The impacts of colonisation on the inequities of smoking during pregnancy in Aotearoa

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Background: Smoking during pregnancy is one of the most common preventable causes of pregnancy complications and remains a significant health issue worldwide.[1] Children born to mothers who smoked during pregnancy are at increased risk of a number of morbidities, including poor neurodevelopment.[2] Moreover, smoking during pregnancy has been associated with metabolic disorders and cardiovascular disease.[3] The prevalence of smoking during pregnancy in Aotearoa remains significant, with 11.7% of all women smoking during pregnancy. Unfortunately, inequities exist between Māori and non-Māori in the burden of smoking during pregnancy, with 31.8% of all women who identified as Māori smoking during pregnancy.[4]

The rainbow model is often used to understand the determinants of health at several layers of rainbow-like influence. From an upstream perspective, the colonisation of Aotearoa by Pākehā marked a significant transition in the socioeconomic, cultural and environmental conditions experienced by Māori.[5] Such a marked change strongly implicates the colonisation of Aotearoa as a driver of the inequity of smoking during pregnancy between Māori and non-Māori.

Aim: To understand the impacts of colonisation on the inequities of smoking during pregnancy that exist between Māori and non-Māori.

Methods: A non-systematic literature review was conducted over a two-week period.

Results: Three major themes were identified in the literature:

1) The introduction of tobacco with colonisation: Tūpeka (a transliteration from tobacco) quickly became a standard trade item for Pākehā. In the 19th century, smoking became prevalent amongst Māori, and its use amongst Māori was not restricted by sex or age as it was with Pākehā. The colonial beliefs about wāhine smoking and the trends that occurred subsequent to introduction of tūpeka can be viewed as the event responsible for the inequities that exist between Māori and non-Māori hapū mama (pregnant mothers) that we see today.

2) The marginalisation of Māori with colonisation: The redistribution of resources from Māori to Pākehā led to the displacement of a significant proportion of Māori, and the poverty suffered by Māori following colonisation has had intergenerational impacts. The colonial systems designed to benefit Pākehā exacerbated the inequities in smoking during pregnancy between Māori and non-Māori through marginalisation and intergenerational poverty.

3) The ineffectiveness of smoking cessation interventions for Māori mothers:
It has been found that many Māori wāhine were not aware of the interventions available to them, and the interventions that they had trialed had not been successful. Current interventions also fail to acknowledge the negative impact that environment has on smoking cessation efforts; many Māori wāhine use smoking as a coping mechanism in lieu of other effective social supports.

Conclusion: The introduction of tūpeka, the marginalisation of Māori and the development of Eurocentric smoking cessation interventions has placed a much greater burden on Māori hapū mama. Until interventions are developed using a Māori worldview, these inequities will continue to affect future generations of Māori.

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