Wāhine Māori nurses who smoke and their role in smoking cessation

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Abstract

Tobacco is known to be the major cause of preventable deaths in New Zealand and is established as the leading cause of heart disease, emphysema and different types of cancers. Tobacco products not only cause harm to those who smoke but also to non-smokers by exposing them to the harmful effects of toxins that are emitted from tobacco products once lit. Smoking is a major problem for Māori as it impacts health and economic status and cultural identity. Smoking rates for both Māori youth and adults are higher than their New Zealand European counterparts.

Smoking prevalence for Māori wāhine (women) remains high 41.8% and Māori nurses are in an ideal position to be positive non-smoking role models for other wāhine Māori. Smoking cessation programmes focusing on the individual, rather than the whole whānau (family) have been unsuccessful for Māori. Some researchers suggest there is a desperate need for more culturally appropriate cessation programmes to be developed as culturally appropriate and whānau centred smoking cessation programmes are more likely to support wāhine Māori to quit smoking.

This study examined the experiences Māori nurses have as smokers and how this impacts providing smoking cessation advice. Qualitative research methods were used to collect data using semi-structured interviews with six wāhine Māori nurses, who were from diverse nursing backgrounds, and one Māori student nurse. Both paired and single interviews with the wāhine Māori nurses were undertaken. Braun and Clarke's (2013) thematic analysis framework was used to analyse the findings and develop themes and subthemes. Five key themes were found: initiation, quit attempts, being a nurse, being a smoker and a nurse and putting my nursing hat on. Wāhine Māori nurses had an early initiation to their current smoking status. Being a smoker impacted them in their role as a nurse when providing smoking cessation advice to others.

My findings show nurses have a clear awareness of their identity as a nurse practitioner who is expected to role model healthy behaviours but the daily conflicts they have around this role, and as a smoker, continue to create difficulties. Similar research

carried out by Gifford et al., (2013) found nurses who smoked expressed great anxiety over role modelling healthy behaviour, and that their continued smoking behaviours sent out conflicting messages. The nurses in my research claim they feel like a fraud and question how are they able to preach smoking cessation when as a smoker they also find it difficult to quit. Heath et al's., (2004) findings lend support to this claim that nurses are in a difficult situation when encouraging patients to stop smoking especially when they cannot stop smoking themselves.

My findings also point to this personal versus professional tug of war Māori nurses experience that creates a conflict. This "tug of war" the nurses say places them in a difficult position as the expectation is that smoking cessation is part of their role. Gifford et al., (2013) found that Māori nurses saw themselves as crucial elements in preventing smoking uptake for Māori, however, they felt inadequate when promoting smoking prevention and providing cessation advice. The nurses in my research voiced they realise smoking intervention is part of their role but conflicting feelings as a smoker surface and increase the anxiety and hypocrisy they experience when confronted with promoting smoking cessation.

Acknowledgements

To my dad and my mum (who has passed on) thank you for being proud of me and believing in me all these years.

Lastly I want to dedicate this thesis to my grandmother and brother who both died, far too young, from cancers related to smoking.

Tē taea e te kupu noa ngā mihi o te ngakau te whakapuaki ake, nō reira kia penei noa, tena ra koutou katoa.

Words cannot fully express my gratitude to you all.

Māori/English Glossary

Ahau	me, I
Aroha	love, sympathise
Aroha ki te tangata	to show respect towards people
Auahi kore	smokefree
Aroha	love
Awhi	help
Awhinatanga	to assist or care for
Hapū	subtribe
Hauora	lifebreathe, health
Hinengaro	mind, intellect
Hui	meeting, gathering
Iwi	tribe
Kai	food
Kaiārahi	a guide
Kanohi ki te kanohi	face to face
Karakia	prayer or incantation
Kaumātua	elderly men
Kaupapa	theme, strategy
Kawa	protocol
Kaua e māhaki	to be humble
Kaua e takahia	do not trample upon
Kia tupato	to be careful, be aware
Kingitanga	kingship

Koe	you (singular)
Koha	gift
Kōrero	to speak, talk
Koutou	to you all
Kuia	elderly women
Mahana	warm
Mana	prestige, authority
Mana wāhine	the prestige of Māori women
Mana whenua	having power/rights over the land
Manaaki ki te tangata	to care for, show hospitality towards people
Māori	people of New Zealand
Māoritanga	Māori cultural values and beliefs
Marae	Māori gathering place
Mātauranga	wisdom
Mātauranga Māori	Māori ways of knowing
Mihi	greetings
Mirimiri	massage
Mokopuna	grandchildren
Noho marae	overnight stay at the marae
Nui	large, big
Pākehā	non Māori, European, Caucasian
Pono	truth, valid, principle
Rangatira	leader
Rangatira ki te hauora	noble leader in health
Reo	language
Rohe	district

Rohe o te iwi	district of a particular iwi
Rongoā	traditional medicine
Tainui	people of the Tainui waka
Tamariki	children
Tangata	people
Taonga	precious, treasure
Taonga tuku iho	precious, treasure that is passed down
Tapu	sacred
Tautoko	support
Te Ao Māori	Māori world view
Tika	authentic, realistic
Tikanga	protocols and practices
Tino rangatiratanga	sovereignty, self determination
Titiro, whakarongo, kōrero	look/watch, listen, then speak
Tūpuna	ancestors
Waiata	song
Waka	canoe
Wānanga	learning, place of learning
Wāhine	women
Whakapapa	genealogy
Whakapono	trust, honesty
Whakamā	embarrassed, shy, loss of mana
Whakataukī	proverb
Whānau	family
Whanau ora	extended family wellbeing
Whanaunga	relatives

Whakawhanaungatanga   kinship, relationship, to make connections

Whenua   land

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Chapter 1: Introduction

This thesis centres on the experiences of Māori nurses who smoke and their role in providing smoking cessation advice to others in their role as health professionals. Early smoking initiation, role of whānau (family) and friends, quit attempts and strategies used to remain smokefree are areas that impact not only on Māori nurses that smoke, but are linked to high smoking statistics for wāhine Māori (Māori women) (Gifford, 2011). Implications from the findings of this research could be useful in providing a clearer understanding of what the impact is of those Māori nurses who smoke on carrying out their role of providing cessation advice to others.

Wāhine Māori play an important role in establishing and maintaining positive health behaviours within their whānau (family), hapū (subtribe), iwi (tribe) and the communities that they live and work in. Fernandez and Wilson (2008) concluded that wāhine Māori non-smoking role models could have a positive influence on their whānau's health. Evidence from their research found that by remaining smokefree role models the wāhine maintained they were also ensuring their children would choose not to smoke in the future.

Data gathered from the interviews Fernandez & Wilson (2008) undertook with Māori women who smoked, gave an insight into the views of Māori women's experiences of smoking and the reasons for their continued smoking. The influence of whānau and the impact of smoking on whanau's health were cited by Fernandez and Wilson as a factor influencing wāhine Māori and smoking. Some wāhine Māori may use smoking as a coping mechanism to confront their issues, stress and tensions that they experience within their daily lives. A literature review on nurses and smoking by Rowe and MacLeod Clark (2000) concluded that nurses too were subjected to the same stressors as other women, and that they smoked for similar reasons.

Māori nurses continue to play an important role in improving positive health outcomes for Māori. Whānau and other wahine Māori look up to Māori nurses as they see them as role models and key and trusted health professionals. Interaction with whānau

and patients during their working day requires them to provide smoking cessation advice. Māori nurses, therefore, are strongly positioned to influence wider whānau and Māori communities' health, particuarly around smoking cessation (Gifford, Wilson, Boulton, Walker, & Shepherd-Sinclair, 2013).

The potential for Māori nurses to influence whānau, hāpu and iwi with prevention of smoking uptake and cessation is significant. Despite this potential, evidence shows that as health professionals who smoke they are often in a worse position to fulfill such a role, both personally and professionally (Wong et al., 2007). Not only are they at risk of poorer health, but they experience disapproval and stigma from their non-smoking colleagues because of their smoking behaviours (Gifford, Wilson, et al., 2013; Heath, Andrews, Kelley, & Sorrell, 2004; Radsma & Bottorff, 2009; Rowe & MacLeod Clark, 2000). More importantly, as healthcare professionals who smoke, Māori nurses compromise their abiltiy to provide smoking prevention and cessation advice to other smokers within their community. There is, however, a need to understand the impact Māori nurses' smoking has on them, when placed in a position of offering smoking cessation advice to others.

Current Ministry of Health (2013) statistics tell us that 32.7% of Māori adults smoke. Whilst evidence points to a reduction in smoking for Māori, down from 42.2% in 2006, higher smoking rates among wāhine Māori women (41.8%), Māori nurses (20%) and student nurses (32%) still exist compared with the National average. This confirms reducing smoking prevalences in these groups remains a priority (Gifford, Walker, Clendon, Wilson, & Boulton, 2013). Recent available evidence seems to suggest that targeted smoking cessation approaches, that are responsive to health professionals needs, are more likely to lead to successful smoking cessation practices (Berkelmans, Burton, Page, & Worrall-Carter, 2011; Pipe, Sorensen, & Reid, 2009). Identifying the characteristics of smoking behaviours that are specific to Māori health professionals and exploring innovative solutions to address tobacco use is an ongoing issue. If addressed could lead to further smoking reduction rates for Māori nurses, student nurses and ultimately wāhine Māori (Gifford, Wilson, et al., 2013). According to Gifford et al. (2013), this gives cause for smoking interventions for Māori nurses to be a public priority.

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as health professionals who smoke they are often in a worse position, both personally and professionally (Wong et al., 2007). Not only are they at risk of poorer health, but they experience disapproval and stigma from their non-smoking colleagues because of their smoking behaviours (Gifford, Wilson, et al., 2013). More importantly, as healthcare professionals who smoke, Māori nurses compromise their abiltiy to provide smoking prevention and cessation advice to other smokers within their community.

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In this chapter I explored the significance of the social determinants of health and their impact on the health outcomes of population groups in New Zealand. The relationship between smoking and health and the impact smoking has on Māori are discussed. A brief outline of the current tobacco health strategies and the role Māori health workers play in these strategies is explored. The chapter will conclude with an overview of the thesis.

The Social Determinants of Health and Health Outcomes for Māori

The World Health Organisation's Commission on the Social Determinants of Health report (2008) indicated factors such as housing, education and income contribute to a

person's health and wellbeing as much as their lifestyle behaviour and physical characteristics. By improving the conditions in which people are born, where they grow up and ultimately live, work and play will go part way to addressing the inequitable distribution of power, money and resources (Commission on Social Determinants of Health, 2008). Higher rates of smoking and extremely low quit rates are associated with living in social deprivation. Inferior housing, low income, single parenting, and unemployment are all contributors to these high rates of smoking (Blakely, Fawcett, Hunt, & Wilson, 2006; Marmot & Wilkinson, 2006).

In New Zealand (NZ), the prospect of having a healthy life is not equitable amongst all New Zealanders (Ministry of Health, 2011a), and in fact health inequities exist between certain population groups. Māori have, on average the poorest health status of any ethnic population group in New Zealand (Ministry of Health, 2010b; Robson, Cormack, & Cram, 2007) Māori experience higher rates of infectious diseases, unnecessary hospitalisation, differential access and quality of healthcare, preventable child mortality and have higher rates of ischemic heart disease, stroke and diabetes (Ministry of Health, 2010b; Robson et al., 2007). Māori also bear an unfair burden in mental illness and addictions, have lower educational attainment, higher imprisonment rates and experience lower life expectancy compared to other population groups (Ministry of Health, 2010b). Behaviours, such as smoking, only partly explain inequities, and are strongly related to social and economic factors and broader structural and systemic inequalities (Craig, 2006; Reid & Robson, 2007).

When discussing Māori health status it is important to recognise and understand the role that colonisation has on contemporary Māori inequities (Reid & Robson, 2007). The history of colonisation and the perpetuated use and misuse of power and transfer of resources from indigenous peoples to the colonisers Reid and Robson argued is an ongoing process. The distribution of resources and establishment of systems that enable who will benefit and how often from the transfer of resources, ultimately leads to inequalities for indigenous peoples. Reid and Robson stated through this process of transfer of power and resources different value systems are utilised and Māori are ultimately seen as the "outsider" as they become reclassified as "different" from Pākeha, non-Māori, and non indigenous models. Māori health needs, therefore, can be classified as arising out of the result of the violation of indigenous rights (Jackson, 2002).

The inequities in our society, therefore, occur because of the circumstances in which people are born, how they grow up, where they live and work. Social and economic circumstances can limit access to healthy food, quality education and a decent income, which in turn may add to being predisposed to certain diseases such as diabetes and heart conditions. If a child is disadvantaged early in life, and social and economic inequalities are not addressed, these factors can continue to impact upon their health well into adulthood (Ministry of Health, 2010b). This overall loss of good health not only takes an increasing toll on an individual's health, but impacts on others within their whānau (Ministry of Health, 2002).

The correlations between poor health and inferior housing have been well documented and continue to be a strong influence on health inequity (Howden-Chapman, 2004). A causal factor that contributes to inequities in health outcomes for Māori is that they are 13% more likely to be discriminated against when buying or renting a property, leading to limited choices where housing is concerned (Ministry of Health, 2010a). Household overcrowding and the long-term consequences to a child's health through exposure to environmental dangers such as mould, dampness, lack of insulation and cigarette smoke can lead to respiratory diseases and chronic lung infections. Children and young people are more likely to take up smoking, if they are living in a house with a smoker. Without interventions to improve access to affordable housing, including adding insulation to make homes more healthy, the social, economic and ethnic disparities in New Zealand will continue to lead to unhealthy children becoming unhealthy adults (Craig, 2006; Howden-Chapman et al., 2007; Ministry of Health, 2002, 2010a).

Māori experience lower life expectancy, and health disadvantage across most mortality and morbidity indicators compared to New Zealand Europeans, as well as socioeconomic disadvantages in areas such as housing, education, income and employment (Robson et al., 2007). These inequities are factors that contribute towards Māori children being put at increased risk of preventable poor health outcomes. Logic dictates that it is up to society and governments to address the imbalances that exist for ethnic populations, within their own country (Woodwood, Drager, Beaglehole, & Lipson, 2001).

The debate as to what resources are required to improve Māori health outcomes and remove inequities, and who should be involved in providing meaningful and appropriate

healthcare has been referred to by Reid and Robson (2006) as multi-layered and complex. They contend understanding the complexities of Māori health challenges and the likely underlying causes will enable health interventions to be more successful for Māori. Recognising the diverse perspectives and opinions as well as the evidence and research on Māori health will assist us to understand Māori health within the context of Treaty rights (Ministry of Health, 2011a).

Smoking and Health Status

The Ministry of Health (2007) stated that New Zealand's greatest public health problem is premature mortality and morbidity caused by smoking, with over 5000 deaths occurring annually. Māori are three times more likely to die from lung cancer than non-Māori (Gifford, Parata, & Thomson, 2010). More wāhine Māori die prematurely due to smoking-related diseases, and in far greater numbers than their NZ European counterparts (Ministry of Health, 2010c).

The Ministry of Health's (2013) newly released report Health Loss in New Zealand links the long-term health effects of tobacco smoking to 75% of health loss for Māori, which is almost 1.8 times higher than non-Māori. They say more than half of Māori health loss occurs before middle age. Moreover, Māori are more likely to experience greater exposures to risk factors for poor health than non-Māori, which in turn leads to poorer outcomes over the term of their lifespan (Ministry of Health, 2013a).

While smoking rates for Māori have been substantially reduced since the 2006 Census, the current 32.7% smoking prevalence rate for Māori adults is double the non-Māori smoking prevalence average for adults 15.1% (Ministry of Health, 2013b). These figures equate to over a third (36%) of Māori adults smoking each day. Considerably higher rates of smoking occur in deprived areas, where 28% of adults are daily smokers, compared with 9% of adults living in the least deprived areas (Ministry of Health, 2013b).

The average initiation age for smoking in New Zealand is 12.7 years for non-Māori and 11.5 years for Māori (Ministry of Health, 2011a). A child who starts smoking at 12 years

of age or younger is four times more likely to die of lung cancer than someone who starts to smoke at age 25 years or over, and 15 times more likely to die of lung cancer than someone who never smokes. The consequences to a person's health through a lifetime of smoking, from such a young age, are overwhelming (Ministry of Health, 2013a).

While a gradual decline in smoking prevalence for Māori males and Māori youth has occurred since 2006, wāhine Māori remain a concern having the highest smoking prevalence of any ethnic group (41.8%) (Ministry of Health, 2013b). Māori females aged between 25 to 29 years smoke at four times the rate of non-Māori females in this age bracket (Ministry of Health, 2007a) and 39% of Māori women smoke during pregnancy. Smoking during pregnancy risks damage to the unborn child, through exposure to second-hand smoke. This can result in a range of adverse pregnancy outcomes including stillbirth, preterm birth and intrauterine growth restriction (Ministry of Health, 2013b).

Exposure to second-hand smoke is significantly higher in Māori households than non Māori households (Ministry of Health, 2011a). Sudden unexplained death in infancy, respiratory illnesses, middle ear infections, asthma and reduced lung growth in children, and an increased risk of smoking in later life are all linked to exposure to second-hand smoke. Children and young people are more likely to take up smoking, as an adolescent, if they are living in a house with a smoker (Ministry of Health, 2010a). Smoking is still a leading issue in terms of health equity and economic status, as smoking prevalence rates for wāhine Māori remain higher than any other population group (Ministry of Health, 2013a, 2013b).

Gifford (2011) asserted that smoking is still a key health issue for Māori that perpetuates health inequalities, and contributes to inequity in life expectancies between Māori and non-Māori. Probably the single most important activity to reduce health inequities, after focusing on the socioeconomic determinants of health, would be to make New Zealand tobacco-free (Gifford, 2011; Ministry of Health, 2004). Making New Zealand smoke-free could result in an increased life expectancy of up to five years for Māori and three years for non-Māori, thus creating a two-year reduction in the life expectancy gaps (Blakely et al., 2006; Ministry of Health, 2010a). Strengthening smoke-free legislation and increasing social marketing campaigns has led to a reduction in the exposure to second-hand smoke and an increase in smoking cessation rates for some population groups (Ministry of Health, 2010a). Gifford et al. (2010), and Fernandez and Wilson (2008), however, contend that mainstream

smoking cessation campaigns have not been as effective for wāhine Māori. In their latest research Gifford et al. (2013) claim an increase in quit attempts are more closely linked with providing culturally appropriate cessation services for wāhine Māori, and that Māori nurses are the ideal health professionals to lead this intervention. Providing better access to healthcare and ensuring services that are appropriate and responsive to Māori, will help improve health outcomes and reduce socio economic disparities for Māori populations in the future (Ministry of Health, 2013b).

Current Tobacco Health Strategies

The Māori world was tupeka kore (tobacco free) before the arrival of the Pākehā. Since the introduction of tobacco in New Zealand its use has been noted as an important cause of disparity in health status between Maori and non-Māori (Carr-Gregg, 1993; Grigg, Waa, & Bradbrook, 2008). Advocacy by health groups and communities have worked tirelessly over the decades to strive for change in government policies to reduce socioeconomic and ethnic disparities by eradicating smoking, and pushing for a tupeka kore status again in New Zealand. Tobacco control initiatives in 2010 by the Smokefree Coalition resulted in launching its *Tupeka Kore Aotearoa 2020 Tobacco Free New Zealand 2020 Achieving the Vision* background document. This document outlined the actions necessary to achieve the vision of tupeka kore New Zealand (Smokefree Coalition, 2010). The road to tupeka kore includes a short-term goal of auahi kore (smoke free) and tupeka kore for New Zealand within the next ten years, and long-term, when tobacco will not be part of the lives of our future generations.

In March 2011, the New Zealand government made a commitment to becoming smokefree by 2025. The government's *Tupeka Kore 2025* goal recognises the social, health and economic costs associated with smoking to specific population groups, and aims to reduce smoking prevalence to below 5% by 2025 (Ministry of Health, 2011b). Interventions include lessening the exposure to tobacco through point-of-sale displays, introduction of plain packaging, and restrictions on marketing as part of the denormalisation, regulation, harm reduction and cessation of smoking in New Zealand (Smokefree Coalition, 2010). By reducing children's exposure to cigarettes and protecting them from setting out on a path to addiction it is possible to significantly reduce adolescent and young people's motivation to try smoking, thereby, making a smoke-free New Zealand by 2025 an achievable goal

(Cunningham, 2013). To achieve this goal, an increase in the smoking cessation services will be needed to target those most in need, and delivered in settings where they can have the most impact.

A key recommendation from the Maori Affairs Select Committee's (MASC) *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori (2010)* includes extending the range and reach of services for priority populations to further reduce their smoking rates, particularly Māori women. To achieve this goal the MASC report further recommended that effective cessation services designed and delivered by Māori for Māori be made increasingly available (Māori Affairs Select Committee, 2010).

Māori health workers could play a more central role in ensuring all Māori have equitable access to these services and receive optimal health care. These health professionals could positively influence smoking cessation and reduction of smoking uptake within Māori whānau, hapū and iwi. (Gifford, Walker, et al., 2013; Puska, Barrueco, Roussos, Hider, & Hogue, 2005). Bridging the cultural gap between the Māori world and the medical world could also be a task assigned to Māori health workers, to ensure fairness in access and delivery of the most appropriate healthcare needed. Building a compete and skilled experienced Māori health and disability workforce is, therefore, crucial to providing appropriate care and improving health outcomes for Māori individuals and their whānau (Ministry of Health, 2007b).

Tobacco control approaches addressing tax increases, further restrictions on sale and supply, enlarging smokefree environments and increasing support for quitters are all welcome initiatives that ensure New Zealand maintains its position as one of the leaders in this important public health area. Support and leadership in the health sector is essential if smoking prevalence rates for Māori are to continue to decline and for whānau to remain smokefree in the future. The recently established National Māori Tobacco Control Leadership Service (hosted by Hapai te Hauora Tapui and Action on Smoking and Health) will provide much needed guidance and direction in the tobacco control sector to support the goal of a smokefree NZ in 2025 (Cunningham, 2013).

Significant gains in achieving the broader goal of Tupeka Kore 2025 could be made by reducing smoking prevalence among the 20% of Māori nurses who smoke (Ponniah & Bloomfield, 2008a). This group of health professionals are strongly positioned to influence wider whānau and Māori communities not only in their role as vital and trusted healthcare practitioners in a range of health care settings, but also as key influential members of their wider whānau (Gifford, 2011; Radsma & Bottorff, 2009). To achieve this goal an increase in smoking cessation services will be needed to target those most in need, and delivered in settings where they can have the most impact. It is well established that health professionals can positively influence smoking cessation when they provide advice on quitting to those who smoke (Puska et al., 2005). The New Zealand Nurses Organisation (NZNO) have almost 3000 Māori nurses as members, and they are ideally placed to deliver an effective smoking cessation intervention, as they come in direct contact with 6,850,000 patients per year (Gifford, Walker, et al., 2013).

This research therefore, seeks to address the following primary question: What are the experiences wāhine Māori nurses have who smoke and how does this impact on them providing smoking cessation advice to others? The aim of the research is to gain an understanding of wāhine Māori nurses stories of smoking and smoking cessation, and how this affects their role as a nurse.

Overview of Thesis

Chapter One of this thesis explores the relationship between the social determinants of health and health outcomes, with a particular focus on Māori health. The current smoking status of Māori is also examined and discussed. A brief outline of the current tobacco strategies in New Zealand, and how these strategies aim to reduce inequalities for populations affected by tobacco use, is included.

Chapter Two provides a literature review of nurses who smoke and their role in smoking cessation. Literature from within New Zealand and internationally is reviewed, and seeks to identify gaps in the current literature on Māori nurses who smoke and to provide a rationale for this study.

Chapter Three outlines the methodology that informed this research and the rationale for the kaupapa Māori research methods employed. How the participants were identified, recruited and interviewed is discussed, and the tools and methods used to collect the data are also explained. In this chapter the ethical considerations of this research and the processes used to ensure participant confidentiality is outlined. Evidence of how the rigour for the research was established is explained.

Chapter Four presents the research findings. The themes and subthemes that emerged from the participants' interviews are presented.

Chapter Five provides a discussion of the research findings. The findings are discussed and situated amongst the existing body of literature. The research strengths and weaknesses are examined.

Chapter Six The conclusion summarises the research. Opportunities for future research and the implications for potential interventions are discussed.

Conclusion

In conclusion, it is acknowledged by the tobacco control sector that one of the greatest public health interventions to reduce disparities in Māori health is to reduce smoking rates for Māori (Ministry of Health, 2009, 2010b). To reduce smoking rates the health sector and the New Zealand government need to intervene together. By reducing the uptake of smoking this will be an effective intervention in reducing the tobacco epidemic. Evidence suggests a prevention approach to reducing smoking initiation is favoured by restricting access to tobacco products and supporting whānau to denormalise smoking. Hopefully, this will result in adolescents that are less likely to become smokers as adults (Smokefree Coalition, 2010). By realising the 2025 vision of a tupeka kore, New Zealand would greatly reduce health inequalities for Māori whānau, hapū and iwi (Gifford, 2011).

Chapter Two: Literature Review

Having an understanding of why Māori nurses smoke and their role in smoking cessation is essential for supporting them to successfully quit smoking. This chapter will outline the purpose of this literature review and provide a critique of the current body of literature on health professionals who smoke and their role in smoking cessation. Critical assessment and analysis of the literature facilitated me to have a deeper understanding of the conflict and tensions nurses who smoke experience when providing smoking cessation and of the expectations there are of them in their role as health professionals, to be smoke-free.

This chapter begins with a general introduction that centres on the main points of the literature review. The first two sections relate to the rationale for undertaking the research. Current epidemiological information on the smoking prevalence amongst health professionals in New Zealand is explored. This gives context as to why health professionals, particularly wāhine Māori nurses, need to be researched. Literature examining current understandings of health professionals who smoke in New Zealand will be explored. This provides insights into the causes and reasons why smoking prevalence amongst nurses remains high, particularly for wāhine Māori nurses. The next section reviews the international research about nurses' roles in smoking cessation and relates this research to similar indigenous experiences in other countries. Literature is then reviewed on the smoking history, knowledge and attitudes of nurses in New Zealand.

Search Strategy

A systematic approach was used to access literature for review from 2003 to 2013 using PubMed, Ebscohost, Cochrane and CINHAL databases as well as the internet and Ministry of Health website. Information was available on national smoking rates, mortality and health impacts relating to smoking. However, research about wāhine Māori nurse's smoking habits

and interventions that successfully supported them to quit smoking and their role in providing smoking cessation was scarce.

Research parameters

The components of the literature search included the years used to select the articles, databases used, key words or terms selected and the inclusion and exclusion criteria. In order to acquire the current best evidence of Māori nurses and non-Māori nurses' cessation behaviour the literature search was restricted to the last ten years 2003-2013. Keywords used to access literature included: smoking; nurses; health professionals role; Māori; Māori women; tobacco use; smoking uptake and prevention; cessation; giving up smoking; quit attempts; quit support and quit programmes.

The inclusion criteria for selecting articles for the literature review included:

- National and International literature that explored Māori and/or health professionals' personal and professional contexts of smoking behaviour

- Articles that ideally incorporated a kaupapa Māori approach

- Included other indigenous populations

- Relevancy to the role nurses had in providing smoking cessation uptake

- Identified potential conflicts nurses' had that smoked when offering smoking cessation advice to others

Articles were excluded if they:

- Were older than ten years

- Did not have scholarly reliability and credibility

- Had no broad relevance to my study

A total of thirty articles were retrieved and seven were excluded. Twenty three research articles met the inclusion criteria, and were reviewed.

The one exception to the exclusion criteria was a scholarly article published by Nagle, Schofield and Redman (1999). They described the behaviour, knowledge and attitudes of Australian nurses towards providing smoking cessation care to their patients, and was

therefore considered highly relevant. This article provided evidence of nurses' tensions and conflicts when providing smoking cessation to patients. It was included as it added value to the body of evidence of smoking and quitting behaviours among nurses.

Current Smoking Prevalence of New Zealand Health Professionals

The current smoking status of health professionals, by gender and nursing speciality is reported by Edwards et al. (2011), as the 2013 Census data was not available (Statistics New Zealand, 2013). Edwards et al. (2011) found a decrease in smoking prevalence amongst male doctors (4%), female doctors (3%) and female nurses (13%) whilst male nurses (20%) remained closer to the NZ population prevalence rate of 15.1% (Ministry of Health, 2013b). Mental health nurses smoking prevalence (29%) was higher than for other nurses and the general population (Edwards et al., 2011).

A research partnership between NZNO, Whakauae Research and Taupua Waiora aimed to determine Māori registered nurses' and student nurses' smoking behaviours and attitudes to smoking cessation. Their national survey results have provided valuable information about the behaviours attitudes, and beliefs of Māori nurses and student nurses towards smoking cessation (Gifford, Wilson, et al., 2013).

A national web-based survey of 410 NZNO Māori nurses, student nurses and other health workers confirmed that Māori nursing students had a high smoking prevalence of 32% compared to Māori registered nurses 20% (Gifford, Wilson, et al., 2013). Seventy-five percent of the nurses smoked fewer than 10 cigarettes a day, mostly outside of their homes. These figures show that smoking prevalence rates for registered Māori nurses was lower than previous research has indicated. Importantly, 84% of the respondents that were still smoking indicated strong intentions of quitting in the future.

Results from Gifford et al.'s (2013) research show that whilst Māori nurses' smoking prevalence has reduced to 20% this prevalence is higher than all nurses and midwives (13.6%), but is much lower than the smoking rate for wāhine Māori 43.2%. These figures also indicate that supporting Māori nurses to quit smoking is paramount so

they can support members of whānau, hapū and iwi to reduce their smoking prevalence further (Gifford, Wilson, et al., 2013).

Until recently there remained an absence of qualitative research literature about the views of wāhine Māori nurses who smoke, and their role in smoking cessation. The 2007 ASHKAN (Assessment of smoking history, knowledge and attitudes of nurses in New Zealand) survey assessed nurse's smoking history, knowledge and behaviour, but had a very low response rate (2%) by Māori nurses. Therefore the researchers were unable to make any conclusion about wāhine Māori nurses' smoking status (Wong et al., 2007). The low response rate indicated that a kaupapa Māori approach may have been more suited to increase Māori involvement in the research. Kanohi ki te kanohi (face to face) approaches are inclusive of Māori values and beliefs and are more culturally appropriate, and essential to use in a Māori centred research approach (Cunningham, 2000; Gifford, 2011; Smith, 1999). Māori-led research that highlights new knowledge about the smoking behaviours of wāhine Māori nurses was cited by Gifford (2011) as a top priority.

Current Understandings of Why Nurses Smoke

A review by Greek health professionals of international literature acknowledged that a nurse's working environment could be seen as a possible barrier to smoking cessation and for maintaining quit attempts (Perdikaris, Kletsiou, Gymnopoulou, & Vasiliki, 2010). However, Perdikaris et al. (2010) found inconsistencies in the evidence in the literature they reviewed. They established the relationship between stressful working environments and nurses' smoking habits was contrary to belief that the work environment causes smoking initiation. They found certain variables linked "job stress" to the way in which some nurses dealt with stress management and smoking initiation. These variables included: the strain of heavy lifting, long hours of work, mental and emotional demands, the degree of support from colleagues and supervisors, and patient care activities.

Malik, Blake and Batt (2011) contended that whilst nursing is a valued occupation, they found nurses' worked in highly stressful environments. Their study examined the health behaviours of new and registered nurses in the United Kingdom. They reported

many nurses regularly worked a 12-hour shift, endured high levels of burn-out, experienced regular staff turnover, and incurred illnesses that lead to long periods of absence. Nurses said they smoked a way of taking time out from their jobs, as a strategy to relieve stress and as a means of coping (Sarna, Bialous, Sinha, Qing, & Wewers, 2010). A robust mixed method study with Californian nurses by Sarna et al. (2010) suggested that the alliance of stress and the environment nurses work in is linked to the failure of nurses to quit smoking. Institutional racism and cultural insensitivity were also cited by Aboriginal Health Workers (AHWs) as a source of severe stress throughout their working environments (Dawson et al., 2012). Dawson et al.'s research noted that AHWs used smoking as a way to combat a range of stressors in their lives. AHWs identified stress as a trigger and smoking was the means of coping. One participant commented, "It just seems to relax me when I'm experiencing those high level stress situations; I know it's bad for me and yet I do it" (Dawson et al., p.5). These social, emotional and environmental factors that act as stressors are barriers for many nurses when it comes to quitting (Wong et al., 2007).

Sarna et al. (2010) found through their focus groups and self- reported questionaires that worksite settings in hospitals differed, and that these different institutional settings were linked to nurses' continued smoking prevalence. Their findings indicated different workplace cultures meant nurses would have to carefully plan smoking breaks and who was available to smoke with them. Nurses claimed smoking with workmates on a break was seen as a key component to their smoking habits. Smoking was also described as a "collective social practice" by AHWs, where colleagues met and socialised over a cigarette (Dawson et al., 2012, p.7). The sense of belonging to a group and connectedness was seen by AHWs as strong motivating factors to smoke, which enhanced interaction with family, friends, colleagues, and patients. Dawson et al. concluded that smoking was seen to strengthen the connection people felt whilst in this setting. This endorses the idea that a cigarette with a colleague is a way of maintaining friendships and belonging to a group (Dawson et al.).

Fernandez and Wilson (2008) found the attitude whānau took towards family members who smoked impacted heavily on smoking prevalence. Teenage years are often a time for experimentation. Thomas and Glover (2010) cited these years as times when youth experiment with smoking. Parental attitudes towards their young people's smoking

behaviours often influenced smoking initiation together with the availability and affordability of cigarettes, and social acceptance of smoking by whānau and friends (Thomas & Glover, 2010). The Ministry of Health (2007) indicated that adolescents of all ethnicities are more at risk of smoking uptake when they come from homes where parents smoke. Fernandez and Wilson's (2008) research showed that smoking initiation occurred between the ages of 12 to16 years. Common triggers for smoking initiation were whānau members, peer group, partners that smoked and socialising that led to smoking and drinking. These influences, coupled with parental smoking, may explain why smoking prevalence rates for Māori remain high (Glover, 2005).

Sarna el al. (2010) maintained nurses who smoked regularly experienced stigma and shame from non-smoking colleagues. They contended that nurses who smoked were perceived by colleagues to spend less time with patients, and were also accused of taking longer and more frequent breaks. Their study showed a strong link between the intensity of shame and guilt felt by nurses who smoked, and the lengths nurses would go to hide their smoking status from workmates, family, friends and patients. They asserted that strategies, such as brushing teeth or using mouthwash to hide the smell of smoking are ploys often used by nurses to mask their smoking. Further guilt and shame was also felt by nurses due to the increasing societal pressures regarding the unacceptability of smoking (Sarna et al., 2010). As a member of the Nurses for Smokefree Aotearoa (NZ), Nuku (2010) argued that many Māori nurses do experience stigma, guilt and shame for their addiction. These feelings of guilt and shame, Radsma and Bottorff (2009) stated, led to nurses' feeling inadequate as role models, influencing their ability to provide cessation advice to patients. Gifford (2011) also noted that for Māori nurses the feeling of whakamā (shame) is one of the reasons they were reluctant to discuss smoking cessation with patients and whānau.

Even though current trends suggest that nurses are amongst the leaders in role modelling smoking cessation practices, the barriers for nurses to quit smoking remain (Nagle, Schofield, & Redman, 1999). Nagle et al. (1999) contended if nurses do not have the support from their colleagues, and their work environment is not supportive, any attempts to quit smoking will fail. Their study with Australian nurses found that 12-hour shifts and lack of access to smoking cessation resources were barriers to nurses' smoking cessation. Radsma and Bottorff (2009) further concluded that nurses were not prepared to alter their smoking behaviours, and in fact most resisted all attempts to make

changes. This ambivalent attitude, they asserted, protected them to some extent from humiliation and shame. Wong et al. (2007) acknowledged that smoking by nurses was an ongoing challenge and that further understanding of their needs and the barriers to smoke-free practice needs further research. Sarna et al. (2009) maintained that many nurses were determined to smoke despite no smoking policies in their workplaces and having to walk out of hospital grounds during breaks. This promotes the idea that some nurses are prepared to go to extreme lengths to smoke, even when a number of barriers exist (Sarna et al., 2010).

Nurses' Role in Smoking Cessation

Prevention of disease, involvement in health promotion activities and care of the ill are all essential roles of nursing. Evidence-based interventions, health promotion, client education and professional development are vital elements of nursing (Wong et al., 2007). Nurses are perfectly placed to promote a smoke-free society due to their high level of awareness of the major health effects of smoking and are an ideal group for achieving lower smoking prevalence in populations (Puska et al., 2005). The evidence base for nurses delivering of smoking cessation treatments is sound, as they have the largest reach of any group of health professionals (M. Jones & McLaclan, 2006). Sarna et al. (2010) promoted the idea that nurses' roles in supporting individuals to quit smoking are vital for public health, which makes smoking among nurses a paradox (Radsma & Bottorff, 2009).

Māori nurses have the potential to be highly instrumental in reducing smoking uptake and providing cessation support. However, those who smoke put themselves both professionally and personally at-risk by jeopardising their own health, and subjecting themselves to criticism and disapproval from colleagues and whānau (Gifford, Wilson, et al., 2013; Ponniah & Bloomfield, 2008b).

The debate, therefore, around the role of nurses who smoke, and whether they take their role in smoking cessation too lightly still exists (Campbell, 2012). Campbell argued that health professions often undervalue the costs of smoking on a person's

health. She stated smoking hindered their role in providing health promotion and advocacy, affecting nurses' abilities to provide smoking cessation advice to clients (Sarna, Bialous, Wewers, Froelicher, & Danao, 2005). It could also be argued that the biggest barrier to supporting whānau, hapū and iwi to quit smoking are the very health professionals that work with these communities (Nuku, 2010).

Radsma and Bottorff's (2009) research with nurses who provided smoking cessation advice to patients highlighted the conflict nurses displayed when faced with providing this type of direct care. They speculated that the cognitive dissonance theory promoted by Festinger (Festinger, 1957) explained inconsistencies in nurses' behavioural and cognitive actions, to justify their smoking. They found nurses who smoked viewed themselves as imperfect role models, and experienced conflicting feelings when confronted with their nursing responsibilities. They maintained this could explain why nurses continued to smoke, fully knowing the health consequences of their actions. This does not, however, explain the double standards that arise within the nurse-patient settings, especially for nurses who smoke and their daily associated smoking cessation activities (Radsma & Bottorff, 2009).

Gifford et al. (2013) showed that Māori nurses who smoke find it more challenging to promote smoking prevention and cessation advice, than nurses who do not smoke. Māori nurses who participated in their research felt that their health promotion skills and knowledge were under utilised. They did feel, however, that smoking compromised their ability to support Māori to quit or prevent smoking uptake (Gifford, Wilson, et al., 2013). Forty-four percent of the respondents in Gifford et al.'s., survey, *"Māori nurses and their smoking behaviours and attitudes towards smoking cessation"*, indicated that they would not be able to provide effective advice to others about smoking cessation. Their responses were more aligned to the fact they would feel guilty if they were seen smoking in their nurses' uniform, as opposed to lacking of knowledge about the health risks of smoking and cessation advice for patients. Provision of cessation services to whānau, (especially Māori whānau) by health professionals, is a public health focus (Ministry of Health, 2007b). The dilemma caused by nurses who smoke in promoting these smoking cessation health messages further compounds the conflict already felt by this group (Gifford, Walker, et al., 2013).

Nagle et al. (1999) claimed that Australian nurses lacked the skills to provide adequate smoking cessation advice. They concluded their research provided an argument for the provision of smoking cessation training courses to nurses at all levels that focuses on the health impacts of smoking and the subsequent health benefits of quitting. Nagel et al.'s conclusions contrasted with the results of Gifford et al's., and Wong et al's (2007). In these NZ studies most respondents reported they had the necessary skills to be able to give patients key information on quitting smoking. Wong et al. (2007) noted that just under half (43%) of respondents said they had received some sort of training, 34% had been trained to use the NZ smoking cessation guidelines, and 19% were able to provide nicotine replacement therapy. Wong et al. (2007) advocated for the promotion of release time for nurses to increase smoking cessation intervention skills and to attend education cessation courses. This promotes the idea that attending these sessions would increase nurses' broader understanding of the relevancy of smoking cessation programmes and the significance of tobacco policy control measures for achieving a Smokefree New Zealand by 2025 (Wong et al., 2007).

Best Practice Interventions for Nurses Who Smoke

Radsma and Bottorff (2009) suggested that interventions needed to focus on the conflict some health professionals experienced towards their own smoking practice. In a European study, health professionals who smoked and undertook counselling were then able to give vastly improved advice and support to their patients and clients who smoked (Puska et al., 2005). Nuku (2010) maintained that smoking cessation programmes that included specific counselling and expressly targeted nurses' needs are backed by international research as a valuable way of supporting health professional to quit smoking. If smoking is seen as the norm, it is harder to quit. Therefore, a nurse's own need to reduce and quit smoking requires institutional support, especially by senior management and their work colleagues (Wong et al., 2007).

In reviewing the results of their survey, Wong et al. (2007) concluded that creating a smokefree nurses advocacy group would provide peer leadership and role modelling for those nurses wanting to quit. The advocacy group could push for nurses to deliver smoking cessation interventions across public health and primary, secondary and tertiary

settings. Wong et al. further suggested onsite quit services, access to 24-hour phone and internet quit support, along with pharmacological support-Nicotine Replacement Therapy (NRT) to assist in overcoming nicotine withdrawal symptoms, and time off work to quit would be ideal in aiding nurses to quit smoking. Furthermore, targeted quit support for nurses would need to be sensitive to the difficulties encountered by nurses who try to quit (Gifford, Walker, et al., 2013).

Working With Wāhine Māori Nurses

Continued high smoking prevalence for wāhine Māori nurses raises questions about the effectiveness of mainstream interventions (Fernandez & Wilson, 2008; Gifford, Walker, et al., 2013; Gifford, Wilson, et al., 2013; Ministry of Health, 2003). Māori nurses saw value in smoking cessation interventions to advance their own or other's health (Gifford, Wilson, et al., 2013). Specialised smoking cessation programmes with a kaupapa Māori focus are required to support Māori nurses to realise their full potential as role models, increase their impact to reduce smoking cessation rates, and support them to become smokefree, and ultimately to stay smokefree (Gifford, Walker, et al., 2013). Planning these interventions and strategies with wāhine Māori nurses requires clinical and management support as well as leadership to facilitate the inclusion of Māori values, beliefs and approaches (Gifford et al., 2010; Gifford, Wilson, et al., 2013).

A Māori-centred approach employs processes that are collaborative, participatory, emancipating and empowering, and enables Māori to better control and improve their own health status (Durie, 2001) A Māori-centred approach also facilitates Māori aspirations and initiatives, and rejects the notion that Māori are 'passive' subjects (Bishop & Glyn, 1999). Fernandez and Wilson (2008) suggested that by incorporating Māori values and beliefs into smokefree initiatives would be more successful to assist Māori women wanting to quit smoking. They stated these values and beliefs include "*whānau ora* (extended family wellbeing), *whanaungatanga* (the process of making connections), *awhinatanga* (to assist or care for), *whakapono* (trust, honesty, and integrity), *mana wāhine* (the prestige of Maori women) and *tino rangatiratanga* (self-determination)" (p.37)

The connectedness between self, whānau, hapū, iwi and whanaungatanga are contributing factors to developing collaborative partnerships that will help to achieve positive outcomes and addresses health equity for Maōri (Durie, 2012). Networking through hui and incorporating links to noho marae and rongōa practitioners are seen as key strategies to address the effects of smoking, and to support smoking cessation interventions for wāhine Māori (Apārangi Tautoko Auahi Kore -Smokefree Coalition, 2003).

Maori women must be encouraged and supported to take control of their own health (Durie, 2001). Gifford et al. (2010) contended that when Māori women are in control of their own health and wellbeing, they and their whānau are able to effectively learn about the harmful effects of smoking in a culturally relevant manner. If undertaken through a process of sharing experiences, providing positive support and influencing each other toward smoking cessation then tino rangatiratanga (self-determination) will enabled through empowerment, independence and ownership (Durie, 2012). By including wāhine Māori nurses to actively seeking smoking cessation solutions promotes sustainability of ideas and commitment to supporting and advocating for auahi kore practices (Gifford, 2011; Ministry of Health, 2011).

Enhancing self-confidence that supports wāhine Māori to have a positive self-image and promoting health education activities are critical aspects to achieving smoking cessation for wāhine Māori (Fernandez & Wilson, 2008). Fernandez and Wilson promoted health education activities in a group setting whereby wāhine Māori nurses work alongside other wāhine Māori who intend to quit smoking. This facilitates a tuakana-teina relationship where supportive role modelling, mentoring, leadership and goal setting , and enables wāhine Māori to share of their own quit smoking success stories, and provides essential non-smoking role modelling (Fernandez & Wilson, 2008). A call for auhai kore (smokefree) advocacy by wāhine Māori nurses enables best practice guidelines to be developed based on the Māori models of health, such as Te Whēke, Whare Tapa Whā and Te Pae Mahutonga (Apārangi Tautoko Auahi Kore -Smokefree Coalition, 2003; Glover, 2005).

Smoking is particularly prevalent among Maori women between the age of 15 to 65 years and remains a concern, despite numerous anti-smoking campaigns (Edwards et

al., 2009; Ministry of Health, 2010c; Ponniah & Bloomfield, 2008b). Questions still remain as to the effectiveness of current mainstream tobacco smoking cessation initiatives as they have not benefited Maori to the same extent as non-Māori (Gifford, 2011; Ministry of Health, 2003). Fernandez and Wilson (2008) found that wāhine Māori women felt more at ease with services that were provided by a Māori provider, rather than a mainstream service. In their study with wāhine Māori, all participants stated they would never ring the National Quit Line as trust, honesty, and integrity (whakapono) was a concern, particularly when it came to revealing personal aspects about themselves (Fernandez & Wilson, 2008). Their research highlighted that wāhine Māori were clear it was inappropriate to ask a stranger for smoking cessation help, whereas face to face (kanohi ki te kanohi) was an appropriate method. Traditional healing methods, such as mirimiri (massage), and rongōa (traditional medicine), Fernandez and Wilson maintained, are considered to be important for Māori women to assist them in quitting. The evaluation of the effectiveness of the Aukati Kai Paipa 2000 programme aimed at wāhine Māori signified high quit rates and changed smoking-related behaviours of those who participated (Ministry of Health, 2003). Success was due to the inclusion of whānau for support and understanding, participant's access to quit coaches, and cultural suitability of the programme (Fernandez & Wilson, 2008; Glover, 2005).

Conclusion

For many Māori smoking has been shaped by childhood and wider whānau social experiences, and has become a socially acceptable behaviour (Barnett, Pearce, & Moon, 2009; Edwards et al., 2009). Early initiation and a willingness by whānau to support uptake of smoking was cited by Fernandez and Wilson (2008) as a factor that influenced wāhine Māori and smoking. The stress of family pressures, felt by wāhine Māori indirectly impacted how often they smoked. Approaches that address the needs of wāhine Māori are more likely to effectively support them and wāhine Māori nurses wanting to quit smoking (Fernandez & Wilson, 2008; Gifford, 2011; Gifford, Walker, et al., 2013; Gifford, Wilson, et al., 2013). Fernandez and Wilson (2008) and Gifford et al., (2013) provide valuable insight into wāhine Māori and Māori nurses' perspectives on smoking cessation. They draw attention to the need for future research and support, to focus on smoking cessation interventions for Māori nurses, and to understand the complex issues and

challenges faced by Māori nurses who smoke. Gifford et al.'s (2013) research is the most compelling undertaken in the last five years and emphasises there is a gap in the current literature and more is required to address this gap. This alone justifies the need for my research and other research like it, to gain insight into how smoking affects nurses' roles in smoking cessation activities.

Chapter Three: Methodology

This chapter outlines the methodology that informs how this research was conducted and the rationale for using a kaupapa Māori research method. The research methods and practice guided by Māori cultural values, knowledge and contemporary realities will be explained. How participants were identified and recruited is discussed and the tools and methods used to analyse data will be made clear. The ethical requirements as outlined by the AUT ethics committee (AUTEC) are summarised in this chapter and an outline of the research rigour is provided.

Using appropriate research methodologies when undertaking research with indigenous populations is essential in engendering trust and respect of people a researcher proposes to work with. Failure to recognise the significant practices, cultural beliefs, or worldviews that pertain to indigenous peoples can lead to those being researched feeling as if they have been used, and taken for granted. It is essential, therefore, that as researchers we recognise indigenous ways of knowing, and chosen methodologies are suitable for the particular populace involved (Cochran et al., 2008).

This Māori-centred research is a collaborative endeavour initiated by Māori nurses within New Zealand Nurses Organisation (NZNO) and represents a partnership between NZNO, Māori nurses and Māori researchers. The research design will be guided by Māori-centred research, whereby the participants, their cultural beliefs and practices, and their mana will be held central to, and honoured throughout the research process. "As researchers, we have a duty to respect the knowledge bestowed upon us and ensure it is used legitimately" (Mead, 2003, p.317). Kaupapa Māori research, therefore, recognises that Māori hold the balance of power by retaining autonomy (tino rangatiratanga) over the research processes from start to finish (Cram, et al., 2010).

Aims and Research Question

Using a Kaupapa Māori research framework and narrative processes this research addressed the following primary question: What are the experiences wāhine Māori nurses have who smoke and how does this impact on them providing smoking cessation advice to others? The aim was to gain an understanding of wāhine Māori stories of smoking and smoking cessation and how this affected their role as a nurse when required to deliver smoking cessation advice to others. My research is a qualitative study, informed by a literature search, will use semi-structured interviews with wāhine Māori nurses to explore the topic (Stokes & Bergin, 2006).

This research will be part of a larger study conducted by Whakauae Research, Taupua Waiora Centre for Māori Research and the New Zealand Nurses Organisation (NZNO). Their research aims to explore the context of smoking for Māori nurses (in particular the tensions for them as smokers and health professionals), review the impact of a range of national regulations (such as tax increases) and workplace policies on quitting and staying quit, and draw on the findings to design a multi-point intervention related to smoking cessation and relapse prevention for this influential sub group of smokers.

Their study has completed stage one which involved quantitative data collection (a survey of all Māori NZNO members) and a literature review. Stage two involved qualitative interviews with 50 nurses, included a literature review and early intervention development was explored. Stage Three of the research will include finalising the intervention and feasibility testing with research participants with support from the Advisory Group members and wider stakeholders.

Kaupapa Māori Methodology

A qualitative research design using kaupapa Māori research methodology was utilised to gain an understanding of wāhine Māori nurses stories of smoking and their role in smoking cessation. The underlying principles of tika (authentic) and pono (truth) and the

values manaaki (show respect) and tautoko (support) that are drawn from a Māori kaupapa research approach underpinned the methodology used in this research.

This methodology was chosen to ensure Māori cultural values, knowledge and contemporary realities were inherently respected and upheld throughout the research process. The strength of kaupapa Māori research is that it centres on research for, with and by Māori, and ensures that Māori will have exclusive control over what happens to the information and knowledge given during the research process (Smith, 1999). This type of research demonstrates that by adhering to Māori principles and values a kaupapa Māori approach is more suited to Māori involvement in research. Kaupapa research methodologies posed are inclusive of Māori values and beliefs and that apply the principles of kanohi ki te kanohi (face to face) demonstrate that they are more culturally appropriate (Cunningham, 2000; Smith, 1999). As a wāhine Māori in a research role, I wanted to ensure tikanga (protocol and practices) were adhered to and that my actions and endeavours leading up to and during data collection were underpinned by Māori values and beliefs.

Kaupapa Māori research uses an indigenous approach to research from a Māori worldview. The epistemological theory of knowing from Te Ao Māori (Māori worldview) is grounded in mātauranga Māori (Māori knowledge and information). The foundation of this worldview for Māori is based on the " nature of being" (Mead, 2003). From a Māori perspective this includes how the world was created, the role the gods had within the world, and how Māori people interpret this interaction. The diversity that exists within Māori influences and determines this view it, shapes thinking and how Māori interact and identify with being Māori (Barlow, 1996).

Research that is undertaken by, for and with Māori requires that it follows the ethical principle of tika and pono. Mead (2003) asserted that tika is about taking the right approach. Pono describes the concept of standards of behaviour or practice that are to be satisfactorily observed. In terms of research, this is about ensuring the research is done correctly and that it genuinely reflects the principles of Māori tikanga. Research that reflects a Māori code of conduct, which adheres to the kawa or protocols of the rohe (area), is necessary for it to be tika and pono. Barlow (1993) stressed that the relationship and connectedness to land, maunga (mountain), awa (river), marae (meeting place), customs, language, rituals, and beliefs are all central to Māori tikanga. These practises, cultural beliefs and needs were,

therefore, acknowledged and respected correctly when undertaking this kaupapa Māori research.

These ontological principles or spheres of influence are consistent with the belief systems and values are entwined within tikanga Māori. According to Mead (2008), tikanga is a fundamental part of mātauranga Māori. Tikanga Māori puts mātauranga Māori into practice and gives value to the aspects of correctness and customs that shape it. The actions, speech and behaviours dictated by a unique Māori tikanga framework, help to guide and organise these behaviours.

Mead (2003) proclaimed tikanga Māori is the "Māori way" (p.11) in which the values and customs practised by Māori are upheld. Māori epistemology includes the tikanga practices, the taonga tuku iho (something precious, treasured passed down) that have been handed down from generation to generation (Mead, 2003). Tikanga Māori is for the most part a widespread term and the understanding of what it means varies within regions. Mead further acknowledged that tribal areas will have different kawa (protocols), waiata (songs), kōrero (speeches), and tikanga that ground their theory of knowledge. As I travelled to facilitate the paired interviews within the Auckland rohe o te iwi (territory) I was mindful that I acknowledged that mana whenua and Tainui tikanga (the people of Tainui waka) played an important role in how the paired interviews were conducted and how tikanga was observed. A mark of respect to mana whenua and Tainui kawa (protocol) was given to the kingitanga (kingship) and King Tuhaetia, the present representative of the kingitanga. This was given and included when I conducted my mihi (greetings) to participants as they were conducted within the Tainui rohe.

It is also important to understand the ontological hypothetical assumptions underpinning kaupapa Māori research before utilising these research practices. To be Māori is to acknowledge that retaining culture and language is central to self-determination and is an essential part to enhancing Māori cultural wellbeing (Smith, 1999). Acknowledging that "kaupapa Māori research operates out of this philosophical base" is central to kaupapa Māori research (B. Jones, Ingham, Davies, & Cram, 2010) This was a crucial element in gaining trust from participants and for the success of the research.

Māori are often the sole or major contributors in kaupapa Māori research. If a dual role is undertaken, with researchers who are not Māori, then it is imperative Māori have ownership throughout the research process. It is through this empowerment that Māori will have exclusive control over what happens to the information and knowledge given during the research process. A culturally safe and fulfilling experience is more likely to result and whānau involvement ensures they achieve benefits from the research (Cram et al., 2010).

When using an Indigenous approach to research that takes a Māori worldview perspective, Smith (2012) outlines seven practises that should inherently guide Kaupapa Māori researchers. My adherence to these practises ensured Māori cultural values, beliefs and protocols were adhered to when I undertook this research. These practises were:

1. **"Aroha ki te tangata"** (to show respect towards people) Respect was shown towards the people involved in the research through whakawhanaungatanga. Links were made to the participants' whānau, hapū and iwi, their maunga and marae through initial kōrero. Social relationships were established through mihi and kōrero. This ensured an element of trust encompassed the research processes that took place.

2. **"Kanohi ki te kanohi"** (face to face) getting to know the community through face to face discussions and kōrero (conversations) served to demonstrate that a legitimate and genuine interest in the people involved in the research existed.

3. **"Titiro, whakarongo, kōrero"** (Look/watch, listen, then speak) It was important that I ensured I listened carefully to people's questions before I spoke. I was equally mindful of the participants' surroundings and remembered to show respect for the protocols and kawa of the iwi and hapū involved with the research. This was vital as it was their collaborative stories I was telling.

4. **"Manaaki ki te tangata"** (to care for) acting as a good host by offering kai (food), karakia (prayer), koha (gift) and reciprocity was an important part of being accepted as whānau (family) during my research. I took kai to all the interviews and this was shared over a cup of tea with the participants. A gift voucher was also given to each participant as a koha to acknowledge their participation in the research.

5. **"Kia tupato"** (to be careful) the tikanga practices and values were set by kaupapa Māori and these were carefully followed. Kaumatua and kuia were available to guide and mentor me if I needed them.

1. **"Accountability to the Māori participants"** Whānau hapū and iwi played a lead role in this kaupapa Māori research process. Participants were contacted by me early on in the data collection process and were included in how the information was collected and disseminated.

6. **"Kaua e takahia te mana o te tangata"** (do not stamp/trample on) Māori kaupapa was at the forefront of the research and it was up to me, as a Māori researcher, to follow this kaupapa by ensuring the mana of all concerned remained intact at all times. Kaumatua and kuia were consulted so the correct tikanga was used.

7. **"Kaua e māhaki"** (to be humble) a variety of contemporary Māori and mainstream research tools were used to collect the data. Paired interviews were conducted that facilitated Māori support systems, namely tautoko (to support) and awhinatanga (to assist or care for). The whakataukī (proverb) "Kaore te kumara e kōrero mō tōna reka- the kumara vine does not say how sweet it is" was used as a guide to remind me to be humble with the knowledge I was given via the data collection process.

Recruitment of Participants

The NZNO membership database was for used recruitment through the partnership the wider Whakauae research team had with the NZNO. NZNO Māori nurse members were invited to take part. A list of participants was identified as those who had already participated in the Stage 1 survey, or were referred by word of mouth through whānau and health sector networks and nurses who had attended the NZNO Te Rūnanga Regional Hui and agreed to participate.

The inclusion criteria for interview participants were:

- Participants' identified as being Māori;

- Currently in nursing practice or in nursing training; and

- Be smokers in any of the following categories; weekly, daily or social smokers and include those who are engaged in quit activity.

Participants that did not meet the inclusion criteria were, therefore, excluded. That is, if they did not identify as Māori, were not a current practising nurse or in nursing education, and did not meet any of the smoking status criteria. Using a range of smoking status criteria for recruitment allowed a range of smokers to be involved in the research and avoided excluding data that may have been beneficial.

The Whakauae research team provided me with a list of suitable participants to interview who resided in either the Northland or the Auckland region. Twelve participants were identified from the list and I contacted them via email and phone and invited them to take part in the qualitative research interviews. Five of the 12 contacted were unavailable or declined to participate in the interviews. Seven participants agreed to take part in the interviews. The participants included six registered nurses from five separate nursing settings; three from District Health Boards (DHBs), one in primary health care, two non-government organisations (NGOs) and one nursing student who was completing her nursing degree. This sample represented a range of nursing practice, and included an education setting and allowed for varying needs and contexts to be represented in the collection of data. All seven participants were female and aged between 24-45 years of age.

Participants who indicated that they wished to take part in the research were asked if it was acceptable that their data would be used for analysis by me, with the intention of using it in my Master's thesis. This was clearly stated in the Participants' Information Sheet, (Appendix 2) which was sent to the participants via email before the interview process. The information sheet described the interviews and gave the rationale and purpose for the research. How the research was to be used and any risks and how they would be alleviated was also outlined.

Paired Interviews and Data Collection

Semi-structured paired interviews were held as an effective means of qualitative data collection (Stokes & Bergin, 2006). This approach was used as it was anticipated that some health professionals may have been unwilling to discuss their smoking status or to share

their ideas within a large focus group. Paired interviewing also provided an opportunity for participants to hear what others were experiencing and potentially this could facilitate wider discussion and give a broader depth and richness to the information collected. This method had previously been used by the Whakauae Research team as a successful method of collecting data from Māori participants. In their experience having "a friend" with them during an interview was a common need among Māori participants, as this offered a better support base to those being interviewed. Participants were also offered the opportunity to participate in individual interviews if they preferred to.

I had intended to undertake 10 paired interviews of 45-60 minutes in duration, using the interview schedule developed by the researchers in the main study. However, it was considered by the wider Whakauae and Taupua Waiora research team that by July 2013 data saturation point for the main research project had been achieved, with a total of 50 paired interviews undertaken by them, and my interview schedule was, therefore, reduced. My resulting data therefore came from seven participants and consisted of two paired interviews (n=4) and three individual interviews (n=3). The interviews were of 60 minutes duration. Findings from these interviews make up the foundation of this thesis.

The purpose of the qualitative interviews was to explore participants' perceptions and experiences of smoking and how this impacted on them in their nurses' role when offering cessation advice. The Interviews were semi-structured with open ended questions designed to explore participants' smoking practises under the themes: history of smoking, current smoking practise, factors that influenced continuation of smoking, experiences as Māori nurses who smoked, quit experiences, how external influences such as policies and regulations prompted and supported quit attempts, and what might be required from an intervention to support Māori nurses to stay smoke-free. Questions included:

- What is your current role?

- What are some of the current messages you are hearing about smoking?

- What are the major factors that influence why you continue to smoke?

For the full list of questions see the paired interview schedule (Appendix 4).

The Whakauae research team initially piloted five paired interviews. The qualitative data from these interviews was reviewed by them and the wider advisory group to ensure integrity and validity of this data. Reviewing the interviews at this stage ensured that the questions posed were of value, were relevant and provided an understanding of the participant's viewpoints (Braun & Clarke, 2013). The questions used on the larger study were used by myself in the interviews I under took with the 7 participants. The point of difference between the larger study and my study was my focus on how smoking affected the Māori nurses in undertaking their role in smoking cessation activities.

Location of interviews

Choosing a suitable location for the interviews depended upon the availability of participants. Having a location that participants felt comfortable in, was on neutral territory and devoid of distractions and background noise is promoted as the ideal setting to undertake a qualitative interview (Braun & Clarke, 2013). All but one of my interviews, that I undertook, was conducted in the participants' homes. For the most part they were successful in that I was able to ask participants the intended questions and clear and coherent answers were given. Two of the locations for the interviews however were less than ideal, as they were either undertaken in the participants' lounge or bedroom. Interruptions by family members, particularly children, and back- ground noise, at times made it difficult for both me and the participant to converse and concentrate on the interview questions. Braun and Clarke (2013) warn of the limitations interviewing in someone else's space may have and caution that such disruptions may hinder the data collection process. I was confident, however, that the data I received from these participants was what had truly been expressed by them and that the rigour of the research was not compromised.

Interviews were digitally recorded to ensure accuracy of the participants' responses. In Braun and Clarke's (2013) opinion this allowed for elements of the participants' language, their thoughts and point of view to be precisely captured. The practical advice offered by Braun and Clarke's (2013) and by my supervisor on digital recording was sound advice indeed, especially for a novice researcher. Carrying a spare set of batteries and having an awareness of whether the recording light was on or not during my interviews paid off for me. In two of the interviews we had to restart because the light was not on! Fortunately we were

only a few minutes into the interview, but this was a valuable lesson learnt. Testing the recording device before the interview began was also invaluable as this provided me with an opportunity to test whether I was using the device correctly. But more importantly it gave me added confidence in the interviewing techniques I was about to employ.

Before each interview began I offered the participants the opportunity to start with karakia and whakawhanaungatanga was used. Opening the interviews in a relaxed manner and thanking the participants for taking part also allowed me to settle my nerves and helped me to focus on the purpose of my research. Providing the opportunity for participants to ask questions about why the research was being conducting allowed both myself and participants to articulate motives for the research (Braun & Clarke, 2013).

The participants were then provided with a consent form to read and were encouraged to ask any questions they had about the interviews (Appendix 3 copy of the consent form). I was able to talk through the information sheet and the consent form outlining that I would take notes during the interviews, and that the interviews would be digitally recorded and transcribed. The participants were again advised that the transcript of the interview would also be used by me for the purpose of completing my Masters of Public Health thesis. Once consent was given I was able to begin the interviews, using the paired interview schedule as a guide to gain information from the participants.

Initially I used the paired interview schedule strictly as it was set out, moving from one question to the other in the order prescribed. I quickly learnt that the participants themselves often dictated the order of questions, and I began to tailor the wording of the questions accordingly. At one stage a participant raised something towards the beginning of the interview that I was going to ask about later, but I felt it was ok to discuss it at that stage of the interview. Using the prepared questions as a guide and adapting the timing of the questions according to the account given by the participant was a skill I became more proficient in as the interviews progressed. Responding in a spontaneous manner in an interview can be highly relevant, as this allowed flexibility to the interviews and provided data that was very useful (Braun & Clarke, 2013).

At the conclusion of the interviews I asked if the participants had any questions, and if not, this concluded the interview. The digital recorder was then turned off. A mihi was extended to the participants thanking them for their time and contribution towards the research. A koha was given in the form of a gift voucher.

Data Analysis

To transcribe qualitative data a certain degree of skill and experience is required in this area. How quickly you can type, how good the recording is, number of participants involved, and quality of speech are some of the factors that influence how long it will take to transcribe data (Braun & Clarke, 2013). As a novice researcher, with no previous experience in transcribing, my supervisor and I decided it would be best to use a reliable and trustworthy transcribing service to complete the transcribing of the seven interviews I undertook. A confidentially agreement form (Appendix 5) was used and signed by the transcriber. This agreement outlined that the material they were transcribing was confidential and no copies of the transcripts would be kept or third parties allowed access to them. Lastly, the contents of the recordings were to be discussed with the researchers and no-one else.

I chose thematic analysis to analyse the data as it provided me a clear framework whereby I was able to analyse the participants' responses for recurrent themes (Braun & Clarke, 2006). Thematic analysis is a method used to help discover themes and examine and identify patterns within data (Braun & Clarke, 2006). It organised and described the data set without too much effort, yet enabling me to see the main charcteristics of the data. Thematic analysis was used to infer particular characteristics and features of the research topic (Boyatzis, 1998).

The beauty of thematic analysis for the inexperienced researcher, such as myself, is that it offered a method that was more easily reached in terms of understanding theoretical and technical knowledge of research approaches (Braun & Clarke, 2006). The lack of restrictions within the framework of thematic analysis allowed for a true account of the data to take place within the research, without being bound to an explicit theoretical framework. Braun and Clarke (2006) emphasised that thematic analysis should underpin

good qualitative research methods. They also highlighted the skills that researchers gain from using thematic analysis would put them in good stead when using other types of qualitative analysis.

Braun and Clarke (2006) argued that the benefits of thematic analysis lie within its flexibility as it is free of theory and epistemology. Having the freedom to apply theoretical independence encourages flexibility of research tools, which can possibly lead to a broader, more wide-ranging description of the data. Thematic analysis can also be used within different frameworks if need be, such as an essentialist or realist method that reports experiences and reality of participants. Therefore it can be used across a range of theoretical and epistemological approaches. Boyatzis (1998) also endorses thematic analysis as a means of investigating data that can be utilised across diverse methods of data collection. When using thematic analysis we need to be clear about what we are doing and why we are using this approach, and to include how analysis is done in the reporting of data (Boyatzis, 1998). Thematic analysis can reflect reality as well as unravel the facade of reality (Braun).

Once the transcribing was completed the data was then ready to be analysed and consigned into themes, as outlined by Braun and Clarke (2013). I used Braun and Clarke's (2013) steps to analyse the data as follows:

1. Transcribing the data – this was given to a professional transcriber

2. Reading the data and making notes with some initial ideas – once transcribing was completed I made codes for each participant and wrote down ideas in the margins of the transcripts.

3. Coding the whole dataset – the data was loaded into the computer and the software Dedoose was used to code the data.

4. Searching for themes within the data – I made a list of 10-15 themes from the transcripts.

5. Reviewing themes and creating a "thematic map" of the analysis – I used large A1 sized paper and placed the data under the themes and subtheme headings to create a thematic map.

6. Define and label the themes, subthemes – Dedoose was used to narrow down the number of themes.

7. Write up an analysis of the themes – Discussions with my supervisor and the wider research team enabled me to start writing up my findings.

The web-based analytical programme Dedoose was used to further support the analysis of the data collected from the interviews and to assist in the research findings. Using Dedoose also facilitated the ability of the wider research team to work on the data online at the same time, in different locations, whilst still retaining a high degree of security of the data. The key themes and subthemes that I identified from the results of the qualitative data analysis are as described in Table 1.

Table 1.

Example of Themes, Descriptors and Sub-Themes

Theme	Descriptor	Sub-theme
Initiation	The participants described their initiation to smoking and the contributors and enablers to uptake of smoking.	Most started at an early age.
		Peer pressure, being cool
		Whānau were enablers
		A "social thing.
		Smoking and alcohol when socialising.

Ethical Considerations

Ethical approval for this thesis research was gained from the Auckland University of Technology Ethics Committee (AUTEC), as a variation on the larger Health Research Council funded study (see Appendix 1).

Informed and voluntary consent: I provided participants with an Information Sheet (Appendix 2) that explained the purpose of the research and what their participation

would involve. Participants were informed that the information they shared would be used for two studies. Participation was totally voluntary and potential participants were informed they could withdraw at any time up until data was collected.

Confidentiality*:* Confidentiality was managed by storing consent forms (Appendix 3) separately to the data. All data, including transcribed interviews and consent forms were kept separately in a locked filing cabinet. All identifying information was removed from the transcripts and names substituted with codes. General labels replaced references to geographical places and organisations. Once transcribing was completed the digital recordings were erased.

Minimisations of risk: Strategies were put in place if participants became whakamā (embarrassed, had loss of mana) or experienced distress at any stage during their interview. To minimise the risk of emotional or psychological distress participants were offered three free counselling sessions through the AUT health, counselling and wellbeing services if required. This included an online counselling option or access to telephone counselling. The sensitive nature of the topic and the sharing of personal stories by participants could have triggered deep seated emotional feelings. Therefore, having awareness around alleviating any unnecessary stress to the participants was essential.

Establishing Research Rigour

Using the correct tools to meet the stated objectives of a study requires research rigor being applied (Ryan & Bernard, 2000). According to Ryan and Bernard a systematic approach ensures the appropriate approach and methods used for the research are correct. I used a number of features they outlined in their study of research rigour methods. These have contributed to the rigour of this research. They are the integrity, credibility and standing of the wider research team, appropriate supervision, piloting of the interview schedule, accurate accounts of the participants' dialogues and the genuine desire, as the researcher, to provide an unbiased viewpoint.

I acknowledge that as a beginner to the research field this research has played a huge part in my learning to be a researcher. I've had to draw upon my different life experiences in the teaching world, previous health promotion roles and my current role in public health to support the development of my research knowledge and to enhance my research skills. As an apprentice researcher I was guided by the wider Whakauae research team and my supervisor. Having academic guidance around methodology and research processes was essential and my supervisor was able to provide this necessary skill set and support. The wider Whakauae, Taupua Waiora research team complemented this skill set by providing invaluable advice and knowledge of the topic area, and was able to offer tikanga Māori support when needed.

The wider Whakauae research team piloted the interview schedule for the data collection, prior to use. This helped to ensure the semi-structured interview questions would facilitate and guide the participants to speak freely of their experiences and produce information to answer the research questions.

Finally, explaining in simple language what I did and how I did it, via my thesis forms part of the research rigour of qualitative analysis. In other words what the researcher maintains they have done and what is actually revealed, matches up (Braun & Clarke, 2013). This allows for others to shape their own interpretations and to gain a better understanding of the processes used in the research (Ryan & Bernard, 2000). The next chapter explains the findings from the interviews and describes the analysis of the themes and subthemes that explore the realities of the participants who were interviewed. The discussion chapter then focuses on exploring the meaning of the data.

Chapter Four: Findings

This chapter presents the findings from the interviews with the six Māori nurses and one student nurse that I undertook. The qualitative interviews explored 5 key themes: initiation, quit attempts, being a nurse, putting my nursing hat on and being a smoker and a nurse.

Table 2.

Themes, Descriptors and Sub-Themes

Theme	Descriptor	Sub-theme
Initiation	The participants described their initiation to smoking and the contributors and enablers to uptake of smoking.	Most started at an early age. Peer pressure, being cool Whānau were enablers A "social thing. Smoking and alcohol when socialising.
Quit attempts	Number of times they tried and the methods used. Quitting involved multiple attempts and methods used.	Smoking was bad habit. Serious or not serious. Cold turkey and word of mouth quit methods used. Relapses were common. Smoking a personal choice. Nagging being punished.
Being a nurse	Participants described their knowledge of smoking and evidence of harm. Described expectations as a nurse.	Basic knowledge of harm. Links not made to own smoking behaviour. Putting my nursing hat.
Putting my nursing hat on	Restrictions at work. How managed	If work colleagues knew they are a smoker. Support given. Positive and negative impacts on role.
Being a smoker and a nurse	Role Impact on practise	Hiding identity as a smoker, shame, hypocrisy and guilt felt. Empathy with patients that smoked. Cessation messages not advocated as hard. Student nurses used smoking as way of coping with stress.

The themes aimed to explore the experiences Māori nurses have as smokers and how these experiences impacted on them providing smoking cessation advice. Questions based on current literature and the need to know more as to why Māori nurses have a high prevalence of smoking and the impacts of smoking on their nursing practice helped to shape the key themes. The intent of the questions was to act as a stimulus for story telling by the participants, and to support my understanding of the complexity of issues faced by Māori nurses who smoked.

Participants

All seven participants were female and aged between 24-45 years of age. Six participants were registered practising nurses and one participant was a student nurse. The nurses worked in a variety of settings for District Health Boards, public health and non-government organisations. The areas of work included community work with outpatients, adult and children's intensive care wards and nursing in private prisons. The participants smoked between 5-10 cigarettes a day. Most participants had been smoking between 13-25 years.

Initiation

Nurses started smoking early (between 11-16 years of age) with the primary reason for initiation to fit into their desired peer group, aided by the easy accessibility of tobacco. Smoking was enabled by whānau role models as parents, siblings and wider whānau members of the participants were all users of tobacco products. Smoking was used as a way of maintaining desired social relationships at school and later in social settings with colleagues and friends.

The following subthemes were selected to identify the participants' experiences of smoking initiation: It's cool, a whānau thing, it's just a social thing

It's cool

Experimentation with smoking by most participants occurred at an early age, where learning to inhale and taking puffs of their first cigarette took place with schoolmates or with members of their whānau:

> *I learnt how to inhale when I was eleven* (34 year old nurse).

> *I started when I was 11 years old, with my school mates. I did it to be cool (38 year old nurse).*

The temptation of trying something out that was prohibited and the resulting "thrill" was enough for some to give smoking a go. For others the introduction to smoking was activated through boredom and the desire to be "cool":

> *We were bored, me and my cousins, so we just thought we were cool (34 year old nurse).*

> *It was cool to smoke and that's why I smoked yep. Nobody forced me into smoking, nobody. No it was just cool (40 year old nurse).*

> *I just liked doing it because it was a thrill I guess (32 year old nurse).*

Peer groups were the most influential in smoking initiation, as smoking was seen as something everyone was involved in, so why not smoke like everyone else?:

> *At Intermediate everyone else was doing it, so why not? (36 year old nurse)*

Smoking was, therefore, acknowledged as part of the "rights of passage" to belong to a predominant group. "Hanging out" with the right group, particularly the "cool group" came through strongly as the most important reason participants chose to smoke. To not attempt to smoke could mean isolation from peers and exclusion from the group, particularly the "cool group":

> *I hung in two different groups. So I'd choose which group to hang out with at different times of the day, and yeah, that group were all smokers (32 year old nurse).*

> *Tried to hang with the cool crowd pretty much and try and fit in with everyone else....do what everyone else was doing (24 year old nurse) .*

An increase in smoking behaviour at high school was directly linked to availability of tobacco products. Ingenious methods were used to ensure a continued supply of "smokes":

It just got worse at high school, thirteen-ish…they (cigarettes) were just easier to get when I was that age because of our shopkeeper. I used to be able to get my Mum's smokes just by a hand written note. So I used to always keep her hand written notes and get them when I had money for mine (32 year old nurse).

For some, ease of access to tobacco was not always straightforward and continued use of cigarettes was dependent on supply. Purchasing cigarettes from a retail outlet was not always an option. Therefore, creativity that included stealing, pinching from mates or whānau, "scabbing" from friends, and if needed picking up used butts:

I stole my smokes off my Mum (38 yearold nurse).

I only smoked when I could get hold of the smokes. I'd pinch them from my parents, scabbed them from my mates, even picked up butts; anything brown (35 year old nurse).

A whānau thing

Whānau were seen as enablers of early smoking experimentation. Initiation rates also increased for those who had smokers within their extended whānau. The nurses were surrounded by smokers and acceptance of smoking was commonplace:

I was about 12 years old and most of my whanau smoked (35 year old nurse).

Everybody around me smoked (38 year old nurse).

Whānau was given to include cousins, as well as siblings and extended family members:

Everybody around me smoked; cousins, heaps of people (40 year old nurse).

I was up North and we were bored, me and my cousins ….I must have been eight; they would have been eleven (32 year old nurse).

From initiation to role modelling whānau who smoked impacted on the nurses. Five participants had mothers and siblings who smoked and four had both parents who smoked:

…my Mum used to smoke…., my sisters but that was when they were young (42 year old nurse).

...my Mum and lot more on my Dad's side (38 year old nurse).

My parents and my sister smoked (40 year old nurse).

Social norms within the whānau and desire to fit in were strong indicators as to why some nurses continued to smoke. From hiding their smoking status to openly smoking in front of parents became the norm:

The rest of my whānau smoked so they did not really care (34 year old nurse).

I started from hiding to smoking in front of the parents. So the smoking become really when I felt like one. I would go out into the garden and have a cigarette (24 year old nurse).

After initial experimentation with cigarettes was over, a sense of helplessness was expressed by some when lack of encouragement from whānau to discontinue smoking was missing. For others smoking had occurred within their whānau for generations and they were resigned to the fact that this was their fate too:

I didn't have the encouragement to not smoke (38 year old nurse).

Within my family it has been in for years (42 year old nurse).

Smoking as a student nurse

The need to smoke for some student nurses was linked to how they coped with the pressure of study and the expectations placed upon them to complete nursing training. Using tobacco as a way of releasing this stress highlighted that strategies for stress management are needed:

To be a student really it's quite stressful, so to see other students smoke I feel it's good for them if it helps them release a bit of stress, otherwise it is just going to build up. I used to think like that stress, so having a cigarette will calm me down a little, not that much, but it would calm me down a little. And I think for students,

to maybe release their stress having a cigarette instead of maybe quitting the course is better (26 year old nurse).

The knowledge gap for some however was dependent upon what information was currently being presented to them and what they were hearing:

Not much really, it's not based around smoking at the moment. It's just learning the nursing stuff at the moment. But right now they're not doing any smoking stuff, it's just basic.

As their identity as a nurse was developing the student nurse was eager to please as there was new group socialise with and appeared to be more susceptible to external triggers:

What we see and hear is what we see on TV, yeah on TV. There is nothing said around our smoking or with our group of friends (26 year old nurse).

It's just a social thing

Belonging to a collective group that socialised together and shared the same interests in like-minded activities was voiced by participants as a "social thing". Smoking behaviours were still forming and a big part of the "social thing" included "hanging out" with others and having a cigarette together:

It was not habitual probably until after I finished high school. But it was just a social thing, just to do at the bus depot after school. Everyone hanging out and everyone's having a cigarette (35 year old nurse).

So yeah, it would probably be more of the social scene I would think (42 year old nurse).

Smoking was used to create a sense of identifying with and belonging to a group. Establishing relationships within in this group meant being prepared to follow the group's behaviour to fit in. Smoking was managed in these social situations because of the desire to maintain the connection with the group. Opportunities to smoke were created daily, increasing smoking behaviour as well as cementing a place in the group:

Well before I go to school I'd stop at a friend's place, have a smoke before we go to class. Have a cigarette after class and during lunch breaks (26 year old nurse).

When asked about the supposed "benefits" derived from smoking as part of "the social thing" the common response was the camaraderie and satisfaction experienced by smoking with a group of like-minded people. Tobacco use and the sharing of tobacco products helped to form a close bond, and were attractive and powerful symbols of this relationship:

> There's immediate satisfaction and because everyone else is smoking. I think it's that you need to feel part of the group, the social, because everyone else is smoking (36 year old nurse).

The physical aspect of sharing a cigarette between other smokers helped to encourage and sustain smoking behaviours, whilst the nurturing aspect that took place within the group drew others towards the group of smokers:

> And there is a certain thing about it too, like someone doesn't have cigarettes. "Oh here have a cigarette, you know, here have one." We are sharing, it's a sharing thing. I guess that's what attracts me too (36 year old nurse).

Nurses voiced the place to be when socialising was with the smokers as they were hilarious and the group you had the most fun with. Non-smokers were depicted as boring and people whose company you avoided:

> If you ever go to the pub and stuff like that, everyone's with the smokers you know because its fun and it's hilarious. No one wants to sit inside with people that are pretty boring (42 year old nurse).

Using tobacco products in a social setting, rather than on an everyday basis, was described as being a "social smoker." The idea that social smoking only occurred when alcohol was involved was described as "just the way it is":

> I'm a social smoker, especially when I am drinking (35 year old nurse).

> Because I smoke when I drink and that's just how it is now. But I don't smoke ordinarily (34 year old nurse).

A strong connection between smoking and drinking when socialising with friends and whānau was identified by some as "real bad but real nice". One activity went with the other, and reinforced the association that smoking and drinking go hand in hand, especially after a busy day at work:

I found that every time I had a drink is when I wanted a cigarette (32 year old nurse).

Parties will just be where to smoke with my friends or family (32 year old nurse).

When you've had a busy Friday and you want to have a beer, a smoke goes hand in hand. And it just, I know this is real bad but it's just nice (34 year old nurse).

"Real socialising" with mates and heavy drinking sessions were identified by some as the catalyst to increase smoking compared to their daily tobacco consumption. Increases of up to three times the daily amount usually smoked was put down to encouragement from mates who also smoked when it was "real social':

Currently I smoke a pack a week. It's more when I am socialising and drinking.... heavy drinking sessions I could smoke up to 3 packs (35 year old nurse).

When it is real social I can smoke up to two packets. It depends who I'm with.

It was because of my mates, because they all smoke you know (42 year old nurse).

For some, the time spent having a smoke with a partner was an essential way of catching up and socialising together. Sharing a cigarette with a partner could make smoking seem a more worthwhile activity, leading to increased tobacco consumption.

My partner smokes and the only time we really do get together is when we both finish work and he's outside having a cigarette and I'll make me a coffee and go have one with him. It's socialising with him as well (32 year old nurse)

Over half of the participants had partners that smoked. They strongly influenced the smoking behaviours in their relationship as they smoked the same amount of cigarettes, and usually agreed to quit at the same time. The support of their partners to stop smoking was voiced by some as all the encouragement they would need to give up. Wanting to stop smoking, however, was not something either party wanted.

I think the biggest support would be my partner. If he was to stop smoking or support me to stop smoking that would be the support I would need. But he does

not want to stop and I don't want to stop, so once we get to that stage of wanting to stop then… (32 year old nurse).

If my partner was giving up, we could encourage each other (36 year old nurse).

Lack of partner criticism by non-smoking partners could also be seen as enablers for continued smoking behaviour and a barrier to quit attempts:

My darling does not smoke anyway. Oh my darling does not go on about it, I mean he just goes "ooh yuck" you know when you give him a kiss and stuff like that (42 year old nurse).

Quit Attempts

Personal stories replaced medical knowledge when attempting to quit smoking. Nurses disregarded the current body of evidence around best practice quit smoking practices, relying instead on what others said worked for them. Comments by friends, whānau and colleagues who had attempted to quit smoking using quit products like patches and gum and said they were "yuck" were believed and no attempt was made to try them out:

They said it was yuck so I don't want to use it (34 year old nurse).

For others the idea of having chemicals in their body did not appeal:

The other thing is I don't like the patches and I don't like have a try… I've just heard people's stories and I just don't like the thought of having that stuff in my body. Just doesn't appeal to me at all (36 year old nurse).

When some nurses did attempt to use pharmaceutical products, a lack of in- depth pathophysiology and pharmaceutical knowledge, coupled with a lack of evidence around what works for cessation practice was revealed:

Champix made me sick, so I had a smoke to feel better (32 year old nurse).

One day I used a patch. It took the edge off I think (40 year old nurse).

Have tried the lozengers and the patches and the gum and didn't like any of them, and was on Champix. Had that, but then the second pack that comes around the higher dosage, actually made me sick. So stopped taking that and continued smoking (38 year old nurse).

Smoking was seen as a personal choice by nurses and they needed the right mind set and reason to quit. Agreeing to quit had to be carried out on their terms, otherwise long-term changes in their smoking behaviour would not occur:

Want to do it on my terms (40 year old nurse).

Just set my mind to it… need the right mind set or reason (42 year old nurse).

The nurses acknowledged deep down they knew they could quit. Giving up smoking depended upon their desire to quit:

I know I can give up if I want it. I know it in my heart (40 year old nurse).

Cost of tobacco had an influence for some student nurses who made a decision to quit:

Maybe just the prices. Yeah being raised a lot and for students it's really not really affordable at the moment and half the people probably stop buying their cigarettes. That would have been my biggest problem when I was a smoker was the prices, but otherwise the pictures that did not bother me (26 year old nurse).

Coping with study and trying to quit, as want to be seen to be doing the right thing, presented its own set of challenges:

Just the studies, being pregnant. Being pregnant while studying and then trying to give up smoking and then you've got the stress on top of all that. That was the hardest for me (26 year old nurse).

Cold turkey was the method of choice for some as their baby's health became more important than smoking:

Well I went cold turkey, the health of my baby is more important than a cigarette a day. So it was not easy at first, but I just put it to myself, like my son, my baby is more important. So two weeks later I did not want one. I was

Ok, did not feel like a cigarette. There was no cravings, no nothing (26 year old nurse).

Serious and not so serious quit attempts

The desire and readiness to quit smoking fell into two camps: serious and not so serious quit attempts. Nurses tried a range of supportive quit smoking products but results were mixed:

> *First 3 days were hardest. I have used patches…gum was hideous (40 year old nurse).*

> *Patches are ok; gum is yuck (42 year old nurse).*

Not asking for help on how to use these products hindered nurse's serious quit attempts. Feigned indifference was shown towards information given on how to use sprays and patches, as some were too embarrassed to ask how to administer the product correctly. The products then sat in participants' drawers and the effectiveness of these products to help the nurse quit was lost:

> *We were all given this spray stuff to put under our tongue. We were all heroes. We were like, "yeah, yeah, yeah". I couldn't even open it. It's just sitting in a draw somewhere (42 year old nurse).*

Some participants did not seek outside support as they wanted to quit on their own. Serious quit attempts options then included going cold turkey. Having to manage withdrawal symptoms on their own was the biggest challenge:

> *When I gave up cold turkey it didn't take long, but I have really bad withdrawals, real bad (40 year old nurse).*

> *When I was studying before, I actually stopped smoking for five months. Cold turkey, really enjoyed it (38 year old nurse).*

Sheer determination and a will to succeed without the use of patches, gum or lozengers was another serious approach taken by some nurses as they felt they no longer needed cigarettes and wanted to give up on their own terms:

> *No, no nothing else. I didn't want to take patches. I didn't want to take the lozenges and I didn't want anything else. I just wanted to give it up on my own if I could. I knew I did not need the cigarettes (24 year old nurse).*

No, I did not do anything different. I did not have any NRT. I did not have any patches or lozenges. I just stopped. There is another thing, not being around it as well (32 year old nurse) .

The wish to be chemical free and to quit the natural way was also contemplated:

I'm just not interested in the patches and stuff; I would rather do it as a natural way (36 year old nurse).

Serious approaches and quit methods were used with varying levels of success, and as a result, relapses were common. Stressful and emotional situations were linked to renewal of smoking behaviour often due to lack of whānau or partner support:

I gave up smoking when I was sixteen. Just this dude I was hanging out with and then he pissed me off so I started smoking again because he annoyed me and then, I don't know. I haven't stopped since (40 year old nurse).

We all did really, really well for three days, and I got really sick so that's how I gave up for the whole seven days, cause I was sick. And then as soon as I saw them smoking I was like sweet, and I started smoking again because I wanted to (42 year old nurse).

The challenge to remain smokefree for some occured most when socialising. The use of alcohol and the socialisation that occured when amoung certain people triggered the urge to smoke. Remaining smokefree for longer than three days became a struggle:

It's the first three days that's the hardest for me, after that it's pretty easy. But it's if I socialise with certain people after those three days that's when I sort of start and I don't want to blame anyone, you know, like then I will start again. But you know I have given up even for a year probably (42 year old nurse).

Drinking. I found that every time I had a drink is when I wanted a cigarette. If I'm not drinking I want a cigarette because just to socialise, but there was not that urge or strong desire to smoke (32 year old nurse) .

For others the struggle to quit and to stay smokefree became more difficult when hanging around the smell of other smokers. When the stress of studying was "thrown in the mix" this was enough to cause relapse:

I was just around too many people who smoked and the smell (40 year old nurse).

....with the stress of study and hanging around with the smell of smokers. I just lit up a cigarette, and started again (38 year old nurse).

When I was studying before I actually stopped smoking for five months. Cold turkey. Really enjoyed it but then was hanging around with the stress of study and hanging around with the smell of smokers. I just lit up a cigarette and started again (40 year old nurse).

Its just a bad habit

Most of the participants tended to play down the seriousness of their addiction, refering to their smoking behaviour as "just a bad habit, or "a dirty habit". Smoking was acknowledged by the nurses as habit forming and their smoking behaviour was seen as something they had control over. Smoking was described as a dirty habit without any benefits, and only one participant recognised it was a habit that had become an addiction:

I know that it is a dirty habit (40 year old nurse).

It is probably an addiction now and a habit (38 year old nurse) .

Work was said to impact on the nurse's smoking "habit", as smelling of cigarette smoke at work was not an option they wanted to explore. Smoking at night after work, therefore, became habitual:

Well I don't smoke during the day, I only smoke at night. It's a habit because of work. I don't want to smell like smoke. So I have chosen not to smoke (42 year old nurse).

There are no benefits. It's a habit a bad habit (32 year old nurse).

 Smoking was seen as an everyday feature of participants' life; a daily habit that just occured along with the daily cup of coffee and was linked to socialising with mates:

Now I think about it, it is probably a habit because I have a smoke with coffee, social occasions and because I am studying (42 year old nurse).

Recognising the difference between addiction and habit was realised by some. Coming to terms with the difference between habit and addiction depended upon the perceived enjoyment from smoking, as well as the desire and readiness to stop smoking:

The reasons I am still smoking are knowing what I know about smoking, I don't want to give up, I still like it. I think before it was habitual, I think more now it is more addiction now. It wasn't before. I could quite easily stop, and I have been wanting to give up for a while. But now it's one of the reasons is that I am not ready to, I don't think (32 year old nurse).

Nagging and being punished

Participants described the government's stance towards tobacco harm reduction as too harsh. Some felt they were being punished by the government's smoking cessation strategies. Other nurses heard these messages as a nagging, a constant nagging telling them to "give up".

Why don't they target obesity, alcohol instead (38 year old nurse) .
It is like a nagging, like a constant nag to give up (42 year old nurse).

A violation of rights was felt by others as they talked about their smoking behaviour and how it is frowned upon by today's smokefree society. Judgements people made about smokers and the way smokers were treated irked some :

I feel like my rights have been taken away because you are not allowed to smoke here, you are not allowed to smoke there. People give you a dirty look (40 year old nurse).

Being a Nurse

Participant's had a sound knowledge of the risks and harm to a person's health through long-term smoking. The common response from nurses in this study was smoking

caused lung cancer. For some their greatest fear was they might get "rubbish lungs" and have a high chance of developing lung cancer too:

Cancer, early death, heart attack, high blood pressure (38 year old year)

Our health would be rubbish. We have more chance of getting lung cancer, rubbish lungs. It influences diabetes and stuff like that as well, but to me that wouldn't be massive. The massive one would be the lung cancer (42 year old nurse).

It's bad, you get rubbish lungs. The list goes on (42 year old nurse).

I asked about the key messages they were hearing regarding smoking and their role as a nurse, as I wanted to establish if there was a link between these messages and their smoking behaviour.

Just from the health professionals. Talking about the ones that don't smoke, about how smoking causes this and it causes that. But I believe there are many other factors as well. Your culture, your lifestyle, your… Like when you do the CVA, the risk assessment, and how old your heart is. There are a lot of other factors (38 year old nurse).

Ok, the key messages about smoking. One factor is it's the biggest leading cause of all cancers and cardiovascular disease, umm… very difficult to give up, needs a lot of support (32 year old nurse).

A lot. Second hand smoke kills (38 year old nurse).

Nurses knew of the risks associated with tobacco use, but they tended to minimise these risks when it came to their own smoking behaviour. The impact key messages had on smoking behaviour had a minimal effect for some as they had seen worse in their role as nurses. Nursing whānau members as well as patients who had died of smoking related cancer hardened some to the reality of smoking:

No, none. My Mother died of lung cancer, no (40 year old nurse).

It doesn't mean anything to me. Yeah there are pictures and I have seen worse. They don't, it doesn't do anything to me. It might do something to other people, but it doesn't do anything to me, and because you already know that anyway (42 year old nurse).

My dad's mum she was a smoker. She died in her 60's. She had it quite rough. She had lung cancer, and she had about every cancer you could get (38 year old nurse) .

I've have seen worse in my role as a nurse (40 year old nurse).

It annoys me

Anger was expressed by some nurses, as they alleged smokers were the "target group" and "picked upon" when key messages around non-smoking were promoted. Hearing these messages was annoying as some felt alcohol was more detrimental to people and smoking wasn't as harmful as drink driving:

Who are they to say how I should spend my money? Why don't they focus on alcohol?(40 year old nurse).

Second hand smoke kills, but when I hear it, it annoys me. I don't drink. I don't do anything else except smoke cigarettes. My smoking cigarettes will not cause an accident, unless I'm an alcoholic, or I go to sleep with one in my hand or I drive and I am not focusing on what I am doing. But how they put people down, when I see alcohol as a bigger problem for a lot of people for a lot of cultures, more than I do smoking. I don't know if that is because I am a smoker myself (38 year old nurse).

 ….find it annoying people going on about it. (*40 year old nurse*)

The current quit smoking strategies further angered participants who deemed them to be intrusive and annoying. They suggested the cessation agencies and the government "backed off a little bit" as non-smoking messages were heard nearly everyday. Why couldn't they push for something to be done with all the alcoholics:

Honestly? They could back off a little bit, because we hear it all the time, every day nearly. Where is the push on all the alcoholics? It is just really annoying and for myself being a smoker and probably other people that I know who are smoking (42 year old nurse).

Being treated with distain for some added to the stigmatisation felt as a Māori nurse that smoked:

> Any people walking passed and they give you the look. I don't say anything, even when I was at tech. When I was studying they made a special gazebo for smokers. I found I felt like I was being herded like an animal, but it still didn't put me off (40 year old nurse).

> They have made the grounds no smoking so if you want a cigarette you have to go out of the gates which is the public domain. In the public there is a say, but in the tech grounds there is no smoking at all (26 year old nurse).

Putting My Nursing Hat On

Nurses appeared to disassociate themselves as smokers from their nursing role. Smoking was seen as something that had little impact on their competency or performance as a nurse. There were,, however, limitations for some as feelings of guilt, shame, hypocrisy and feeling like a fraud was acknowledged. A lack of knowledge around addiction and the impact their own addiction had on their role as a nurse was rationalised as "I am competent at my job amd my smoking doesn't affect what I do."

You wouldn't know I am a smoker

Some were confident their smoking had no effect on their nursing roles, as they managed to provide advice to patients without disclosing their own smoking status:

> So to a patient I do my job and I advise them of the dangers of smoking. I ask them if they want assistance with cessation of smoking. If they do, if they take that option, I will support them through that. You wouldn't know I'm a smoker. If you were my patient you would not know I'm a smoker (42 year old nurse).

Separation of self as a smoker was employed by some when giving cessation advice. The nurses explained that as they did not smell of smoke they did not see themselves as a smoker:

> *Don't see myself as a smoker when giving advice-cause I don't smell of smoke (42 year old nurse).*

Some nurses were adamant their smoking was not detectable by their patients as they went about their daily work. By preloading with nicotene and not breathing over patients with their smoker's breath nurses felt their smoking would go undetected:

> *Sometimes at night time I will have a smoke if I want to. Only if I take my "smoke screen" but other than that you know I don't like breathing all over the patients and stuff like that (42 year old nurse).*

> *If you were my patient you would not know I'm a smoker. Because I have had a cigarette at nine o'clock but I am not seeing you until twelve o'clock. You don't know. I don't carry them into the house with me. You don't smell it on me, no (42 year old nurse).*

I'm pretty competent

Some nurses were adamant their ability to do their job was in no way compromised by being a smoker. They were certain they were good at their job and their smoking didn't affect their competency or effectiveness to provide cessation advice:

> *I'm pretty good at my job and you know well I'm pretty sure I'm good at my job. I'm pretty competent and to me smoking doesn't affect that (42 year old nurse).*

> *My smoking it doesn't interfere with the job that I do. I do my job. I do it very effectively (40 year old nurse).*

Just doing my job

Wearing their "nurses hat" meant nurses who smoked were able to separate themselves as a smoker or as a nurse. Wearing the hat meant they were in their role as a nurse. Once their "nursing hat" was removed this then gave them permission to be the smoker, and this made it "ok":

In other forms of my practice I don't think it would, it's separate from when I am working, I don't smoke at all. Smoking happens after when I take the nurse hat off then I have a smoke. I never smoke with my nursing hat on. I don't know if that makes it ok, but otherwise it does not really. I am aware of what is happening to my body because I am aware of what the consequences are (32 year old nurse).

Others were not as confident when they put their "nursing hat on", as they experienced feelings of guilt, shame and hypocrisy as a smoker. Advocating for cessation was difficult as they acknowledged they couldn't promote cessation if they practised smoking themselves:

I feel like a fraud really. I am giving brief intervention and smoking cessation, I don't want to come across as a smoker. I don't smell like smoke, how can I preach it if I practise myself? Sometimes I feel hypocritical when talking to them about it. But in saying that it is still needed to be said if I am a smoker or not. They need to hear the brief interventions to help them to stop smoking (32 year old nurse).

Knowing that that nurse smoked, I would probably think how (named other participant) felt like being a hypocrite. You are telling someone else you should not smoke first, but behind their backs you going out to have a cigarette. I would probably feel like her, you are being a hypocrite (26 year old nurse).

Lack of confidence and experience around providing cessation was a barrier for one participant:

Even if I was trying to give advice to give up smoking, it would probably be a little too hard at the moment (26 year old nurse).

Being A Smoker and A Nurse

Nurses were expected to be non-smoking role models by work colleagues and employers. Some contracts bound nurses to agree to be smokefree. Smoking in uniform or smoking on the grounds at work was prohibited as part of their contracts:

> *There is one colleague here that would like us all to be smokefree, would like the building to be smokefree. The building as in all the staff to be smokefree. And every year she tells us that and every year we give her the thumbs up. And the employer, well I just know on my contract that I'm not allowed to be seen smoking in uniform and I am not allowed to smoke on the grounds (42 year old nurse).*

Work policies further restricted nurses who smoked and some were encouraged by employers to quit smoking:

> *Well the employers try and encourage staff to stop smoking so that's why they have pushed this no-smoking policy so that you can be encouraged to quit smoking (32 year old nurse).*

Criticism and judgement from colleagues and in some cases friends, was felt by most of the nurses. Health professionals who smoked set a bad example and failed to set positive health behaviours for others:

> *So among my colleagues and among my social friends the key message is always: "Why are you still smoking?" Ooh that's disgusting, put your cigarette out, go outside, go away" (32 year old nurse).*

> *Makes me what to have a smoke at the end of it (32 year old nurse).*

One participant expressed the conflict of feelings they had experienced as a student nurse who smoked, as there were expectations that as a health professional they would not smoke:

> *Smoking was no good and becoming a health professional, so that even when I talked to people about smoking and if they asked me honestly if I am a smoker I will say yes I am, and I will tell them about the times that I have tried to give up, and it is not as easy as people make it out to be (40 year old nurse).*

It's not good as a nurse these days to smoke

Nurses kept their identity as a smoker from work colleagues through embarrassment and guilt. Hiding their smoking status was necessary as being a nurse who smoked was not a good look as they were often discriminated against.

We've got some nurses there that hide it, the fact that they smoke...they are embarrassed (42 year old nurse).

My colleagues don't know I smoke (35 year old nurse).

You know it's not good as a nurse these days to smoke. I mean in the old days doctors, nurses, everyone used to smoke (42 year old nurse).

Judgement from work collegues towards nurses who smoked ment some nurses went to extreme lengths to conceal their smoking. Pre-loading with nicotene before and after work was a method used by some to manage their smoking addiction and to conceal their smoking status from work colleagues:

Every break I have a cigarette, and when I eat, straight after I have a cigarette. I will have at least two before I get to work, and two before I get home (38 year old nurse).

The fear of being discovered as a nurse who smoked resulted in some smoking in their cars before and after work. Aware of the harm their smoking caused to passengers who would later ride in their cars, the nurses explained that this was not a regular occurence:

I will smoke after work in my car after a 12 hour shift. It's the only time I smoke in the car (36 year old nurse).

I know it's bad. In my car (38 year old nurse) .

How smoking is perceived by others

Whānau members who had given up smoking had the expectation the nurses would too, further reinforcing the shame and guilt felt as Māori nurses who smoked. Receiving a telling off from whānau members and friends compounded this shame and guilt. For other nurses their smoking status was met with disbelief and condemnation from whānau:

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"You are a nurse you should not be smoking, you should know better." Those are the sort of things I hear from my friends, and my family too (32 year old nurse).

"I did not know you were a smoker.... how surprising. Aren't you a nurse?"(34 year old nurse).

The "stink of cigarettes", the amount of money a person could save by not smoking and the warning "smokings going to kill you" were messages nurses were hearing from whānau:

My mother tells me to give up. My sister tells me to give up. It stinks and stuff like that (42 year old nurse).

Everyday my children tell me I stink (40 year old nurse).

Stop smoking, that's going to kill you. You stink. Do you know how much money you will have if you didn't smoke? (40 year old nurse)

Having empathy as a smoker

How smoking impacts on their role and a nurse's ability to give cessation advice was explored with the participants. Being a health professional and a smoker meant some did not advocate as hard when providing cessation advice to patients who smoked. Non-smoking colleagues were considered to be harsher and more judgemental when providing cessation advice. Some nurses who smoked took the line that it wasn't any of their business what the patient did and their work practise reflected this:

I know I don't try as hard, being a smoker, when providing cessation advise to patients and their whānau. If I wasn't a smoker maybe I'd advocate more about giving cessation advise. Non smoking colleagues tend to be more judgemental when giving patients advise around cessation (36 year old nurse).

Obviously, if it's your patient like (names other participant) said you would talk and discuss it with them and offer them advice and support, yadda, yadda, yadda. But I'm not really one of those people that care what other people do aye.

If they're going to smoke, they're going to smoke. It's none of my business (38 year old nurse).

Empathising with other smokers meant some nurses advocacy efforts were not as strong, as their belief was that people should be left to make up their own mind. Being two-faced did not sit comfortably for some nurses when offering cessation advice, so they "did not go on about it":

I tell people, but I don't go on about it because I smoke. I feel it is just being two-faced. You know what I mean? I give them the option if they choose not to that's fine with me. You know these people are like old enough as far as I'm concerned and I don't think like going on to them is beneficial to them and banging on just turns people off, you know. They already know we know the message; it is the stopping that's the hard thing (42 year old nurse).

The perception that smokers judge and non-smokers don't, caused empathy for the patients that smoked, with some of the nurses:

But as a nurse I don't think I'd still bang on about it because you know these people are under stress, and like I said before, some of them have already given up (42 year old nurse).

Nurses' behaviour was split between rapport building and showing empathy towards their patients. There was a belief by some nurses that if patients knew they were smokers, respect and understanding would be reciprocated:

You know like some patients say: "If you do bang on about it how do you know, you don't smoke?" "Well actually darling I do I just don't smoke at work". And you get respect from them because they know, you know, because they understand. Well it can't be that bad, you know, not that bad the habit itself, but that they know (42 year old nurse).

By not being judgemental and empathising with patients who smoked one nurse offered sympathy and her feedback gave an insight into what it was like being a smoker and "being nagged" by health professionals to look after their health:

I am not judgemental. I never have been. People are their own person they should do whatever they want. I was studying last year going into my second

postgrad cert and we were by (names hospital), where the museum is. You have the little booths out the front, I went across there and I sat in there. I was sitting with two Māori people, a man and a woman and I was listening to them talking about how health professionals were always nagging at them, so not encouraging them, nagging at them to give up. "Your health would be much better." They were quite upset. I looked at them and they looked at me and they asked me my opinion. And I said I do understand where the health professional is coming from and they went, "How do you understand that?" and I told them that I am a nurse myself, and yes, I do smoke but I have not lit up yet, as the smell and the smoke in the booth was enough for me not to light up a cigarette. It was just yuck. It was just full of smoke. They were speaking to me and I go, "If they had come across differently. If they were not judgmental would you think you would give up?" "Yes, we would because it is like we are being told off for what we have done for many years" (38 year old nurse).

There was an opposing response from one participant though as they indicated their providing cessation advice was not "clouded" because they were a smoker therefore sympathy with the smoker was not shown:

I don't think there would be a difference. The fact that I'm a smoker should not do anything to the advice I am giving the patient. If you're asking me being a smoker am I more accepting of patients that smokes? No, not at all. Not if they've got an ulcer on their leg that they've had for the last three years, that, you know, their arteries are blocking because of their smoking, and if they don't stop the smoking they could lose that leg. No, I am not going to be any more accepting of that than my non-smoking colleague is (42 year old nurse).

Summary of the Findings

The findings provide insight to help understand the behaviours, attitudes, beliefs and complex issues faced by Māori nurses and student nurses who smoke when providing cessation advice to patients and their whānau. Early initiation influences were complex and the findings revealed both whānau and peer groups as the major contributors when influencing smoking initiation. The sense of inevitability felt by many participants towards smoking uptake was accentuated by ease of access to tobacco products, and whānau

acceptance of their smoking behaviour. Peer group relationships and the interaction they had during and after school also played a key part in initiation.

Alcohol was a major influence in continued smoking behaviours and was linked to use in wider social group settings that provided friendship, support and acceptance of the groups' behaviours. Social smoking was also linked to alcohol use, and nurses' smoking behaviour appears to intensify when use of alcohol was involved.

There was an overriding sense of frustration and hopelessness voiced by the nurses at the lack of control over their smoking behaviour. However, the lack of recognition and denial that smoking was an addiction further added to their sense of frustration. Workplace rules about smoking, the government's focus and implementation of tobacco control strategies, and judgement by colleagues irritated and angered some of the nurses, as these factors were also out of their control.

Nurses had good intentions to quit smoking but more often than not relapsed. Relapses were frequent. Lack of support by partners and whānau and poor quit methods contributed to the many relapses. Pharmacological support was either ignored or under-utilised as most participants chose to go cold turkey when quitting. Criticism by work colleagues, stigmatism and the lack of understanding of the difficulties faced as nurses who smoked added to the hypocrisy nurses felt and further impacted on their smoking behaviours. The impact the nurses' smoking had on their ability to provide impartial smoking cessation advice to patients was clearly evident. Empathy towards patients that smoked and providing cessation advice was compromised by their own smoking behaviour.

There are many complex issues why wāhine Māori nurse smoke. Some of the issues can be linked to social contexts when they are with whānau and friends. Behavioural issues, such as how to deal with stress and the overwhelming sense of powerlessness felt around their smoking behaviour, add to these complexities. An in-depth look at the factors which continue to contribute to Māori nurses and smoking, and the conflicts and dilemmas they experience will be discussed in the next chapter.

Chapter Five: Discussion

In their private life habitual use of tobacco products and acceptance of smoking behaviours by whānau, partners and their social circle meant smoking was a complex issue for the nurses in this study to deal with. At work the nurses had to confront their own smoking status on many levels and were faced, daily, with the implications of being a nurse and a smoker. In this chapter the findings are discussed and examined in relation to the research question, what are the experiences wāhine Māori nurses have who smoke and how does this impact on them when providing smoking cessation advice to others? How the findings fit within the existing body of literature will also be outlined and implications of the findings are summarized.

Application of Knowledge

My findings show nurses know smoking is not good for them, but they do not appear to be applying this knowledge to their own smoking behaviours. The nurses readily admitted the graphic warnings on cigarette packets showing diseased lungs did not discourage them from smoking. Radsma and Bottorff 2009 explained one reason nurses who smoked did not apply this knowledge to their smoking behaviours is that they played down the health risks connected to smoking. Chapman and Liberman's (2005) research on tobacco consumers' rights acknowledged that for most smokers there is a definite knowledge gap around the health dangers associated with smoking. Chapman and Liberman's findings, however, are in direct contrast to Gifford et al.'s (2013) research that indicated nurses wanted to quit or intended to quit as they had concerns for their personal health and wellbeing and as smokers this was an issue for them. My findings support Chapman and Liberman's claim that whilst nurses have concerns about lung cancer and know of the risks associated with smoking they do not connect this to their own health. Further, the research reported in this thesis shows one of the difficulties the nurses faced and therefore, minimise, is the risks of smoking to them. Through their role as nurses they are hardened to the realities of smoking and say smoking related diseases, pictures on tobacco packaging and other negative health

factors that result from smoking do not mean a thing to them. The other issue my findings show is that the nurses justify their smoking in a "hierarchy of badness" by voicing smoking in their opinion is not as bad a diabetes or as detrimental as alcohol. The nurses defend this hierarchy by saying the other health issues create far bigger problems and cause more harm in society than their smoking does.

Nurses' Personal Beliefs about Smoking

After reviewing the literature on nurses' beliefs around smoking, it appears nurses who smoke concluded it was a person's choice to smoke or not, and as smokers they could understand the reasons for a person choosing to smoke (Gifford, Walker, et al., 2013; Heath et al., 2004; Perdikaris et al., 2010). I found also that nurses in this research support this belief, respecting the rights of their patients to make decisions around their health, and therefore, avoid giving cessation advice. It was a matter of being non-judgemental. The nurses talked about being a smoker meant they did not judge other smokers, as the option to smoke is their own. Making their own choice to smoke or not is corroborated by Gifford et al's (2013) study that found nurses felt smoking came down to a matter of individual choice and that the nurses understood the reasons behind a person's choice to smoke. Moreover, Gifford et al.'s findings show that nurses experience conflict when they are expected to promote smoking cessation, especially as their personal behaviour conflicts with the messages they hear and give as health professionals.

Professional and personal realities

Nurses' struggle with the push and pull of how to cope with the realities of living in two worlds: that is as a health professional and as a smoker in their personal life. Living in these two worlds impacts on their headspace as the nurses reported knowing their nursing experience and evidence tells them smoking is not good for their health. Acting on this knowledge, however, the findings indicate that the nurses are not linking the actual evidence of ill-health associated with smoking to their personal and professional realities. In Radsma and Bottorff's research (2009) they hypothesised that cognitive dissonance theory (Festinger, 1957) explained the contradictions in nurses' behavioural and cognitive actions to

rationalise their smoking. They found nurses who smoked considered they were inadequate role models, and experienced conflicting feelings when confronted with their nursing responsibilities. Radsma and Bottorff maintained this may well explain why nurses continued to smoke, knowing the health consequences of their actions.

Nurses who smoke do face daily dilemmas and conflict over the realities of their professional role when providing smoking cessation to others. This research shows that being a nurse and a smoker impacts on their job, how they approach cessation, how hard they advocate or the degree of empathy they show smokers when providing smoking cessation to them. Similar research from Gifford et al. (2013) also found being a smoker and a nurse created conflict and compromised their position when offering effective cessation advice to others. As a nurse and a smoker the nurses in my study were often placed in a difficult position when wearing their "nursing hat" and that led to embarrassment and guilt-laden feelings. Additional evidence from Gifford et al.'s research also validates the findings that nurses who smoked regarded their conduct as incompatible with their role as health promoters. A nurses' smoking status also impacts upon their ability to provide quality healthcare to patients. As a smoker the nurses empathised with tobacco-dependent patients, gave limited intervention advice, neither did they advocate as hard when faced with providing cessation advice to others (Gifford, Walker, et al., 2013; Heath et al., 2004; Radsma & Bottorff, 2009; Wong et al., 2007).

The ability to provide impartial advice and advocate for smoking cessation is compromised by the nurses' smoking behaviours. My research shows that because nurses feel empathetic towards their patients who smoke they do not advocate as hard as they sympathise with them and their status as a smoker. This view is supported by other studies that highlighted nurses who smoked felt inadequate when tasked with providing cessation advice to others (Gifford, Walker, et al., 2013; Heath et al., 2004; Radsma & Bottorff, 2009; Sarna et al., 2010; Wong et al., 2007). Heath et al., (2004) argued that nurses should have a degree of accountability to promote providing cessation advice to patients. While nurses in my research accepted that providing smoking cessation advice to patients was part of their role they did feel "two-faced" and hypocritical when they did. The nurses articulated that they did not want to be known as a smoker because of the hypocrisy of promoting smoking cessation advice when they are not practising it too.

My findings show nurses in my study had a clear awareness of their identity as nurse clinicians who are expected to role model healthy behaviours. But they also had daily conflicts when carrying out this role as smokers, thus creating ongoing difficulties. Similar research carried out by Gifford et al., (2013) found nurses who smoked expressed great anxiety over role modelling healthy behaviours, and that their continued smoking behaviours sent out conflicting messages. The nurses in my research claimed they felt like frauds and questioned how could they preach smoking cessation when, as smokers, they also found it difficult to quit. Heath et al's., (2004) also found that nurses are in a difficult situation when encouraging patients to stop smoking, especially when they cannot stop smoking themselves.

Radsma and Bottorff (2009) also found nurses that smoke understood patients who smoked and empathised with them when they faced decisions about whether to continue to smoke or not. Heath et al. (2004) stated the nurses who smoked in their research struggled when they were caught in a tug of war between their personal dilemma of understanding smokers and their professional responsibility to provide smoking cessation advice. My findings also point to a personal-versus professional tug of war Māori nurses experience creating a conflict for them about when it is appropriate to talk to patients and their families about smoking cessation. The nurses claimed this "tug of war" places them in a difficult position, especially with the expectation that smoking cessation is part of their role. Gifford et al. (2013) found that Māori nurses saw themselves as crucial elements in preventing smoking uptake for Māori. However, they felt inadequate when promoting smoking prevention and providing smoking cessation advice. The nurses' realised smoking intervention was a part of their role but, they experienced conflicting feelings as smokers, which increased their anxiety and sense of hypocrisy when confronted with promoting smoking cessation.

Radsma and Bottorff's (2009) findings lend support to the findings that the nurses feel conflicting emotions and responsibilities as role models, and therefore, avoided promoting smoking cessation to patients. The nurses in my research spoke of the predicament their collective responsibilities imposed and hesitated to approach smoking cessation rationalising that patients had enough to worry about without them "banging on" about giving up smoking. Adding to that conflict and avoidance is the deception some nurses employed by portraying themselves as non-smokers to the patients and families they conversed with. I found the

nurses attempted to get around this conflict by giving patients the choice to quit or continue smoking. If patients chose to smoke then that was okay as they felt that they had accomplished their professional obligations by at least offering smoking cessation advice.

My findings also showed that the nurses were adamant that their patients would not know that they were smokers or could detect that they were smokers. The nurses smoked cigarettes either before work or several hours before they saw their patients or clients in the community. The smell of smoke, they believed, was not on them nor were they carrying cigarettes. This helped nurse to rationalise their non-smoking status as they believed it was undetectable to the patients they saw. The deception continued as nurses did not see themselves as smokers in their professional role. Heath et al. (2004) confirmed this deception occurs, and found the nurses in their research did not want their patients to know they were smokers because they did not want to give the impression they condoned smoking. Nurses in this study also had conflicting feelings as a nurse and a smoker and were fully aware of the hypocrisy of the situation that they were in, and the image this created.

Stress and the Conflicts of Being a Smoker and a Nurse

Data from this research shows that while nurses face daily stress connected to their job and family, they also experience extra stress in their life associated with the conflict of being a nurse and a smoker. The degree of subterfuge nurses employed to hide their smoking status from colleagues was enormous. Radsma and Bottorff (2009) agreed that nurses kept smoking status from work colleagues because they were often judged and criticised about their smoking behaviour. The nurses in this study indicated they felt embarrassed and that the pretence of being a different person at work resulted in self-recrimination that added to their stress. Berklemans et al. (2010) and Heath et al. (2004) also described the interpersonal struggle nurses experienced when dealing with the shame and embarrassment of coping with their smoking status as a health practitioner.

The findings show that nurses wear "two hats" to cope with the scrutiny from colleagues and lead a double life. In their personal life they are a smoker who happens to be

a nurse, and when they put on their "nurses' hat" they are a practising health professional. The nurses described being two different people is hugely stressful. When wearing their nursing hat the nurses said they disassociated themselves from being a smoker to cope with the stress, shame and tension this causes in their work environment. The nurses stated their smoking occurs before or after they don their nursing hat. The respondents in Heath et al.'s (2004) study had varying views of themselves as smokers to cope with the stress of being a nurse who smoked. Many of the nurses in their study had a non-smoking image of themselves because they felt they didn't look like a hard core smoker. They kept this daily pretence up so work colleagues assumed they didn't smoke.

Respondents in Heath et al.'s (2004) study of nursing practitioners concluded that the stress associated with tobacco use affects all aspects of their daily lives, especially their professional life as a nurse. They argued it was no longer acceptable to be a health professional and a smoker. This forced nurses to live daily with this paradox and the subsequent responsibilities and expectations that went with their role as health professionals. The findings in my research support Heath et al.'s arguments, as the nurses say smoking was once accepted but now it is not a "good look." Sarna et al.'s (2010) are of the same opinion, and state that increasing societal pressures are being put upon nurses to be smokefree and continued smoking practise leads to stigmatisation which adds to that stress.

Collective Obligations and Responsibilities

My findings show that nurses who smoke have expectations from their workplace, work colleagues and whānau that they will be non-smoking role models. Nurses' smoking impacts on work relationships especially because some work colleagues are totally unaware they smoke. The stress of hiding this fact impacts on the nurses physically and psychologically on a daily basis. Discrimination and intolerance of their smoking by work colleagues forced the nurses to go to extreme measures to cover up their smoking status. In Dawson et al.'s (2010) study they found institutional racism and discrimination by staff against Aboriginal health workers who smoked led to severe stress and fear of recrimination. The nurses in my research stated they feared being discovered as a nurse and a smoker, and this drives them to pre-load with nicotine before they start the day in order to cope with

the scrutiny and prejudice they experience from their non-smoking work colleagues. The nurse practitioners in Heath et al.'s (2004) study described the stress of hiding their smoking status and the judgmental behaviour imposed upon them by work colleagues was intolerable. Heath et al.'s confirmed the intolerance and bigotry nurses experienced from hurtful and negative comments around their smoking behaviour had a detrimental impact on them and their work practises. Berklemans et al. (2010) put forward the idea that nurses used smoking as a means of escaping from the criticism and allegation by work colleagues that their smoking impacted on their job.

The nurses in my research stated they felt their smoking did not compromise their ability to do their job. They reported they are effective at their job and deserved recognition for the work they did in health promotion. Comments from respondents in Heath et al.'s (2004) study similarly identified that colleagues disapproved of them as they smoked. However, the nurses in their study also believed this did not alter the fact they too felt they were outstanding at their job. The findings from this research and that of Nagle, Schofield and Redman (1999) concur that nurses believe their smoking status is actually helpful in the provision of smoking cessation advice to others. The nurses in my study indicated that as a smoker they understood others who smoked and this supported them in their role as a health practitioner.

Social Life Supports Smoking

The social context of the nurses' smoking is an important issue to understand and my findings show there are a number of complex issues in relation to socialisation and the nurses' smoking. The nurses said their smoking was directly linked with their involvement in their social networks that include friends, whānau and work colleagues who also smoke. Acceptance from the group and the camaraderie with other smokers outweighed the evidence and knowledge nurses have around the harm of smoking. However, while nurses made multiple, but unsuccessful, quit attempts they were unable to sustain abstinence from smoking because their social circle of friends was more accepting of them as a smoker. Similar research by Dawson et al. (2012) showed the social aspects of smoking with work colleagues also brought acceptance as a smoker and promoted camaraderie from belonging to the group. Gifford et al.'s (2013) data is similar to my findings that point to a family history

of smoking and acceptance within their community as key contributors to their social context, and added to the reasons why smoking for Māori nurses is more acceptable.

The nurses in my research all agreed their social life supports and rewards their smoking. They stated it was the way they cared about and looked after each other that supported their desire to continue to smoke, especially when they socialised. Smoking with a group of like-minded people, they indicated was a supportive experience as this made them feel part of the group, and contributed to a sense of belonging. Belonging to a group is a strong motivator and having a drink and a smoke was described as "real bad, but real nice". The place to be was with the smokers when socialising which they identified as the "fun group" to hang out with. Likewise, the nurses describe socialising and drinking with mates and whānau as "a social thing".

An increase in tobacco consumption occurs in a social setting especially amongst the nurses who class themselves as social smokers. Fernandez and Wilson's (2008) research concluded that some Māori women who smoked also had partners, whānau and peer groups that supported and sustained their smoking behaviours. The findings of this research show nurses who have partners who smoke strongly influence their smoking behaviour and motivation to quit smoking. The nurses' voiced if their partners and whānau were to give up that would be all the motivation they needed to quit.

A Strong Desire to Quit

The findings of this research and that of Gifford et al. (2013) indicated the nurses are open to quit attempts and they say they were thinking of quitting or had experienced quit attempts on a regular basis. When the nurses undertake quit attempts, however, they rely on personal experiences of quit smoking success rather than evidence-based quit smoking methods. The nurses in my research and that of Gifford et al. (2013) revealed the method they prefer to use to quit was cold turkey. Research carried out by Hung, Dunlop, Perez, and Carter (2011) that set out to study successful cessation methods (used at population levels) found participants claimed cutting down tobacco consumption and cold turkey quit methods were the most helpful. However, use of cold turkey as a quit method, nicotine replacement

patches and other pharmaceutical products used by the nurses in this study and Gifford et al's. (2013) research found these were used with varying degrees of success by nurses.

Successful quitting is dependent upon the nurses' knowledge of the pharmaceutical products and how to use them correctly. My findings and that of Gifford et al.'s (2013) assert that a lack of in depth knowledge around what works best for successful quit smoking support is evident. The nurses in my study reported that pharmaceutical products remain in draws after one use because they made them feel sick, or they were unsure how to use them. Not asking for support or clarification on how to use them also hindered their quit attempts. Nurses' lack of knowledge coupled with the denial of their addiction contributed to mixed results when attempting to quit.

Denial of Addiction

There was a strong desire to quit smoking amongst the nurses in my study but they denied that they were addicted to nicotine. Denial and the seriousness of their addiction was not readily addressed as the nurses described their smoking behaviour as a habit, "just a bad habit." Māori nurses in Gifford et al.'s (2013) web-based research also described their smoking as a bad habit, and like this study, the nurses' said is was something they could control and that they would quit smoking when ready; the time just needed to be right.

However, nurses are addicted to tobacco products just like other members of the population who find it difficult to quit smoking. Radsma and Bottorff (2009) found nurses in their study experienced the same physiological traumas as other smokers and had to deal with this addiction on a daily basis. The daily struggle nurses have with tobacco addiction mentally impacted upon their "head space" and on their role as nurses. The hunger or urge to smoke was described by respondents in Health et al.'s (2004) study as the biggest issue they struggled with, and endorse my findings that nurses face daily psychological barriers.

Nicotine locks into the reward centre of the brain by mimicking the action of the neurotransmitters that release the feel good chemicals or endorphins (Heath et al., 2004).

The nurses I interviewed confirmed they manipulated their nicotine levels to satisfy their addiction as they loaded up before and after work. Heath et al.'s stated this action of pre-loading not only allowed the smoker to tap into the reward system of the brain, but it reinforced their smoking behaviour. Respondents in their research stated the power of nicotine was so strong they would happily drive through a storm to purchase cigarettes, if needed.

Some of the nurses in my research described themselves as social smokers only, and denied any addiction as they were not daily smokers. These nurses share similar views with smokers in Pulvers et al.'s (2013) study. Pulvers et al. posited that their research on classifying a smoker according to their self-view as a daily or nondaily smoker was an indicator of smoking behaviour. Their research concluded that nondaily smokers did not see themselves as smokers and accordingly played down their risks for tobacco-related diseases. They also passed up the opportunities for cessation interventions. My findings agree with Pulvers et al. in that the nurses who said they were non-daily smokers did not associate the risks of contracting tobacco-related diseases to their own smoking behaviour, nor do they see the significance of cessation interventions in their role as a nurse. The non-daily smokers in my study rationalised their smoking by saying they smoked on an irregular basis and therefore were not a "hard core" smoker. Hence they did not see the need to quit. The need to quit smoking, therefore, did not register with them, as they did not see themselves as consumers who could also justifiably access quit smoking services. Maybe the nurses believed those services were for clients/patients and as they were the providers of smoking cessation intervention advice they believed they were not eligible to access Aukati Kai Paipa and other quit service support.

Evidence that nicotine dependence is a complex issue is borne out by Berklemans et al.'s (2011) research that showed many unsuccessful quit attempts occurred when the nurses in their study tried to change this dependence. My findings show some of the nurses who quit smoking relapsed when they were around other smokers or when they exposed themselves to the smell of cigarettes. Socialisation with other smokers triggered the urge to smoke and relapse was common. An upsetting incident or argument also set off the desire to smoke again. Heath et al. (2004) asserted that most individuals who have tried to quit relapsed after a traumatic incident, or when incurring high levels of stress, and engaged in destructive social circumstances or when they also experienced cravings for nicotine. The

data from my research supports Heath at al. in that the nurses' relapses occurred when they confronted stressful and emotional situations and lacked whānau or partner support which contributed to renewing their smoking behaviours.

Accusations by whānau around their being a nurse and smoker and, questions about why they did not give up smoking added to the guilt and shame the nurses felt. The nurses in this study spoke about feeling victimised and a target group in society. They wished the focus could turn to someone else, like all the alcoholics for example. Gifford et al.'s (2013) research also found participants expressed anger at the government's auahi kore strategy and stated whilst the messages reinforced the negative affects of smoking the anti-smoking lobbying made them feel they were brainless and persecuted for being a smoker. The data from this research and that of Gifford et al. shows nurses see this as further "nagging" to give up smoking, and described it as interference in their lives. The decision to make a personal choice to give up, when they are ready and not when they are told to is borne out by the findings in this study and that of Gifford et al.'s (2013) .

Chapter Summary

Useful insights into the entrenched smoking behaviours of Māori nurses and how these behaviours impacted upon them in their role as nurses were revealed. The expectation that nurses would provide smoking cessation advice and be smoke-free models caused tension and created conflict amongst colleagues and whānau. Nurses' addiction to tobacco and the subsequent relapses that occurred after quit attempts failed were play down, and described as something that just happened. The lack of knowledge around how nicotine worked and the effectiveness of evidence-based quit methods were highlighted by nurses' non-use of these methods when attempting to quit.

Chapter Six: Conclusion

This chapter summarises the results of thesis and explains how the findings of this study are important, how they influence our knowledge and understanding of Māori nurses who smoke, and the impact their smoking has upon them when providing smoking cessation advice to others. The strengths and weaknesses of this research are discussed and the limitations of the research are explored.

Research Strengths and Limitations

A restriction of this research was the amount of current literature that pertained to Māori nurses who smoked and how their smoking behaviours impacted on them when promoting smoking cessation to others. Whilst the literature research was expansive only the recent articles by Gifford et al. (2013), came close to capturing data specific to this study and provided some insight into highlighting the tensions and triggers Māori nurses who smoked experienced in their role as health practitioners. More investigation in this area could support researchers to add to the limited body of knowledge in this field so a better understanding of Māori nurses who smoke and how their smoking impacts on their role is achieved.

Initial contact with Māori nurses regarding participation in the interviews was made via email and this method of contact may have limited the range of respondents and excluded those who did not use email. The nurses I interviewed came from a variety of nursing settings, however, none of the nurses interviewed worked in a mental health setting, where smoking prevalence for this group remains higher than other health professionals (Edwards et al., 2011). The age range of the participants at 25-42 years of age was younger than the average age of the nursing population at 43.7 years (Nursing Council of New Zealand, 2012). If nurses in an older age-range were included in the study, and from more varied nursing backgrounds, they may have provided a different perspective. Only one trainee student nurse took part in the interviews and this may have limited the understanding of why smoking prevalence for Māori student nurses at 32% is higher than Māori nurses' smoking prevalence at 20% (Gifford, Wilson, et al., 2013).

The strength of this research was its ability to draw from a Māori world view. A kaupapa Māori research framework and narrative process helped to address the research question and supported me, as a Māori researcher, to uphold Te Ao Maōri world views throughout the research process. Māori tikanga and protocols that underpinned the research were adhered to and ensured a Māori perspective was maintained throughout this study. As experienced Māori health, tobacco control and nursing research the researchers from Whakauae research and Taupua Waiora centre for Māori research were able to provide me with extra insight and knowledge with issues nurses faced with tobacco usage.

The Principal Implications

The data from this research revealed invaluable information and insights into the difficulties associated with being a nurse and a smoker. The tensions, conflicts and hypocrisy nurses experienced when faced with offering cessation advice to others suggests there is a strong need to support this group to quit smoking. To do this, nurses need supportive environments with their colleagues and employers on board to help them quit. Better understanding of Māori nurses who smoke and how they manage addiction would go some ways towards supporting them to quit. If Māori nurses quit smoking before entering the workforce they could become even more effective in supporting whānau, hapū and iwi to quit smoking and the benefits to Māori communities and their health would be two-fold.

Conclusion

Being a smoker and a nurse created huge conflict for the participants in this research. The nurses behaved at times like they were in a war zone as they wore a protective shield around them due to the tensions created by non-smoking colleagues. This constant judgement at work created animosity between the nurses and colleagues and resulted in stigmatisation of the nurses who smoked. Many nurses, therefore, hid the fact that they were smokers from their disapproving colleagues to reduce the tensions felt within their working environment and to counteract the negativity they experienced. Hurtful negative comments from colleagues were commonplace and the "nagging" inflicted upon them by some whānau

and societal pressures to be a non-smoker further condemned the nurses. Workplace expectations and obligations to be seen as non-smoking role models further added to the tension nurses experienced nurse as a smoker. To change nurses' smoking status at work colleagues, therefore, need to be more sympathetic in supporting nurses to quit. Rather than taking the moral high ground regarding nurses' smoking status, work colleagues need to realise the impact of their negative comments. Supportive programmes have to be offered to nurses to quit without making them feel guilty about their addiction or fearful of being judged by colleagues for their smoking status. Nursing teams and their employers, therefore, play a vital role in providing leadership and support to nurses who smoke, so they become more empowered to be smokefree.

Part of the government's push towards auahi kore 2025 is to encourage health professionals to promote smoking cessation, therefore, leaving nurses who smoke feeling two-faced and frauds. This research identified that nurses who smoked saw themselves as inadequate role models. In addition to this, their sense of hypocrisy reduced their ability to work effectively with patients who smoked. To counteract the hypocrisy felt the nurses "wore two hats". By wearing two hats, nurses were able to cope with the negativity exhibited by work colleagues regarding their smoking status and also deal with work demands and expectations of providing cessation advice to others. When wearing their nurses' hat the nurses did not smoke, therefore, they felt removed as smokers. They did not make the connection with the cessation advice they were providing to other smokers as they did not see themselves as smokers.

The nurses did, however, recognise that their smoking conflicted with their identity as a health professional and recognised the impact their smoking had on their ability to provide effective cessation advice. Nurses, therefore, were caught in the middle, knowing that there were definite expectations of them as health practitioners to be non-smoking role models and that by smoking this sent out inconsistent messages to others. Nurses who smoked were compromised when it came to providing cessation advice. The interpersonal struggle nurses had with their role of providing smoking cessation advice to patients and the need to minimise the hypocrisy they felt as a nurse who smoked, further added to their guilt and shame.

Denial of the health risks of smoking, despite seeing and knowing the impact smoking had on whānau members or patients in their care did little to convince nurses to quit. Years of entrenched behaviour and acceptance of smoking by whānau and compliance by partners around their smoking status compounded nurses' smoking behaviours. Consequently, the nurses' experienced daily struggles with their smoking behaviour especially as many had been smokers since their early teens. Acceptance of smoking within their social group continued to support their sense of identity and maintained their social connections. Nurses need support to recognise they are the role models for their whānau, hapū and iwi to bring about change so that their long term health and the health of future generations remain healthy and well. In order to achieve this, Māori nurses need to first value themselves and recognise the effect their smoking behaviours have by impacting on wider whanau and their health behaviours. If nurses are in control of their own health and wellbeing they can support whānau to effectively learn about the harmful effects of smoking in a culturally relevant manner. If undertaken through processes of sharing experiences, creating positive support and influencing each other toward smoking cessation then tino rangatiratanga (self-determination) will occur through empowerment, independence and ownership. To support the nurses' awareness around behaviour change is required. Strategies are essential for nurses that make them think about their current behaviour. Messages therefore are required that empathise with nurses' smoking behaviours as well as motivate change to occur.

Maori nurses have a strong intention to quit but are not using the current range of cessation support services to full effect. The quit attempts in this occupation group, therefore, could be better informed by evidence. Being a nurse and a smoker can make it tougher for them to quit, as the expectation is they shouldn't be smoking. Nurses, therefore need to be in a state of readiness to quit. Nurses, however, are seeing relapses as failure, rather than something that just happened. This study found nurses appeared to have little knowledge around addiction, as relapses were common. The entrenched smoking behaviours by nurses and heavy addiction to nicotine means awareness to address their addiction will be necessary before nurses can contemplate quitting.

Nurses' tobacco addiction, therefore, threatens the very nature of their work and destroys confidence in their profession. Nurses, however, classified smoking as a choice, not an addiction, and stated they would quit smoking when they were ready to, when the time was right. But is smoking really a choice, when evidence tells us nicotine is a highly addictive

substance. Providing nurses with a knowledge package that includes awareness around whether smoking is a choice or an addiction could be an effective way of supporting nurses to gain an understanding of the addictive properties of nicotine. Gaining an understanding of nurses' tobacco addiction, therefore, and how their addiction impacts on offering cessation advice warrants more investigation.

To address the prevalence of smoking by Māori nurses regard must be given to the triggers and enablers of their smoking. Whānau support to increase the number of quit attempts and interventions that are underpinned by Māori kaupapa (strategies) are needed to enable Māori nurses to be smokefree. If nurses were given a "toolbox" of quit options that included: an awareness of behaviour change management strategies, a knowledge package of nicotine and how it works and proven quit methods, as opposed to using word of mouth, then this may go toward creating an environment where nurses who smoke are supported to quit.

Nurses are seen as valued and trusted members of the health profession. Being addicted to tobacco does not make them any less trustworthy and skilful. However, nurses' smoking is a barrier and being smokefree is crucial to them playing a vital role of increasing efficacy of cessation interventions with wider whānau. To lay blame and stigmatise nurses for their smoking status is adding another barrier to the guilt and burden they already carry as nurses who smoke. Smoking, therefore, is the barrier to be removed. As non-smokers nurses would be positive role models for other wāhine Māori, especially Maōri student nurses and be more able to support whānau to quit. This research concludes advocacy for a kaupapa Māori smoking cessation intervention for Māori nurses, with key tools based around a knowledge package for effective smoking cessation intervention for nurses could be invaluable. Improving quit rates for Māori nurses who smoke has the added benefits of increasing efficacy of cessation interventions with wider whānau and for the largest population group of smokers in New Zealand- Māori women.

I'd like to conclude my thesis with a whakatauki that I believe has strong relevancy to the work ahead of us all in supporting Māori nurses to be empowered to achieve an auahi kore status for themselves and whanau and to achieve the end goal of a Tupeka kore 2025.

Me ka moemoeā au, ko au anake

Me ka moemoeā e tātou ka taea e tātou

If I am to dream, I dream alone

If we all dream together then we shall achieve

Te Puea Herangi

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Appendices

Appendix 1: Ethical Approval

A U T E C

S E C R E T A R I A T

21 March 2013

Denise Wilson
Faculty of Health and Environmental Sciences

Dear Denise

1. Re: Ethics Application: **12/190 Maori nurses and smoking - Wāhine Māori nurses' and their role in smoking cessation**

Thank you for your request for approval of amendments to your ethics application.

I have approved minor amendments to your ethics application allowing the addition of a Masters student to the research team.

I remind you that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 23 August 2015;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 23 August 2015 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Dr Rosemary Godbold

Executive Secretary, **Auckland University of Technology Ethics Committee**

Appendix 2: Participant Information Sheet

Participant Information Sheet

Paired Interviews – Wiki Shepherd-Sinclair

Date Information Sheet Produced: 28 February 2013

Project Title

Māori nurses and smoking: Exploring the context and opportunity for change

Wāhine Māori nurses' and their role in smoking cessation

An Invitation

Tēnā koe. Ngā mihi mahana ki a koe.

We are carrying out research to find better ways to help Māori nurses quit smoking. This research is being funded by the Health Research Council (HRC).

The people who are carrying out the research are Dr Heather Gifford, the Director of Whakauae Research for Māori Health and Development (also known as Whakauae Research), an iwi based research centre located in Whanganui; Associate Professor Denise Wilson, the Director of Taupua Waiora Centre for Māori Health Research at AUT University; Dr Leonie Walker, a full-time researcher with the New Zealand Nurses Organisation (NZNO); Ms Melody Potaka–Osborne, a full-time research assistant with Whakauae Research; Dr Amohia Boulton senior researcher with Whakauae Research; and Lynley Cvitanovic also a researcher with Whakauae Research. My name is Wiki Shepherd-Sinclair, and I am a student completing a Master's of Public Health thesis at AUT, titled: *Wāhine Māori nurses who smoke and their role in smoking cessation.*

What is the purpose of this research?

Smoking is a serious health concern for Māori, particularly Māori women who have a 50% smoking prevalence rate. Māori nurses are well positioned to support smoking cessation among Māori, although a number (30%) are also smokers. The literature suggests that a tailored smoking cessation intervention is likely to work better for health professionals than those interventions readily available to the public. In order to maximise the potential for Māori nurses to encourage Māori to quit smoking, a quit intervention specifically for Māori nurses first needs to be developed.

This research will use multiple methods with the aim of designing, developing, and testing the feasibility and acceptability of a quit intervention suitable for Māori nurses. The outcome will be a

kaupapa Māori quit intervention specifically for this group of smokers. In addition to the main study, I would also like to use the information collected to understand the role of Māori nurses who are smokers in smoking cessation activities.

How was I identified and why am I being invited to participate in this research?

You have been asked to take part in this research because you indicated an interest in being interviewed when you completed our recent survey. We hope that you are still willing to help as your thoughts on smoking issues and quit support are critical.

What will happen in this research?

You are invited to take part in a paired interview (an interview with another Māori nurse in your area). The interview will involve sharing your views on smoking, on quitting smoking and on the particular quit challenges you feel Māori nurses face. The interview will take place at a time and place convenient to you and could take up to two hours. The interview will be digitally recorded and later transcribed. During the interview we will take interview notes. You will be offered the opportunity to review your transcribed interview. I will also be using your transcript to analyse the data for my Masters of Public Health thesis. It is planned that the study will be finished by February 2014.

What are the discomforts and risks?

We understand that talking about these issues may cause uncomfortable feelings, and perhaps remind you of times in the past when you have struggled with smoking, the health effects of smoking for you and your whānau. We are aware that in the past there have been negative, blaming approaches taken, particularly toward Māori nurses and their smoking.

How will these discomforts and risks be alleviated?

We hope that by providing a safe, confidential, non-judgmental and supportive space you can talk openly about issues with other Māori nurses with similar experiences that the discomforts and risks will be kept to a minimum. In the event of real distress, in-person or online counselling will be made available to any participant who feels that they need this.

If you need to access counselling services you will need to:

Contact AUT counselling centres at WB219 or AS104 or phone 09 921 9992 City Campus or 09 921 9998 North Shore campus to make an appointment.

Let the receptionist know that you are a research participant and provide your contact details so they can confirm this.

AUT has a Counsellor for Maori within the AUT Counselling Team and you may consider this an option.

More information about the counsellors and the option of online counselling on the following website:

http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

What are the benefits?

The benefits of completing this survey will be that the information you provide will help us to develop a more effective and supportive quit intervention specifically for Māori nurses. There are also likely to be benefits for the wider Māori community if Māori nurses become even more effective in supporting Māori to quit smoking.

How will my privacy be protected?

Confidentiality: Every effort will be taken to ensure your confidentiality, although given the context of the research and smaller numbers of Māori nurses who smoke there is a remote chance of identification. The information you provide in the paired interview will be accessible only to members of the research team involved in the study and will not be disclosed to any other person. Information shared within the interview will be known to those present, however, all participants will sign a statement of confidentiality prior to beginning the interview whereby there is agreement by participants not to share any information shared during the interview. In addition, all information gathered from interviews will be aggregated, and the transcribing of interviews and notes and any presentations or publications will remove any identifying features so your identity will be kept confidential. You will see your de-identified transcript and will have the opportunity to make any amendments so you are happy with the information we may use in publications and presentations.

Storage of Information/Material – Signed consent forms will be stored in a locked filing cabinet at Whakauae Research separately from data produced during the course of this research. The notes and digital recordings will be securely stored and computer files will be password protected at Whakauae Research for a period of six years after the research has been completed. After this time they will be destroyed.

What are the costs of participating in this research?

We will cover your transport costs, and provide refreshments so that you are not left too out of pocket as a result of taking part.

What opportunity do I have to consider this invitation?

Please read this information sheet carefully. If you have any questions, please contact Heather Gifford Ph: 06 3476772 or email **Heather@whakauae.co.nz**

How do I agree to take part in this research?

If you decide that you would like to take part in the research, you will be asked to complete and sign a form consenting to your participation before the start of the paired interview.

Will I receive feedback on the results of this research?

If you would like to receive a summary of the findings these will be emailed or posted to you. We are intending to present the findings at conferences and hui (for example the NZNO Annual General Hui in 2014), and in peer-reviewed journals. We will also be submitting a report to the Health Research Council.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the AUT Project Lead, Associate Professor Denise Wilson either by email at dlwilson@aut.ac.nz or by phone 09 921 9999 ext. 7392

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, *rosemary.godbold@aut.ac.nz* , 9 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Dr Heather Gifford, Director Whakauae Research for Māori Health and Development, *heather@whakauae.co.nz or phone 06 3476772*

Approved by the Auckland University of Technology Ethics Committee on *23 August 2013*, AUTEC Reference 12/190.

Consent Form

Paired Interviews - Wiki

Project title: **Māori nurses and smoking: Exploring the context and opportunity for change**

Researchers: **Dr Heather Gifford (Principal Investigator), Dr Denise Wilson, Dr Leonie Walker, Ms Melody Potaka Osborne, Dr Amohia Boulton, Ms Lynley Cvitanovic, Ms Wiki Shepherd-Sinclair**

○ I have read and understood the information provided about this research project in the Information Sheet dated 28 February 2013.

○ I have had an opportunity to ask questions and to have them answered to my satisfaction

○ I understand that notes will be taken during the interview and that the interview will also be digitally recorded and transcribed.

○ I understand that the transcript of the interview will also be used by Ms Wiki Shepherd-Sinclair for the purposes of completing her Masters of Public Health thesis.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participant's signature: ....…………………………………………………

Participant's name: ....…………………………………………………

Participant's Contact Details (if appropriate):

Dr Heather Gifford

Whakauae Research for Māori Health and Development

Heather@whakauae.co.nz

Phone: O6 347 6772

Date:

Approved by the Auckland University of Technology Ethics Committee on 23 August 2012 AUTEC Reference number 12/190

Note: The Participant should retain a copy of this form

Appendix 4: Interview Schedule

The following questions will be used as a guide to elicit information from participants in the paired interviews. As issues or important points are raised by participants these will be explored by interviewers in more detail. The intent of the guide questions below is to act as stimulus for story telling by participants- they are high level prompts only.

1. Tell us about your history of smoking;

   Prompts Include what was happening at the time of initiation, who was influential in your initiation, how did initiation occur?

2. Tell us about your current smoking.

   Prompts include how many, where does smoking occur, who with, what circumstances, how often, where?

3. What are the major factors that influence your continuing to smoke?

   Prompts: Tell us about the benefits that you derive from smoking; tell us about what you see are the negative consequences of your smoking.

4. Tell us about your experiences as a Māori nurse who smokes

   Prompts: explore what tensions if any this causes; what are the expectations of those around you, in what ways does smoking impact, both positively and negatively on your work? How does being a nurse make you think/ feel about smoking?

5. In what ways do external factors, including policy and regulations, prompt and support quit attempts?

   Prompts: Explore a range of policy impacts and tease out the positive and negative implications of these on the smokers. For example smokefree environments, tobacco tax rises (price of smokes), smokefree workplaces, compulsory ABC training as part of the Health Targets, restrictions on marketing eg plain packs and no displays in supermarkets, garages dairies etc.

6. Tell us about your own quit experiences

   Prompts: Include how many times have you quit, what resources have you used if any, and what happened as a result of these quit attempts, what worked and didn't work for you? (What were the factors that promoted and or created barriers to successful quitting of smoking?)

7. What is required from any intervention to support you to stay smoke-free?

We would like you to suggest what needs to happen to support you in your quit journey, where do resources need to be placed, what resources, what changes need to happen, what

needs to happen for nurses to quit; what can the workplace do to support you? Who needs to do what? What would a successful intervention look like?

What intervention elements are considered important by participants? What variables do they consider may affect success? What do advisors consider a model programme, policy or practice that has been successful / unsuccessful in changing smoking behaviours and outcomes for Māori, Which events appeared critical to success?

Using all available existing data, a final intervention model will be developed that meet a number of criteria such as: Is it likely to be effective? Is it practical? What is the likely cost of implementation? Is the intervention adaptable to various contexts? Will it work for Māori?

Confidentiality Agreement

For someone transcribing data, e.g. audio-tapes of interviews.

Project title: **Māori nurses and smoking: Exploring the context and opportunity for change**

Researchers: **Dr Heather Gifford (Principal Investigator), Dr Denise Wilson, Dr Leonie Walker, Ms Melody Potaka Osborne, Dr Amohia Boulton, Ms Lynley Cvitanovic**

○ I understand that all the material I will be asked to transcribe is confidential.

○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.

○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ………………………………………………………………………………………………………

Transcriber's name: ………………………………………………………………………………………………………

Transcriber's Contact Details (if appropriate):

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……………………………………………………………………………………………..

……………………………………………………………………………………………..

……………………………………………………………………………………………..

Date:

Project Supervisor's Contact Details (if appropriate):

Dr Heather Gifford

Whakauae Research for Māori Health and Development

Heather@whakauae.co.nz

Phone: O6 347 6772

Approved by the Auckland University of Technology Ethics Committee on 23 August 2012 AUTEC Reference number 12/190