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Fefine Tonga moe ifi tapaka: A qualitative study to explore Tongan female tobacco smoking & cessation in the Auckland region

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ABSTRACT

Introduction: Tongan female smokers' smoking experiences have manifested within a realm of socioeconomic and cultural conditions in New Zealand with cessation service engagement relatively low. Due to the projected tobacco burden attributed to Pacific women, pertinent research proves vital to bettering understandings of smoking and cessation within this group. This study explored the knowledge and experiences of smoking and smoking cessation services among Tongan women aged 16 years and over, living in the Auckland region.

Methods: This qualitative research design utilised the *Kakala* model to ensure processes were culturally appropriate and meaningful. Data was collected through eight face-to-face semi-structured interviews transcribed by the researcher and employed the *toli*, *teu* and *luva* process from the *Kakala* model to form relevant themes.

Findings/Outcomes measure: The findings suggest smoking among Tongan females is a social vector that marks independence and maintains friendships, despite known adverse health effects and stigma. It is characterised as stress relief that has habituated into day-to-day routine for most. Their aspirations to live longer for their family is a strong motivator but quitting remains difficult and should be done autonomously by the individual.

Tongan female smokers stated smoking cessation services as ineffective and need to be adapted and consulted by and within the community. Stop smoking services should encourage autonomy among Tonga women in order to improve utilisation and engagement. Service delivery for Tongan female smokers needs to be on-going and long-term support reoriented within the community for more Tongan women to become completely smokefree.

Conclusions: Tongan female smoking in New Zealand is comprised of experiences surrounding friendships, family and culture. This study concludes that although smoking harms are widely known, cessation service delivery can be transformed by utilizing existing Tongan cultural roles such as that of the *mehikitanga* (paternal aunt) to encourage non-smoking among extended female generations.

Key words: Tonga, female, smoking, smoking cessation, Kakala

INTRODUCTION

Tobacco smoking is a significant agent of morbidity and mortality worldwide, with the burden disproportionately affecting disadvantaged Pacific communities.[1-5] Although the Pacific smoking literature is immense, it inequitably does not contain detailed accounts of Pacific subgroups.[5,-7] Due to the projected tobacco burden attributed to Pacific women, pertinent research among Pacific females proves vital to understanding their evidently low cessation utilisation.[5,6] As health service regulation remains a priority in New Zealand to account for the growth of the Pacific population, specific needs and experiences of subgroups is

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essential.[5-9] The aim of this paper is to explore the knowledge, experiences and challenges Tongan female smokers had of smoking and within smoking cessation services.

METHODS

This study utilised the Kakala model (a Pacific research framework) and its three steps *toli* (to pick), *teu* (to weave) and *luva* (gifting of garland) to theorize and inform research processes.[9] Its use not only enhances a Pacific way of doing research but prioritizes the Pacific worldview by ensuring Pacific understandings and values are respectfully kept at the forefront of the research.[2,10]

Once ethics was approved by The University of Auckland Human Participants Ethics Committee, recruitment commenced with a total of eight participants recruited. Participants had to be female, 16 years and over, of Tongan descent, a current or ex-smoker, living in the Auckland region and had used a New Zealand stop smoking service. Participants were briefed with information sheets and signed consent was obtained. Data was collected using one-on-one face-to-face interviews with the researcher conducted in participant homes. The interviews followed a semi-structured schedule consisting of 20 open-ended questions exploring smoking knowledge and cessation service experiences. All interviews were audio recorded and approximated 1-2 hours, with each participant receiving a $20 petrol voucher as compensation for their time.

Data analysis

Audio recordings were transcribed by the researcher and data analysis guided by *toli* and *tui* from the *Kakala* model.[11,12] *Toli* involved examining transcripts multiple times to highlight themes deemed relevant.[11,13] Then *tui* (weaving) commenced involving gathering important themes and identifying relevant connections between them.[14] *Toli* and *tui* continued until data saturation, with *luva,* commencing once findings were ready to be presented.[11]

RESULTS

Participants ranged from 23 to 63 years old with seven full Tongan and one half Tongan and half Samoan. Five participants were born in Tonga, with the three remaining New Zealand-born. The majority resided in South Auckland, with five married, two single and one in a relationship. Six participants were mothers and those over 50 years of age were also grandmothers. The majority were Methodist (5), with one Catholic, one Christian and one Wesleyan. The cohort lacked formalized education with the majority (4) holding a certificate and only two held a Bachelor's degree.

The cohort comprised six current smokers and two ex-smokers. Over half smoked more than ten cigarettes per day. The average number of cigarettes smoked per day and number of cigarette packets smoked per week, was relatively higher amongst those aged 40 years and over. Those who reportedly smoked more cigarettes per day and more packets per week, also had their last cigarette more recently than those who reportedly smoked less.

All participants had tried a cessation service through general practitioner referral. Three of the five females residing in South Auckland had cessation provided by the Counties Manukau District Health Board (CMDHB) stop smoking service with the remaining two using a community outreach programme or QuitBus (a mobile Quit service). The remaining three participants had cessation provided by the Auckland District Health Board (ADHB), with two using 'Ready Steady Quit' and the other using a Workplace support programme.

Knowledge of smoking

I know smoking is bad for health

All females knew smoking was detrimental to their health prior to initiation. Their knowledge of smoking harms became more eminent over time, especially those who migrated to New Zealand from Tonga. The majority recognized their knowledge of smoking harms was due to the effects of exposure from family. For those whose parents were non-smokers, their knowledge of smoking harms was often advice given by their mothers. The harms generally did not deter smoking amongst the cohort because they 'did not care' and effects were not an immediate threat. Those who smoked less than ten years said their 'short' smoking duration meant adverse health effects were minimal, which prolonged their smoking.

"…because my mum. She's a nurse. She used to be a midwife at the hospital. And she said to me where you going to get with that, it's bad for your health…" – P5

Smoking is a friendship thing

Friendship was the foundation for smoking amongst all of the women. The value of friends, upholding friendship and doing things together helped initiate most participants' smoking behaviour. Smoking was perceived as 'fun' and

'cool', which motivated smoking engagement within friendships. Friendship seemed more like a sisterhood as opposed to a mere relationship between individuals.

"Sometimes, I would just sit there and avoid it, and then, I thought 'let me try', for social, for trying to be part of that fun group… I guess that's when I started. Because I felt left out, I was just the only one sitting there (not smoking), there was no fun, they're all there smoking and laughing, and I thought, 'oh okay, let's go and (smoke)…" – P2

Smoking is a rite of passage

Smoking for most was a rite of passage once they were of legal age. Initiation was often when they were single, had no children and no major responsibilities. It was when they were gaining independence, generally around mid to late teens. Smoking was generally associated with a new phase in life where they began University, drinking or clubbing. Smoking was seemingly perceived to be acceptable once they were of legal age, which influenced their willingness to engage.

"…I think Tongan women, when they start smoking, they start at an age they clubbing and drinking and schooling…" - P2

The stigma of Tongan women who smoke

Most women knew smoking was perceived as a 'bad thing' for Tongan women to engage in suggesting promiscuity and other risky behaviours. For older participants, the stigma attached to Tongan women smoking was informed by their mothers. The stigma made most women hesitant to smoke, which led to concealment because of the fear of being judged. This meant not smoking at home and only around friends and social circles. Non-smokers were a deterrent, with most women also denying that they smoked when they were asked by family.

"…I know it's a stigma. Tongan women not expected to be smoking, it's not appropriate for Tongan women to smoke. So whenever I smoked in public, people staring and I was conscious of that… Being a Tongan woman smoking there's expectation, 'That's a bad woman', 'You're like a roamer'...it's not womanly, it's not acceptable, and it's not appropriate for Tongan women to smoke… I experience that…" – P2

Experiences of smoking

I smoke to deal with Stress

All participants highlighted smoking because they felt stressed out. This stress related to day-to-day responsibilities, with the majority being working mothers and the main stressor being their work. Most women mentioned that smoking was an activity they used to de-stress and relax. Smoking levels were regulated according to the level of stress they were feeling.

"…when I work, the kind of work that I do... it's a stressful job. And I think, I don't need the smoke, it's smoking away the stress. You know sometime my body and my mindset know don't smoke... but I do because I'm stressed out." – P1

My smoking and the influence on my children

Most women spoke about their smoking in regard to the effects on their children. For current smokers this noted modelling smoking for their children and for ex-smokers centered on their regret of smoking in front of and around their children. Most mothers felt they were bad role models and some blamed themselves for their children smoking. The materialization of their children smoking was highlighted as an important motivator for them to stop.

"...in my mind, I better stop smoking because the kids will see me I'm smoking at home. Like you know, how I teach them, you can't smoke but I'm the one that's smoking. I am the good example" – P5

Smoking is a habit

The cohort felt smoking was a 'bad habit' that became engrained in their day-to-day lives. Smokers that had smoked over ten years stated their loss of control was because of their addiction to the nicotine. This idea that smoking was a bad habit was developed further by a few more experienced smokers that felt their smoking was no longer a habit but an addiction.

"…it was hard because I grieved a smoke after meals. Stopping all of a sudden, something that you're used to, it's not easy…something that you're so used to for many, many years. I crave for a smoke every single day. I need just to have a smoke, it's like… a bad habit to me... it's a habit…" – P1

Smoking and health

I want to live longer

Life longevity for most women was the most important aspect of health affected by smoking. The want to live longer was mentioned by most in regard to being there for their family and future generations to come. This was largely centred on being a grandmother and having grandchildren, which outweighed the want to live longer for themselves.

"I think to just live longer. Yeah live longer to see all my children, married and have grandchildren…I want to live longer to see my family" – P6

I didn't smoke when I was pregnant

All the mothers mentioned they went 'cold turkey' (stopped smoking) during their pregnancies. For current smoking mothers, pregnancy was the only time they were able to stop smoking successfully. This improved their belief in quitting on their own again, with most specifying they would do so without cessation support.

"…I stopped in 1998 when I was pregnant with my son, stopped. Absolutely no discussion, mentally, stopped. I never smoked as soon as I found out I was carrying my son. Because I thinking about the health of my son, so I stopped there…" - P2

Quit smoking

Cutting down

All participants said they tried to stop smoking at least once. Some mentioned trying multiple times without being able to completely quit, with their unsuccessful attempts putting them off trying again. Cold turkey was the most common method to quitting as they perceived it was up to themselves to do so. The majority detailed quitting was difficult, which led them to cut down as it seemed more achievable. Cutting down was a perceived stepping stone towards becoming smokefree.

"...what I have done is I've actually cut down tremendously. So the only way is to cut down first..." – P2

I'm spending money on smoking instead

All women mentioned how much money they spent on smoking and how it could have been better spent elsewhere. For current smokers, quitting meant they can save a lot of money and ex-smokers spoke of the money wasted. The opportunity cost forgone was centered on the loss of money for their families, especially amongst smokers with children.

"…Its money wise too. I could save that for something more important than just buying a smoke, which I can just burn and the dollar sign go down the drain… That money could save for something important, for your children's education. Or perhaps invest it in something for future" – P1

I got the willpower to do things

Most women stated willpower was important to be able to quit. For instance, one smoker said quitting was easier because of her willpower and another felt her willpower was not strong enough to overcome her smoking habits. Although the relationship between quitting smoking and a person's innate willpower were consistent across the cohort, experiences were dependent on whether their willpower was perceived positive or negative.

"When I'm determined to do something, or achieve a goal, I do it… that willpower I believe I can do things... You know for smoking, that kind of mentality and willpower…" – P1

The right time to quit

The right time to quit smoking was important in being able and willing to quit. Most participants felt they should not be forced to quit if they did not feel ready. Quitting was seen as a personal choice that was up to the individual. Some spoke of time in regard to God's timing for them to quit. Timing, in relation to when participants felt ready, God's timing and also timing of service visits were important aspects to assist quitting.

"...before I tried to give up because I'm doing it for everybody else who's telling me to stop. But God will do it, when I'm ready, mentally, because I did it before, I can do it again. I gave up on my own". – P2

Smoking cessation services

The medicine don't work

Most women stated nicotine patches and gum were the only thing provided in cessation services, which did not help them stop smoking. One woman felt doctors just prescribed gum and patches as a requirement as a health professional, putting her off using the service again. Patches and gum were perceived as 'medication', with some explaining that stopping smoking should not include 'chemicals' (gum and patches) that may do more harm or lead to addiction. The majority felt more comfortable trying to quit alone as opposed to using a service because of these products.

"I went to the service and I tried it for a week and the doctor gave me tablets, Champex or something and I take it and thought to myself, forget it because it might give me another disease these tablets" – P7

It is up to the individual whether they use it or not

The majority felt cessation utilisation should be up to the individual. All participants acknowledged although the service did not work for them, it may work for others. Some younger participants mentioned they knew the service was available but they would only access it if they really needed it. Some felt the service was appropriate for more 'addicted' smokers, which highlighted notions that services were unnecessary to quitting.

"... I feel I would do it on my own. It's not the service, I feel like it's just me. Because I feel like the services are for some people. But not for like everyone. It's probably just like if you're ready". – P4

Not at the hospital

All women strongly advised cessation services should not be operated out of the hospital because of the difficulty in access, specifically the time and costs. The hospital was also perceived as a place only 'sick' people went to, with some smokers noting they were not sick and did not need to be going to the hospital for quit smoking help.

"… I know they provide support at the hospital too... But like see that's shit. Cause no one's got time to go in, no one is going to go and get fucking support for smoking… like why even advertise it at the hospital to begin with. It's a smoking fucking support system. Ugh. They have people dying at the hospital and then they want us to go…I just think it's stupid". – P3

Service Recommendations

In the community

The cohort conclusively stated the service should be provided in the community and not elsewhere. The service delivered in the community, or in a community setting was strongly emphasized by all participants. This would make it easier for smokers to not only access, but being in a familiar setting would make particularly Tongan women feel more comfortable.

"They need to come out to the community. Stop sitting in that little shell and pretending people will come to them. No. It won't happen. They need to go to the community". – P1

Tongan community consultation

Most participants stated better service utilization required community consultation. They proposed a presentation or workshop to Tongan female smokers to identify and explain how they want the service to be provided. This would not only build a relationship and awareness in the community but also familiarize services. The church or community groups were identified as avenues for consultation. Consultation should attract smokers by ensuring gatherings are done in a 'Pacific way' (e.g. food and games for children).

"Talk. Engage... Engage means listening... But some of the church they should talk with their people, they should get someone from the health department and do like the 'apitanga (camp), tapu inu kava mālohi (stop drinking) one-, so they talk and ask those people like that to come and have a talk you know". – P5

On-going support

The cohort required on-going support within the services. Most women felt they were given 'medication' and left to fend for themselves. They felt the service was not a long-term or on-going thing as once the programme lapsed that was also when support ended. On-going support included constant reminders, visits or having someone there to encourage them. This is because smoking was easy due to access and availability of cigarettes. An on-going stop smoking support group or a stop smoking ambassador that looked like them and had the same characteristics as them was also proposed for motivational on-going support.

"It doesn't just go through once. You ask them for a second time, you need to reassure the programme or talanoa, maybe three times, going back to the group. You can't just do once and expect them to do it themselves, because people don't have willpower - you need to revisit to see that its goes through properly". – P1

DISCUSSION

This study provided context specific insights into the smoking knowledge and cessation experiences among an un-researched Pacific subgroup. It uniquely explored Tongan female smoking, by utilising a Tongan-specific methodology as well as being implemented from the lens of a Tongan female researcher.[2] Despite a small sample size and data being possibly subject to over or underreporting, the findings yielded help illustrate the state of smoking and cessation among Tongan female smokers in New Zealand.

The social side of smoking and the effect of stress were reoccurring themes in these findings that were consistent with broader smoking literature.[15,16] A study confirmed that heightened stress as well as social isolation during unexpected events such as the recent COVID-19 2020 lockdown exacerbated New Zealand adult smoking behaviours.[15] This demonstrates cessation must be more accommodating to smokers' stress, anxiety and isolation during such unprecedented times.[2,15,16] The mobilization of Pacific providers during the COVID-19 response is an exemplary community-driven approach that could be utilized for cessation support.[5]

Stopping smoking must consider one's ability to quit, the right time to quit (some in regards to God's timing) and their perceived willpower. It is

an autonomous decision, with the government's new Guidelines for Helping People to Stop Smoking recognizing Pacific smokers' spiritual and familial dimension.[18-20] Family and familial ties was a powerful theme present in the findings regarding stop smoking motivators, which included pregnancy, life longevity and becoming a grandmother. The strong familial hierarchy present in Tongan culture, particularly the *mehikitanga* (paternal sister), is an important position that could be explored in cessation.[17] This is because of the matriarchal power she has over her brother and his children that could encourage non-smoking amongst younger female generations.[17]

The negative perceptions of ineffectiveness and believed harmfulness of nicotine gum and patches were consistent with previous reports examining low Pacific cessation utilisation and engagement.[18-21] Access issues and perceptions of the hospital being for 'sick' people steered smokers away from hospital-based cessation. The findings affirmed cessation needed to be long-term and on-going, with consultation and delivery in the community (i.e. church or community groups). These notions have been reiterated in reports noting system-level changes entailed Pacific leadership and Pacific partnership for different Pacific solutions and treatment options.[2,5,18]

This study recommends:

1. *Family*: The role of the *mehikitanga* (paternal aunt) can be utilised in familial stop smoking programmes among Tongan female smokers to encourage stop smoking among younger generations.
2. *Community:* Cessation being positioned and delivered within the community to aid accessibility and give the community an active voice in how services are provisioned.
3. *Service delivery:* Re-evaluation of patient referral and cessation advice at primary care so patients are fully aware of secondary cessation available.
4. *Pacific smoking research:* Future research should encompass Pacific methodologies and specific to Pacific subgroups.[5]
5. *Policy implications:* Pacific smoking is understood and experienced differently thus policies must embrace Pacific worldviews and approaches to smoking.[5]

CONCLUSION

This study concludes that cessation services can be transformed to be more accessible and more appealing for Tongan female smokers to become and remain smokefree**.** That means utilising existing cultural roles such as that of the *mehikitanga* (paternal aunt) to encourage, support and advocate non-smoking for future female generations.

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