and unhygienic conditions” (Pool, 2011). Equally important was the cultural poverty that Māori suffered. With colonization came the development of a new history centered around Pākehā, and with this, Māori beliefs and knowledge were “relabelled as myths, legends and superstition” (Reid & Robson, 2006).

The poverty suffered by Māori following colonization has had intergenerational impacts, with the effects of colonization still present today. Māori are more disadvantaged than non-Māori across a range of socioeconomic indicators, including unemployment, income and overcrowding in households (Ministry of Health, 2016b). This is important, as “tobacco and poverty have become linked in a vicious circle” (World Health Organization, 2018). The prioritization of spending on ūpēka with limited income means that whānau (families) living in poverty have less expendable income for other necessities such as food, education and healthcare. Additionally, smoking is more prevalent amongst deprived populations (World Health Organization, 2018). The intergenerational poverty resulting from colonization, along with the integration of smoking in Māori communities, has established intergenerational use of ūpēka. As one Māori wahinē (woman) stated:

“Well, the majority of Māori people are brought up around alcohol and drugs and cigarettes. Like you’re born into it. And then you’ve got Māori people who have nothing, like they live in poverty… Then that is your life. Like that becomes your life. And that is what you know, so you smoke” (Ministry of Health, 2016a).

Ultimately, the colonial systems designed to benefit Pākehā have exacerbated the inequities in smoking during pregnancy between Māori and non-Māori through marginalization and intergenerational poverty.

Why are the Current Interventions Not Working for Hapū Mama?

The presence of inequities between Māori and non-Māori with regards to smoking during pregnancy demonstrates that current interventions are insufficient, and that national interventions specifically designed for Māori are urgently required (Glover et al., 2013). It has been found that many Māori wahine were not aware of the interventions available to them, and the interventions that they had trialed had not been successful (Ministry of Health, 2016a). The development of regional interventions specifically targeted for Māori wahine has shown promise. In the Waikato region of Aotearoa, Te Punu Oranga (Māori health service providers) have based their Māori antenatal classes (Hapū Wānanga) on Te Whare Tapa Whā, a Māori health model that considers not only the physical aspect of health, but also the whānau, emotional and spiritual aspects (Pollock, 2011). Alongside these classes, smoking cessation services are provided. ‘Once and For All’ is an incentive-based smoking cessation intervention available in the Waikato and Tairāwhiti regions of Aotearoa. Hapū mama receive NZD $50 on signing up and a further NZD $250 if they remain smokefree for four weeks (Pinnacle Midlands Health Network, 2016). These interventions have been immensely successful: prior enrolment in the wānanga, 11% of hapū mama considered smoking cessation, which increased to 89% after enrolment. Unfortunately, the Māori-centric design of such interventions appears to be an exception rather than a rule.
Another reason current interventions are unsuccessful is that they fail to acknowledge the negative impact that environment has on smoking cessation efforts. Many Māori wāhine begin smoking because of their whānau. As smoking is so pervasive in many day-to-day situations for these wāhine, smoking cessation is made much more difficult. In order for smoking cessation interventions to be effective, they need to take a whānau-centric approach and reduce the prevalence of smoking in the home or workplace environments (Ministry of Health, 2016a).

Many Māori wāhine face other complex challenges on a day-to-day basis as a consequence of intergenerational poverty, and use smoking as a coping mechanism in lieu of other effective social support (Ministry of Health, 2016a). Consequently, smoking cessation may not necessarily be a priority for these wāhine, and “forcing smoking cessation to the fore without addressing the wider conditions and circumstances is likely to be counterproductive and alienating” (Ministry of Health, 2016a).

Until interventions target the upstream determinants impacting on the welfare of Māori hapū mama, and take a more holistic approach to smoking cessation, reduction in the inequities that currently exist is unlikely.

Conclusion

Smoking in pregnancy is associated with many consequences at all phases of life and development in not only the perinatal period, but also in child- and adulthood. Using the rainbow model, the inequities that exist between Māori and non-Māori regarding smoking in pregnancy can be traced back to the colonization of Aotearoa. The introduction of tūpeka, the marginalization of Māori, and the development of Eurocentric smoking cessation interventions has placed a much greater burden on Māori hapū mama. Until interventions are developed using a Māori worldview, these inequities will continue to affect future generations of Māori.

References


