PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	A qualitative analysis of Māori and Pacific smokers' views on informed choice and smoking
AUTHORS	Gifford, Heather; Tautolo, El-Shadan; Erick, Stephanie; Hoek, Janet; Gray, Rebecca; Edwards, Richard

VERSION 1 - REVIEW

REVIEWER	Masoud Mohammadnezhad Fiji National University Fiji
REVIEW RETURNED	25-Feb-2016

GENERAL COMMENTS	Reviewer: Masoud Mohammadnezhad Manuscript ID: bmjopen-2016-011415 This is a well written manuscript that described the findings of a qualitative study about Māori and Pacific smokers' views on informed choice and smoking. This is an interesting manuscript reporting on an underserved population for whom little data are available. Overall, the manuscript reads well and provides sufficient details about the methodology and the results. However, there are some issues that should be taken into consideration, in order to make this manuscript suitable for publication. General Question: Why the authors considered Māori and Pacific people as a unique group while these two ethnic groups are not similar. Any Maori can be a pacific person while any Pacific person can't be a Maori. Abstract: Kind of sampling needs to be mentioned in the abstract. Keywords: The keywords are not chosen well. It is suggested to remove "Public Health" and "Social Medicine" and add "Māori and Pacific smokers" and "informed choice" and "Chapman and Liberman framework". Background: 1- It would be good to justify why you should focus on Māori and Pacific smokers? Please present some numbers showing the high prevalence of smoking among Māori and Pacific young adults aged 18-26. 2- In the last paragraph, it is better to mention the objective (s) of the study clearly. Methods: 1- The inclusion and exclusion criteria of participants need to be

	mentioned accurately. For example, how long the Pacific people need to live in NZ to be able to participate in the study? 2- How the participants were considered as a Pacific or Maori? Based on self-identification or..? 3- Page 7, lines 135-136: it is better to move the sentence which is about the ethic approval to the end of the “Method”. 4- Table 1 has two MF19 and also two PF19 which make recognizing the quotes very difficult. They need to be separated. 5- Did two people conduct all the interviews? Did they have previous similar experience? Did they undergo any training before the initiation of this study? Why a Pacific person has been chosen when the interview was conducted with a Maori? Or Vise Vera. 6- The interview took between 25 and 50 minutes. As the appendix shows there were about 29 questions. Maori and Pacific people are very conservative and they talk very slow. It is interesting how some interviews took only 25 minutes. 7- In the “Procedure” it is better to talk about the information sheet, introduction letter and also consent form. 8- Page 8, line 158: the authors talk about three ethnic groups while whole parts of the study they talk about two groups (Maori and Pacific). It needs to be revised. 9- More detail is needed on “data saturation”. Do you have a reference that this sample size is sufficient for data saturation (as they are two different ethnic groups)? Or did you just continue sampling until saturation/redundancy was reached (i.e. no new themes emerged and comparable themes were recurring across interviews)? 10- A bit more detail on the interview would be helpful. Which language the interviews were conducted? Were interviews conducted in the respondent’s preferred language? How was the interview guide developed? 11- A standard practice is to have one person translate into another language (here Maori or Pacific) and then to have someone else back-translate to the original language (here, English) to ensure that the content remains the same. Or did you have the translations checked by another translator? 12- How many transcribers? Who were they (Researcher? Other?) 13- Was transcription done after all data collection was complete? The temporality of events is unclear. Also, when did the researchers look at the data to determine that saturation was achieved? Was this based on transcripts? If so, then was transcription concurrent with data collection? Again, temporality is unclear. 14-Who did transcription? Was it done by a single researcher? Multiple researchers? If a single researcher, what steps were taken to protect against bias? Were results presented to the subjects or comparable groups for feedback on adequately capturing the themes? 15- How many people were involved in the qualitative analysis of the gathered data? What was their background? Did they have previous similar experience? Did anyone check the analysis independently? Results: 1- You have used words such as “many”, few”, “most”, “others”, “majority”, and “several” to show the participants quantity. It is not clear what was the base to choose relevant word for the relevant number. 2- Page 9, line 186; page 10, lines 201 and 209; page 11, line 237; and page 13, line 274: you used quotes from MF19, while in the table 1 there are two MF19. Please make it clear. 3- Page 10, line 196: PM19c is an intermittent smoker (not daily

	smoker), while you are talking about participants who had developed a regular smoking pattern. Discussion 1. It is suggested to start the “Discussion” section with a paragraph summarizing the main findings of the study, leaving the comparison with existing literature for the next paragraphs. The Discussion could include the strengths of this study and should mention all the limitations that are currently not mentioned. It could end by suggesting implications for future research or for future smoking cessation interventions. 2- Page 16, line 364: the words “the strong association between” will usually use for the quantitative study not the qualitative study. Similarly, on page 18, line 397: the words “little relationship”.

REVIEWER	Elizabeth (Libby) Smith University of California, San Francisco, USA
REVIEW RETURNED	01-Mar-2016

GENERAL COMMENTS	This paper uses in depth interviews to explore whether the tobacco industry’s framing of smoking as an “informed adult choice” has any validity when it comes to the understanding and practices of Maori and Pacific smokers in New Zealand. Overall, the methods and conclusions seem sound. Some changes could be made to improve the paper. The authors frame the paper around the Maori Affairs Select Committee, and representations the tobacco industry made about “informed choice” to that body. However, we are given little sense of what power that body has, how seriously it might have taken comments of the industry, or even whether it is still functioning. If, for example, the Committee suggested it didn’t take these comments seriously, the central question of the paper (as framed) seems less consequential. Again, if the Committee has already taken whatever action it is going to take, that seemingly renders the question somewhat moot. I would like some clarification on this. Are the suggestions made in the conclusion addressed to the Committee? Perhaps the larger question has to do with accepting the industry’s framing. What if smoking were an “informed choice”? Would it still be okay to sell lethal products? We don’t think selling other unreasonably dangerous products (defective cars, asbestos) is okay. Authors outline some of the factors that might influence choice, but of course all choices are influenced by all kinds of things – that doesn’t necessarily make them not informed choices (see, defective cars, above). The authors should perhaps take on the idea of choice itself in the context of tobacco use more directly, by unpacking this idea a little more in the introduction, and using it to inform their conclusions. The study protocol clearly suggests that they understand that making an “informed choice” and thinking that one has made an informed choice can be very different things. Along these lines, I would also like to see more space devoted to participants’ thoughts about the industry formulation of “informed choice”: this section is very brief, given that in some ways it is at the heart of the paper. There is also a little discrepancy on this: in the results, authors say that “most” thought smoking was an informed choice, but in the discussion “several” thought they had made an informed choice. Does this mean that some thought it was in general an informed choice, but not in their own cases, or does it just need to be reworded?

	One of the factors the authors cite as influencing smoking uptake is the relative normalization of smoking in the Maori/Pacific communities, but they don't give any specific prevalence rates. This might also be worth exploring: do a majority of Maori/Pacific people smoke? What makes it seem that "everyone" does it? The conclusion, as it relates specifically to Maori/Pacific people seems a little weak. As the authors point out, their policy proposals are more general, but they only suggest "additional efforts" to engage with the specific population they discuss. The paper would be stronger if the nuances pointed out in the results and the discussion also were reflected in the conclusions.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Masoud Mohammadnezhad

1. This is a well written manuscript that described the findings of a qualitative study about Māori and Pacific smokers' views on informed choice and smoking. This is an interesting manuscript reporting on an underserved population for whom little data are available. Overall, the manuscript reads well and provides sufficient details about the methodology and the results. However, there are some issues that should be taken into consideration, in order to make this manuscript suitable for publication.

Thank you for these positive comments. We appreciate the time you have taken to provide detailed feedback on our MS.

2. Why the authors considered Māori and Pacific people as a unique group while these two ethnic groups are not similar. Any Maori can be a pacific person while any Pacific person can't be a Maori.

We did not intend to give the impression that we treated Māori and Pacific people as one unique group. We had separate Māori and Pacific researchers recruit, interview and analyse data from our Māori and Pacific participants. We have reported both data sets in the one paper because smoking prevalence among Māori and Pacific people is much higher than among the NZ European population and we wished to examine where smoking uptake and aspects of informed choice differed and were similar among Māori and Pacific people.

3. Kind of sampling needs to be mentioned in the abstract.

We have amended the abstract as suggested.

4. The keywords are not chosen well. It is suggested to remove "Public Health" and "Social Medicine" and add "Māori and Pacific smokers" and "informed choice" and "Chapman and Liberman framework".

We followed BMJ Open's author guidelines and selected our keywords from the list provided. We are not aware of an option to propose our own keywords but, if this exists, we would be pleased to add your suggestions.

5. It would be good to justify why you should focus on Māori and Pacific smokers? Please present some numbers showing the high prevalence of smoking among Māori and Pacific young adults aged 18-26.

We explain the sharp disparities in smoking prevalence between Māori and Pacific peoples on the one hand, and NZ European on the other, and referenced national smoking prevalence data. We have now provided details of these differences within the text.

6. In the last paragraph, it is better to mention the objective (s) of the study clearly.
We have clarified the research objectives.

7. The inclusion and exclusion criteria of participants need to be mentioned accurately. For example, how long the Pacific people need to live in NZ to be able to participate in the study?

We asked participants to self-identify their ethnicity (allowing for multiple identifications) this approach is consistent with that taken by the NZ census, and is recommended in ethnicity data collection guidelines. This approach fits logically with the social context questions we explored with participants and we thus see it as a more valid approach than setting an arbitrary years of residence criterion.

8. How the participants were considered as a Pacific or Maori? Based on self-identification or..?

Please see response to point 7.

9. Page 7, lines 135-136: it is better to move the sentence which is about the ethic approval to the end of the “Method”.

Moving this sentence to the end of the section would locate it in the data analysis section. We feel the sentence is more appropriate in the sample sub-section, where it fits logically with our explanation of participant recruitment.

10. Table 1 has two MF19 and also two PF19 which make recognizing the quotes very difficult. They need to be separated.

We had already labelled the Pacific participants “a”, “b” and “c” and have now made this change for the Māori participants.

11. Did two people conduct all the interviews? Did they have previous similar experience? Did they undergo any training before the initiation of this study? Why a Pacific person has been chosen when the interview was conducted with a Maori? Or Vise Vera.

Participants were interviewed by someone who had a similar ethnicity and we have clarified ll.150 onwards. The interview protocol was developed collaboratively among the research team and all interviewers were experienced qualitative interviewers.

12. The interview took between 25 and 50 minutes. As the appendix shows there were about 29 questions. Maori and Pacific people are very conservative and they talk very slow. It is interesting how some interviews took only 25 minutes.

We are not sure what point the reviewer is making here but he seems to suggest we did not elicit rich data from our participants. Most interviews took considerably longer than 25 minutes and the quotations we have provided illustrate the rich and nuanced data we elicited. We disagree that Māori and Pacific people can be stereotyped as speaking very slowly; several of our participants were very articulate people who did not speak slowly.

13. In the “Procedure” it is better to talk about the information sheet, introduction letter and also consent form.

We have added a sentence to explain that participants received an information sheet and provided written consent prior to the interview commencing.

14. Page 8, line 158: the authors talk about three ethnic groups while whole parts of the study they talk about two groups (Maori and Pacific). It needs to be revised.

Our reference to three ethnic groups is correct as we also interviewed NZ European young adults; these data have been reported separately but we compare findings from each ethnicity in the discussion (see para starting l375).

15. More detail is needed on “data saturation”. Do you have a reference that this sample size is sufficient for data saturation (as they are two different ethnic groups)? Or did you just continue sampling until saturation/redundancy was reached (i.e. no new themes emerged and comparable themes were recurring across interviews)?

We continued interviewing until no new idea elements were identified. We believe this approach is commonly used to explain when interviewing ceases and we have provided more detail of the process we followed.

16. A bit more detail on the interview would be helpful. Which language the interviews were conducted? Were interviews conducted in the respondent’s preferred language? How was the interview guide developed?

All interviews were conducted in English and all participants spoke fluent English. As noted, the interview guide was developed collaboratively within the wider research team and underwent cognitive pre-testing before data collection commenced.

17. A standard practice is to have one person translate into another language (here Maori or Pacific) and then to have someone else back-translate to the original language (here, English) to ensure that the content remains the same. Or did you have the translations checked by another translator?

Please see response to point 16.

18. How many transcribers? Who were they (Researcher? Other?)

We used a trained transcriber who has previously undertaken high quality work for us.

19. Was transcription done after all data collection was complete? The temporality of events is unclear. Also, when did the researchers look at the data to determine that saturation was achieved? Was this based on transcripts? If so, then was transcription concurrent with data collection? Again, temporality is unclear.

Transcription occurred at the same time as data collection was underway. Interviewers reviewed data in an iterative manner throughout the study and determined when saturation was achieved.

20. Who did transcription? Was it done by a single researcher? Multiple researchers? If a single researcher, what steps were taken to protect against bias? Were results presented to the subjects or comparable groups for feedback on adequately capturing the themes?

Please see response to point 18. The transcripts were verbatim thus we do not see bias as being a potential problem. We returned interview transcripts to participants who had requested these but did not seek formal confirmation of the data recorded.

21. How many people were involved in the qualitative analysis of the gathered data? What was their

background? Did they have previous similar experience? Did anyone check the analysis independently?

We have described the process we used to analyse the data on p.8; the interviewers analysed their transcripts initially, then all interviewers (four in total, one responsible for each ethnicity and the PI) met at a workshop where we discussed and compared our findings. The workshop was facilitated by an independent researcher with expertise in qualitative data analyses and her role was to test our emerging findings. We believe this robust process allowed us to develop a strong consensus.

22. You have used words such as “many”, few”, “most”, “others”, “majority”, and “several” to show the participants quantity. It is not clear what was the base to choose relevant word for the relevant number.

Because we undertook a qualitative study, we believe it is inappropriate to quantify our findings; we used the adjectives you have noted to indicate the strength of a particular opinion. We note this practice is widely used by qualitative researchers.

23. Page 9, line 186; page 10, lines 201 and 209; page 11, line 237; and page 13, line 274: you used quotes from MF19, while in the table 1 there are two MF19. Please make it clear.

Thank you for noting this ambiguity; as per our response to query 10, we have now differentiated between these two participants.

24. Page 10, line 196: PM19c is an intermittent smoker (not daily smoker), while you are talking about participants who had developed a regular smoking pattern.

We are not quite sure how you surmised that we were talking about regular smokers at this point in the MS as we do not make that claim. This participant is an intermittent smoker and had “cut down” as a pathway to quitting; this behaviour is quite common among both daily and intermittent smokers.

25. It is suggested to start the “Discussion” section with a paragraph summarizing the main findings of the study, leaving the comparison with existing literature for the next paragraphs. The Discussion could include the strengths of this study and should mention all the limitations that are currently not mentioned. It could end by suggesting implications for future research or for future smoking cessation interventions.

With respect, we follow the structure recommended in the guidelines to authors. There is one appropriate reference to another study in the first paragraph of our discussion. The remainder of the discussion follows the recommended structure. Although you suggest we should cite additional limitations, you do not indicate what you believe these to be; we thus find it difficult to respond specifically to these points.

26. Page 16, line 364: the words “the strong association between” will usually use for the quantitative study not the qualitative study. Similarly, on page 18, line 397: the words “little relationship”.

From the title of our MS onwards, we have made it clear that our study takes a qualitative approach. We thus think the likelihood that someone would progress to p.16 of our MS and believe we were describing a quantitative study is so remote that it can be reasonably dismissed. To the best of our knowledge, quantitative researchers do not have exclusive rights to the word “association” and “relationships”. We thus do not propose changing these words.

Reviewer: Libby Smith
27. This paper uses in depth interviews to explore whether the tobacco industry's framing of smoking as an "informed adult choice" has any validity when it comes to the understanding and practices of Maori and Pacific smokers in New Zealand. Overall, the methods and conclusions seem sound. Some changes could be made to improve the paper.

Thank you.

28. The authors frame the paper around the Maori Affairs Select Committee, and representations the tobacco industry made about "informed choice" to that body. However, we are given little sense of what power that body has, how seriously it might have taken comments of the industry, or even whether it is still functioning. If, for example, the Committee suggested it didn't take these comments seriously, the central question of the paper (as framed) seems less consequential. Again, if the Committee has already taken whatever action it is going to take, that seemingly renders the question somewhat moot. I would like some clarification on this. Are the suggestions made in the conclusion addressed to the Committee?

We have provided more information about the Māori Affairs Select Committee (MASC) and agree that non-NZ readers would be unfamiliar with this background. The NZ Parliament has several select committees that have quite wide-ranging powers; they review legislation, hear submissions on Bills, recommend changes, and order Inquiries, among other things. The MASC ordered tobacco company executives to appear before it during its Inquiry so they could be questioned on their written submissions and more generally. Although tobacco companies made many points in their submissions, the "informed choice" argument has been rehearsed subsequently (for example, in opposition to plain packaging) and is used to oppose proportionate tobacco control measures. Because the MASC recommended New Zealand set a smokefree 2025 goal (which the government adopted), we need new measures to achieve that goal and "informed choice" arguments impede both consideration and adoption of new policy measures. For this reason, we believe the argument needed closer scrutiny and our suggestions are addressed to policy makers, politicians and members of the NGO and advocacy community who we hope will find analysis of the argument useful in their work.

29. Perhaps the larger question has to do with accepting the industry's framing. What if smoking were an "informed choice"? Would it still be okay to sell lethal products? We don't think selling other unreasonably dangerous products (defective cars, asbestos) is okay. Authors outline some of the factors that might influence choice, but of course all choices are influenced by all kinds of things – that doesn't necessarily make them not informed choices (see, defective cars, above). The authors should perhaps take on the idea of choice itself in the context of tobacco use more directly, by unpacking this idea a little more in the introduction, and using it to inform their conclusions.

We agree that choices are limited by many factors but note that selling defective cars and asbestos now contravenes product safety standards, which do not apply to tobacco. The industry has successfully argued that people know the risks of smoking and choose to take them, an argument we felt merited closer analysis. Our findings suggest young adults have a very limited understanding of smoking's risks and rarely see the risks they do comprehend as personally relevant. Almost none understand addiction before they experience it. We have outlined these ideas more clearly in our introduction and conclusion, as suggested.

30. The study protocol clearly suggests that they understand that making an "informed choice" and thinking that one has made an informed choice can be very different things. Along these lines, I would also like to see more space devoted to participants' thoughts about the industry formulation of "informed choice": this section is very brief, given that in some ways it is at the heart of the paper. There is also a little discrepancy on this: in the results, authors say that "most" thought smoking was

an informed choice, but in the discussion “several” thought they had made an informed choice. Does this mean that some thought it was in general an informed choice, but not in their own cases, or does it just need to be reworded?

Thank you for noting this ambiguity. Participants’ responses were paradoxical – most saw smoking as an informed choice and agreed with the industry’s proposition even though few had understood general or specific risks, and even fewer applied these risks to themselves. We have extended this discussion and clarified the “most”- “several” discrepancy.

31. One of the factors the authors cite as influencing smoking uptake is the relative normalization of smoking in the Maori/Pacific communities, but they don’t give any specific prevalence rates. This might also be worth exploring: do a majority of Maori/Pacific people smoke? What makes it seem that “everyone” does it?

R1 also suggested we provide data on smoking prevalence rates and we have now included this information in our introduction. Smoking prevalence is very high among some population sub-groups (e.g. 42% among Māori women), which gives rise to the impression that “everyone” smokes.

32. The conclusion, as it relates specifically to Maori/Pacific people seems a little weak. As the authors point out, their policy proposals are more general, but they only suggest “additional efforts” to engage with the specific population they discuss. The paper would be stronger if the nuances pointed out in the results and the discussion also were reflected in the conclusions.

We have tried to balance being too prescriptive with offering some detail. Prior to European settlement, Māori were a tupeka kore
(tobacco free) society and there have been strong calls for Māori to determine their own smokefree pathway without having solutions imposed on them by those from the ethnicity that introduced tobacco. We have offered some more detailed suggestions to reflect our findings but have also tried to avoid appearing to impose solutions that Māori may or may not regard as appropriate.

VERSION 2 – REVIEW

REVIEWER	Masoud Mohammadnezhad Fiji National University Suva, Fiji
REVIEW RETURNED	16-Apr-2016

GENERAL COMMENTS	Overall, this is an interesting manuscript reporting on an underserved population for whom little data are available. This is a much improved manuscript. The authors are to be commended for their work and for their careful responses to reviewer comments. However, the authors answered all the comments carefully; they made few changes in the manuscript (specially, in the Methods section). I recommend a careful read the comments and include some of provided responses in the manuscript (in the Sample, Protocol and Procedure, and Data analysis parts). It will definitely increase the quality of the manuscript. There is only one minor remaining comment: Table 1 and the way authors tried to introduce the participants in the results part of the manuscript is also confusing. The authors need to find a solution for this issue (there are four male Pacific participants while you can see only 19a, 19b, and 19c).

REVIEWER	Elizabeth (Libby) Smith

	Professor, University of California, San Francisco, USA
REVIEW RETURNED	12-Apr-2016

GENERAL COMMENTS	Authors have responded adequately to the issues raised before, except for the issue of accepting the idea that “informed choice” is a relevant issue for tobacco. In my previous review I raised this, but perhaps not clearly enough. The authors responded to my parallels (asbestos, defective cars) by noting that these are now not legal to sell, which is precisely my point: we have decided that it is not enough that consumers should make “informed choices” to buy such products, but that they should not be allowed to make that choice at all because the products are just too dangerous. Should this not be the case with tobacco products? I raise this because the most obvious/simplistic response to the paper’s findings (people’s “choice” to use tobacco is not “informed”) is to say that people should be better informed to make that choice. The authors are (rightly) not making this argument, and suggest numerous stronger policy measures in their conclusion. I think it is important to be explicit about this and to say that MASC should not only reject as incorrect the industry’s argument that people are making an “informed choice” to smoke, but it should also reject this framing of the issue, and focus instead on the qualities that make tobacco use not a “choice” at all, informed or not (e.g., addiction, long-term harms, industry promotion, etc.). Without unpacking the idea of “choice”, the paper runs the risk of playing into the idea that the problem is that smokers or potential smokers are simply not well-informed enough.

VERSION 2 – AUTHOR RESPONSE

Reviewer 1
Overall, this is an interesting manuscript reporting on an underserved population for whom little data are available. This is a much improved manuscript. The authors are to be commended for their work and for their careful responses to reviewer comments.
However, the authors answered all the comments carefully; they made few changes in the manuscript (specially, in the Methods section). I recommend a careful read the comments and include some of provided responses in the manuscript (in the Sample, Protocol and Procedure, and Data analysis parts). It will definitely increase the quality of the manuscript.

There is only one minor remaining comment: Table 1 and the way authors tried to introduce the participants in the results part of the manuscript is also confusing. The authors need to find a solution for this issue (there are four male Pacific participants while you can see only 19a, 19b, and 19c).

_____
Thank you for your supportive comments. We have modified Table 1 and introduced codes that we use to identify each participant in the text. We hope this change resolves the confusion you identified.

Because of the word limits, we have felt unable to add more detail to the methods section; we believe the methods are described in sufficient detail to enable another researcher to replicate our study. We have also reviewed other BMJ Open papers and believe we have provided comparable methodological detail to these.

Reviewer 2
Authors have responded adequately to the issues raised before, except for the issue of accepting the idea that “informed choice” is a relevant issue for tobacco. In my previous review I raised this, but perhaps not clearly enough. The authors responded to my parallels (asbestos, defective cars) by

noting that these are now not legal to sell, which is precisely my point: we have decided that it is not enough that consumers should make “informed choices” to buy such products, but that they should not be allowed to make that choice at all because the products are just too dangerous. Should this not be the case with tobacco products? I raise this because the most obvious/simplistic response to the paper’s findings (people’s “choice” to use tobacco is not “informed”) is to say that people should be better informed to make that choice. The authors are (rightly) not making this argument, and suggest numerous stronger policy measures in their conclusion. I think it is important to be explicit about this and to say that MASC should not only reject as incorrect the industry’s argument that people are making an “informed choice” to smoke, but it should also reject this framing of the issue, and focus instead on the qualities that make tobacco use not a “choice” at all, informed or not (e.g., addiction, long-term harms, industry promotion, etc.). Without unpacking the idea of “choice”, the paper runs the risk of playing into the idea that the problem is that smokers or potential smokers are simply not well-informed enough.

_____

Thank you for your clarification and apologies for not having addressed your comment in full. We agree completely with your argument and have clarified our conclusion that smoking is often not a choice in any sense, let alone an informed choice. We have made more explicit the factors that militate against choice and strengthened our suggestion that policy makers address these factors using environmental (policy) measures.