

WHYKWIT

A qualitative study of what motivates Māori, Pacific Island and low socio-economic peoples in Aotearoa/New Zealand to stop smoking

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Report Two: Methodology report (pp. 1-34)

Report Three: Results report (pp. 1-195)

REPORT ONE

Literature Review

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FOREWORD

This literature review was undertaken by the Centre for Tobacco Control Research (CTCR) with support from Pacific Health at the University of Auckland and Action on Smoking and Health (ASH). The review should be read in the context of providing a background to the broader WhyKwit study, which aims to investigate why New Zealanders stop smoking. This document provides a review of health belief models and theories of motivation, and reviews international and national literature on what motivates, facilitates, and impedes people to stop smoking.

The co-investigators gratefully acknowledge Bibi de Zeeuw, Raina Tutini, Jane Stephen, Missy Purnomo and Erana Kaye-Berghan; the students who worked on various sections of this review. We are grateful also to Jade Le Grice for reviewing the draft report and Katie Marriner for additional literature searching.

PART ONE: Overview

1. The WhyKwit Study

The prevalence of tobacco smoking in New Zealand has been in gradual decline since the 1970s (Ministry of Health, (MoH) 2006). However, approximately 700,000 New Zealand adults smoke; half of whom are likely to die of a tobacco related disease (MoH, 2009a). Smoking rates are significantly higher amongst Māori, Pacific Island ethnicities and those of lower socio-economic status (SES). Reducing tobacco smoking is a key priority for improving health and reducing health and economic inequalities between Māori and Pacific Island people, and other New Zealanders (MoH, 2004a).

Studies that have examined predictors of smoking cessation success and differential cessation rates indicate that increasing the number of times people attempt to quit smoking improves their chances of successfully quitting, which overall, decreases smoking prevalence.

Motivation to quit amongst Māori has been explored, but less is known about the change in motivation to quit over time or how this motivation is related to quit attempts. There have been few studies of smoking attitudes and knowledge amongst Pacific Island ethnicities and no studies explore cessation in detail.

2. Research aims of the WhyKwit study

The aim of the WhyKwit study is to investigate what motivates Māori, Pacific Island and low socio-economic users of tobacco to stop smoking.

3. Purpose and content of the literature review

This literature review provides the background for the WhyKwit study. It also provides a basis from which to analyse the research findings.

The literature review contains a background section outlining smoking related harm globally and in New Zealand. Use of tobacco in New Zealand and the tobacco control programme in New Zealand is briefly described. Some theories and health belief models, with a particular on Māori and Pacific models, are explored for their potential use as analytical frameworks for the study. Finally the document examines literature on the factors that motivate, facilitate and impede quitting.

4. Methodology

4.1 Search terms

Search terms and combinations of terms varied according to the database and/or category of literature being searched. Broadly, the search terms can be summarised into the following categories:

- Tobacco/smoking/cigarettes/nicotine
- Motive/motivation/trigger/reasons
- Cessation/quit/stop
- Māori
- Pacific peoples/Pacific Islanders
- Socio-economic status
- Risk factors/protective factors

4.2 Literature sources

PubMed, Medline and PsychInfo were searched in addition to the following journals: *Pacific Health Dialog*, *New Zealand Medical Journal*, *British Medical Journal*, and *Nicotine & Tobacco Research* and *Science Direct*. Scopus and Google Scholar were also used. Monthly updates from PubMed were subscribed for using the search terms: "Motivation" AND "Smoking Cessation" AND "Tobacco Use Cessation" and limits: English, Adult 19+ years.

To find organisational reports and publications which were not journal publications, a search on Google was undertaken. Additional relevant publications were manually found in the CTCR library and ASH library.

Articles which appeared relevant from the title and abstract were read to decide if they were to be included in the review. The reference section of each article to be included in the literature review was examined to identify additional relevant publications.

Inclusion criteria were: English AND participants asked why they stopped and/or why they would want to stop smoking AND accessible to University students. Peer-reviewed journal articles, books, unpublished studies, government documents, and reports were all included in the literature search. Given the disproportionate harm caused by smoking to Māori and Pacific peoples, and people of low SES, and reflecting the focus of the WhyKwit study, priority was given to cessation and motivation literature which focussed on these groups in particular or ethnic minorities more generally.

4.3 Building research capacity

The CTCR is currently conducting two research projects, *Keeping Kids Smokefree* and *WhyKwit* which specifically addresses Māori and Pacific smoking. In addition the University of Auckland offers a postgraduate course in tobacco control. One of the objectives for the CTCR is to build Māori and Pacific Island tobacco control research capacity. To this end, the current project provided several training opportunities for undergraduate and postgraduate students. Following is a list of those students, their study programme and their specific area of contribution to WhyKwit:

Bibi de Zeeuw (Wageningen University, Holland)

Masters of Management, Economics and Consumer studies

Motivations to stop smoking amongst lower socio-economic smokers and ex-smokers in New Zealand.

Raina Tutini (University of Auckland)

Bachelor of Health Science Honours (BHSc) Dissertation

What motivates Pacific Island men to stop smoking?

Raina also undertook a Summer Studentship during which time he worked on the compilation of the present literature review.

Jane Stephen (University of Auckland)

Bachelor of Health Science Honours (BHSc) Dissertation

What motivates Pacific Island women to stop smoking?

Missy Purnomo and Erana Kaye-Berghan (University of Auckland)

Bachelor of Health Science, Population Health 302 Internship

What motivates Māori to stop smoking?

PART TWO: Background

1. Smoking related harm – globally

Tobacco smoking is the world's leading killer, killing more than HIV/AIDS, tuberculosis and malaria combined (World Health Organization [WHO], 2008). For the year 2009 it was estimated that 5.4 million people would die because of tobacco related harms (WHO, 2008). If more effective preventative measures are not implemented, death by tobacco related illness is estimated to increase to over 8 million per year by 2030 (WHO, 2008). Of the estimated one billion smokers alive today, it is anticipated that approximately one third to half will die fifteen years prematurely because of tobacco (WHO, 2008).

Worldwide, tobacco is the fourth largest risk factor for disease, not only killing prematurely but also eroding quality of life in the process (WHO, 2006; Chapman, 2007). It is a major cause of heart and respiratory disease, increases the risk of cardiovascular disease (CVD), stroke, blindness, and causes hearing loss, teeth loss, osteoporosis and erectile dysfunction (Chapman, 2007).

Global estimates suggest around one in four women will die before middle age due to tobacco; this number is expected to double over the next twenty years as female smoking rates increase (WHO, 2001). Women face disproportionately greater health risks from smoking than men given increased risk of osteoporosis, and additional risk of cervical cancer, breast cancer, early menopause, reduced fertility, ectopic pregnancy, infants of low birth weight, stillbirths, neonatal deaths and sudden infant death syndrome (SIDS) (WHO, 2001; Butler, Williams, Paterson et al., 2004).

Smoking during pregnancy is a significant health issue in many countries, including New Zealand (WHO, 2001). Women who smoke are less likely to breastfeed or breastfeed for a shorter period of time. Children exposed to secondhand smoke are more susceptible to ear infections, asthma and respiratory illness (WHO, 2001).

The economic impact of tobacco use, globally, is a multibillion dollar burden. (WHO, 2008). Economic loss from tobacco use is incurred by: social costs, welfare costs and healthcare costs (Mackay & Ericksen, 2002). In America, the annual loss of economic productivity from tobacco use is estimated to be US\$92 billion, with healthcare costs reaching US\$81 billion a year (WHO, 2008).

Worldwide, approximately 12% (250 million) of women smoke tobacco daily compared to 48% of men (WHO, 2001). Though, in countries such as New Zealand, Hong Kong, Norway and Sweden, smoking rates between men and women are equal (Mackay & Ericksen, 2002).

While smoking rates among men are generally decreasing worldwide, smoking rates among women show more variation within and between countries. (WHO, 2001). Globally, increases in tobacco consumption are seen in mid to low income countries and amongst young women

in high population countries (WHO, 2008). In developing countries women's smoking rates are rising rapidly (Mackay & Ericksen, 2002). Decreases in smoking prevalence are seen among women in many developed countries including Australia, USA, UK and Canada (Mackay & Ericksen, 2002).

2. Tobacco in the Pacific

Of the 100 countries with the highest adult smoking prevalence, nine are in the South Pacific region (Shatey, Dolwick, & Guindon, 2003). While little is published about the history of tobacco in Polynesia, what has been documented tends to illustrate that tobacco was mainly used as a social gesture and relaxant among Polynesian men (Linnekin & Poyer, 1990). Tobacco was introduced to the South Pacific by European whalers, traders, and settlers during the period of colonization (Crocombe, 2001).

The intention of colonial traders was to quickly establish a fascination for smoking among the local Islanders. By doing so, this allowed tobacco to be set up as a commercialized product for profitable trade (Linnekin & Poyer, 1990). Following the Second World War, imported manufactured cigarettes quickly replaced loose tobacco. Factory made cigarettes had an immediate and significant impact in the Pacific region, and shortly after its introduction cigarette factories were established. By the 1950's, cigarette factories were active in Fiji and Tonga, with Samoa following suit in the 1960's.

In a study of smoking amongst adults over 20 years old in South Pacific nations, including the Cook Islands, Western Samoa, Niue, Tuvalu, Nauru, New Caledonia, Fiji, and Kiribati, significant ethnic disparities in tobacco smoking were common (Tuomilehto et al., 1986). For example, Fijian Melanesian men from urban areas were more than twice as likely to smoke as Fijian Asian men from within the same district. This effect demonstrates how the prevalence of smoking can vary between two ethnically different groups living side by side. Further, smoking prevalence increased with increasing deprivation.

The uptake of tobacco in the Pacific region is illustrated in the smoking rates of Pacific men in this study (Tuomilehto et al, 1986). Pacific adult men generally had higher smoking rates compared to women, although for Cook Island men this trend was reversed. Smoking rates reported were: 86% of men in Kiribati, 76% of men in New Caledonia, 75% of men in Western Samoa and 58% amongst Niuean men. Comparatively lower rates were reported in the 1986 New Zealand Census, during the same time period. The high incidence of tobacco use in the Pacific region suggests that little was known about the harms from tobacco smoking, at that time.

Smoking prevalence in Pacific countries has been noted as more common in traditional rural areas where tobacco is cultivated, providing greater access to tobacco, than in urban areas (Collins, Dowse & Zimmet, 1996; Tuomilehto, et al., 1986). Correspondingly, high levels of non-communicable diseases arising from widespread tobacco use has been reported in rural areas of Pacific countries (Collins et al., 1996). This pattern of morbidity prevalence suggests an increasing trend of foreign diseases (Allen & Clarke, 2007).

Historically, prior to the arrival of tobacco, the South Pacific region was described as one of the most disease free regions in the world and tobacco related diseases like lung cancer, bronchitis and emphysema were non-existent (Crocombe, 2001). Following the introduction of tobacco, and then manufactured cigarettes in the 1940s, tobacco now represents one of the largest single causes of avoidable mortality in the South Pacific (Rasanathan & Tukuitonga, 2007). While the most recent data shows that the prevalence of smoking in the Pacific region has gradually declined since the 1980's and 90's, smoking levels in the Pacific remain high (Rasanathan & Tukuitonga, 2007).

3. Tobacco use in New Zealand

Over 700,000 New Zealanders smoke on a regular basis (MoH, 2009a). Table 1 shows the smoking prevalence in New Zealand by ethnic group for 2008. Given that tobacco control in New Zealand intends to manage and reduce tobacco related harms by reducing the number of people who smoke, this has not reached Māori and Pacific peoples. Smoking is most prevalent among Māori and Pacific Islanders, with Māori men and women two times more likely to be current smokers compared to the total New Zealand population (MoH, 2009b). Whereas, European male smoking rates aged 15-64 years for the periods 1996-2006 decreased by 1%, for Pacific males smoking rates were seen to have increased by 3%.

Table 1: Smoking prevalence for 15-64 year olds, by ethnic group and gender, 2008

Ethnic group	Males		Females		Total	
	Prevalence (95% CI)	Number	Prevalence (95% CI)	Number	Prevalence (95% CI)	Number
European/Other	22.5 (20.3-24.7)	2,227,100	20.2 (18.0-22.5)	218,800	21.3 (19.8-22.8)	446,000
Māori	40.4 (34.7-46.0)	63,400	49.7 (44.4-55.1)	913,000	45.4 (41.1-49.4)	1,547,000
Pacific	34.7 (26.6-42.8)	26,100	28.5 (23.3-33.6)	23,700	31.4 (26.9-36.0)	49,800
Asian	20.1 (13.2-26.9)	31,200	5.2 (2.7-9.0)	8,600	12.4 (8.7-16.2)	39,800

(Source: MoH, 2009a).

3.1 Māori

Māori smoking prevalence is significantly higher than that of New Zealand Europeans and consequently, smoking has a disproportionate effect on Māori. In 2008, 45% of Māori (15 years and older) were regular smokers compared to only 21% of New Zealanders of European origin. Māori women continue to have one of the highest smoking rates in the world for women, with more Māori women smoking tobacco (50%) than Māori men (40%). Smoking among Māori women is highest during child-bearing years (15-45 yrs) at 55% (MoH, 2009).

On a more positive note, from 1996 to 2006 the rate of Māori smokers reduced more than that of non-Māori smokers (Ponniah & Bloomfield, 2008). In 2006, Māori smokers stopped smoking at around half the rate (.54) of European New Zealanders, although at least as many Māori smokers made quit attempts in the preceding five years as did European New Zealanders who smoke (68% compared to 65%) (MoH, 2007b). Data collected from the 2006 census reports prevalence of European ex-smokers at 24.5% and Māori ex-smokers at 19.1% (Ponniah & Bloomfield, 2008). These rates are reflected in the vast differences in life expectancies between Māori and non-Māori where non-Māori are expected to live approximately 7.6 years longer than Māori (Robson & Harris, 2007).

3.2 Pacific

The overall decline in smoking prevalence in New Zealand has not been evident amongst Pacific peoples (see figure 1.) (MoH, 2009b). Pacific peoples continue to have significantly higher rates of smoking compared to the national average, although have lower rates than Māori (MoH, 2009b). One in three Pacific people are likely to smoke compared to one in five New Zealand Europeans (MoH, 2009b). Census statistics from 2006 indicate that, among the four Pacific populations studied, Cook Islanders (38%) have the highest prevalence of smoking followed by Niueans (33%), Tongans (29%) and Samoans (28%). An estimated 31% of Pacific smokers had attempted to quit smoking in 2008 (MoH, 2009a).

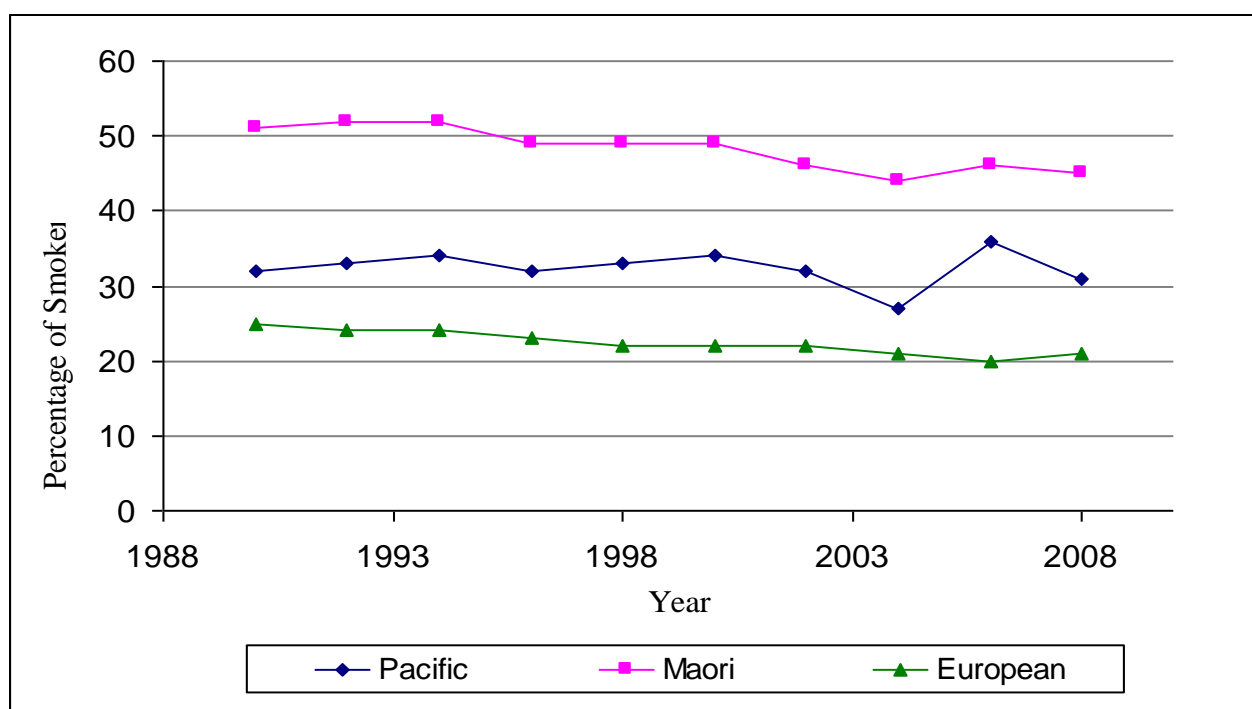


Figure 1: Prevalence of cigarette smoking, ages 15 years and over, by ethnic group, 1990-2008.

(Source: MoH, 2009b)

3.3 Socioeconomic Status (SES)

Tobacco smoking is more common amongst people of low socioeconomic status, and contributes to maintaining socioeconomic and ethnic disparities in New Zealand. Smoking prevalence rates increase amongst populations with greater levels of deprivation (MoH, 2007b). whereby smoking is three times more likely in areas of low deprivation (MoH, 2009a). This pattern has existed since the 1980s when tobacco control strategies were implemented, and reversed the higher prevalence of smoking among people of high socioeconomic status (MoH, 2007b).

People who reside in areas of greater deprivation are not only more likely to be smokers, they are also more likely to be exposed to higher levels of second-hand smoke (MoH, 2004b), and are four times more likely to die from smoking than those from least deprived areas (MoH & University of Otago, 2006). Persons belonging to lower socioeconomic status groups are also less likely to quit smoking and are less likely to succeed at quitting if they try (Britton, 2004). Adverse health outcomes related to tobacco-related disease is high among New Zealanders in lower socio-economic groups. According to the Ministry of Health, (2003b) if social inequalities are not addressed, these negative health indicators will remain prevalent through life and across generations.

According to Blakely et al. (2006) the contribution of smoking to ethnic inequalities in mortality increased over time (between 1981-1984 and 1996-1999) and is expected to grow more if differences in smoking between ethnic groups continue to increase. They posit that redress in socioeconomic gaps and further tobacco control is critical to reducing ethnic inequalities in health.

Smoking by SES and Ethnicity

In addition to having the highest smoking prevalence, Māori and Pacific people in New Zealand are overrepresented among lower socio-economic groups (MoH, 1999). Having a lower socioeconomic status has been reported as a risk factor for Māori youth smoking uptake (Waa et al., 1997), although this is not specific to Māori youth. In a study assessing the contribution of ethnicity and deprivation levels to smoking prevalence, a three-fold difference in smoking rates was reported between the least deprived areas (10.7%) and most deprived areas (36.5%) (Ponniah & Bloomfield, 2008).

4. Tobacco Control in New Zealand

The World Health Organization (WHO) proposed six broad policy approaches to reverse the global tobacco epidemic. These are:

1. monitor tobacco use and prevention policies;
2. protect people from tobacco smoke;
3. offer help to quit tobacco use;
4. warn about the dangers of tobacco;
5. enforce bans on tobacco advertising, promotion and sponsorship; and

6. raise taxes on tobacco (WHO, 2008).

As yet, no government has fully implemented all six strategies (WHO, 2008).

In 2004, New Zealand ratified the Framework Convention on Tobacco Control, which legally binds it to mandatory aspects of the convention (MoH, 2004a).

The government's five-year plan for tobacco control in New Zealand from 2004–2009, had four goals:

1. Significantly reduce levels of tobacco consumption and smoking prevalence
2. Reduce inequalities in health outcomes
3. Reduce Māori smoking prevalence to at least the same level as non-Māori
4. Reduce exposure to second-hand smoke for all New Zealanders.

This plan involved a comprehensive tobacco control programme that incorporates the internationally recommended strategies of legislation, taxation, health promotion and smoking cessation services (MoH, 2004a). The importance of tobacco control for Pacific peoples was recognised in the plan.

4.1 Smoking cessation

The New Zealand smoking cessation guidelines (MoH, 2007a) recommend a combination of multi-session support and pharmacotherapy. People who want to stop smoking should be referred to services that provide effective interventions, such as Aukati Kai Paipa (a Māori smoking cessation programme delivered by a range of predominantly Maori health providers throughout the country) or Quitline (the national free telephone support service). Of the smoking cessation programs available in New Zealand, Quitline is the most commonly used.

Quitline have a Pacific team who speak a number of Pacific languages. The number of Pacific callers to Quitline increased 54% between 2001-2005, but still made up only 4.3% of total callers (Quit Group, 2008). Six Quit Group resources have been translated into Samoan and Tongan and are available online. K'aute Pasifika and Pacific Quit are Pacific programmes which provide cessation advice in Hamilton and Waitemata respectively (National Pacific Diabetes Initiative [NPDI], 2008). Langimalie Health Centre in Auckland City and Health Pacifica in South Auckland are health providers that also give smoking cessation advice for Pacific people (NPDI, 2008). Currently no service or programme exists in South Auckland to help Pacific people quit.

Pacific Heartbeat offer smoking cessation services training which equips attendees with the skills and knowledge to register as Quit Card providers with Quit Group (NPDI, 2008). In 2000, SPAN made up of Pacific health workers was established to promote and advocate for Pacific tobacco control initiatives.

The effectiveness of smoking cessation interventions for Pacific smokers has not been studied. According to *Tupu Ola Moui: Pacific Health Chart Book* (MoH, 2004b), Pacific people who smoke fail to capture the health promotional messages of tobacco harms, mainly because the delivery message lacks cultural content, fails to deliver a holistic approach to quitting, and usually includes a cost factor as well.

Kaholokula, Braun, Santos and Chang (2008) who looked at the smoking attitudes and behaviours, and motivations for quitting among Hawaiian natives, found that Hawaiian natives who smoked were more likely to access combined behavioural and pharmacological smoking cessation programs provided the service included family, cultural and spiritual aspects.

Meo and Phillips (1999) found that an individually focused cessation treatment program set up by medical doctors failed as a result of remaining culturally unaware. It was only after community consultation with the village, that a culturally guided smoking cessation program using the rapid smoking method was developed. While the program was successful in recognizing Fijian culture, among the smokers who had relapsed, this failure to remain smokefree was interpreted by the participants as either a cultural curse or withdrawal symptoms. According to Suaalii-Sauni et al, (2009) using a culturally holistic approach as a guideline for addressing smoking cessation in Pacific communities is essential.

PART THREE: Understanding and Motivating Behavioural Change – Models and Theories

To inform this study in to motivation to quit, a selection of models and theories were reviewed:

- Te Whare Tapa Wha
- The Pandanus Mat
- West's P.R.I.M.E. theory
- The 3 T's Model
- Self Determination theory
- William's Conceptual Framework.

The objective was to identify appropriate theoretical frameworks for the analysis of the data.

Māori and Pacific people are the primary focus of the study, therefore Māori and Pacific models that can be used to guide the analysis and presentation of the results are presented first. Robert West's P.R.I.M.E. theory of addiction is then considered and the related 3 T's framework.

The Transtheoretical or Stages of Change Model (Prochaska & DiClemente, 1983) is *not* considered here. This model is considered redundant (West, 2005) and is no longer used in New Zealand to guide smoking cessation policy and programme planning (MoH, 2007).

1. Māori and Pacific Health belief models

The WHO (1947) defines health as a “state of complete physical, social, mental and spiritual well-being and not merely the absence of disease and infirmity” (p.29). This is consistent with the holistic approach associated with Māori and Pacific models of health. Both Māori and Pacific perspectives acknowledge that the mental, physical, spiritual and social well-being of the person is inter-related, and good health is contingent on the balance of these aspects.

Despite the differences among Māori and Pacific populations, underlying core values make it possible to talk about culture and cultural health beliefs in general (Suaalii-Sauni et al., 2009; Anae, Coxon, Mara et al., 2001). Māori and Pacific health paradigms place high value on the communities' role in maintaining health as well as the environment's medicinal healing qualities (Samu & Suaalii-Sauni, 2009). This in turn has significant implications on how health concerns are diagnosed and which health services are accessed.

According to Macpherson and Macpherson (1990) the way in which health is defined, how people experience health, the process of enquiry and their understanding of etiology are all set within a cultural framework. Whether an organisation's target population is Māori, Pacific or the general public, each organisation will encompass a philosophy and model of healthcare. To understand Māori and Pacific health is to recognise the importance of relationships and

cultural concepts. Without the addition of cultural supports which recognise the complexity of Māori and Pacific people's needs, Māori and Pacific peoples who smoke are less likely to be attracted to Western cessation services (Li & Grigg, 2007).

Robinson, Warren, Samu, Wheeler, Matangi-Karsten, and Agnew (2006) argue there is a tendency in New Zealand for the framework of some health models to be given legitimacy over others. Smoking cessation in New Zealand is predominantly based on the Western framework of the biomedical paradigm. As a result, the emphasis towards treatment is one that combines behavioural counselling with pharmacotherapy. As the biomedical paradigm expresses conceptual views of Western culture, scientific reasoning for understanding smoking behaviour, attitudes, and treatment are given prominence over cultural and holistic views of health and illness Suaalii-Sauni et al., (2009).

1.1 Te Whare Tapa Wha

Te Whare Tapa Wha (Figure 2) is based on the metaphor of a meeting-house where the four walls symbolise the four dimensions of wellbeing: mental, spiritual, physical, and family. A fifth realm, that is the ground upon which the whare sits – *Te Ao Turoa* (the longstanding environment) provides for environmental and political factors beyond the immediate realm of the whanau and social realm of influence (Glover, 2005). Wellbeing is dependent on these dimensions being in balance.

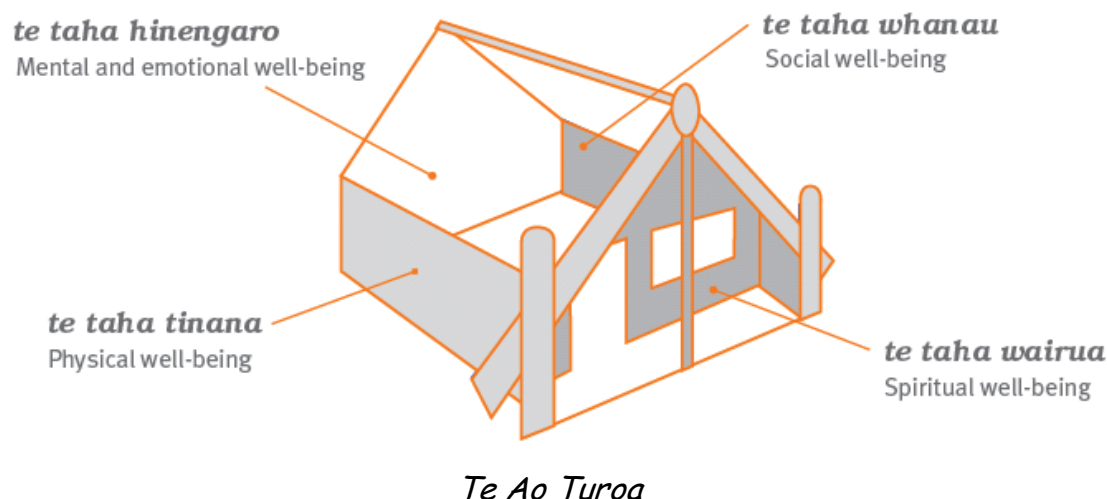


Figure 2: Te Whare Tapa Wha

(Source: Glover, 2005)

A number of Maori cessation programmes consistent with Te Whare Tapa Wha have been designed and evaluated: *Health Through The Marae* (Ministry of Māori Development, 1995; <http://www.maraehealth.co.nz/>) incorporates Maori 'therapies' (e.g. karakia, rongoa rakau) to support smoking cessation into a broader programme promoting fitness. *Noho Marae* residential stop smoking programmes, were holistic in that they incorporated change strategies across the physical, mental, familial and spiritual realms as espoused in Te Whare Tapa Wha (Glover, 2000). Te Whare Tapa Wha was used in the design of *Aukati Kai Paipa*.

The success of the *Aukati Kai Paipa* program was related to the Māori community having ownership of the program, recognition of traditional and cultural characteristics, and employing Māori quit coaches to deliver the program (Ministry of Health, 2003a).

1.2 The Pandanus Mat

Pacific people in New Zealand are often statistically categorised as an homogenous population with shared cultural values and customs. However, New Zealand migrants from the South Pacific region represent diverse and unique cultures with their own distinct history, traditions and spoken languages.

Searches of the ‘grey’ and published literature did not uncover a pan-Pacific or ethnic specific health model that addresses tobacco smoking and tobacco related harms among Pacific peoples. According to the Pacific Health and Disability Action Plan, the way to address Pacific health is through the development of Pacific health promotion models (Ministry of Health, 2002). Like the Māori models of health, Pacific models also adhere to cultural traits and characteristics (Taufe’ulungaki, 2004).

In a qualitative study by Suaalii-Sauni et al. (2009) Pacific health researchers presented a variety of Pacific cultural models nationwide to 20 focus groups of participants including mental health professionals as well as members from the Pacific community. Of the eight Pacific cultural models presented, three were frequently mentioned by a majority of the participants. These included the Samoan Fonofale Model, Tongan Kakala Model, and the Cook Islands Tivaevae Model. Although there were slight differences when comparing the cultural models of health, in this study these differences were seen as insignificant. The study objective was to deliberate on how the delivery of mental health services in New Zealand could be improved to increase Pacific participation. The study concluded that Pacific people would be more likely to respond to a holistic approach that included appropriate cultural and social supports, as well as culturally competent staff.

All three models mentioned above express Pacific traditions and beliefs that are prevalent throughout the entire Pacific region. Therefore, given the similarities between the above models and that for Pacific people, the factors that influence their attitudes and behaviours towards smoking are interwoven with culture, demography, and the social context in which they interact (Capstick, Norris, Sopoaga & Tobata, 2009), we have chosen the Pandanus Mat (Figure 3).

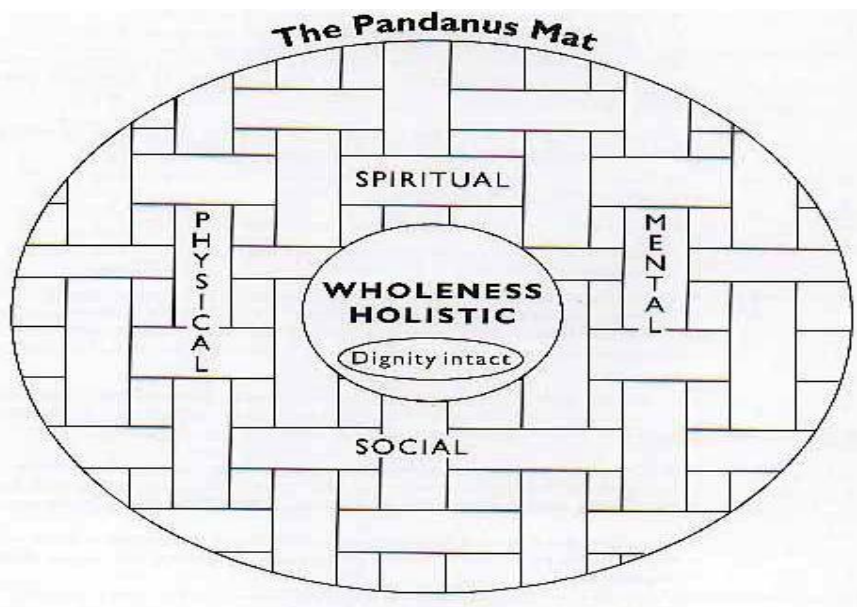


Figure 3: A Pacific model of health

(Source: <http://www.hpforum.org.nz/resources/22ndJan1.pdf>)

The pandanus mat is regarded highly within most Pacific cultural groups. The pandanus mat is a flax woven, hand-crafted traditional mat often presented as a valued gift of cultural exchange at Pacific ceremonies such as weddings, baptisms, or dance festivals (Suaalii-Sauni, 2009). Central to the notion of the Pandanus Mat model of health is the theme of Pacific wholeness and the concept that effective healthcare and recovery requires a holistic approach that encompasses the dimensions of the interweaving strands. The Pandanus Mat model illustrates how the key strands of Pacific people's life are interwoven. The four key strands refer to the physical, spiritual, mental and social elements of Pacific culture, each having a direct influence on each other. The interlocking of the weaves refers to the strength of the mat, and determines the vigour and resiliency of Pacific people's durability when tested under adverse contextual and environmental conditions over time (Suaalii-Sauni et al., 2009).

In terms of healthcare delivery, replicating the concept of a Pacific health belief model that spans the entire Pacific population as a unified group is problematic. Further, given the acculturation of Pacific youth into Westernised culture, a Pacific health belief model such as this may appear outdated and irrelevant to the younger and increasingly New Zealand born Pacific generation.

2. West's P.R.I.M.E Theory of Addiction

The most current and relevant theory for understanding addiction, and therefore motivation, is West's P.R.I.M.E. Theory (2006). The P.R.I.M.E. theory of addiction is a synthesis of many previous theories and models that individually contributed to the ever evolving

addictions knowledge base, but on their own were not sufficient to explain addictive behaviour.

Not dissimilar to the previous two models presented (Te Whare Tapa Wha and the Pandanus Mat), West proposes that addiction results from an imbalance in the motivational system (Figure 4). He similarly proposes that there is a complex interdependent relationship between psychological (beliefs, emotions, desire), physiological drives (genetic susceptibility, drug-induced dependency and conditioned responses) and social and environmental supports for or constraints on behaviour. What P.R.I.M.E. lacks perhaps is a metaphorical vehicle that would assist the dissemination, comprehension and application of the theory.

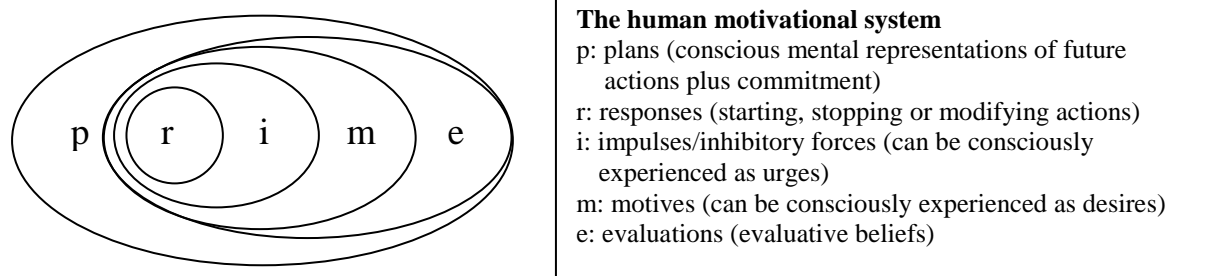


Figure 4: Top level elements of the motivational system

(Source: West, 2006).

West (2006) does however, translate the implications of his theory for interventions. With regards to motivating people to end addiction to tobacco use, to be effective he suggests that interventions need to:

1. reduce impulses to smoke or create inhibitions that will operate when people are presented with an opportunity to smoke;
2. monitor motivational balance and add, remove, strengthen or weaken elements to restore balance;
3. reduce the strength or extent of motivational forces, or strengthen forces that counter these. For example, medication can assist with reducing the urge to smoke or by removing the pleasure usually received from smoking.
4. there is a need for intervention programmes to set clear objectives regarding the extent of individual change treatment programmes will facilitate. If set at an insufficient level, balance in people's underlying motivational system will not be reset and the tobacco control programme will have to continue applying interventions that merely suppress smoking behaviour.
5. Bringing about shifts in identity, for example, from a "smoker" to a "non-smoker" or to being "auahi kore" requires a more holistic approach that attempts to institute supportive changes in people's whanau and social network, work and social environments. It requires recognition of the social determinants of smoking behaviour and a commitment to systemic changes that remove some of the forces that imbalance the motivational system.

Essential to understanding the motivational system is West and Sohal's (2006) proposal that change occurs 'chaotically' rather than adhering to any logical or rational staged process that can be neatly manipulated. Drawing on catastrophe theory, they posit that beliefs, past experiences and current situations create varying levels of motivational tension. Depending on the level of tension, even a small trigger could prompt a shift from desire to quit to a plan to quit, or a seemingly sudden catastrophic shift to stopping smoking immediately. West and Sohal (ibid) suspect commitment to change is lower in those that make a plan to quit versus those that 'spontaneously' attempt to quit. Thus, motivation to quit can vary considerably with time and motivation is strongly influenced by the smoker's environment (West, 2004).

3. The 3T's model

West and Sohal (2006) suggest that public health campaigns focus on the "3 T's": creating motivational tension, triggering action in smokers on the cusp of a change in their orientation to smoking, and providing immediate access to effective cessation treatments and support. Glover and McRobbie (2008) developed the Figure (5) below to illustrate this.

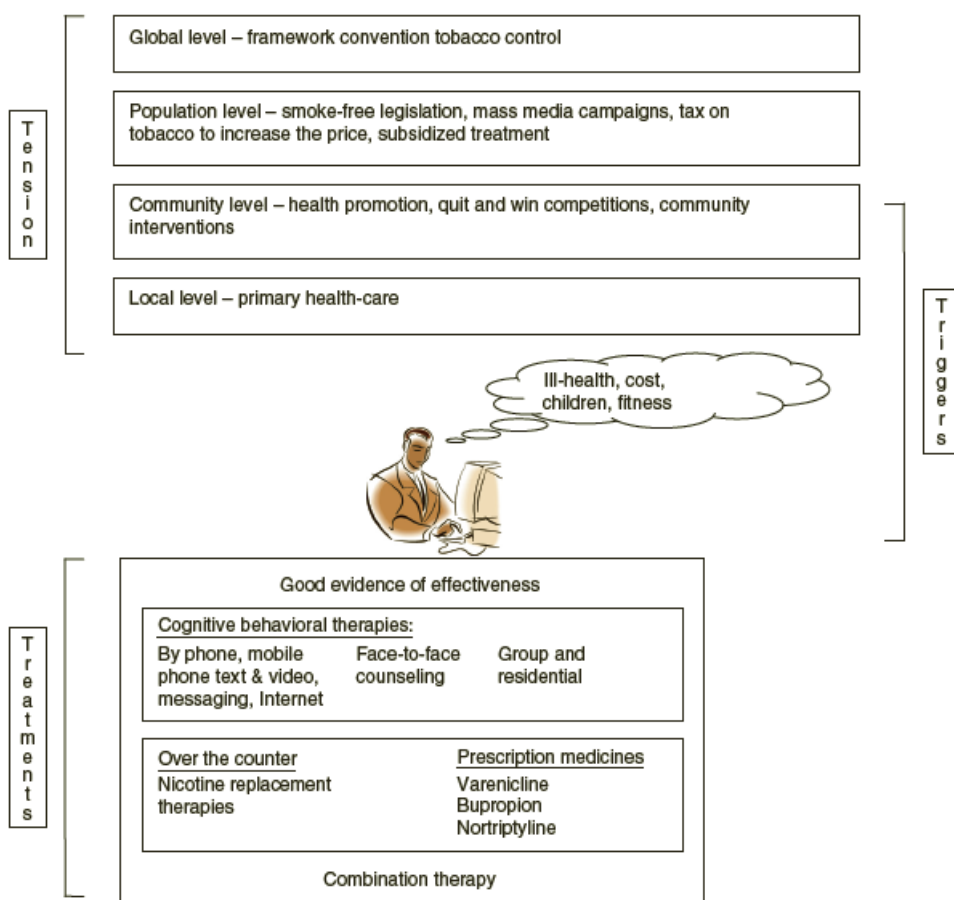


Figure 5: The 3Ts conceptual framework for understanding smoking cessation. (McRobbie & Glover, 2008).

Tensions can occur at the global, population, community and local level. For example, a smoker can be motivated to stop smoking by smokefree environments legislation, a mass media campaign or by increased tax on tobacco. Triggers prompt action to stop smoking. Examples of triggers could be: community led health promotion activity or personal level prompting e.g. pregnancy, ill-health, financial stress and fitness. Some tensions can also act as triggers, for example, the tax increase that is experienced as ‘the final straw’ which tips motivational balance and results in a quit attempt. The availability of treatment can also be a trigger. Thus, it should be understood that there is not a clear distinction between what is a tension or a trigger.

4. Self-determination theory

Self Determination Theory (SDT) offers a conceptual framework for explaining how environmental influences shape and constrain an individual’s motivation (Ryan & Deci, 2000).

Intrinsic motivation

Unique to this theory is the importance of intrinsic motivation. Intrinsically motivated behaviours are ones where the behaviour change is driven by rewards which are internal to the person (Curry, McBride, Grothaus et al., 2001). When someone is intrinsically motivated they experience feelings of competence and self determination (Deci, 1975). An activity is intrinsically motivated when the person gets enjoyment from the activity (Ryan & Deci, 2000). Partaking in intrinsically motivated behaviour is said to fulfil basic human psychological needs – to feel competent, self-determining and engaged (Deci, 1975).

Competence in this context is the extent to which smokers feel they can achieve their goal of being smokefree and maintaining abstinence. A cognitive evaluation theory argues that communication or feedback which bolsters feelings of competence will enhance intrinsic motivation (Ryan & Deci, 2000). But this also needs to be supported by a sense of autonomy. Support persons and health care professionals need to offer smokers choices and opportunities to be self-directing (Ryan & Deci, 2000). Studies in the classroom, for example, have shown that children who are overly controlled quickly lose interest (Ryan & Deci, 2000). Intrinsic motivation can only occur if the person is interested in achieving the goal (Deci, 1975).

Extrinsic motivation

The concept of *intrinsic motivation* sits on a continuum opposed to *extrinsic motivation*, where the behaviour change is driven by rewards outside the person (Deci & Ryan, 1985). People participate in extrinsically motivated behaviour because they are driven by positive or negative reinforcement, punishment, the need for self/peer approval, or self-endorsement (Ryan & Deci, 2000).

The degree of autonomy in extrinsic motivation varies greatly (Ryan & Deci, 2000). For example the teenager who quits smoking to avoid being grounded is being controlled

externally. The aspiring rugby player who stops smoking because it will improve his fitness levels is also externally motivated because he gets no enjoyment from being smokefree (Ryan & Deci, 2000). However the rugby player has greater freedom in choosing to be smokefree (Ryan & Deci, 2000).

Internalisation, introjection, and integration

In general, studies have shown that people who perceived themselves to be intrinsically motivated were more likely to succeed in maintaining smoking abstinence than those who were extrinsically motivated (Curry, Grothaus & McBride, 1997; Duncan, Cummings, Hudes et al., 1992). The challenge then is how to increase intrinsic motivation. Ryan & Deci (2000) talk of an *internalisation* continuum. They describe the process whereby the smoker takes the external regulation and makes it their own. Over a period of time the regulation ceases to be external and becomes part of the person's identity (Ryan & Deci, 2000). When an external motivator is personally evocative, yet not integrated with one's beliefs, this remains at the level of *extrinsic motivation*, a process termed *introjection*. In the example of smoking cessation, the theory postulates that the degree to which people are *intrinsically motivated* to stop smoking will predict maintained cessation over and above the contributions made by one's perceived competence or efficacy (Williams et al., 2002). Complete internalisation of external motivators to align with personal beliefs is a process called *integration*.

5. Williams' Conceptual Framework

The framework developed by Williams (1990) (see Figure 6) is useful in demonstrating the relationship between psychosocial factors, SES, and health outcomes. Williams depicts how demographic, biomedical factors and medical care are interrelated with smoking behaviour and health outcomes. That is, inequalities in health are not explained by SES alone (Harwood et al., 2007), rather there are interconnected pathways linking risky health practices (smoking), social ties, perceptions of control, stress and affective states.

For example:

- Fewer social ties are reported by persons of lower socioeconomic status (Cohen et al., 2003);
- Disadvantaged populations have lower perceived control, believing in the existence of external constraint. Therefore, disadvantaged people are likely to smoke more as a way of managing the lack of control experienced;
- Stress and SES influences disease both directly, in stress-related physiology, and indirectly, by impacting health practices (smoking).
- Low SES people live and work in more stressful environments, with insecure employment and low control at work if they have it. Thus, it is proposed that lower SES people use smoking as a way to cope with stress.
- Affective states such as depression, anxiety and panic disorder are linked to stress. There is a strong relationship between SES, and all types of mental illnesses (Hudson, 2005).

The psychosocial factors named below in figure 6, are interrelated. For example, a low perceived control leads to a sense of powerlessness, low self-esteem and social isolation. Harwood et al. (2007) suggest that other factors influence the relationship between SES and smoking behaviour, such as demographic and environmental factors, such as the work environment.

Williams' framework can be used to identify important determinants of smoking, including those upstream (population-level, public policy), midstream (focus on groups with higher risk) and downstream (concentrate on individual; tailored smoking cessation programs) (Harwood, 2007).

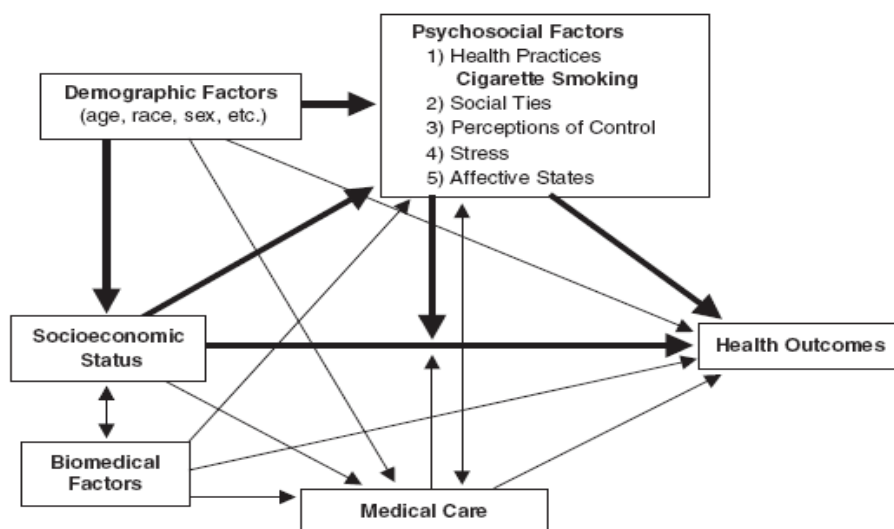


Figure 6: Williams' Conceptual Framework (1990)

(Source: Harwood et al., 2007)

PART FOUR: What motivates people to stop smoking

This section investigates motivating factors to stop and abstain from smoking, drawing on both international and local studies.

1. International literature

The international literature reviewed here falls broadly into three categories: 1) retrospective reports of former and/or current smokers regarding reasons for previous attempts to stop smoking; 2) cross-sectional studies of current smokers regarding factors they think would help them to stop smoking and 3) cross-sectional studies of current smokers regarding factors correlated with their desire to stop smoking. The review presents multiple reasons for quitting smoking including both interpersonal and social contextual concerns.

1.1 Retrospective studies

Table 2 summarises 13 studies where ex- and/or current smokers were asked about their reasons for attempting to stop, and/or for stopping smoking. The first nine studies accepted multiple responses, either asking open-ended questions or providing multiple-response-allowed checklists of reasons for participants. The second group of four studies considered the main reason provided by respondents either via an open-ended question or from a provided checklist of reasons for stopping smoking.

A number of caveats are worth noting regarding these studies. Retrospective studies rely on the self-report of participants about a particular phenomenon. As such, there are potential issues concerning accuracy of recall of past events and relatedly, social desirability (McCaul et al., 2006). In spite of this, retrospective study designs are useful for making associations between two variables in large populations.

More generally, studies which provide checklists may limit participants if their reason is not listed, or lead participants to select more socially desirable responses such as “pregnancy” over “cost” (Vangeli & West, 2008). Moreover, some of the reasons for stopping smoking provided in response to open-ended questions may be considered differently by different researchers. For example, in the study by Gilpin et al (1992), “pregnancy” as cited by participants was not considered an eligible response for analysis. Some studies recruited participants from medical centres, and may therefore be limited by selection bias. Referral criteria for centres were not always outlined and results may be confounded as health centres are likely accessed by populations with already high health needs (McBride, Pollak, Lyna et al., 2001).

Given the limitations outlined, the studies provide a starting point from which to consider similarities across samples. Despite the variation in population samples and study methods, health or some aspect of health was cited as the most important motivator to quit smoking in 12 of the 13 studies. Health was conceptualised in various ways across the studies; some differentiated between smoker’s health and the health of others, future health problems or

present health problems, general health issues, specific health ailments, or awareness of the effects of smoking on health (McCaul et al., 2006). In some cases (e.g. Gilpin et al., 1992), “health reasons” (for example, to avoid future illness, because of existing health problems, to improve fitness) were conflated. Where personal health was distinguished from the health of others, the former always ranked higher than the latter (McCaul et al., 2006). In the single study (Lando et al., 1992) where health was not the number one reason cited, it was second only to “being sick of smoking”. It is unclear how much “health” is implicated in this latter reason.

“Social concerns” or “social environment” along with cost-related factors also featured highly across many of the studies, although to a much lesser degree than did health. Social concerns included, for example, encouragement or pressure from family/friends, health professional’s advice, and setting an example for children. Where health concerns were merged and reported as a single item, social concerns (or variations of this) and cost related factors were more likely to appear in the top four rankings.

Cost featured a poor seventh and respectively, not at all in the two US studies with lower income populations (see Orleans et al., 1989 and Lando et al., 1989). Orleans et al., (1989) suggest that low SES populations use smoking as a coping mechanism for stress. Negative emotional states including stress, nerves, boredom and depression were the most common relapse triggers for participants in the study by Lando et al., (1992). Variable ranking of cost across studies may reflect the relative affordability of cigarettes to the consumer. In the US where a packet of 20 cigarettes costs less than half the price of a Big Mac hamburger and where, at less than 24%, the United States has amongst the lowest tax proportional to cigarette price, in the world (Shafey et al., 2009), cigarettes are still relatively affordable. The absence of concern about cost for smokers may reflect this affordability. Elsewhere, rather than cost acting as a reason for stopping smoking, smoking was reported amongst lower income African American women, as one of the few pleasures they could afford (Lacey et al., 1993).

Vangeli and West (2008) found that cost featured as a reason for stopping smoking more amongst lower than higher SES smokers. Vangeli and West however challenge the assumption of responsiveness to cigarette price fluctuations by low income smokers. They cite the continued disproportionately high prevalence of smoking amongst people of lower SES in spite of the high cost of cigarettes in the UK (i.e. a packet of cigarettes cost 164% of the price of a Big Mac hamburger, and 78% of the price of cigarettes in the UK is apportioned to tax, amongst the highest rate in the world (Shafey et al., 2009). Vangeli and West (2008) thus suggest that although cost may be considered a significant motivation for stopping amongst lower SES smokers, “this may not translate into actual long-term cessation” (p.414).

Table 3: Retrospective studies of ex- and/or current smokers' reasons for stopping or attempting to stop smoking

Author	Participants	Question asked	Results
	Multiple Responses		
1. Swenson & Dalton (1983)	American nurses (n=106 Ex-smokers/601)	Asked to indicate which of 6 reasons influenced them to stop	1) Statistics on mortality and morbidity associated with smoking (68%) 2) Decreased respiratory function (58%) 3) Pressure from family or friend (47%) 4) Death/illness of family/friend related to smoking (29%)
2. Orleans et al., (1989)	African American ex-smokers of low SES (n=175)	Reasons for quitting endorsed by ex-smokers.	1) To feel better physically (77%) 2) Prevent future illness (63%) 3) Take more control of life (54%) 4) To set example for children/others (43%)
3. Gilpin et al., (1992)	American adults in National Health Interview survey (Ex-smokers n= 1,172; Current smokers n=2,616)	"Thinking about the time you tried to quit smoking, please tell me the reasons you had for trying to quit" ¹ .	1) Health reasons (62%) 2) Social reasons (22%) 3) Cost (9%) 4) Lost desire to smoke (5%)
4. Duncan et al., (1992)	Ex-smokers from Kaiser Permanente Medical Centers, US (n=245)	"In your own words, briefly explain why you quit smoking".	1) Because of health symptoms (26%) 2) Because of health diagnosis (23%) 3) For better health, to feel better, because it's bad for my health (23%) 4) Fear of illness or desire to prevent illness in myself (22%)
5. Halpern & Warner (1993)	American adults in the Adult Use of Tobacco Survey (Ex-smokers n=4,614;	"Was this reason important to you in attempting to quit smoking?" (Yes/No). 6 options.	Ex-smokers results 1) Future health (75%) 2) Present health (59%) 3) Effect on others (36%) 4) Example for children (35%)

	Current smokers n=3,080)		Current smokers results 1) Future health (80%) 2) Present health (64%) 3) Effect on others (46%) 4) Example for children & Cost (36% each)
6. Hymowitz et al., (1997)	American and Canadian adults in the NCI's ³ Community Intervention Trial. (Ex-smokers n=3,214; Current smokers n=5,807)	Asked to indicate whether any of 9 reasons provided were important to them when they last tried to stop smoking.	Ex-smokers results 1) Concern for current or future health (90%) 2) Expense associated with smoking (53%) 3) Concern for the effect of ETS on others & Setting a good example (52% each) 4). Bad breath, smell or taste (43%) Current smokers results 1) Concern for current or future health (90%) 2) Expense associated with smoking (65%) 3) Concern for the effect of ETS on others (57%) 4) Setting a good example (56%)
7. Riedel et al., (2002)	American adolescent smokers (n=120)	"Which of the following things motivated you to quit" (Yes/No) 8 options + "other"	1) Concern for future health (73%) 2) Concern for current health (65%) 3) Concerns about physical appearance, hair teeth etc. (59%) 4) Cost of cigarettes & Athletic performance (52% each)
8. Sieminska et al., (2008)	Polish adult users of four healthcare services. (Ex-smokers n=385; Current smokers n=233)	Asked whether and which of 7 reasons were relevant when they last tried to stop smoking.	Ex-smokers results 1) Health concern (52%) 2) Personal health problem (37%) 3) Concern about family member's health (16%) 4) Physician instigation (13%) Current smokers results 1) Health concern (65%) 2) Personal health problem (23%) 3) Cost (22%) 4) Concern about family members' health (15%)

9. Reid, Pipe et al., (2009)	Adult smokers from Canada, Belgium, France, Germany, Italy, Japan, Mexico, the Netherlands, Poland, Portugal, South Korea, Spain, Sweden, Turkey, UK, and USA. (n=3,755)	Asked whether and which of 17 reasons describes why have tried to stop smoking.	1) Concerns about long-term health effects (60%) 2) Concerns about affecting the health of others (33%) 3) Cost (32%) 4) Life changes (23%)
Single Response			
10. Oei & Hallam (1991)	Australian ex-smoker, self quitters (n=70)	Asked to indicate the main reason for stopping smoking	1) Health problems (44%) 2) Smoking lost its appeal (17%) 3) Financial reasons (11%) 4) Please/benefit someone & Fears about loss of health (9% each)
11. Lando et al., (1992)	Urban Native American Indians (Ex-smokers n=173; Current smokers n=419)	Open-ended items asked about reasons for stopping, or attempting to stop smoking	Ex-smokers main reasons for stopping 1) “Sick” of smoking (18%) 2) Health reasons (17%) 3) Respiratory problems & Pregnancy (12% each) Current smokers main reasons for stopping (% not provided) 1) Respiratory problems 2) “Sick” of smoking 3) Health reasons 4) Becoming pregnant
12. Pederson et al., (1996) ⁴	Canadian ex-smokers (1983 n=311; 1991 n=396)	Asked to specify the most important reason for stopping smoking	1983 Results 1) Health problem (30%) 2) No longer enjoy (19%) 3) Relatives encouraged (9%) 4) Cost (7%)

13. Vangeli & West (2008)	English ex- and current smokers (n=2,441)	“What finally triggered your most recent quit attempt?” Select one reason from 12 or specify “other” on response	1991 Results 1) Health problem (23%) 2) No longer enjoy & Physical fitness (11% each) 3) Cost of tobacco, Relatives encouraged & “Other” including religious convictions, ETS, and aesthetics (9% each) 4) Example for children (7%) 1) Future health problems (29%) 2) Health problems I had at the time (19%) 3) Cost (12%) 4) Health professional advice (6%)
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¹ “Pregnancy” as a reason for stopping smoking was considered ineligible for analysis “given the different circumstances relating to smoking during pregnancy” (p.257).

² Social reasons in this context included “pressure from family or friends”, “advice from a doctor”, “setting a good example”, “effect of smoking on others”, and “dirty habit”.

³ National Cancer Institute’s Community Intervention Trial for Smoking Cessation

⁴ Study also included cross-sectional data; see Table 3.

While the main reasons for stopping smoking cited in Table 2 were health, social concerns and cost, additional reasons were also evident. Of interest were the reasons associated with the lack of enjoyment of smoking (i.e. “sick of smoking” (Lando et al., 1992); “no longer enjoyed smoking” (Pederson et al., 1996); “lost the desire to smoke” (Gilpin et al., 1992); and approximately one-fifth of the smokers in the large multi-national study by Reid, Pipe et al., (2009) reported “lack of enjoyment of smoking” had previously prompted an attempt to stop.)

Finally the effects of second hand smoking on others features as a prominent reason for stopping in several of the later studies (i.e. Halpern & Warner, 1993; Hymowitz et al., 1997; Pederson et al., 1997, Sieminska et al., 2008; and Reid, Pipe et al., 2009). This is likely to reflect an increasing international awareness of and knowledge about the effects of secondhand smoking.

1.2 Cross-sectional studies

Cross-sectional studies provide a “snapshot” of a population’s characteristics at one point in time. Although causal relationships between motivation and future quit attempts cannot be made, cross-sectional methods circumvent the confound of recalling past events, present in retrospective studies (McCaul et al., 2006).

Of the nine studies reviewed (Table 3), four asked smokers what they thought would prompt them to stop smoking, while the latter five sought to understand the factors associated with the desire to stop smoking. None of the results in the latter section are presented as percentages, reflecting their methodology.

As in the retrospective reports, health concerns or manifestations of this rated highly as a factor that would prompt a cessation attempt and as a correlate of the desire to stop smoking. The age of participants in the cross-sectional studies was more diverse than in the retrospective reports, with two of the former studies (Orleans et al., 1994; Breitling et al., 2009) surveying older adults. Health concerns were similarly ranked by younger (21-29 years) and older (50-74 years) smokers in Orleans et al. (1994), although the overall importance of such concerns was rated lower by older than younger smokers. This latter finding contradicts the suggestion that as smokers get older, personal concern for health becomes more important (Lotecka & MacWhinney, 1983; Leatherdale & Shields, 2009). Vangeli and West (2008) found a curvilinear relationship between age and readiness to quit. That is, between 16-25 years and 65 years and older, people were less likely to quote health as a reason for stopping smoking. This is supported by two studies in Table 3 of young people (under 20 years of age), where social concerns such as “pressure from a boy/girlfriend” (Sussman et al., 1998) and financial concerns (Fisher et al., 1999) were prioritised over health reasons. Moreover, Clark et al., (1997) found that 30-49 year olds (established smokers) were most likely to be contemplating stopping smoking compared to 18-29 year olds (recently initiated smokers) and 50+ year olds (long term smokers) (1997). Clark et al. reasoned that this was because 30-49 year olds were most likely to have received recent medical advice to quit smoking and were most likely to be beginning to feel the negative effects of smoking. Breitling et al., (2009) found that women over 70 years were less inclined to want to stop smoking than younger women, although it was

unclear if/how their health concerns were related to this. The younger adults (aged 21-49 years) in this study were more likely than the older adults to implicate the poor “example to children” of smoking as a potential prompt to stop smoking.

Almost one third of current smokers surveyed by Pederson et al. (1996) identified legislative restrictions on smoking as an important potential aid to stopping smoking. Smoking restrictions at work was nominated by just 22% of current smokers retrospectively as a reason for making a previous cessation attempt (Hymowitz et al., 1997). It is possible the different weight given to the importance of cessation restrictions in these studies is a product of the different questions asked of participants. In the former study, participants were asked “What would help you quit smoking?” while smokers in the Hymowitz et al’s study were asked “What reasons were important to you when you last tried to stop smoking?” It may be that smoking restrictions are perceived to aid attempts rather than drive them.

Table 3: Cross-sectional studies of smokers' reasons to stop and factors correlated with stopping smoking

Author	Participants	Question Asked	Results
	Factors that would assist quit attempts		
1. Orleans et al., (1994)	American current smokers (21-49 yrs old n=2,134; 50-74 yrs old n=784)	Asked to rate the importance of 6 motives for stopping smoking.	<p>21-49 yrs old</p> <p>1) Future health (83%) 2) Present health (68%) 3) Effect on others (50%) 4) Example to children (38%)</p> <p>50-74 yrs old</p> <p>1) Future health (73%) 2) Present health (57%) 3) Effect on others (36%) 4) Pressure from family/friends (33%)</p>
2. Pederson et al., (1996) ¹	Canadian current smokers (1983 n=381;1991 n=297)	Asked which reasons from a list of 11 items (+ other) would help participants stop smoking.	<p>1983 Results</p> <p>1) Information about harmful effects (38%) 2) Restrictions on smoking (30%) 3) Restrictions on sales and Programmes on radio/TV (22% each) 4) Cessation clinic (21%)</p> <p>1991 Results</p> <p>1) Other² (50%) 2) Information about harmful effects (34%) 3) Restrictions on smoking (28%) 4) Restriction on sales (23%)</p>
3. Sussman et al., (1998)	American high school students who smoke. (n=1,430)	“What might make you want to stop smoking?” Multiple responses, 22 reasons given.	<p>1) Pressure from a boyfriend/girlfriend to quit (54%) 2) Knowing someone who died because of smoking (45%) 3) Doctor's advice and To live longer (41% each) 4) Cost (34%)</p>

4. Fisher et al., (1999)	Unemployed Australian youth who smoke. (n=446)	“Which of the following reasons would convince you not to smoke?” Multiple responses, 13 options + “none of these”	(Ranked in order of importance but %s not provided) 1) Saving money 2) Becoming a parent 3) Seeing a person ill from smoking 4) Going out with a non-smoker
Factors correlated with desire to quit smoking			
5. Manfredi et al., (1998)	African American women who smoke, aged 18-39 years, of low SES (n=248)	Measured correlates of the motivation to stop smoking	Concern about the health effects of smoking and having loved ones wanting them to stop smoking correlated positively with participants’ desire and intention to stop smoking.
6. Orleans et al., (1989) ¹	African Americans smokers of low SES (n=185)	Measured correlates of strong desire to stop smoking	Having an existing health concern or receiving medical advice to stop smoking, holding beliefs about the healthful effects of smoking and the benefits of stopping, having greater social support for stopping all correlated strongly with the desire to stop.
7. Clark et al., (1997)	American adults who smoke (n=2,599)	Measured correlates of readiness to stop smoking	Agreeing that smoking was harmful to health correlated with readiness to stop smoking irrespective of participant’s age. Receiving doctor’s advice to stop smoking and perceived serious health problems from smoking were both correlated with readiness to stop for smokers over 30 years old.
8. Rundmo et al., (1997)	Norwegian adults. (Current smokers n=1,639;smokers n =5,014)	Measured correlates of motivation to stop smoking using Smoking Effects Questionnaire.	Negative psychological effects of smoking (such as perception of social undesirability and reduced self-esteem) and negative physical effects were associated with general motivation to stop smoking.
9. Breitling et al., (2009)	German adults (aged 50-74 years) who smoke, recruited via health services. n=1,505	Measured correlates of the desire to stop smoking	Women aged 70 years and older were less likely to express a desire to stop smoking than women under 60 years of age. Having a pre-existing heart condition correlated with a desire to stop smoking.

Study also included retrospective data; see Table 2.

²Includes willpower, medical problems/pregnancy, others also quit, relief of stress, acupuncture, hypnosis, laser and Nicorette.

2. New Zealand literature: Reasons for stopping smoking

Table 4 provides a summary of New Zealand studies related to smoking cessation and reasons for stopping smoking. Given the smaller number of NZ studies relative to the international studies, they are arranged in chronological order according to the date of publication. Studies 1, 3-5, 7, 8, 10 and 11 concern reasons given for previous attempts to stop smoking by ex- and/or current smokers, or associated with an interest in stopping by current smokers. The second study concerns reasons given by adolescent current and non-smokers for not smoking. The ninth study, by Bramley et al. (2005) is included here although it was not concerned with eliciting reasons from participants for stopping smoking. This study trialled a novel approach that was effective in recruiting young Māori, and in aiding smoking cessation in Māori and non-Māori participants alike. As such, it demonstrates the capacity of ‘treatments’ (i.e. cessation support), to operate as triggers for stopping smoking.

The most current publication, The New Zealand Tobacco Use Survey (NZTUS) (2009a) surveyed 5,132 respondents about their smoking behaviour. Amongst former and current smokers, those who had made an attempt to stop smoking in the past 12 months were asked what prompted that attempt. Stopping for their own health was cited most commonly (77%), although this reason was cited less often by Pacific participants (63%). Overall 37% of recent quitters identified cost as a factor in their decision to stop smoking. This reason was more prevalent amongst Pacific participants (52%). Just over one third (35%) of recent quitters cited being “sick of smoking” motivated them to try to stop. “Someone else’s health” was a reason for making a quit attempt for 27% of participants - almost half the female participants aged 20-24 (49%) cited this latter reason.

Reasons identified across other studies reviewed here are consistent with the findings from the NZTUS, and are largely organised around health, cost, and concern for others. Thus, these are summarised below.

Table 4: New Zealand studies of reasons for stopping, for attempting to stop, or for not smoking

Author	Participants	Question asked	Results												
1. Broughton and Lawrence (1993)	Maori women 15+ years in Auckland and Otago (n=603)	Open-ended questions related to reasons for stopping smoking	1) Concerns about health effects of smoking (42%) 2) Cost (32%)												
2. Stanton et al. (1993)	13 year old smokers and non-smokers. (Ex-smokers n=507; Current smokers n=227)	Participants responded ‘yes’ or ‘no’ to a list of 17 reasons for not smoking (Multiple response allowed).	<table><tr><th colspan="2">Reasons for not smoking:</th></tr><tr><th>Smokers</th><th>Non-smokers</th></tr><tr><td>1) It is bad for me (97.6%)</td><td>1) It is bad for me (93%)</td></tr><tr><td>2) Smoking is not good for my health (96.8%)</td><td>2) Smoking is not good for my health (88.5%)</td></tr><tr><td>3) It might make me feel sick (83.4%)</td><td>3) It smells (76.7%)</td></tr><tr><td>4) It smells (78.9%)</td><td>4) It tastes bad (76.7%)</td></tr></table>	Reasons for not smoking:		Smokers	Non-smokers	1) It is bad for me (97.6%)	1) It is bad for me (93%)	2) Smoking is not good for my health (96.8%)	2) Smoking is not good for my health (88.5%)	3) It might make me feel sick (83.4%)	3) It smells (76.7%)	4) It smells (78.9%)	4) It tastes bad (76.7%)
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3) It might make me feel sick (83.4%)	3) It smells (76.7%)														
4) It smells (78.9%)	4) It tastes bad (76.7%)														
3. Klemp et al. (1998)	374 Maori and 339 European participants living in Rotorua and Ruatahuna (Ex-smokers n=200)	Participants were asked about their reasons for stopping smoking	1) Own health (38%) 2) Health awareness (20%) 3) Cost (14%)												
4. McClellan (1998)	Ex-smokers aged 21-60+ years (n=62)	Underlying reasons for quitting, critical triggers or events that led to the actual decision to quit.	1) Concerns about health consequences of smoking (58%) 2) Influence or pressure from a non-smoking significant other (32%) 3) Cost (27%)												
5. Glover (2000)	Current smokers aged 16-62 years (n=130)	Participants were asked about their reasons for stopping smoking	1) Health (85%) 2) Cost (53%) 3) Quit for children (51%)												
6. McLeod et al. (2003)	11 women from the lower North Island who had recently given birth.	Experiences of smoking cessation or reduction during pregnancy	Factors that prompted participants to consider their smoking behaviour included being pregnant, the health of the baby, public advertising of anti-smoking messages, public attitudes to smoking during pregnancy and feelings of guilt.												

7. McLeod et al. (2003)	Pregnant women who had stopped smoking in their first trimester of pregnancy (n=49)	Participants were asked their reasons for giving up smoking.	<ul style="list-style-type: none"> 1) Baby's health (42.8%) 2) Focussed on pregnancy (34.6%) 3) Sickness or aggravation of morning sickness (22.4%)
8. Glover (2004)	Pregnant Maori women (n=60)	Participants who said that they were interested in stopping smoking (n=37) were asked to give reasons why. (Multiple response allowed)	<ul style="list-style-type: none"> 1) For baby's health (78%) 2) For their own health (54%) 3) Cost (43%) 4) Pregnancy (32%)
9. Bramley et al. (2005)	355 Maori and 1350 non-Maori 16 years and over who were able to send and receive text messages	Text messages that encouraged cessation and provided support were sent to participants.	Maori in the intervention group were more likely to report quitting in 6 weeks (26.1%) than those in the control group (11.2%).
10. Fernandez and Wilson (2008)	Single focus group of Maori ex-smokers between 28-45 years (n=5)	Open-ended prompts to guide discussion which included feelings and beliefs about quitting.	Reasons for quitting smoking included personal health, children's health, being a role model for other members of the whanau and pregnancy.
11. MoH (2009a)	New Zealand adults aged 15-64 (n=5,132)	Ex-and current smokers who had made a quit attempt in the last year were asked about their reasons for stopping	<ul style="list-style-type: none"> 1) Own health (77%) 2) Cost (37%) 3) "Sick of smoking" (35%) 4) Someone else's health (27%)

2.1 Health

Health has been the most commonly cited motive for Māori to stop smoking. Broughton and Lawrence (1993) led one of the first investigative studies on the smoking behaviour of Māori women. They conducted personal interviews with 603 Māori women over 15 years old in the Auckland and Otago regions. These included smokers, non-smokers and ex-smokers. The sampling method was opportunistic (obtained by attending hui, marae, Māori organisations and sports clubs). The interviews were guided by a questionnaire that included both closed and open-ended questions. Amongst participants who smoked, concerns about the health effects of smoking was the primary reason they wanted to stop smoking (42%). The fear of dying was also a common theme in respondents' narratives as were concerns about their children's health. Ex-smokers also identified their health as the primary reason for remaining smokefree (47%). Additionally, concern for their unborn babies' health was an important motivator factor for these women not to relapse (9%).

In relation to pregnancy and smoking, Glover (2004) found that the health of the baby and the mother's own personal health were the predominant reasons for stopping smoking. Of the 60 pregnant Maori women participating in the study, those who were interested in quitting were asked to give the reasons why they would quit. McLeod et al. (2003) surveyed 1,283 pregnant women at the time of registering with a maternity care provider. The sample included both current and ex-smokers. The results emphasised the participant's belief of the importance of health, with the foremost reason for quitting being the health of the baby (42.8%). Other motivations for stopping smoking were linked to the pregnancy, such as aggravation of morning sickness (22.4%) and a focus on the pregnancy (34.6%). In a different study, McLeod et al. (2003) focussed on the role of the midwife in encouraging smoking cessation during pregnancy. As part of this project, participants were asked to consider factors that had influenced smoking cessation during pregnancy. Health concerns for the baby were identified in this part of the study.

Klemp et al. (1998) interviewed 374 Māori and 339 European participants living in Rotorua and Ruatahuna. The aim was to compare the correlates of smoking and the reasons for cessation between the groups. For the majority of the Māori and European participants, health was cited as the primary motive for stopping smoking. Of those who cited health as their primary motive, most had existing health problems. Only a minority of participants referred to concerns about future health problems. Pregnancy was a salient theme for Māori women which reflected apprehension for their babies' health.

In a prospective study of 130 current smokers, Glover (2000) also found that health was the main reason for stopping smoking. Most participants were women (78%) and the age range was from 16 to 62 years old. The majority of the participants (85%) gave health as their primary reason for wanting to stop smoking. About half of these were due to perceived declining physical health that ranged from "shortness of breath" to more serious health concerns such as "diabetes" and "stroke". Furthermore, about a quarter of those who cited health as their primary reason discussed their wish for better health and quality of life in

their future. Almost three quarters of the participants reported having physical illnesses which explains why “health” was such a pervasive motivating factor to stop smoking.

In a retrospective study of middle-aged and older former smokers, health concerns were further found to be the most common reason for stopping smoking (58%) (McLellan, 1998). Half of this group also identified specific health concerns that acted as an added motivation to quit; the most common of which was a smoker’s cough. Asthma was also mentioned as a contributing factor for stopping smoking.

Fernandez and Wilson (2008) conducted a small focus group of five Māori female ex-smokers aged from 28-45 years old to investigate their views on the current smoking cessation initiatives. Consistent with other studies, Fernandez and Wilson found personal health was a motivating factor for stopping smoking and abstaining from smoking. However, concerns regarding children’s health emerged as a dominant theme. Pregnancy was identified as a crucial turning point where most participants decided to stop smoking.

Health concerns have similarly been identified as a predominant factor amongst adolescents for not smoking. A recent exploratory study of first time Quitline callers aged 15 to 24 years interviewed in focus groups 32 Māori youth and 64 New Zealand European youth (Hooper, 2008). This study found that long term health concerns was a motivator for both genders and across Māori and European groups. However, it was found that young Māori were more likely to express that seeing older relatives having smoking-related illness was a motivation for them to stop smoking. They wished to avoid having the same future health problems as their elders, and wanted to prevent their own children going through the same negative experience they did.

Moreover, Stanton et al. (1993) surveyed a large sample of adolescent smokers and non-smokers from the Dunedin area about their reasons for not smoking. Irrespective of smoking status, health was identified as the main reason for not smoking, thus highlighting that adolescents are aware of the negative impacts of tobacco on their health.

There is paucity in the literature looking at reasons for stopping smoking among Pacific people. Of the few studies found, what is suggested is health is a reason for stopping but not a motivating factor to pursue a cessation attempt. Furthermore, these findings were only evident among Pacific men over the age of 40 years (MoH, 2009a).

2.2 Cost

The expense associated with smoking is also frequently cited by New Zealand participants as a reason for stopping smoking. In the Broughton and Lawrence (1993) study, cost was the second most commonly cited reason for Māori women to stop smoking (32%). Participants expressed that they could not afford to buy cigarettes, and would rather spend the money elsewhere or save it. Moreover, the cost of cigarettes was ranked as the fifth reason for why ex-smokers abstained from smoking (8%).

Klemp et al (1998) found that financial reasons for giving up smoking was ranked third across genders and for both Māori and European participants but it was particularly salient for Māori men (26 % of Māori men compared to 13% of European male participants, 12% of Māori women and 10% of European women).

McLellan (1998) found that the cost of cigarettes and tobacco was the third highest contributing factor in wanting to stop smoking; and cost was cited as a reason by 53% and 43% of participants respectively in studies by Glover (2000, 2004). In contrast, the 5 women in Fernandez and Wilson's (2008) group said expense was not a reason to stop, rather it was a constraining factor on their smoking.

2.3 Whanau

Although the research into what motivates Māori to stop smoking is sparse, there is a widely held view that whanau (family) is a strong motivator for Māori (Waa & Grigg, 2003). In Broughton and Lawrence (1993) smokers listed stopping smoking for the children as a motivator to quit; however this was found to be less important than the previous literature discussed. Only 3% of smokers in the study listed "the effect on the children" as their main reason for stopping smoking. However, of the ex-smokers who were interviewed, whanau played a much more significant role. Eleven percent of participants reported quitting due to the influence of friends and whanau, and similar to findings elsewhere, 9% reported quitting due to pregnancy (Broughton & Lawrence, 1993).

In *Tihei Mauri Ora* (Reid, 1993), a smoking cessation help book tailored specifically to Māori, case studies revealed similar associations between whanau and wanting to quit smoking. One woman said: "My motivator was my mokopuna (grandchildren). I wanted to be alive when they turned 21" (Reid, 1993, p.4). Another woman said: "A major influence (to stop smoking) was when I saw my kids who go to Kohanga Reo use a rakau (stick) like a cigarette. That really worried me", (Reid, 1993, p.43).

Glover (2000) also found that children and being a role model were significant motivators for Māori to quit smoking. Approximately 51% of the participants claimed that they wanted to quit for their children. Many believed that it was important to be a non-smoker in order to be a good role model for their children.

The concept of whanau emerged as a dominant theme in Fernandez and Wilson's (2008) group. Some of the women felt it was important to be a role model for their children and others wanted to protect the health of their children. Pregnancy was also a major factor in quitting for these women.

The "It's about whanau" Quitline advertising campaign was developed in recognition of the importance of whanau to Māori (The Quit Group, 2009). Nation-wide surveys of both current smokers and smokers who had recently quit, and their families found that the campaign was well-received by Māori (Grigg et al., 2008). Unfortunately the findings suggest that the campaign was more thought provoking than behaviour changing. However,

in support of the previous studies, whanau once again, emerged as a significant motivator for Māori to quit smoking (Grigg et al., 2008).

Summary

In summary, health related concerns dominate as a reason for stopping smoking, irrespective of study design and population. This holds true for both international and local studies. While international studies have explored differences in cessation intentions and behaviour by age, this is an area which little is known about amongst NZ smokers.

Concerns about the health of family (whanau), and about modelling smokefree behaviour to children featured more significantly for Māori, particularly women, than was evident in the international literature. Former Māori smokers however were more likely to acknowledge the negative effects of smoking on whanau than were current smokers.

Across international and NZ research, cost is also a factor in motivating people to stop smoking.

PART FIVE: Concluding remarks

The theoretical models reviewed suggest that a co-ordinated comprehensive tobacco control programme is required to achieve the government's goal to reduce smoking prevalence overall, and to reduce the inequalities and disparities in prevalence rates between Maori and non-Maori, and Pacific and Pakeha.

There is a strong desire expressed in the New Zealand and Pacific/Indigenous literature for tobacco control interventions to be culturally relevant for Māori and Pacific. Some evidence is presented supporting that acceptability to Maori is dependent on that. Te Whare Tapa Wha and the Pandanus Mat provide a clear framework against which to assess the comprehensiveness or 'holism' of NZ's tobacco control programme and interventions within it.

The tobacco control programme as a whole could also usefully be reviewed against West's P.R.I.M.E. (2006) guidelines. That is, each component of the tobacco control programme could be examined for its potential contribution as a tension or trigger to quit. West's work particularly helps to explain the complex and mercurial nature of addiction. That is, that smoking behaviour is highly responsive to constraints but equally able to adapt and resist annihilation; or quite contrarily some people seemingly stop smoking without forethought. This can be seen at a population level, for instance, in the past some educative campaigns and some tax increases precipitated a sharp drop in smoking prevalence (Laugesen & Swinburn, 2000). In more recent years (e.g. the last 15 years) with consistent application of one of the most comprehensive tobacco control programmes in the world, smoking prevalence in NZ appears highly resistant to reduction.

Understanding this is crucial for understanding the need for co-ordination. Implementation of interventions in isolation may create tension and/or trigger quitting (e.g. the 'Adrian' mass media quitting campaign, see <http://www.quit.org.nz/page/media/campaigns/healthWarningsAdrian.php>), but if other critical tensions are alleviated (e.g. tobacco becomes more affordable through lack of price increases) the tension is 'balanced' out and change in the motivational system is not sustained. A combination of Te Whare Tapa Wha/Pandanus Mat and the 3 T's (Figure 7) could facilitate design of a blanket approach, that exerts even tension across key realms of influence. Simultaneously, a repetitive and pervasive stream of triggers should be encountered by the smoker along with opportunities to access treatments that support immediate change and resource people to make change sustainable.

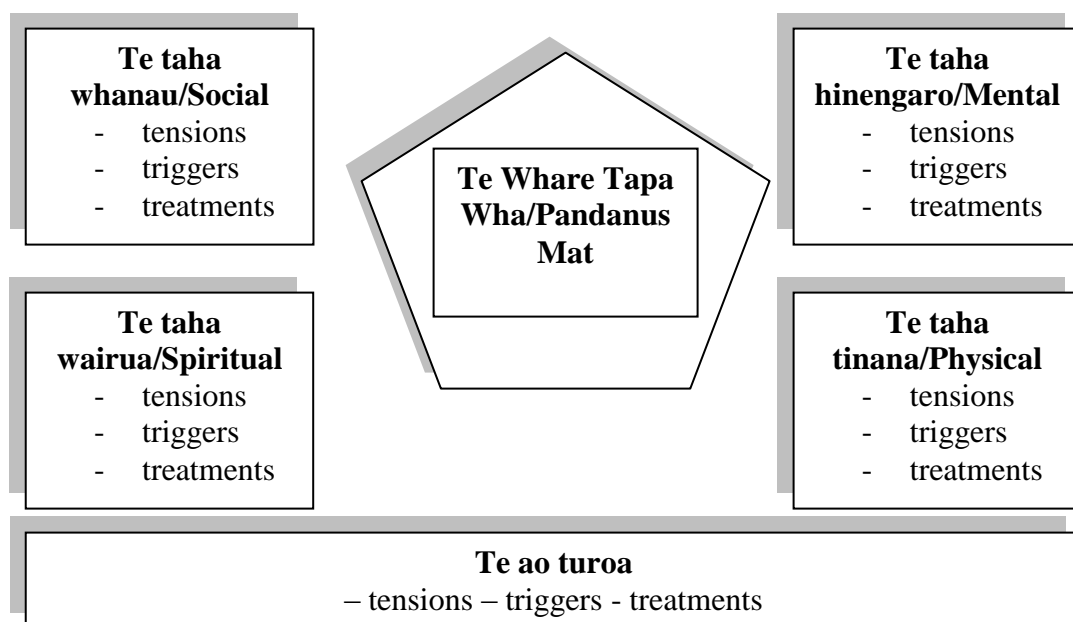


Figure 7: Te Whare Tapa Wha/Pandanus Mat and 3T's model

The shadows on this model represent motivational forces that counter tobacco control aims. Any programme designed to motivate quitting, needs to acknowledge a counter-model that produces opposing tensions and triggers, set within a discursive space where tobacco use is encouraged, normalised and privileged, and the ways in which it may impact on, and undermine treatment.

The counter-model incorporates aspects of the political system that support tobacco to be bought and sold here, the retailers that promote and sell tobacco, tobacco companies, and the boards of retailer associations and charitable trusts, they patron. Current smokers, through their public and social smoking behaviours and attitudes can also operate as an opposing motivational force.

Williams' framework is useful when considering opposing motivational forces as it helps guide the identification of important determinants of smoking, such as low socioeconomic status.

The literature suggests that health is the most common reason for stopping smoking. Pregnancy is a key trigger to quit for women of child-bearing age. The financial cost of smoking is commonly cited, though latter literature suggests wide variance in the relevance of this reason for different demographic groups. Quitting for children, be it for their health or for modelling also varies in importance across groups. In conclusion, looking for what motivates people to stop smoking is a bit like looking for the Holy Grail – there are many reasons to quit, occasionally a powerful trigger to quit will manifest itself, but ultimately the identification of motivating factors with miraculous powers is impossible. Instead, we need to identify sets of motivational forces: which ones are too strong or too weak? Which ones

need to be removed? Can new ones be added? To this end the combined Te Whare Tapa Wha/Pandanus Mat + 3 Ts model will be used as the theoretical framework for the analysis of WhyKwit data. Williams' framework will be referred to when considering motivation to quit among low SEC smokers.

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REPORT TWO

Methodology report

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Introduction

This report outlines the research methodology of the WhyKwit study. Following the research aims and objectives, the report provides a justification and description of the qualitative approach used. It then details how focus group facilitators and participants were recruited and then briefly describes some characteristics of the participants. We then explain how the data was gathered from focus group material through the focus group process. Finally we describe how the data was cleaned, sorted, and analysed.

Research Aims and Objectives

The aim of this study was to investigate what motivates Māori, Pacific Island and low socio-economic (SEC) users of tobacco to stop smoking, and to investigate what products, services and people support their efforts to quit and stay smokefree.

The research questions asked were:

1. What motivates, or has the potential to motivate Māori, Pacific Island and low socio-economic (SEC) people to stop smoking?
2. What smoking cessation products and services do Māori, Pacific Island and low SEC people access?
3. What factors support Māori, Pacific Island and low SEC people's attempts to stop smoking?
4. What factors hinder Māori, Pacific Island and low SEC people's attempts to stop smoking?

Research design

This study employed a qualitative exploratory research design. Pope and Mays (2000) argue that qualitative research is particularly suitable for topics upon which little previous research has been conducted. While there has been quite a bit of exploratory and evaluative research on Māori smoking and quitting behaviour, much of it pre-dates the vastly expanded tobacco control programme in operation in New Zealand (NZ) today (Bramley et al., 2005; Broughton & Lawrence, 1993; Glover 2000, 2005;

Holt et al., 2005; Ministry of Health, 2003, Reid 1993; Reid & Pouwhare, 1991; Grigg et al., 2008, Wilson et al., 2006). Minimal research on NZ resident Pacific Island people's smoking and quitting behaviours has been carried out (Nosa, 2005).

Qualitative research is useful for understanding the phenomenon of smoking cessation behaviour within its social context. It is not only concerned with the phenomenon being studied but also the meanings people apply and how participants interpret the phenomenon (Pope & Mays, 2000). Throughout this research we assume that knowledge is situational (Adams, 2008). Taken out of its original context, whether that be culture, gender, time or geography, it loses its initial meaning (Adam, 2008). It is important when collecting, analysing and interpreting data that it is handled in its intended context.

Qualitative research rejects notions of universal "truth" and embraces subjectivity and diversity (Broom & Willis, 2007; Germov, 2005). It therefore allows us to explore participant's differing interpretations of unique or shared experiences without having to restrict the flow of dialogue to preconceived ideas of "right" or "normal" (Adams, 2008). A further strength of qualitative research is that it studies people in their natural environment as opposed to clinical settings which adds to the authenticity of the data gathered. The motive behind the study design was not to obtain a representative range of perspectives but rich, deep data which may help with our understanding of the stop smoking motivations and needs of the groups studied.

Data were collected using a structured focus group method. Focus groups are useful when seeking to understand why certain population groups access health services differently (Kitzinger, 1995). Kitzinger argues that when working with disempowered or minority groups, focus group participants may provide each other the support needed to give critical or negative feedback. This data is invaluable as we seek to improve smoking cessation services for Māori, Pacific Island and low SEC people who smoke.

Focus group facilitator dyads' selection and training

Each group was conducted by a dyad consisting of a lead facilitator and a second research team member (henceforth referred to as the scribe) in a supporting role who assisted with administrative tasks (recording attendance numbers, distribution of participants information sheets (PIS), consent forms (CF) and demographics questionnaires, collection of CF and questionnaires, setting up recording equipment, taking notes throughout discussion to assist with checking of transcripts, catering and packing up).

Facilitators and scribes were recruited via consultation with and dissemination of notices amongst local and national tobacco control networks. They also included two Bachelor of Health Science (BHSc) interns, two BHSc (Hons) candidates, and one International Scholar from the University of Wageningen (NL), all of whom were attached to the Centre for Tobacco Control Research for their studies.

Facilitator training was carried out in Auckland and run by senior researchers Dr. Marewa Glover, Dr. Vili Nosa, Donna Watson and Dr. Janine Paynter. The training day was video recorded and the DVD sent to the Christchurch dyad who were unable to attend. The training day ensured that facilitators understood the aims and objectives of the WhyKwit project and sought to standardise the focus group procedure as much as possible.

Training began with a mock focus group whereby trainees assumed the identity of current smokers. In addition to demonstrating a simulated focus group for facilitators. Further refinement to both the schedule and process were made as a result of the feedback from the training day. Trainees were briefed on focus group etiquette and on how to gently probe participants for clarification or expansion. Throughout the training day facilitators exchanged ideas about where to recruit participants from and who best to contact.

Participants

A random recruitment method was neither possible nor necessary for the current study. Therefore, convenience sampling was used. A purposive sampling frame was used to ensure participants were recruited across a range of criteria (age 16-26, >26; urban, metropolitan and rural; male & female; smokers & recent quitters) across the country (Auckland, Canterbury, Hawkes Bay, Tokoroa and Wairapa) [see Table 1]. Groups of Pacific people who smoke were grouped according to Pacific ethnicity (i.e. Cook Island, Samoan, Tongan and Niuean) and were restricted to Auckland. The Samoan groups were gender specific. Groups for the ex-smokers (people who had stopped smoking 2-4 years ago and who had been smokefree for at least 12 months) were mixed in ethnicity (i.e. groups combined Māori and Pacific participants).

Where possible, we used the parallel culturally appropriate method of matching the ethnicity of the facilitators with that of the participants. We also endeavoured to match the age (i.e. younger/older) of the facilitators with participants of the group they were facilitating.

	Current smokers												Ex-smokers		
	Māori		Cook Island		Samoan Women		Samoan Men		Tongan		Niuean		Mixed ethnicity		
	16-26	>26	16-26	>26	16-26	>26	16-26	>26	16-26	>26	16-26	>26	16-26	>26	Mix
Akld	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
W'rapa	1	1													1
Cntbry	1	1													1
H's Bay	1	1													1
Tokoroa	1	1													1
Total	5	5	1	1	1	1	1	1	1	1	1	1	1	1	4

Table 1: Sampling frame

Recruitment

Locally based focus group facilitators identified and contacted community groups to recruit at least 6 people per focus group (using the criteria supplied re: smoking status, ethnicity and age group) from their membership. Community group contacts were provided with a community information sheet and those who agreed to recruit

participants were asked to sign a community group consent form. A koha of \$200 was offered to the community group for their assistance and participation. Some groups were comprised of individual participants (that is, not participating as part of a community group). These participants were recruited in a number of ways including word of mouth, via community and/or research team member contacts, and through advertising in a suburban newspaper. Participants recruited as individuals received a \$25 retail voucher for their participation.

Initially we planned to recruit participants for the ex-smokers groups from Quitline's pool of callers who had consented to be contacted to take part in research. The Quit Group supplied contact details for Māori and Pacific people who had registered with them since May, 2005 and who resided in our data collection areas. As recruiters in the non-Auckland centres sourced ex-smokers via their own contacts, Quitline data for these areas was not utilised. A small sample from the Quitline list of Auckland registrants was selected, and we mailed letters briefly outlining the study to these potential participants and to notify them we would be phoning to invite them to participate. No participants were able to be recruited from the follow up phone calls. Reasons for this were that the phone numbers were disconnected or incorrect, or that participants were either unable to be reached after at least three attempts or they had not been smokefree for the required one year minimum.

Focus group procedure

Local kawa (protocols) determined which tikanga (practices) regarding opening, conduct and closing of the groups were observed and how. Accordingly for example, in some cases, groups were opened with a karakia/tatalo.

Following introductions, all participants were provided with the written PIS for their group [i.e. people who currently smoke or who no longer smoke, Appendices A & F respectively], the facilitator explained the research, informed the participants that the group would be audio taped and invited participants to sign a consent form. The facilitator then lead participants through the demographic questionnaire.

Demographic questionnaire

Demographic details collected included age, gender and ethnicity. Participants were then asked if they were New Zealand (NZ) born, and if not, how long they had lived in NZ. Increased smoking prevalence amongst Pacific peoples has been associated with migration, most likely via the process of acculturation, which describes how immigrants modify their culture in adopting the values and behaviours of the dominant host culture (Berry, 2002).

Eight questions asked about participants' smoking behaviour. The first two asked participants their age when they had their first cigarette and subsequently when they became daily smokers. The next question asked about participants' current smoking status and type of tobacco used. In addition to differentiating between current and ex-smokers, this enquiry aimed to learn about the use of loose tobacco versus factory-made cigarettes by participants. Two questions assessed nicotine dependence; the first asked how many times a day the participant smoke, and the second item drew on the Fagerström Tolerance Questionnaire (Fagerström & Schneider, 1989), and asked about time to first cigarette upon waking.

The intention to stop smoking was measured by three items which asked if participants intended to stop smoking ever/in the next six months/in the next three months. These items were included to provide an indication of the participants' stage of change (Prochaska & DiClemente, 1984).

Four items asked participants about their employment status, and a single item which asked if they were eligible for a community services card aimed to assess their socio economic status.

Focus group exercises

A number of guided exercises were used to facilitate participant discussion.

Exercise 1: Motivations/triggers to stop smoking (unprompted) and how these develop over time

In order to answer the research question ‘How do motivations to quit develop over time?’ participants were invited to recall past quit attempts and their reason for and age at each attempt, and write each quit on a sticker provided. Information about subsequent relapses were also collected. The stickers were placed chronologically on a large wall chart with a row for each participant. Participants were encouraged to discuss any patterns, such as differences across time, why motivating factors may differ with age, and/or how they ‘developed’ or changed over time.

Exercise 2: Relative ranking of motivations/triggers to stop smoking (prompted)

Participants were provided with a set of reasons for stopping smoking (nineteen laminated cards with a reason for stopping smoking printed on each). This list [Appendix A] was developed from the literature. Two additional Māori-specific cards were provided for the Māori groups and correspondingly, an additional card was used for the Pacific groups (and ex-smokers groups). Where necessary, information on the back of the cards assisted understanding and clarified the intended meaning.

Participants were asked to rank the cards from the most to least important reason for stopping smoking for their community i.e. Tongan people. Blank cards were provided to all groups in the event that they wanted to add any reasons. The facilitator encouraged discussion of the reasons for the ranking order. The scribe took photos of the final ranking.

Exercise 3: Knowledge of cessation products/services

The third exercise was designed to ascertain the extent of participants’ knowledge of cessation products and services. Participants were prompted to identify any methods they knew for stopping smoking and to comment on the perceived effectiveness of each method, and if there was anything specifically desirable or undesirable about those products/services. An extensive products and services flipchart [Appendix B] was then shown to the group and similar feedback was sought about any remaining products/services that had not been previously mentioned.

Exercise 4: Factors that help or hinder attempts to be smokefree

In this final exercise, participants were encouraged to brainstorm a list of things, people or organisations that had either helped or hindered their attempts to be smokefree. Prompts such as “What kinds of things did you find helped you to stay smokefree in the past?”, “What kinds of things made it hard?” and “Were there any people or groups that supported you in the past when you were trying to stop smoking?” were asked of the participants. Responses were recorded on butcher’s paper.

Closing

A contact sheet was circulated and participants were invited to provide contact details if they wanted to receive a summary report of the study findings. Retail vouchers were distributed where participants were being reimbursed individually. Where koha/meaalofa was being offered to a community group for convening the group, an invoicing memo was given to the community contact.

Information on cessation services were provided where necessary and participants were thanked for their participation.

Research settings

Focus groups were conducted in a variety of settings. Six were conducted on health services premises; four of the focus groups were conducted on University of Auckland City or Tamaki campus premises; three were carried out concurrently in different locations on a church site following Sunday service; three took place in a sports clubroom; two were conducted in community centre rooms specifically hired for the purpose; two took place after hours on school/kura premises; one group was conducted in the evening in a tent erected for the purposes of carrying out a kava ceremony; another took place on a weeknight at a participant’s home; another at a community recruiter’s house; and another at workplace.

Data Entry

Focus group recordings

In cases where the groups were recorded using digital recorders, and where the groups had been conducted primarily in English, the recording was sent electronically to a confidential transcribing service. Some transcribing was handled in-house where the recording was not digital, or the groups were primarily in a Pacific language.

Focus group transcripts were then forwarded to the focus group facilitator with a copy of the audio. In addition to checking the accuracy of the transcript against the recording, the facilitator coded participants' speech with the focus group number and either a "W" for woman or a "M" for man. This coding enabled the original location of the data to be readily identifiable once it was removed from the transcripts and for the data to be grouped by gender across transcripts where necessary. A second accuracy check against the recording of the transcript and the coding was carried out by the scribe.

Focus group demographic and exercise data

Demographic data from the questionnaires were entered in Excel, as were data from the wall charts, photographs of the ranking cards, different quit methods, and factors that made it hard or easy to stop smoking.

Data Analysis

Coding

Focus group transcripts

In the first instance, data analysis of the transcripts followed a general inductive approach which allows themes to emerge from the data. The raw transcript was read and text identified as data (as opposed to facilitators' instructions) was extracted, divided into 'units of analysis' (word or phrase with a distinct meaning) and grouped according to commonalities and the categories provided by the interview process (e.g. reasons for stopping smoking, methods of stopping smoking).

As a validity check, each transcript was read and categorised by two researchers independently. The two researchers then met to discuss their respective categories and to check and correct for consistency. Where disagreements occurred the category choice was discussed until agreement was achieved and if necessary the data was re-coded.

Categorised data from each transcript per sub-group were merged to form results for Māori and Pacific Island participants. Cross-group analysis was conducted by the research team together in order to draw out points of difference or consistencies across subgroups, as per Glover et al. (2006). Cross-case analysis provides for further checks on the consistency of handling and interpretations of data.

At this point the analysis becomes more deductive, in the application of the theoretical frameworks of Te Whare Tapa Wha (Durie, 1984) for the Māori data and the Fonofale model for the Pasifika data. Both models are holistic in their consideration of multiple influences as essential components of good health.

The results for Māori were categorized as belonging to categories provided by Te Whare Tapa Wha model: te haha tinana (the physical body); te taha hinengaro (the psychological body); te haha whānau (the family and wider community); and te taha wairua (the spiritual realm), in addition to the broader factor of te ao turoa (the long-standing world which represents the environment which impacts on health).

Similarly, the Fonofale model applies physical, spiritual, mental and “other” (including environmental, spatial, and contextual factors) aspects encompassed within the context of family and culture in the analysis of the Pacific data.

Focus group exercises

Standard frequency analysis for each variable in the demographic questionnaire was calculated for descriptive purposes. As with the transcript data, qualitative data collected from the focus group exercise were examined in order to identify recurrent themes. “Coding trees” were developed to classify responses into categories and sub-categories, and the number of occurrences of each category counted. Common methods used to aid quit attempts were also grouped together and counted. Means

were generated to assess the (prompted) relative ranking of the reasons for stopping smoking and these were compared across sub-groups.

Validity

Preliminary results are to be presented to key stakeholders for discussion. This provides a further method for checking the face validity of the data.

Ethics

Ethics approval was obtained from the University of Auckland Human Participant Ethics Committee in May 2009.

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Appendices

Appendix A: Reasons for stopping smoking ranking cards

Appendix B: Products and services flipchart

Appendix A:

Ranking cards

Front of card: (Back of card, where applicable, in brackets)

- To stay healthy (i.e. if people were healthy and stopping smoking would make sure they stayed that way)
- To get better (i.e. if people were sick, and stopping smoking would improve their health)
- Smokefree environments (e.g. not being able to smoke in some areas at work, in bars/restaurants makes it difficult to keep smoking)
- Seeing what smoking does to someone close (i.e. seeing someone close get sick or die would make people stop smoking)
- It stinks (e.g. bad breath and/or smelly clothes)
- Fitness (e.g. for sport, to achieve exercise goals)
- It's not cool anymore (i.e. it's not as socially acceptable as it used to be)
- For my children's health (e.g. so they get fewer coughs and colds)
- Doctor (or health professional) said to stop
- Cost
- If they can, I can (i.e. knowing someone else who stopped smoking and thinking "I can do that.")
- It's time (i.e. quitting happens when it's just time to stop)
- To be a positive role model to my children
- To have more energy to do things (e.g. like keeping up with my children)
- To live longer
- To not grow old early (e.g. fewer wrinkles, avoid early menopause, less grey hair)
- To have a healthier pregnancy (i.e. to protect the unborn baby)
- Getting pregnant (i.e. smoking reduces the chance of getting pregnant and may cause impotence in men)
- TV ads about not smoking
- *Tino rangaitiratanga; Māori having control over Māori matters
- *Tino rangaitiratanga: Making one's own choices (i.e. not being controlled by a drug)
- **Making one's own choices (i.e. not being controlled by a drug)

*Included for the focus groups of Māori

**Included for the focus groups of Pacific peoples and ex-smokers' groups

Appendix B: Flipchart

WHYKWIT

Products and Services



Nicotine Patches





Nicotine Microtab





Nicotine Inhaler





Nicotine Gum





Nicotine Lozenges





Champix (Varenicline)





Norpress (Nortriptyline)





Zyban (Bupropion)



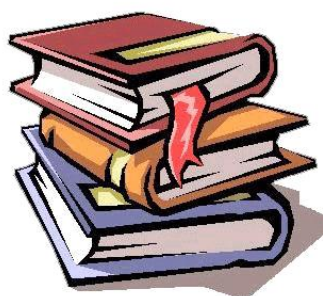
WHYKWIT

Just stopped - didn't use anything



WHYKWIT

Self-help Books



WHYKWIT

Hypnotherapy



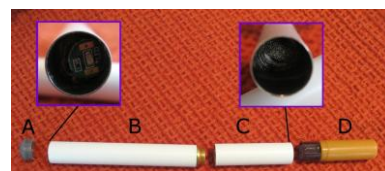
WHYKWIT

Acupuncture



WHYKWIT

E-cigarette



WHYKWIT

The Internet



WHYKWIT

Quitline



WHYKWIT



AUKATI KAIPAIPA

Maori Stop Smoking Service

WHYKWIT

Is there anything you would like to
add about stopping smoking?



WHYKWIT



WHYKWIT

REPORT THREE

Results report

Marewa Glover, Vili Nosa, Donna Watson, Janine Paynter,
Jade Le Grice, Jane Stephen, Raina Tutini

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Overview

This report presents findings from the WhyKwit study, collected from 29 focus groups conducted between August 2009 and January 2010. Also included are selected data from six focus groups from a supplementary study, KwitNeeds. A literature review (Glover, Nosa et al. 2010) and methodology report (Glover, Nosa et al. 2009) for the WhyKwit study is available separately, as are topline results of the KwitNeeds study (Glover, Nosa et al. 2010).

The aim of the WhyKwit study was to investigate what motivates Māori, Pacific Island and low socio-economic New Zealanders who smoke, to stop. KwitNeeds focussed on determining the needs of smokers with regard to cessation support. Some of the exercises used in the WhyKwit focus groups were also used in the KwitNeeds study. Data from these exercises from the Māori and Pacific KwitNeeds groups have been incorporated and reported by ethnicity (i.e. KwitNeeds Māori focus group data are reported with the WhyKwit Māori focus group data where applicable).

There were 168 participants in the WhyKwit study and 43 participants in the six KwitNeeds groups. Characteristics of the overall sample are summarised in Table 1. More than half (63%) of the participants were female, and most identified as Māori (53%) or Pacific (45%). Just over half the participants were under 30 years of age, with more than a quarter (28%) being between 16-20 years old. Almost 60% were eligible for a Community Services Card - a proxy for lower socio-economic status.

The report contains three main results chapters. The first chapter reports data from the Māori focus groups authored by Dr Marewa Glover and Jade Le Grice. The results from the Pacific focus groups are presented in Chapter two (authored by Dr Vili Nosa, Donna Watson, Jane Stephen, and Raina Tutini). The third chapter, authored by Donna Watson and Dr Janine Paynter, presents the results from the focus groups conducted with ex-smokers.

An easy reference guide to the focus groups (Table 2) shows the age range, ethnicity (and sex where applicable), smoking status, and location of each group, along with the number of participants in each. Participants' quotes included in the report are followed by the focus group number and the participant's sex (W for woman, M for man; e.g. 25W represents a female participant from group 25). Emboldened text in a quote indicates the facilitator's speech. Proper names or places cited by participants have been replaced with "[name]" to preserve anonymity.

Table 1: Demographic characteristics of overall WhyKwit and KwitNeeds participants (N=211)

		N	%
Gender	Female	133	63.0
	Male	78	37.0
Ethnicity*	Māori	115	55.6
	Cook Island	31	14.7
	Niuean	11	5.2
	Samoaan	34	16.1
	Tongan	30	13.2
	NZ European/Pākehā	20	9.5
	Tokelauan	1	0.5
	Moriori	1	0.5
	British/European	3	1.4
	Indian	1	0.5
	Other	2	0.9
Age (years)	16-20	59	28.0
	21-25	30	14.2
	26-30	24	11.4
	31-35	16	7.6
	36-40	19	9.0
	41-45	15	7.1
	46-50	18	8.5
	51-55	14	6.6
	56-60	6	2.8
	61+	10	4.7
Eligible for a Community Services Card	Yes	121	57.3
	No	82	38.8
	Missing	8	3.8

*Ethnicity is reported here as multiple response, therefore percentages total more than 100

Table 2: WhyKwit and KwitNeeds focus group details

No.	Age	Ethnicity (and sex where applicable)	Location	Smoking status	N
1	16-26	Samoan women	Auckland	smoker	6
2	≥27yrs	Samoan women	Auckland	smoker	5
3	16-26	Samoan men	Auckland	smoker	5
4	≥27yrs	Samoan men	Auckland	smoker	3
5	16-26	Cook Island	Auckland	smoker	6
6a	≥27yrs	Cook Island	Auckland	smoker	4
6b	≥27yrs	Cook Island	Auckland	smoker	5
7	16-26	Māori	Masterton	smoker	8
8	≥27yrs	Māori	Masterton	smoker	8
9	Mixed	Mixed	Masterton	ex-smoker	8
10	16-26	Māori	Christchurch	smoker	7
11	≥27yrs	Māori	Christchurch	smoker	5
12	Mixed	Mixed	Christchurch	ex-smoker	8
13	16-26	Māori	Hastings	smoker	8
14	≥27yrs	Māori	Hastings	smoker	6
15	Mixed	Mixed	Hastings	ex-smoker	6
16	16-26	Tongan	Auckland	smoker	7
17	≥27yrs	Tongan	Auckland	smoker	9
17b	≥27yrs	Tongan	Auckland	smoker	7
18	16-26	Niuean	Auckland	smoker	3
19	≥27yrs	Niuean	Auckland	smoker	6
20	16-26	Mixed	Auckland	ex-smoker	3
21	≥27yrs	Mixed	Auckland	ex-smoker	4
22	16-26	Māori	Auckland	smoker	3
23a	≥27yrs	Māori	Helensville	smoker	8
23b	≥27yrs	Māori	Auckland	smoker	5
24	16-26	Māori	Tokoroa	smoker	8
25	≥27yrs	Māori	Tokoroa	smoker	4
26	Mixed	Mixed	Tokoroa	ex-smoker	3
KN1	Mixed	Māori	Auckland	smoker	6
KN2	Mixed	Māori	Hamilton	smoker	6
KN3	Mixed	Pacific women	Auckland	smoker	5
KN4	Mixed	Pacific men	Auckland	smoker	12
KN4b	Mixed	Cook Island men	Auckland	smoker	6
KN7	16-26	Māori	Wellsford	smoker	8

Chapter One: Māori data

Dr Marewa Glover & Jade Le Grice

Participants

Demographics

Ninety people participated in Māori focus groups. The demographic data is summarised in Table 3. Seventy four percent of the participants were wāhine. Māori men were underrepresented. Nearly half of the participants were rangatahi, aged 16 to 25. Most of the Māori focus group participants were born in New Zealand. Forty four percent had paid employment, but nearly 60% were eligible for a Community Services Card.

Smoking Behaviour

Age of smoking initiation

Table 4 summarises smoking history data. The most common age range for age at first cigarette was 11 – 15 years. About half (52%) of the participants had progressed to regular smoking before the age of 16, with a further 40% progressing to regular smoking by the time they were 20 years of age.

Current tobacco use

Twenty percent of participants smoked factory-made cigarettes, 18% used loose tobacco and nearly all the rest (59%) smoked both loose tobacco and factory-made cigarettes.

About half (51%) of participants smoked up to 10 cigarettes per day, a third (33%) smoked between 11 and 20 cigarettes a day and 15.5% smoked more than 20 cigarettes a day.

Over half (58%) of participants reported having their first cigarette within the first half hour after waking, indicating high nicotine dependency.

Quitting Behaviour

Intention to quit was high with 98.5% of WhyKwit participants reporting that they intended to quit sometime. Nearly half were intending to quit within the “next 3 months” (Table 5).

Table 6 shows the average and range of number of quit attempts by participants in the Māori focus groups. Participants averaged about two attempts to stop smoking. The number of attempts ranged from none to five.

Table 3. Socio-demographic characteristics of WhyKwit and KwitNeeds Māori group participants (N=90)

		N	%
Gender	Female	67	74.4
	Male	23	25.6
Ethnicity*	Māori	85	94.4
	Cook Island	6	6.7
	Niuean	1	1.1
	Samoan	3	3.3
	Tongan	2	2.2
	NZ European/Pākehā	9	10.0
	Tokelauan	1	1.1
	Moriori	1	1.1
	British/European	3	3.3
	Indian	1	1.1
Age (years)	16-20	33	36.7
	21-25	9	10.0
	26-30	13	14.4
	31-35	9	10.0
	36-40	11	12.2
	41-45	3	3.3
	46-50	6	6.7
	51-55	2	2.2
	56-60	1	1.1
	61+	3	3.3
NZ born	yes	85	94.4
	no	3	3.3
	missing	2	2.2
Length of time in NZ if not NZ born	5-10 yrs	0	0.0
	11-20yrs	2	2.2
	>20yrs	1	1.1
	missing	0	0.0
Employed outside the home	Yes	49	54.4
	No	37	41.1
	On leave	2	2.2
	Missing	2	2.2
In paid employment	Paid	40	44.4
	On a course	2	2.2
Full time employment	Yes	26	28.9
Part time employment	Yes	23	25.6
Eligible for a Community Services Card	Yes	52	57.8
	No	36	40.0
	Missing	2	2.2

*Ethnicity is reported here as multiple response, therefore percentages total more than 100%.

Table 4. Smoking history and behaviour (N=90)

		N	%
Age (years) at first cigarette	<10Yrs	18	20.0
	11-15Yrs	58	64.4
	16-20Yrs	11	12.2
	>20Yrs	0	0.0
	Missing	3	3.3
Age (years) when started regular smoking	<10Yrs	4	4.4
	11-15Yrs	43	47.8
	16-20Yrs	36	40.0
	21-25Yrs	1	1.1
	Missing	6	6.7
How do you smoke tobacco?	I don't smoke	2	2.2
	Roll my own	16	17.8
	Factory-made	18	20.0
	Rollies and factory made	53	58.9
	Cigars/pipes	1	1.1
Cigarettes smoked per day	1-5	18	20.0
	6-10	28	31.1
	11-15	17	18.9
	16-20	13	14.4
	21-25	9	10.0
	26-30	1	1.1
	More than 30	4	4.4
Time to first cigarette	Within 5 mins	22	24.4
	6-30 mins	30	33.3
	31-60 mins	18	20.0
	After 60 mins	20	22.2

Table 5. Intention to stop smoking (WhyKwit participants only) (N=70)

		N	%
Intend to stop ever?	Yes	64	91.4
	No	5	7.1
	missing	1	1.4
Intend to stop next 6mths	Yes	50	71.4
	No	19	27.1
	missing	1	1.4
Intend to stop next 3mths	Yes	30	42.9
	No	35	50.0
	missing	5	7.1

Table 6: Average and range of number of quit attempts

	Average	Range
16-26yrs (n=34)	1.6	0-4
≥27 (n=36)	2.1	0-5
Mixed age (n=20)	2.0	0-5
Total	1.8	0-5

Reasons for stopping smoking

Table 7 summarises the frequency by category of reasons for previous quit attempts. Health was the most cited reason for making a quit attempt. Not liking smoking/wanting to quit, and stopping for pregnancy, whānau or cost were next but were cited less often. Social inclusion and no reason/just trying were other less frequently mentioned reasons for quitting.

Variation by age

Quitting for sports and fitness and stopping while ill were more frequently cited as reasons for participants under aged 21. Quitting to avoid ill health and to maintain good health were cited more by participants over 26 years old.

Pregnancy as a reason for quitting in the past was mainly relevant for participants between the ages of 16 – 25 years.

Participants cited not being able to afford to smoke as a reason for quitting when they were between the ages of 11 and 20 years old. For later quit attempts, participants recalled reasons we have classified as awareness of the financial implications of smoking and many that were categorised generally as 'cost'.

Table 7: Māori reasons for stopping smoking by age quit attempted

Reason for stopping smoking	Age Group									Total
	11-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	
Health	13	26	12	11	12	4	1	5	2	86
Don't like it/want to quit	1	19	2	7	3	1	2	1	0	36
Pregnancy	2	15	10	2	0	0	0	0	0	29
Whānau	5	5	3	1	6	1	1	1	0	23
Cost	1	8	2	2	3	1	3	0	0	20
Social inclusion or identity	2	7	0	0	0	0	0	0	0	9
No reason/just trying	1	2	1	0	0	2	0	0	2	8
Making one's own choices	0	4	0	0	0	0	0	0	0	4
New environment or context	0	2	0	0	2	0	0	0	0	4
It's time	0	1	0	1	0	0	0	1	0	3
Career aspirations	0	1	0	0	0	1	0	0	0	2
TV ads	0	0	0	1	0	0	0	0	0	1
Smokefree environments	1	0	0	0	0	0	0	0	0	1
	26	90	30	25	26	10	7	8	4	226

See Appendix B for full details

Reasons to stop smoking

Te Taha Tinana

Health broadly was the most frequently cited reason for quitting. There are however, many sub-categories within health. Some health reasons for quitting act as tensions and some act as triggers to attempt quitting.

Tensions

Some health reasons that contribute to the overall motivation to stop smoking, that is, add tension, were background states or conditions that people live with on a daily basis, like aging or having asthma.

“Getting old” (8M) for example, occurs gradually. It is not necessarily something people think about on a daily basis, neither is it something that happens suddenly as is expected of a trigger. Though the things that remind people of their aging, like noticing a new wrinkle or a grey hair or reaching a milestone birthday like 30 years or 40 years, could be used by cessation marketing to remind people that they wanted to quit and how to do that.

Having a chronic illness that is exacerbated or worsened by smoking, like asthma, is a background condition that people live with. When prompted to think about reasons for quitting, someone with asthma might say: *“Because I’ve got asthma” (KN2W) ... “I’m an asthmatic and can’t breathe at the best of times” (KN7W)* but to become a trigger to quit people need to be reminded to link difficulty breathing with smoking.

Maintaining good health

Maintaining good health is a background value or goal impacting on general motivation, i.e. a tension. Staying healthy is about maintaining fitness, maintaining sporting prowess, keeping ones’ good looks (as in *“to keep your teeth healthy” (24W)*).

To keep active. ...So you don’t walk around being old already and you’re only young. (24M)

Longevity

Maintaining good health can be about wanting to live a long life.

Probably it’s to stay alive to see your family grow up. (24M)

But as the following quote shows, despite this background reason to quit, this participant had not yet quit.

I do wanna quit because when I was younger I thought well if I stop smoking now, I’ll live longer. And when I’m 90 I’ll start smoking again and enjoy it ‘til the end of my days. But it hasn’t worked that way. (KN7W)

Longevity is not a relevant reason for people who have a fatalistic outlook on life, as one participant said.

No. Because I might get hit by a truck tomorrow. (KN7W)

In one focus group a male participant talked about the need for longevity in terms of the loss to Māori culture generally when people die early due to smoking. But another two participants

expressed scepticism about this, because based upon their life experience, they did not believe that smoking caused people to die early, as the following excerpt shows.

You don't want to lose people that smoke but that have also opened up doors in different ways for young rangatahi coming up. So you still want the encouragement. The ones that are smokers. So of course that's vital. And I think there's a big loss of families as well. Dying at a young age. Lung cancer, heart attacks. (22M) ...I don't know, have they got research to say that? Because I know that my grandfather, he started smoking when he was 17, and he was in the war, and he smoked until he died at the age of 81. I mean that's quite a long life for a person. (22M) ...I don't know any koros that aren't smoking. It's big for them. (22W)

In a young women's focus group, giving up smoking in order to live longer was framed as a positive thinking technique that presumably would outweigh scientific reasons for giving up, for example to avoid the ill-health risks of smoking.

Because then if you do give up because you think it's to live longer, you'll actually think that you'll live longer. (7W)

Fitness may be a value or goal in itself or it may be part of maintaining good health. As a value it works as a tension, contributing to motivation. Thus, participants said they “*wanted to be a bit fitter*” (8M).

One focus group talked about noticing that they were losing fitness:

Walking didn't bother me, but now it does and I can't be bothered walking anywhere. (KN2M)

We had gym and I noticed that I couldn't keep up with the rest like I used to... I don't want to be that person standing at the back. (KN2W)

I think mine is probably that I was really good at sports and I was quite active at sports... (KN2M)

Fitness is not an applicable reason to quit for some people, because they said they were able to stay fit and smoke.

I smoke when I run. (24M)

Avoiding ill health is part of maintaining good health. Thus, cessation marketing that teaches or reminds people of the ill-health risks of smoking poses a contradiction for people, i.e. their smoking contradicts their desire to maintain good health. The following quotes illustrate the cognitive dissonance this can create.

The reason why I wanted to quit was because the advertisements they were broadcasting on network television, and even just the advertising that they have on the packets, you know, are quite disturbing. ...I don't want to do this. ...thinking that your lungs are, can, you know, it may become a reality. (22M)

Triggers

Some health related reasons do act as triggers to quit. Many participants talked about stopping smoking when they were sick. But for some participants these quit attempts were reluctant - they weren't planned or intended quit attempts. For instance, they got the flu or some other acute illness struck and they were simply too sick to smoke.

I couldn't smoke. It was too bad. (KN7W)

Being admitted to hospital forced quitting on a few participants. As they said: “*Well I couldn't get out of hospital for days. I stopped when I was in hospital.*” One man who had had a heart attack stopped smoking while he was in hospital, but he laughed and discounted it as a real attempt to stop.

I did try. ...I just stayed in hospital. [Laughs] (23aM)

Another participant said she'd "only tried once" but even then she still would get people to wheel her outside so she could have a smoke.

I had pneumonia. ...I only tried once. ...even in the hospital I would still get someone to wheel me out. (23bW)

The only time I really, really stopped in my whole life was when I got tonsillitis for three and a half months and was incredibly sick. (11W)

... had a car accident. (23aM)

It seemed quite common that participants would stop smoking while they were sick, for example, with colds and flu, at least until they got better. This was due to the physical discomfort caused by smoking when sick. Again these were reluctant quit attempts, not intended quit attempts.

You only stop smoking until you've stopped coughing. [Laughter] (11W)

I just shrug it off. ...it's no biggie for me because you know that you're going to get better. (11W)

Several participants recalled that they sometimes stopped smoking for a few days or more after going out drinking and smoking to excess. They had unintended breaks from smoking when they were hung over and feeling ill.

Went out, got sick, had too many cigarettes while I was out drinking. And then went nah. (13M)

...drink hard up one night and then the next day you feel like you just want to stop. (KNW)

After having one real bad smoke, it makes you feel put off by it for a few days. You're thinking you're actually in the phase of starting to quit. Until one day you just go oh, fuck that, never mind. Get back into it again. And it just becomes repetitive. (22M) ...Yeah, there'll be that odd moment, eh, when you've had a bad smoke. And you just want to stop completely. But then, and you say that to yourself the whole time, until you just end up giving up. (22M) ... Especially when you smoke when you've got indigestion. (22W)

Overdosing, feeling sick from it and then being able to stop for several days afterwards led one participant to incorrectly conclude that she was just a social smoker and therefore not addicted. She provided insight into how she coped with any cognitive dissonance she may have felt about smoking in two ways: she 'normalised' her behaviour, saying "heaps of people are like that" and she thought this is how she and others 'justified' ongoing smoking, because it was "only a packet here and there" as if intermittent smoking binges were not harmful.

I can smoke a whole packet in one night drinking, and not have to smoke for two or three days afterwards ... Throat's too sore ... Yeah, I think it's just social smoking. I think heaps of people are like that. And maybe people are able to justify because it's only a packet here and there. (10W)

Preventing worsening health

Sometimes participants attributed their getting sick to the cumulative effects of smoking, so stopping smoking was about preventing worsening health.

Because I was smoking and drinking and it was starting to have an effect on my health... At that time I always had a cold. (23aM)

Getting some bad health news can be a trigger. The following quote illustrates the triggering process, as this woman says – it's like "a wake up call", and it's followed with putting aside the cigarettes.

It's a wake up call really. When you find out you've got something and you've been smoking. You're like "oh", so you actually put your packet away. (7W)

One-off crises or health-impacting events can mark the end of smoking as in the following example.

My dad gave up smoking because he put out a fire and got smoke inhalation, and couldn't ever smoke again. (7W)

Receiving advice and support from a general practitioner (GP) or other health professional (HP) should be a trigger to quit. For example, one older Māori female participant said she only tried to quit once, when an Aukati Kai Paipa (AKP) kaimahi initiated a 'session' with her and prescribed nicotine replacement therapy (NRT).

Only when I had a little session with [name], put me on those tablets. (KN1W)

But the following quotes suggest for some people GP or HP advice to quit just adds to the overall tension to quit.

Feel like giving up or? (KN1M)... I'm thinking that I should. Yeah, no, I will. (KN1W)

Loss of fitness or impaired sporting performance can be a trigger to quit, as the following quotes illustrate:

I was running. Because I couldn't run anymore... I couldn't breathe anymore. (14W)

I couldn't surf properly... Breathing (23aM).

Pregnancy

Pregnancy, when cited as a reason for quitting, was usually more of a trigger to quit than a background reason (asserting tension) to quit.

On the smoking history chart of actual recalled reasons for quitting and during discussions, stopping for pregnancy, usually occurred once women found out they were pregnant. For some women, stopping smoking when pregnant was easy.

As soon as I found out I was pregnant I gave up just like that. (23aW)

I stopped three times. Because I had three children. (22W)

Yep. I can give up just like that, and no crave. (13W).

One of the reasons it was so easy for some women to quit when pregnant was that they felt sick and couldn't smoke due to morning sickness.

I couldn't stand the smell of cigarettes. I could smell cigarette butts from a fucking mile away, yeah. I just couldn't stand it, so I just went cold turkey. (KN7W)

Stopping smoking when pregnant was considered a strong reason to quit by a male partner as well, but his partner was unable to quit despite trying to.

She tried to but she just went ape-shit... (13M) ...But you wanted her to aye? (13W) Yeah. (13M)

Not being able to stop smoking when pregnant created cognitive dissonance that some participants coped with by becoming quite dismissive of this as a reason. For example, one woman said despite knowing she should stop for pregnancy, she didn't. Quitting for pregnancy was also seen as a temporary quit, like a reluctant unintended and therefore not real quit attempt, because women just return to smoking as soon after having baby as they can.

Everyone knows you don't smoke when you're pregnant. (23bW)...a reason for stopping, but I didn't actually do it. (23bW)

...went back after the kids were born. (8W)

The role of health effects advertising

Mass media advertisements reminding people of the ill-health effects of smoking appeared to act more as a tension for our participants, though the tension varied in strength as the following quotes show.

The Adrian television commercials (TVCs) were strong for some participants.

...when you see it on TV with that guy. (24M) ... Yeah, it freaked me out. (24M) ...

One focus group discussed the effects of the health effects ads. One young participant attributed his wanting to quit when he was younger to the ads:

*...because of all those ugly pictures and stuff. (24W) ...Like the missing body parts and stuff. (24M) Have you seen the one that's got that bending? (24M). **So that was something that made you want to quit?...**Yeah. (24M)*

Getting gangrene. (14W) ...Yeah, the ugly feet, and (14W) ...and that on your toes? (14W) ...Is that ugly toes? (14W)

But they were dismissive of any impact of the graphic warnings on the cigarette packets.

*Waste of time. (24M) ... Just don't look at it. (24M) ... It's pretty ugly, but then – (24M) ...Looks ugly but not a put-off. (24M) ... Yeah, it's not ugly enough to make me stop. (24M) ...**Is that the same with you girls? Do those things put you off?** Yeah. (24W) No. (24W) ...It's ugly but it won't stop me from smoking. (24W)*

The general feeling about the graphics on cigarette packets was that they were ineffective and are “of no consequence.” (13W)

It's like the ads on the smoke packets. It just really pisses you off in the end. [Laughter] It does. It just annoys you. (11W)

Even with the pictures on the smoking packets, well they don't put me off. So that's something that's not here. You have a smoke from a pack and light it up and have a look at the advertising. And go oh yep. (13W)...It won't happen to me. (13W)...I suppose it's just to make sure the companies are all covering themselves. (13M)...They have to do that though, don't they? (13W)...It's of no consequence. (13W)

Te Taha Whānau

There were many family related reasons for stopping smoking. Some act as tensions for some people and some act as triggers. The following section discusses the various reasons and tries to tease out the difference between what is a tension and what acts more as a trigger to quit.

Tensions

Quitting for children was a common reason. Generally, this refers to participants thinking about their child in some way.

Thinking about my child. (13W)

...it's for the kids. (23aW)

Kids are a good reason to stop. (25W) Most of us are pretty aware of that now, I think. (25W)

Quitting “for children” at the level of a tension is framed as a desire for the future or a value, for example, people didn’t want their children to take up smoking or they had as a parenting value that they needed to role model behaviour they wanted their children to copy.

I don't want my kids to smoke. (7W)

I've got to be a positive role model to my children. (8W)

Some participants indicated that quitting for children might be the only reason with any power for them, for instance they said they wouldn’t do it for themselves.

Maybe to get better, but it would only be for my kids and my brother. Yeah. I wouldn't do it for me. (23bW)...Yeah. Not for myself. (23bW)...If they said I needed to quit smoking. (23bW)

Sometimes children can trigger a quit attempt in a parent/grandparent, as in the following quotes.

My mokopuna tell me that I'm going to die, and it's not fair. (23bW)

I think hearing from my, my youngest, you know, the other two are fine, it's just that hearing it coming from your youngest child, yeah, 'you're going to die if you keep smoking', I mean that's how she said it. 'You're going to die if you keep smoking'. Pretty straight up child so, you know, the impacts of that, of listening to her say that, it's just like 'hmm, true, might not be around'. But then, you know, you start again and then you learn to turn your ears off when they go, 'you're going to cark it'. (KN2W)

But as this woman says, not managing to stay smokefree after a quit attempt meant she had to develop a resistance to her child’s prompting, as she said she learned to turn her ears off to it.

Thus, triggers tend to be something that have a new element to them or a fresh approach. The same trigger might not work again if relapse has occurred and the smoker has lowered self-efficacy about quitting and has had to develop resistance to the trigger to avoid feeling bad about not being able to quit for that reason. Then children wishing that their parents didn’t smoke becomes just a pressure (tension) to quit. Other participants also had children asking them to quit.

My kids already moan, they tell me to give up every day. They learn from school. (8M)

One woman’s resistance strategy was to become, as some participants called it ‘a closet smoker’. She kept her smoking secret from her husband and children.

It's the sneaking. I haven't got the heart to tell [husband]. (25W)...Oh, he doesn't know. (25W)...I don't smoke at home, but my partner knows that I smoke, but my children don't know that I smoke. Just because of all the advertising and they'll give me shit. (25W)

Seeing someone close badly affected by smoking should be a trigger to quit, but for some participants it acted only as a tension that resulted in lowered consumption.

My dad got cancer from smoking (7W)...It didn't make me stop. It's made me slow down. (7W)

Family support was cited as a tension supporting quitting.

It's the support. (23aW)

Triggers

Childrens' ill-health can be a trigger to quit for some people, especially if children have an illness that is smoking-related or exacerbated by exposure to cigarette smoke and this fact is pointed out to the parents by a HP.

The doctor said my son had bronchitis... And he reckons it's because I smoke. (7W)

Some parents elevate their children's health above their own.

I'd rather my kids stay healthy than me. (8W)

Some people are triggered to quit for a partner, husband, wife, boyfriend or girlfriend. This can be because their partner has asked them to quit, or they start a new relationship with someone who doesn't smoke.

Cos my Mrs said! (8M)

The reason for stopping is because I'm involved with someone. (24M)

Young people may stop out of fear of repercussions from parents who disapprove of their child smoking.

I stopped when I got caught. I didn't want a hiding so I stopped. (13M)

Family can support each other to attempt quitting. One method talked about was having a bet to see who could quit and last the longest.

Had a bet with my sister ... we just made a bet to see who could last the longest. (23aM) ...Because they're competitive (23aW)

To be a positive role model to siblings was another reason to quit. One young woman was triggered to quit when her younger brother started smoking and she realised the need to be a role model for him.

Because I didn't want to see him [smoking], he'd just started. (23aW)

No smoking peers – no trigger to smoke

Some of the younger participants found they were not triggered to smoke if there was no one else around them, family or friends, that smoked.

There was, like, 3 teenagers in the whole town and they didn't smoke so you didn't have that influence, like 'oh we need to go for a smoke'. It was more like 'let's go for a swim'. (KN2W)

Nobody in my family smokes and so, and when I hang out with people who don't smoke it was like I had no influence...I didn't think 'oh you should just go tell them

you're 18 and then you can get some smokes'. I didn't think of that. I thought 'bro, you have to be 18, so you've got to wait'. (KN2W)

Cost

Cost as a reason for quitting is discussed under Te Taha Whānau because expenditure impacts on a person's ability to provide for or contribute to whānau wellbeing.

Tensions

How much gets spent on buying tobacco can at some point become a cause for concern for people depending on their personal level of disposable income.

I realised that people can spend up to sixty bucks just on smokes for a week. (KN2M)

Participants thought an increase in the price of tobacco should trigger people to quit.

Imagine how much money we'd all save. Seriously. (10W)

The cost. That could be one maybe. For some people. (10W)

It was a great motivator to give up for me. (10W) ...Yeah, when you add it all up it's ridiculous how much you spend. (10W)

If they put the cost up (23aW) then I'd have to say "It's time!" [laughs] (23aW) ...It's time! (23aW) ...It's time. (23aW) ...Well its over \$20 for a packet of taylies already. (23aW)

I reckon if they lifted the prices up high as. No. (KN2M)

Some participants disagreed that raising the price of tobacco would make it easier for them to quit. They said they would just switch to cheaper loose tobacco or buy from non-legitimate sources.

No, it actually wouldn't, we'll just go to taily's. It's cheaper. (24M) ...Plus there's people we know and they sell, like, 100 grams for ten bucks. (24M)

Triggers

Saving for a specific goal like a trip provided incentive to one participant.

To go to Sydney... we're going in April hopefully. So I've got an incentive to there again give up. (KN2W)

A lot of times, participants did stop because of the cost – they just couldn't afford to buy smokes. But this is a reluctant, i.e. unintended quit.

Only if I didn't have any money. (8W)

It's only if I've got no smokes. (23bW)

Ran out of smokes! (23aM)

Te Taha Hinengaro

Tensions

Inconsistent with identity

A tension for some young people was the cognitive dissonance caused by their previous anti-smoking beliefs and behaviour, for example, if they had been involved in anti-smoking promotion at school, and now they were smoking.

Well I never really thought about how long I was going to smoke and I don't, I don't want to be a smoker for all my life, or even next year. That's the goal for me, is to just give it up because I was a fully anti-smoker when I was at high school and that was only last year. I was all about anti-smoking, done a PowerPoint presentation about anti-smoking. (KN2M)

I hated smoking when I was little, I always used to cover my mouth whenever someone had a smoke. But not much of a big story because it's only been, what, 7 months. (KN2M)

A few people just don't recall or have insight into why they have stopped smoking or tried to stop in the past.

Dunno ...Just did. (7W)

I've got no reasons for stopping. (24M)

A similar theme was just being sick of smoking or just saying they didn't want to smoke "because it's bad." (24M)

...sick of the whole lot. (8M)

Just because I wanted to. (KN2W)

Some young people just thought that smoking was "dumb". (KN2W)

You've got to stand in the cold if you want a smoke on a rainy day and you smell ugly and you get detention anyway, even if they know you didn't smoke but you're standing with the smokers. It was just dumb. So dumb. (KN2W)

Hoha, just a waste of time. That's why I need to stop. (KN2W)

It's time

Many participants didn't have a reason more specific than to just say 'it was time'. They recognise that there was a point at which they decided to quit, but they seem unaware of any particular trigger that tipped the balance. "It's time" was explained thus:

You just say. "I want to give up". (7W)

I think I was ready. I think I was actually, like up here [points to head], I was right with it. (25W)

There are not really "times" as one focus group discussed it. They said they never stop, though they would try "every year." (23W) Or, as another participant said they were "just trying." (8M)

Not being able to stop, led some people to conclude that they were just not ready.

I've been saying for a few years. I'm not quite ready to give up obviously. Or not give it up completely. (8M)

Don't want to quit

Some participants said they didn't want to quit.

I just don't want to. (8W)

If I didn't have a reason to, I wouldn't. (8W)

Well, I don't care. (23bW)

I won't give up. (23bW)

I smoke all the time I'm sick, unless I'm really sick. Well I have a flu most of the time. So you've got to persist with it, or I'd never smoke [laughter]. (11W)

Fatalism

Having a fatalistic attitude to life is one cognitive mechanism used to ease cognitive dissonance caused by continued smoking. Participants said:

...you could get hit by a car. [Laughter] (7W)

If you're already going to die, I wouldn't give up. (7W)

The discussion in one focus group of young women revealed that there was some scepticism about the legitimacy and relevance of known health risks, as the following excerpt shows:

You could have a heart attack! (7W) ...We can't have heart attacks (7W) ...Yeah we can (7W) ...Yeah a 12 year old had a heart attack on the rugby league field. (7W)

Low self efficacy; can't quit

Believing that they can't quit is another cognitive mechanism used to dismiss tensions and triggers to quit.

I choose to smoke. (8W)

If I could stop tomorrow then I would, but I can't. (8W)

...it would be hard to give up, though. (24W)

There were a couple of times I wanted to but I didn't actually do it ...Yeah, that didn't really work though ...I think it was about 2 days. (25W)

These quotes illustrate an awareness of addiction because of being unable to stop, which leads to low self-efficacy that they will ever be able to stop and negative expectations of the quitting experience, i.e. that it will be hard.

Aesthetics

The aesthetics of smoking includes quitting reasons to do with the smell and look of smoking. The effect of smoking on oral health is included here.

Some participants didn't like the smell of smoking.

The smell is yuck. It's disgusting. (10W)

Another said it looked ugly.

And it looks ugly. (KN2W)

And, another wanted to stop smoking "because you get ugly teeth." (24W)

When people are young and they're naive and they start smoking, they tend to forget the fact that it's fast aging in looks. And so, once you get to that stage you lose total confidence of yourself. Your insecurity. (22M)

Te Ao Turoa

Tensions

Working in a profession or a place inconsistent with smoking should give cause to quit.

The only time I wanted to give up smoking was when I worked for [a Māori health provider]. (7W)

But it doesn't always. The following quote illustrates how people who smoke adapt to restrictions on smoking.

I've got a friend that does the opposite; only smokes at home, does not smoke at work ... She works in a dentist... can go all day and night without. (25W)

This also illustrates a kind of sharing of strategies that can help other smokers to find alternatives to quitting; that acts therefore to counter tensions and triggers to quit.

Triggers

Smokefree environments

Starting a new job in a smokefree workplace, or a workplace not conducive to smoking can be a trigger to quit.

I was working at a glass company job where they had chemicals and at that time with smoking, another thing was to be healthy. (KN1M)

Schools are not environments conducive to smoking. So, getting caught smoking at school can be a trigger for young people to quit. Similarly, parents making it known that they don't want their child to smoke can also be a trigger to quit, as it was for the following young participant.

It was against my parents wish, at that age of 16. (KN1W)

One participant had quit smoking once but it was an unexpected quit that occurred when she travelled overseas with a troupe. She said they were just too busy to smoke.

When I was overseas,...because we were real busy. The whole group smoked but none of us did over there... We were allowed but we just didn't have time really. The time we had we were basically asleep. (8W)

Discussion of patterns

When discussing their quitting histories shown on the charts, participants noted health, including fitness, as a predominant reason for quitting. Quitting for children was also prominent. Cost featured but varied in frequency by age of participants, as the following excerpt of discussion from one of the older age-range focus group shows.

It goes on your values aye, as to how much you would pay, but it doesn't influence on buying your smokes. (23bW) ...Yeah, I've done things like, gone shopping with, hold on, one and two cent pieces to get my smokes. (23bW)...There's no impact. (23bW) ...I could run out of bread, milk. I could have a smoke while I'm down at the shop, walking, in the park. (23bW)...Cost doesn't come into it. Obviously, for, our generation. (23bW)

Like cost, participants identified that many of the reported reasons for past quit attempts were due to pregnancy or being sick at the time, that is, they were reluctant quit attempts.

Because I was sick and it hurt when I smoked. (10W)

And that's because they taste yucky. They don't taste very nice at all. (11W) ...They're not very nice when you're sick. And, if you're real desperate you go to menthol. (11W) ...The only time I really, really stopped in my whole life was when I got tonsillitis for three and a half months and was incredibly sick. Like majorly sick to the point of being delirious. (11W) ...So you have to be really, really sick to give it up. (11W) ...Yeah, I did it when I was sick too. (11W) ...Yeah. (11W) ...Well I couldn't swallow, let alone smoke. But then I got better. (11W)

There's no stress from having a negative expectation of quitting as it's a temporary quit.

When I was sick and I don't feel like smoking, I just shrug it off. Yeah, okay. And I don't have a smoke. So it's no biggie for me because you know that you're going to get better. (11W)

Participants noted that reasons for quitting changed across the ages. As age advanced health reasons became more prominent. One group facilitator asked if the participants felt it got easier or harder to quit as people got older.

Harder. (11W)...Harder. (11M)...Harder. (11W)

A younger participant in another group explained why quitting was easier when younger.

I started younger you know like, 14 or 15. But you don't smoke every morning because you don't buy it, you don't, you know it's when you can get your hands on one. So that's not really, you're smoking, but it's not a regular thing. (13W)

Focus groups varied when considering if reasons for quitting varied by gender. Some groups thought the reasons were "basically all the same." (8W) Another group noted that pregnancy came up for women more, as they said:

Oh, then that pregnancy one comes in (23aW) ...For women it's pregnancy (23aM) ...For men it would be health, and fitness. (23aM)

But a male participant thought quitting for kids was relevant for men as well.

Like if we've got a child coming over we'll stop smoking as well. (23aM)

Stress, caused by relationships and whānau, were predominant reasons for relapse.

Staying smokefree- Things that helped

Te Taha Tinana

Focusing on the benefits of quitting, for example, noting and enjoying improvements to health helped participants in their resolve to quit and stay smokefree.

I really feel so much better when you're not smoking. (11W)

And your skin is better. (8W)

Stopped me snoring too, I think. (8M)

Participants also noted how their sense of taste and smell returned after quitting.

The smell was better and everything. I know I could breathe better aye bro. (8M)

I had taste buds and boy did I put on the weight. You taste food that you never ever commonly eat. And you can smell everything. (8W) ...The food started tasting really better. (8M)

There were also lifestyle benefits which appealed to participants such as, saved time and not having to worry about whether they have their smokes all the time.

It's wonderful being able to walk out the house and you don't have to find your smokes... that was a good part about not smoking. (11W)

What I liked about being smokefree is I got more work done ...because you're not stopping every 5 minutes for a fag ...that's what I liked. And I was always up-to-date, I didn't have to spend my Friday afternoon catching up. (25W)

To avoid being triggered to smoke, some participants said it helped them to make a complete break from things that were strongly associated with smoking. However, one woman talked about the downside of this strategy: because of the high prevalence of smoking among Māori, there was a risk of becoming isolated.

Everything that triggered my desire to smoke, I rejected. (23bW) ...The negative side of [giving up] smoking is that you umm, you isolate yourself from the people that you really shouldn't be isolating yourself from. And that's your people. Only because you know it's gonna trigger off the big thing. Umm, and never saved a cent, by the way. (23bW)

You sort of learn to associate more and more activities with not smoking. (11W)

Most of the participants found it easier to quit smoking when they eliminated smoking cues from their life. This included removing cigarettes from sight and not buying any more cigarettes.

Having no smokes and nobody around having smokes. (7W) ...I just hung out with people that didn't smoke. (7W)

I have to give up with no cigarettes around. I can't have tobacco or cigarettes. There has to be none for me to get. (10W)

One for me was I knew how much smokes cost and I knew once I bought my first packet I'd be screwed. But for the longest time I was like, 'no, so long as you don't buy a packet, so long as you don't buy a packet'. But yeah, eventually I just bought one so that was it. It was a pain after that. (25W)

For some participants it was helpful to create a new environment, context or location – “*just changing your environment*” (11M) – with the aim of avoiding triggers for smoking such as alcohol – “*I can’t drink.*” (7W)

Te Taha Whānau

Wanting to be and stay smokefree for others, particularly for children, partners and parents was a common theme. However, if staying smokefree could not be maintained, maintaining the illusion of being smokefree was attempted. It also appeared to be an emerging ‘smoker’s myth:’ that lots of people are ‘closet smokers’.

Wanting to be smokefree for children to prevent them from taking up smoking had been a powerful motivation to quit for one woman. But, as she explains in the following excerpt, she was unable to stay smokefree. Rather than let her son down and risk supporting his initiation to smoking, she hid her smoking from him. She believed that there were many people like her who were ‘smoking in the closet’.

I think my son was about 7 or 8 and he thought that I gave up smoking for him, so there was no way I was going to tell him that I started again. And he’s 11 now. But anyway, what he doesn’t know. (25W) ...So you don’t smoke at home at all? (25W) ...No. Oh occasionally if everyone goes out, I’ll go and have a fag in the carport, but ...I don’t want him to see me doing it because then if it’s okay for me it’s okay for him sort of deal, so. (25W) ...You’re leading a double life. (25W) ... It does actually feel, and there’s a lot of people that smoke in the closet. There is heaps of them. (25W)

It would be quite hard to get a true statistic on how many people actually did smoke because a lot of them hide it from, like, I avoided getting insurance because I knew on the insurance form that I’d have to tick that I was a smoker. (25W) ...well they’d only smoke socially aye, when they’re around other people that smoke, but can go during the weekdays when they’re at home with their kids. (25W)

The discussion in this focus group went on to talk about how people think they can hide that they smoke from partners who did not smoke. Some participants were sceptical that this was possible, because surely the smell of smoking would give it away.

A lot of partners don’t know that their partner smokes. (25W) ...No, I went 2 years without [partner] knowing that I was smoking. (25W) ...Could he not smell it on you? (25W) ...I brushed my teeth and showered and all that. (25W) ...Nah, they know, like [name] knows now. He knows. Because you do, you stink. (25W) ...Well he didn’t say anything about it. (25W) ...when I came back drunk from somewhere stinking of cigarettes. ...You go, ‘oh those friends of mine, they’re terrible’. (25W) ... just made out I was in a room full of smokers. (25W) I went out for dinner, it was like ‘oh cool, that was really good, I’d like to just go and stand on the street and have a smoke’ but he’s with me. So yeah, it was like ...I’m just going to the loo love. (25W)

Participants also spoke of people who did not want their parents to become aware of their smoking behaviour.

Yeah, with her parents, and she’s 40 years old and she doesn’t want her parents to know that she smokes. (25W) ...one of my friends, she doesn’t let her mum know. She hides it from her mum because her nana died of emphysema. (25W)

Having a partner who doesn't smoke usually, however, provided motivation (at a tension level) to stay smokefree.

My partner... She doesn't smoke you see. She's anti it. (8M)

A younger participant did not want to disappoint their parents, and this helped her with staying smokefree.

It was more the, you know, probably high expectations from my parents. Which is why I didn't go there at that time. When I was in school. (22M)

For children

Having a strong attitude, or even value, that smoking around babies and children is not okay can add to the motivational tension supporting a smokefree status.

I wouldn't let anyone else that had been smoking around my babies. ...They could still be around them. But they certainly couldn't smoke anywhere near them. ...Didn't cuddle, no way. ...Not until my babies were older. (11W)

Knowing that there are second hand smoke health risks for their baby helped build motivational tension to not smoke also.

Knowing that you stink of smoke when you're feeding your kid, breastfeeding and stuff. (25W)

Knowing that when I smoke my baby's smoking at the same time, kind of thing. (22W)

Whānau support

While whānau support was a supporting factor for most of the participant's one participant was more cautious pointing out that "my Mum and Dad were non-smokers so it [decision to start smoking] wasn't influenced from my parents. At all".

Not all participants felt supported by whānau in their attempts to stay smokefree. One young woman said her father supported her to stop smoking but this was undermined for her because he continued with smoking himself.

Did you have people that supported you? ...No. (7W) ...Yeah, my dad did. ...My dad tried. He was like "give up bubba". [Makes a fake cigarette smoking action] (7W) ...[boyfriend] did try to help me give up. (7W)

One strategy for dealing with doubters and pushers was, as the following quote suggests, set a challenge and "to place bets" (22W) on who could quit successfully or be smokefree the longest.

*Family and friends. Yep, the bros. (22W) **When they egg you on... I knew you wouldn't give up?** ...Then you don't feel cool at all (22M) ...Then you just like, okay we'll see. Especially when you can place bets. It's a good way to do it. (22W)*

Social inclusion

Sometimes participants thought that avoiding people who smoke and socialising with non-smoking peers would help them stay smokefree.

Having lots of other non-smokers around is quite good. (11W) ...Being around non-smokers is a help. (11W) ...If you're working with non-smokers you don't tend to go out. (11W) If you're having a nice meal at a restaurant and no one's going out for a fag I'll stay with the people that are not smoking. (11W)

It was more just not being around a lot of smokers. Because a lot of our friends smoke. Just not being around them was easier. And my granddad smokes, so not really paying attention to that was easier as well. (10W)

The support from other smokers around plays a critical role in a quit attempt. Without the social support of peers it was more difficult to maintain quitting.

It was easy as to try to quit when we did it as a group. Because we all hang around – everyone that we hang around with smoked. So that was really hard as well. Because you're just constantly around it. (10W)

One participant acknowledged the support of their AKP quit coach during their regular catch up sessions.

The constant support. You know, your support. You know that time when we had those sessions. Just you coming in every week was primo. (11M)

Something else that made it easier to give up was if smoking was perceived to be no longer socially acceptable. When participants first started smoking, smoking may have still been considered 'cool' however tobacco control initiatives have made smoking less acceptable.

I think another thing too is that it's socially unacceptable in a lot of places now which is a, yeah. It is getting less and less because when I first started working at, like, [area] School there would be 14 people who were smokers, and now there's probably 3 or 4. (25W) ...And on the sports grounds, you know, I'm always looking around to see if there's other people smoking. (25W) I see someone smoking in a car with kids in the car, it's like, they're sort of frowned upon, so yeah. (25W) ...So yeah the social unacceptability thingy is – (25W) ...I think when I gave up, I did think I was a little bit better than people that smoked. (25W) ...Did you feel proud of yourself though? Because I was. With me, you know, it was like, yeah. (25W) ...You just think 'dirty, dirty, dirty'. (25W)

One participant rejected the notion that advertising had any effect on her or her Māori peers' decisions to smoke or not smoke.

What's really bugging me is that I'm told we are influenced by the people in magazines. What magazines? We didn't have the money to buy them. I didn't see those 'cool, white chicks' with their cool, white partners smoking. You know, we didn't have that, we didn't have one TV in our street. Oh my gosh. So you know, advertising, and advertisements, they don't impact on my response. (23bW)

Cost

Quite a few participants had financial motives that helped them stay smokefree. For some, they could no longer afford smoking – *"I didn't have any money to buy smokes."* (7W) One participant had no other choice but to give quitting a go when they stopped receiving financial support from their parents.

Leaving home and not being able to ring your parents up and ask them for money. (11W)

Another participant was encouraged to stay smokefree because of the money they were saving from not buying cigarettes.

I'm bummed out that I went back to be honest. I saved heaps of money in three weeks. (10W).

Te Taha Hinengaro

Some participants thought success at quitting was more likely if people think 'it's time' and if they have reached a point where smoking is no longer enjoyable.

I think you've really got to make your mind up that you want to do it. It's not going to happen by chance. I think you've got to really work at it. (11W)

TV adverts

Television adverts about not smoking helped to support quitting by reiterating the effects of smoking on the body.

*Like on the ads and all that. (22M) ...Just the stuff that I've seen on TV like the lungs getting smaller and smaller into this little ball the same size as your fist. (22M) ...It's unattractive also. (22W) ...A baby with an asthma mask. What else? Oh, all those kinds of stuff. (22M) ... **The visual stuff?** ...Yeah, which made me react. (22M)*

Too busy to smoke, keeping busy

Another helpful strategy was to keep busy and occupied. Sometimes this was intentional and other times it was unintentional for example a mother with a young family who finds herself *"running around after them all bloody day"* which means she has *"got no time do anything else"* (10W) including smoking.

Playing video games. (24M) Sports. (24M) ...Outdoor activities. (24M) Work. (24M) ...Yeah, get a job. (24M) ...Working out in the bush. (24M) ...Keeps you occupied. (24M) Just sports and stuff. ...Zumba and aerobics. (24W) ... And body jam. (24W)

Improving access to cessation support

The cost of quitting was a barrier to accessing smoking cessation products and services, so, free cessation support would conversely support quitting. Ideally, participants wanted a free quick fix with no negative side effects.

A quick fix, no symptoms. And apart from that. (23bW) ...And free. (23bW)

One participant recognised that no one approach would be suitable for all people. She suggested that cessation support needed to be individually tailored with *"really good incentives."* (11W)

*They had really good incentives. They got offered gym membership. ...I think it's as per each individual. I mean, what works for me won't work for [name]... And the reasons for giving up are totally different. So having a blanket sort of thing for people, saying this will work for everyone, don't work. But individualised programmes, as per your lifestyle, children, whānau, etc, etc. if it was tailored just for me ...**Something that kind of works on your triggers.** ...Correct. (11W)*

Understanding addiction

Knowing how easy it is to relapse, that 'just a puff' is usually the start of relapsing to smoking, one participant thought would help with setting a resolve against being tempted. She talked about the addiction, or in her words the identity as a smoker, laying in wait.

I think one of the things when you give up is that you have to realise that you're still a smoker. It's just there, it's just in the back. Because, see I believed I was a non-smoker after 3 years and it was like, nah, it was still there. Just step back into those shoes, just like that. (25W) ...It's like you can always be an alcoholic. (25W) I know for the next time when I give up, that's it, I am not going to touch it. Because that's all it took. (25W)

Staying positive

Positive affirmations were a strategy used by one participant to stay smokefree however this method did not appeal to everyone in her focus group. One person thought it was hard work to keep that up.

Keeping up my self motivation. Because if you get up every morning and go I'm smokefree. Or whatever. Positive affirmations. It sounds stupid, but – (10W) ...No harder. Keeping that up. Just getting lazy. (10W)

One woman suggested that it helped to maintain a positive outlook and upbeat mood to avoid stress and subsequently pressure to smoke.

If I'm very happy and relaxed, I smoke less. (25W)

Don't like smoking

A number of focus groups commented on how off-putting the stench of smoking was and how good it was to not smell of smoking anymore.

Being around smokefree people. Because they'd say oh you smell disgusting. (10W) ...Oh my God, did you just have a cigarette. God you reek. Oh, pooh, I can't breathe. (10W) ...you can just smell the difference. They just stink. (10W)

And your clothes not smelling. (11W) ...Your room not smelling because all your clothes are there. (11W)

Te Taha Wairua

One participant found that she coped better with cleaner wairua.

Well I didn't get as stressed when I was smokefree which was weird ... when I did get a bit stressed, I would deal with it straightaway rather than smoking. I'd just like, 'I'm stressed, I'll go and have a fag'. Whereas I'd deal with things far more quickly and wouldn't be as stressed because they'd get done faster. (25W)

Te Ao Turoa

Te ao turoa (the longstanding environment) provides for environmental and political factors beyond the immediate realm of the whānau and social realm of influence.

Smokefree environments help

A number of participants said “a non smoking environment ... smokefree environment” (23bW) was conducive to quitting.

Looking at smokers ...just like you'd see them all go outside and you didn't have to, because it was raining. (25W) Not having to, like, yeah. (25W) You can't smoke in the toilets. (25W) ...Or in the planes. ...Or in the classroom. (25W)

In the experience of one participant it was much easier to quit smoking if the workplace was also smokefree, because they were less likely to crave a cigarette.

I'm different if I'm working and I can't have a smoke because my mind's like, 'you're not allowed to smoke so don't even think of it'. Yeah, 'it's not in your routine today'. (KN2W)

Mine was only in the week, but you could smoke on the weekends. Cos I had to nanny for this family right. And they were rich as, smokefree. So obviously I was “oh shit, I can't smoke”. So I was there Monday to Friday. So on the weekend I'd

go back to my flat and be – [makes smoking gestures] ...But because they didn't smoke, I didn't want one. I didn't want to say "hey, I smoke". But I'm going to look after your kids. (7W)

Although it took time to get used the idea of smokefree bars and restaurants, the majority of comments were in support of the law change.

Because when that whole smokefree environment thing came in and people were I'm not going outside for a fag. And now, like if you see someone reaching for a smoke and start to light up in the pub you're like oh, what are you doing? Get outside. (11W) ...It was like when we had just introduced the law over here and got used to it, went over to Sydney and of course Australia hadn't done it. Man it was disgusting. (11M) ...Yeah, being inside with smokers. (11W)

Smokefree homes

One participant said they *"actually feel naughty smoking inside people's houses."* (10W) The idea of having to go outside for a smoke to maintain a smokefree home was talked about as if it was becoming the norm. Even when there is no one else around to witness them smoking inside one woman said.

I still do it, but I feel guilty. (11W)

Relative Ranking of Reasons for Quitting

The groups' ranking of relative reasons for quitting are presented in Table 8. There were five Māori groups of participants aged between 16 and 26 years of age, and six Māori groups of participants aged over 27 years. The mean is calculated based upon 1 as the highest ranked position, and 21 is the lowest possible ranked position.

Table 8: Relative ranking of reasons for stopping smoking (n=70)

Reasons	Rank order (Mean)		
	16-26yrs (n=34)	27yrs+ (n=36)	Total (n=70)
For my children's health	2 (4.8)	1 (2.2)	1 (3.4)
To be a positive role model to my children	3 (5.0)	1 (2.2)	2 (3.5)
To have a healthier pregnancy	1 (4.4)	2 (3.7)	3 (4.0)
To stay healthy	2 (4.8)	3 (4.3)	4 (4.5)
Getting pregnant	4 (5.4)	4 (4.5)	5 (4.9)
To have more energy to do things	5 (7.2)	5 (5.0)	6 (6.0)
Seeing what smoking does to someone close	3 (5.0)	8 (7.7)	7 (6.5)
Fitness	7 (8.6)	6 (5.7)	8 (7.0)
To get better	12 (10.4)	7 (6.3)	9 (8.2)
To live longer	6 (7.4)	11 (9.2)	10 (8.4)
Doctor told me to stop	6 (7.4)	14 (9.8)	11 (8.7)
Tino rangatiratanga: Making one's own choices	9 (9.4)	13 (9.4)	12 (9.4)
To not grow old early	8 (8.8)	15 (10.2)	13 (9.5)
Cost	13 (11.4)	9 (8.2)	14 (9.6)
It stinks	11 (10.0)	16 (10.3)	15 (10.2)
Tino rangatiratanga: Māori having control over Māori matters	13 (11.4)	12 (9.2)	16 (10.3)
It's time	15 (13.2)	10 (8.5)	17 (10.6)
Smokefree environments	10 (9.8)	18 (11.7)	18 (10.8)
If they can, I can	14 (12.4)	18 (11.7)	19 (12.0)
It's not cool anymore	16 (13.8)	17 (11.5)	20 (12.6)
TV ads about smoking	17 (16.4)	19 (13.7)	21 (14.9)

The Māori focus groups perceived that quitting for pregnancy and for children were the most important reasons for quitting for Māori. The ranking of reasons suggests that children's health is thought to be centralised, but reported actual reasons for quitting suggest that this ideal does not translate in to action.

First it's about your children then it's more sort of about you. (25W)

Quitting for pregnancy, for children and to be a positive role model were the top three overall ranked reasons for quitting. Quitting for more personal reasons, such as to stay healthy ranked in the top three reasons for quitting for both age groups also, but overall ranked fourth.

Quitting to maintain energy levels, fertility and fitness were ranked next. But after the fifth ranked reason, there was little agreement between the overall younger groups' ranking and the overall older groups' ranking. Younger participants thought that quitting to live longer, stave off aging and quitting because a doctor said to were about as important. Older participants ranked quitting to get better as seventh, probably reflecting their lived experience, that is, they would have had more experience of smoking related illnesses given their longer time smoking. Similarly they may have experienced someone close being affected by smoking with no resultant effect on increased quitting. The older groups ranked this lower than the younger participants who thought that seeing someone close badly affected by smoking would be a strong reason for quitting – they ranked it an equal third to being a positive role model to children.

Only after these reasons, did cost begin to factor in perceived importance as a reason for quitting, more so among the older participants. Younger participants ranked cost low at thirteenth position.

The remaining reasons were ranked relatively weakly.

Discussion recorded during the ranking exercise revealed some of the rationale behind the ranking of reasons.

Some participants commented that there was a difference between 'wanting to quit' and 'actually quitting'.

Everyone wants to give up smoking for their reasons ...Whether they do or not is another thing. (8M)

Some participants in some groups did not know or accept that some of the reasons provided to them were legitimate reasons for quitting. For example, in one group, health as a reason for quitting was pulled down in the ranking because a participant didn't agree that stopping smoking improved health.

I find that people who do give up smoking, get sick quicker. Compared to people who smoke. (10W)...So maybe we shouldn't have that one there. (10W)

A further example of participants dismissing a given reason for quitting as irrelevant was when one participant said about quitting for longevity:

(Living longer) that means nothing. (23bW)

Talk about the relative ranking of the specific reasons follows.

Rank order 1-2: Quitting for children

Some participants said that children and whānau come first, before concern for their own health, as the following quotes illustrate.

I think that's probably the most important. For my kids, anyway. (10W)

It's all about whānau first. (13W)

...it would only be for my kids and my brother. Yeah. I wouldn't do it for me. (23bW)

In one focus group, a participant suggested that stopping smoking so children get fewer coughs and colds should be ranked at the top. Then another participant told the following story of her son getting bronchitis and the doctor attributing it to her smoking. This confused her because she said she didn't smoke around him. She couldn't see how her smoking was connected to his illness.

For my children's health, so they get fewer coughs and colds. (7W1) ...That would be right at the top wouldn't it? (7W2) ...The doctor said my son had bronchitis the

other week. And he reckons it's because I smoke. And I was like "I don't smoke around him." (7W3)

For a similar reason, a participant in another group did not agree that stopping smoking to protect children's health was a valid reason, as she believed just not smoking around them was sufficient.

I don't smoke in my house ...I don't smoke near the children ...I don't smoke inside the car. ...Move that down to the bottom. (23bW)

Whilst quitting for children was perceived to be the most important reason overall for quitting for Māori, not all participants agreed that it was.

Family. No, I don't believe so. (23aM) ...I think that makes us smoke more. (23aM)

To be honest, that's pretty low. (22W) ...I just know too many people that smoke that have children, you know?(22W) ...Just the majority. (22W) ...And the majority of them still smoke inside the house. (22W)

Some groups thought quitting for children to protect their health and to be a positive role model for children were similar and similarly important.

My children's health would be with positive role modelling. (23aW)

Not smoking to be a good role model was supported by some participants and rejected by others. For example, one participant said this reason was up the top for her because she didn't want her kids to smoke.

To be a positive role model to my children ...For me, that's up the top... I don't want my kids to smoke. (7W)

Cos they got more chance of doing it. (8W)

Another participant didn't like the implication that by smoking she was not being a good role model, as follows:

Have I chosen not to be a positive role model for my children? (23aW)

Of course this reason for quitting was not applicable if people did not have children, or if their children already smoked.

No, it wouldn't be for me. My kids smoke. Well, one does. (11W)

Some participants with no children of their own still liked this reason, but applied it to their having younger siblings who they were role models for.

I've got siblings, so to be a good role model would be a top one for me. (10W)

Rank order 3 & 5: Quitting for pregnancy

Quitting for pregnancy was seen as a reason mainly relevant to women. But some male participants said it was important to them that their partner give up smoking when pregnant.

I asked her to stop. (13M) ... She couldn't. (13W)

One young woman thought she would give up if she got pregnant. She wouldn't give up to get pregnant though, i.e. to support her fertility.

I wouldn't give up smoking to get pregnant ...I would if I was pregnant. (7W)

But, another young woman, speaking from experience, said despite saying she would stop smoking for pregnancy, she did not.

I said that but it didn't happen – twice. (7W)

In another focus group, the participants were more scathing about it – they didn't think any Māori woman would give up for pregnancy.

Is that a leading reason for quitting? Nah, not as much. Because most Māoris, they get pregnant or they don't. They don't give up cigarettes to get pregnant ...Or I haven't known anyone that has. (23aW)

I can't see a Māori giving up cigarettes so they can get pregnant. (23aW)

Quitting to support fertility was not seen as very important for Māori. Some focus groups laughed at the thought that Māori might have any trouble getting pregnant, or that men experiencing impotence was worth thinking about, as the following quote illustrates:

Well, who's thinking about them [men-impotence]. (10W) [Laughter]

Oh we don't have any problems. ...We conceive, with contraception! [Laughter] (23bW)

Some participants didn't accept that it was proven that smoking negatively effected fertility.

I don't know about the getting pregnant one because who tries these days... Well, I'm not thinking of getting pregnant any time soon (10W) ...Is there proven facts or stuff that it stops pregnancy? (10W) ...No. (10W)

Participants knew women who had smoked and conceived and this personal knowledge of exceptions undermined their believing that fertility was hurt at all by smoking.

My mum smoked for like 30 years and she conceived all of us fine. (10W)

Quitting for pregnancy is not a salient reason for quitting if young people think they might not ever have a pregnancy, and of course it is not relevant or no longer relevant for people experiencing infertility, whom are beyond child-bearing age or those who have completed their family.

I probably won't be getting pregnant. (8W)

Quitting to have a healthy pregnancy or to protect the unborn child from risks to health was rejected by some participants who did not believe smoking caused harm, either because that had been their experience or they had poor health literacy and didn't know.

I smoked through all my pregnancies. (23aW)

For example, one young woman who was pregnant at the time argued for pregnancy as a reason to be dropped to the bottom of the list.

Yeah, you can smoke and still have a healthy pregnancy, I think. (8W) ...Yeah, 'cos if you can't give it up you get stressed out. (8W)

Pregnant - down the bottom. (8W) ...Everyone I know that's pregnant still smokes. (8W) ...I'm pregnant and I still smoke. (8W)

Thinking that quitting during pregnancy was somehow harmful was reiterated by another young woman in a different focus group.

If you've been smoking for so many years over a period of time, then you've fallen pregnant. Wouldn't the likelihood of you stop smoking put more stress on that baby. Because baby's used to the nicotine intake. (7W) ...Or it's just you stressing yourself out because you haven't had one? (7W)

Rank order 4, 6 & 8: Quitting to stay healthy, energetic & fit

Some groups wanted to group reasons together. For instance, they thought quitting for fitness went with staying healthy.

That would probably be under the stay healthy thing wouldn't it? Because that's healthy. Fitness. (8W)

Having more energy to do things was seen to go with staying healthy and fit.

Probably that goes with staying healthy and getting fit (8W).

But, for some people having energy was necessary to being an involved parent, so it was about quitting for children again. As the following two quotes show, quitting to have more energy was about being able to keep up with the kids and it was about showing them how important they are – that they're worth the sacrifice of giving up smoking.

Keeping up with my children. (7W)...That's like at the top for me. (7W)

Well definitely as our world's changing dramatically, you want to keep up with the pace, and definitely show to your kids that, you know, not saying that you're not there all the time, but it shows to them that you're willing to sacrifice everything for them - even though it's just a smoke, giving that up. Because that's a big biggie. My mum did. She quit when she had me. (22M)

Some participants were not aware of smoking undermining energy yet, so they rejected this as an important reason for quitting.

I don't know how energy relates to smoking. (25W)

That's low. Because there are smokers out there like myself, that are full of energy every day. (22M) ...Yep (22W) ...Trust me, I'm hyperactive. (22M) ... It doesn't matter with me. I'm still faster than all of them. (22W)

Similarly some participants rejected that smoking had any effect on fitness levels.

That's never impacted on me. I've been out playing sports. (23bW) ...When I've finish a game of touch, the first thing I run for is a cigarette. (23bW)

Not really to get fit. Because I'm pretty fit. I'm heading off to the police force. So it's a must. Like my running times and swimming time is fine. And I mean I wouldn't say I'm a chain smoker, but I don't think smoking could ever hold me back. But I want to quit just to get a little bit better than the boys. (22W)

One participant suggested that the importance of fitness varied for people at different stages of their life.

That sort of gets you at different times in your life I think. (25W)

Further, participants knew of sports role models that smoked thus disproving the rule and this undermined stopping for fitness/sport as a valid quitting reason.

Stephen Brett, he plays for the Crusaders, he's a smoker. (22M) ...Benji Marshall smokes when he drinks ...And he's one of the fittest freaks out. (22W)

One participant said that she had tried to stop for her fitness, but she had not stopped smoking. As a result, she seemed to attribute the failure to quit to the reason itself, as if it wasn't a powerful enough reason.

Do you reckon that's a common thing? That people would give up smoking for fitness? Not really, because I still smoke. And that's the reason why I wanted to give up. Didn't work. (22W)

Quitting for fitness is not applicable for people not into sport and fitness.

It's the time thing ...I just don't... I'm lazy. (10W)

Rank order 7: Seeing what smoking does to someone close

Overall Māori participants ranked seeing someone close badly affected by smoking as a high ranking reason for stopping smoking. Some participants said it had put them off smoking and others agreed that it "should" put people off.

It did me. Looking after my father. (8W)

Seeing what smoking does to someone close, that one's pretty good. (24W)

That could do it. (25W)

Seeing how our whānau gets sick. (23bW) ...It should go up. (23bW) ...Put it up, high. (23bW)

Did it put you off? (23bW) ...It should. It should. (23bW)

But, as several participants noted – they still all smoked.

I've seen two people though, and I still smoke. (23aW)

I've had a couple of whānau die from cancer. So you can relate to it quite easily. I've had a lot of non-smoking whānau die of cancer as well. But it's always – the message was right. When you think of lung cancer, but you forget about the other cancers. (11W) ...So that was sort of like dropped a couple of smokes off the daily habit. (11W)

For some people then, actually seeing someone close die from a smoking-related illness is not a powerful enough trigger to stop smoking. It scares them, as one participant said, but it acts as a tension only, at most causing them to reduce how much they smoke.

My dad got cancer from smoking. ...It didn't make me stop. It's made me slow down. (7W) ...It's sad. Because I promised that I wouldn't smoke because my nan and granddad died from smoking. (7W) ...It does scare you aye. (7W)

When you see someone dying of cancer or something like that you don't want to go through it. (13W)

For some participants this was a new experience or only someone distant to them was affected.

It's happening right now. (14W) ...Cancer.

I just took a trip down to Timaru. And my partner's grandmother is so decrepit and old and dying. (10W) ...Did she smoke? (10W) ...She did smoke and she's got emphysema like you can't believe. She used to hulk around a great big oxygen thing and have shit all over her all the time. She looks like she's dead already. You know. She had either a stroke or a heart attack, and the hospital won't take her because she's that far gone. So yeah, she did smoke when she was young. So emphysema and health reasons. It's foul. It's pretty upsetting. (10W)

Other participants disagreed that seeing someone close die from smoking had any effect on their motivation to smoke or not.

My nan died from cancer from smoking. But I'm alive so I don't worry. (7W)

Seeing what smoking does to someone, and those are all like, nah. (23bW)

For some others the reason was not relevant as no one in their family had been adversely effected yet.

No one's died from smoking in my family. (7W)

I've never had anyone close to me die of anything, smoking related. Or get sick from it or anything. (25W)

Rank order 9: Quitting to get better

Some groups recognised that some reasons were less relevant for younger people.

To get better? ...Depends how old they are. (22W) ...The older they get the less they care. (22W) ...**If you think about young Māori. For people of our age.** Oh well, definitely up there. (22M)

Rank order 10 & 13: Quitting to stave off aging and live longer

Some of the questions suggested a lack of knowledge about some of the potential ill-effects of smoking.

Can you grow old early from smoking? (7W)

Other comments suggested some participants did not believe some of the claimed effects of smoking.

I see non-smokers look older than me and they're employed. (23bW)

Oh that's got nothing to do with a cigarette! (23bW) If you're black you don't crack. (23bW)

As with other reasons, staving off the early aging effects of smoking was not a concern for some participants or as one participant said, for her it was too late.

But that's not for ages. Don't worry about that ...Too late, I've got the greys. (8W)

I don't give a bar about that. (23aM)

Rank order 11: Why doctor or health professional's advice ranked so low

Participants were divided about the power of a doctor's advice to prompt quitting. Some participants thought that if their doctor did tell them to stop smoking, then they would probably be prompted to stop smoking.

I think, if they were to tell us, aye. (13W) ...Yeah. (13W) ...You need to stop. Then I think probably, that would be a wake up call. (13W) ...Yep. (13W) ...I'd pull up my pants and stop. (13W)

If he said if you have another cigarette you're going to die, I'd probably stop. But if you said you might die early, then I'd take that chance. (8W)

Other participants thought it was highly dependent upon the doctor and the reason the doctor was giving the advice.

It depends why they say it. I mean how many of them say you should give up smoking? But you don't give up smoking. It's whether it's life threatening. (11W) ...We know we should. (11W)

But Māoris' don't listen! (23aM) ... So it would be no good for a Māori. Because it highly depends on the doctor. (23aW) ...I can't remember how many times my doctor's told me to stop. (23aM) ... Some Māori's listen to what the doctor has to say, some don't. (23aW)

One participant avoided having her doctor give this advice, she said, by lying to her doctor about not smoking.

I just lie to my doctor ...And she knows I lie. (23bW)

Another participant had been advised to stop, but he said he just refused.

I just said no. (24M)

Some people might resent a doctor advising them, as the following quote suggests:

It makes me want to smoke more. (25W)

Rank order 12 & 16: Tino rangatiratanga: Quitting to have sovereignty

There were two tino rangatiratanga reasons, one was to do with personal sovereignty (making one's own choices) and the other was the more political use of the term to do with Māori having control over Māori matters. Neither reason were readily recognisable as a reason for stopping smoking in

the focus groups. In several focus groups participants argued that tino rangatiratanga would not motivate quitting. There were lots of questions as to the relevance of it to smoking. For example, the following excerpt shows some questioning, other participants trying to explain the relevance, the facilitator prompting and a young male providing his understanding of it.

What's tino rangatiratanga? That's children eh? (22W)...Having control over Māori matters? (22W) ...Is that an important one for young Māori? Yeah, definitely. Because tino rangatiratanga is also talking about yourself. You know, how you control your own destiny. If you say tino rangatiratanga then you have to probably set an example. Be a role model. That's my understanding of it. (22M)

Thus, tino rangatiratanga attracted more discussion than some of the other reasons. Some participants couldn't connect tino rangatiratanga with the act of smoking.

...tino rangatiratanga isn't a reason to not smoke. (23bW)

When offered the explanation that tino rangatiratanga in this context was about having control over Māori matters, some participants rejected this also. There was a rejection of any political purpose to stopping smoking, for example, to help reduce negative Māori health statistics. There was also some confusion with tino rangatiratanga and assertion that there might be Māori matters being perceived to somehow be aligned with radical political positioning or worse separatism, with sometimes a Brash-like rejection of talk that recognised differences by ethnicity.

Being Māori has got nothing to do with smoking. (11W) It doesn't matter what nationality you are. (11W)

That's not a Māori matter it's an all race matter. (13W) I can't even spell Tino Rangatiratanga. (13W) ...That's just nothing. (13W) ...change the channel. (13W)

So trying to change statistics. Is that important? ...No, I don't care. (7W)

Without being rude or disrespectful to anyone, it goes into the category of I don't give a – what anyone thinks, eh. It doesn't matter if they're black or white. (10W)

Do you really think they think about that when they're having a cigarette? (23aW) ...Nah, that's separationism. (23aM) ...What does Māori matters have to do with smoking cigarettes, though? (23aW) ...That's right. It's what makes you smoke cigarettes. (23aW) ...Pākehā's smoke cigarettes too! (23aW)

Some participants reacted quite strongly during discussions, for example, to the implication that by smoking they didn't have tino rangatiratanga, or were somehow not supportive of Māori sovereignty.

Because in childhood, that, it's harming them too. That's my particular thing about tino rangatiratanga, that's probably my own interpretation of Māori matters ...I don't think that impacts on my smoking, at all ...I can still, I korero Māori... I'm Māori. (23bW) ...as far as I'm concerned I am tino rangatiratanga. I make my own choices. (23bW) ...As a smoker I pay massive taxes. I pay massive tax, I accept that. Then why is everybody making an issue about it when I actually pay, through buying my smokes, the tax is taken out of smokes - it's huge. You should see the bit, the top of that goes to the Government. I don't think I owe anybody anything. I've paid my dues through taxes and I pay taxes through my salary, wages or whatever. And I pay GST. (23bW) ...I'm not too sure how that [tino rangatiratanga] comes up. (23bW) ...tino rangatiratanga has a different meaning to me, it's not about this. (23bW) ...I've been in a Māori environment since I was 7. It's ridiculous. It's our own understanding of tino rangatiratanga. It's not about drugs, drugs, or smoking. (23bW) ...It has no relevance for us. (23bW) ...I think it's not relevant. (23bW)

This focus group extended their rejection of any link between smoking and tino rangatiratanga or being Māori to Māori society's rejection of the link also. As one participant explained – smoking in Māori society is acceptable. Māori who smoke are not alienated in any way. Other participants

agreed, except on the point of marae – a participant suggests that many marae are smokefree now, but this is questioned and rejected by others who haven't experienced that.

Can I just add that it is socially accepted among Māori society to smoke, so we don't do anything. Even though a lot of our Māori don't smoke, what do we do? (23bW) ...We're not alienated, no one is telling us, except the vocal people like, Hone, Hone Harawira. But even he, doesn't alienate you. (23bW) ... Mmm. (23bW) ...You're not alienated, you're not discriminated in any way because you smoke. (23bW) ...No. (23bW) ...And if you got up to smoke at every marae and got alienated... (23bW) ...Most marae nowadays are smokefree. (23bW) ...Yeah. (23bW) ...Aye? (23bW) ...Most marae it's socially acceptable. (23bW)

There was also rejection of the relevance of the historical story of the introduction of tobacco being part of the colonising process.

...colonisation and tobacco was part of colonisation. How do you feel about that, as an introduced habit? Oh, that's a bit old. (8M) ...Yeah (8W) ...That goes back 100 years. (8M) ...It's not like that anymore. (8W)

With regards to being able to make ones own choices and not being controlled by a drug, one participant thought that was cool, but as above some strongly rejected any notion that they did not have control over themselves. One participant, as follows, concluded that their tino rangatiratanga, their control and choice was to smoke.

...to be able to make your own choices without being controlled by something is pretty cool. (25W)

Not being controlled by a drug? (7W) ...Is that a reason why you'd want to give up smoking? (7F) ... Nah. (7W)

Participants in younger focus groups were less likely to know what tino rangatiratanga even meant.

We don't know what that means. (24M)

I hadn't really thought much about that. (14W)

Rank order 14: Quitting to save money or because it's too costly

The costliness of cigarettes and tobacco ranked relatively low: lower for the younger focus groups than the older. Some participants did think that the cost of smoking was high, especially for Māori. But, as several participants noted 'it depends' for example, on whether people are working.

Cost is high. Especially for Māoris. (22W)

Yeah, because they're getting dearer. (25W)

Forty bucks a week now. (24M) ...Depends how much you spend. (24M) ...Depends how you smoke. (24M)

If you're not working [cost would be a reason to quit]. (23aM)

Many participants discounted that cost was an effective motivator to quit for Māori. One reason is that participants thought if people could pay their bills, get their food and still have money left over for smokes then there was no reason to stop smoking. Another reason for rejecting cost as a trigger, was that people had previously said they would stop when tobacco reached a certain price to no avail.

After you pay everything else you have 40 bucks left so you can get your smokes and can get you a feed or something. (7W)

I said before they were ten dollars a pack, I said I'd stop if they got to ten. (7W) ... But you're still smoking. (7W) ... Yeah. (7W)

This focus group discussed how high the price would have to go to stop them. But, they had plenty of ideas about how to continue smoking even if they couldn't afford to.

Fifty bucks. ...Yeah. [Laughter]...if 30g moved to \$40 bucks. ...But in saying, that I'd still buy it. I would too. Yeah. ...If I had the money I would. Yeah. I'd scratch the money together... Because if you can't buy your own smokes, you're going to get smokes off someone else. Or go halves in a packet or something. (7W) ...If they got too dear I wouldn't smoke them I'd just scab them. (7W) ...People could start growing their own. (7W)

Other focus groups, similarly thought people would just find the money somehow or scab tobacco off others.

For Māori, they'll find the money to buy them. (23aW)

It won't stop them from smoking. They'll just go scab off someone else. (22W)

I don't think anyone cares really. You're always gonna find the money to find them, aren't you? (10W) ...Yeah. (10W)

They could charge me \$30 and I'd still buy it. (13W) ... the cost ain't... that bad. (13W) ...That important yet. You just don't always need to go to school lunch. (13W) ...You can just bum your smokes off everyone aye? (13M)

When asked how much they thought they could save if they didn't smoke, one of the younger groups rejected this as a motivator to quit. If they didn't spend the money on tobacco, they'd spend it on food or marijuana.

Not much. (24M) ...What would you get instead though? ...Food. (24M) ...Something else. (24M) ...Yeah, it's either food, or – ...Green one. (24M)

Rank order 15: Quitting because it stinks

That smoking stinks, or has other unpleasant aesthetics effects, was ranked low as a reason for quitting for Māori. A few participants had strong enough feelings against the stink of smoke to say so.

It stinks is up there ...for me. Because it does. (25W) ...I'd even put that at the top. (25W) ...No. (25W) ...Sometimes it's like, 'ew', when I walk up – (25W) ...like the smell on you, like your hair, your clothes. (25W) ...I think I'm so used to it. (25W) ...and the car. I can't even smell it now. (25W) ...But, like, I can smell it on other people. (25W)

I reckon it stinks! Well ashtrays stink. (23aW) ...A butt half butted out, stinks. (23aW)

Other participants didn't think this was a strong reason to stop because if people smoke they can't smell how bad smoking stinks. Because, as one participant suggested, smoking had killed their sense of smell.

If you smoke you don't notice. (23aW)

I don't really notice that it stinks, so. (8M) ...No, you can't smell nothing. (8M)

Nah ...It's like my perfume. (25W)

I think it stinks would come last ...most people I know don't mind. (24M) ...you can just grab some spray straight away and they don't smell though, aye. (24M) ...If they did mind they wouldn't smoke. (24M)

I don't care. (7W) ...We don't care. (7W) ... No, I hate stinking of smoke. (7W)

Everyone knows it stinks. Gives you stink breath. (14W) ...It's smelly. (14W)

Only if I'm around someone who doesn't smoke I'm conscious of it, otherwise if they smoke it's sweet as! (7W)

Bad breath. (23aM) ...Yea, I'm always paranoid about my breath. (23aW) It's kind of like kissing an ashtray. (23aM)

You get stained fingers too. (14W)

Rank order 17: It's Time

It's time as a reason for stopping smoking ranked low for Māori. Younger participants were less likely to understand what it meant.

What does that mean, it's time? (24M)

Others made a joke of it saying they've had plenty of those 'times' – they likened it to saying 'I'm going to quit tomorrow' but tomorrow never comes. Also, as one quote here suggests – it's relying on the need to attain a certain mindset, which similarly might never occur.

I've had about 20 of those times, that's the problem. (23aW) ...So there is no when is it time. (23aM)

...but it's a mindset thing more than it is anything else aye?(25W)

I'm gonna give up someday. (14W) ...Yeah, tomorrow. (14W)

I've always thought that I don't want to be smoking cigarettes when I turn 30... so I'm 29 years old and don't want to be smoking next year. [laughs] (23aW)

Rank order 18: Quitting because it's harder to smoke anywhere

Participants agreed that smokefree environments had made it harder to smoke in some places, or rather there were just places that were no-smoking areas now. Some participants found this uncomfortable, but many accepted that it was right not to smoke around children for instance. But, smokefree environments were seen to be mainly about reducing children's exposure to second hand smoke, and to reduce uptake of smoking among children. One participant also thought smokefree environments was one way of reducing the prevalence of smoking. They however, thought it was a policy to benefit rangatahi.

But it's also getting harder, like the environments. (25W) ...like around schools and hospitals, like those sort of things, you sort of feel a bit - (25W) ...Pressured. (25W) ...Yeah, like you have to smoke in the cold at the pubs, that's the hardest. (25W) ...And then it's the outside environment. (25W) ...you feel a bit sort of funny around, well I do, when you're at somewhere like a restaurant or hospitals, it's a real no-no now. (25W) ...more so for people that are working because you have to work with a wide range of people and not everybody smokes. (25W) ...And children, especially if you're with children or youth. (25W)

Because smokefree environments are a way to try and shorten the percentage of people that smoke. You know what I mean? I think it's something for our young rangatahi to look at. You know. Because once they see it, they might or might not get hooked up to it. I don't know. (22M)

Several participants did not see smokefree environments as having any effect on stopping their smoking. As they said – it just means no smoking in that particular area, so smoke somewhere else.

I'm a smoker. We don't smoke in our house and stuff or our car. (13W) ...even though we're smokers we don't smoke inside.... (13W) ...not with kids and that around aye ...Because otherwise the kids become passive smokers. (13M)

Smokefree environment ...no one cares about that. [Laughs] (23aW)

I saw you the other day, at school smoking. (23bW) ...It wouldn't make me stop. (23bW) ...It doesn't mean you stop, it means that you go somewhere else and do it. (23bW) ...Yeah, around the corner. (23bW) ...To have a smokefree environment, well you just don't smoke in that environment, just walk down the road. (23bW)

...it does help some people. (22W) ...Everybody's different. (22W) ...Some people are just too lazy to go somewhere else. (22W)

You do notice it when you walk in and someone's smoking. (11W) ...It is quite nice but you still haven't given up smoking have you? (11W)

In considering the impact of smokefree environments on their reasons for quitting smoking, participants stated that they would find a way out of it.

Just go outside. We done it at school so why not just do it at work. (7W)

One participant had said they gave up smoking because their parents didn't want them to smoke, but they then said it didn't really affect them for very long.

Because they're not allowed. [Laughter] (7W) ...Didn't stop me! (7W) ...You said you got caught so you gave up? (7W) ...Oh yeah, like for one week, 3 days! (7W) ...That kinda [meant I] wanted to make smoke more, mum said no, but dad said yes! (7W)

Associated with smokefree environments, one person in one focus group proposed career aspirations as a strong reason for quitting.

Your career. I reckon that's a good one. Because, like in my case I'm going to police college in three months ...So I want to give up ...Because I know I have to give up smoking. (10W)

Rank order 19: Quitting to prove you can - If they can, I can

Quitting to prove you can, to better yourself or best someone else or feeling inspired having seen someone else succeed at quitting ranked very low as a reason to quit. Some participants didn't even understand the concept.

Oh, so it's like a way of wanting to better yourself, rather than being competitive? ... Exactly. "Challenge yourself." Yeah. (22M)

Depends who it is. (25W) ...if it was someone that you knew really well. (25W) ...Someone that sucked and then gave up smoking can get lost ...I wouldn't really care. But if it was, yeah, probably someone that was close to you that you saw – (25W) ...Yeah, somebody you liked, that would be different. (25W)

If they can, I can doesn't mean jack shit to me. (23bW)

Nobody else gives me motivation to stop.

I don't care if they can. (10W)

Rank order 20: Quitting because it's not cool anymore

Māori focus groups were generally in agreement that smoking was not 'cool' anymore, if it ever had been. Some participants thought that whether smoking was cool or not cool was more relevant to youth or to them when they were younger and initiating smoking. Mātua (adults) were not perceived to be effected by coolness

That would be for the youth. (23aM)

I don't think it was ever cool was it? (10W) ...It was for me. I thought I was awesome smoking. (10W) ...Until I grew up. (10W) ...Some people look really cool. (10W)

I don't think it's cool. (7W) ...When I first started smoking I thought I was cool. (7W) ...It would have no affect whatsoever. (7W)

In my concept of cool, there's no way of smoking. It's just a habit, that's all. I don't know where people get the word cool as a way of saying that smoking is cool. (22M)

But it is. (24M) ...It doesn't have to be cool. (24M) ...Because, like, times have changed now. It's not so much a pressure anymore, as in like, when we were in high school. (24W) ..No, it's just a habit now. (24M) ...Or doing it in, like, school. (24M) ...See it used to be cool and it used to be sneaky. (24M) ...Yeah, people only think about that stuff at school. (24M) ...No, it's just not cool. (24M) ... It's just a habit now. (24M)

Smoking cessation treatments

This section reports on the treatments used by participants in past quit attempts, and participants' comments about smoking cessation products and services in general.

Cessation methods used in previous quit attempts

Participants were asked to identify smoking methods that were used in the past to quit smoking. The use of cessation methods is summarised in Table 9. Stopping smoking unaided included all references such as “no specific help”, “cold turkey”, “just stopped” and “determination”. Unaided stopping was reported most by participants and highest for participants between 16-20 years of age. All other methods were low by comparison. NRT was the next most cited cessation method used, followed by “substitution” which captured references to stopping smoking by replacing cigarettes with oral substitutes such as food and water, physical or other activity.

Table 9: Cessation methods and age used

Quit method	Age Group									Total
	11-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	
Unaided	14	30	15	10	5	2	1	1	0	78
Nicotine replacement therapy	2	5	3	3	3	1	0	4	2	23
Substitution	2	5	0	3	2	0	0	1	0	13
Reduced consumption or purchase of tobacco	0	4	2	2	1	1	0	0	0	10
Lack of access	1	3	2	0	0	1	0	0	1	8
Smoking cessation programmes and services	0	1	1	3	1	1	1	0	0	8
Family/social environment	0	5	1	0	0	1	0	0	0	7
Pregnancy	0	4	1	0	0	0	0	0	0	5
Nicotine free prescription and doctor's advice	0	0	0	0	2	1	0	0	0	3
Alternative therapies	0	0	0	0	2	0	1	0	0	3
	19	57	25	21	16	8	3	6	3	158

Discussion of products and services

What participants know and think about the various products and services is presented here. Most of the participants had not tried the products and services that have been available and that were discussed.

I haven't tried anything yet. (8M)

Nicotine Replacement Therapy

Not all participants were familiar with the term 'NRT' despite being familiar with NRT products such as nicotine gum and patches.

What's NRT? (10W)

But some were aware that NRT products were subsidised by the government.

I know a lot of it's Government funded. (KN2W) Whereas with the smoking cessation it's free. (KN2W)

There was some cynicism about the cost of NRT products.

Is the medicine to attack the nicotine or the feeling of how you are thinking about it? (23W) [... the brain, the pleasure centre] ...So what do we need to stop that? (23W) Your wallet. (23M)

On several separate occasions participants expressed concern about the safety of nicotine and its use in NRT products.

That's something I have thought about a few times as well. How good can it be to give up smoking to keep putting the drug into your system? (10W)

Some participants did not think they were addicted to nicotine, because for instance they could go without smoking in some contexts. As the following participant explained her smoking was "situational" and therefore it was the "habit" that was seen to be more powerful. Thus they concluded that NRTs would not be able to help them with quitting. They did not understand how nicotine could lessen the strength of a craving to smoke.

They probably all do work but you have to be sussed up here. [Points to head] (25W) ...When I did quit for 2 years, I didn't find that I was addicted to nicotine. It was just the habit. (25W) ...And because I only smoke half the time, I don't smoke when I'm at home – (25W) ...I know that it's not driven by nicotine. I know that it's just where I'm at, situational. (25W)

Gum

Nicotine gum was the most widely recognised cessation method (by group) however there was still some confusion with ordinary chewing gum and product branding. For example, one participant recalled the name Nicobrevin when the group was asked about the gum.

That stop smoking one. What's it called? Nicobrevin. (25W)

At times nicotine gum had been mistaken for "chewing gum" or used incorrectly, for example, chewed like ordinary chewing gum.

We used to steal it because we thought it was just gum ... from my cousin. (24W)

You're not supposed to chew it. (23bW) ...Oh aren't you? (23bW) ...But it's chewing gum? (23bW) ...Well what are you supposed to do with it? (23bW) ...You're supposed to leave it to the side of your mouth, apparently. (23bW)

Participants talked about how smokers share information about the stop smoking products with each other and how they experiment with and share products with each other. This could contribute to incorrect use of the product if introduced or tried without accurate instruction on use. The downfall is that a subsequent negative first experience could put people off using the product again. They could also pass on their experience to others feeding the misinformation that spreads about NRTs.

I gave that to heaps of people at school because I thought it was funny. (KN2M)

My kids like chewing gum, so they'd probably want some. (25W)

We're amongst people who play Housie and I say to them, 'what's that', just because they've stopped smoking. Yeah, and that's where I come to hear about that sort of gum. (KN1W)

They gave it to people at school... We went on a school trip for a week and me and my friend, he bought heaps of those so we didn't have to smoke. And we were chewing them and it was yuck. (KN2W) Did it work? (KN2M) Yeah, well we didn't smoke. (KN2W)

The perceived effectiveness of the nicotine gum was mixed. One participant commented that nicotine gum was "good" but was "not working as good this time." (25W) The same participant also cited cost as a barrier, which was supported by other participants also. Further, some participants were not aware the nicotine gum was subsidised and they believed it was too expensive.

*But we can't afford it (23aW) ...it's too um, too expensive. (23aM) **Did you know that? \$3 for 4 weeks supply?** No we didn't. (23aW)*

I thought they were dear. (25W)

I've never tried any of those. (23aM)...No, 'cause that costs money. (23aW)

Other barriers to using nicotine gum included adverse reactions participants had experienced.

The gum made my gums like flare up. (KN7W)

My teeth, I can't chew it for long. (KN7W)

But most commonly, the "foul" (10W) taste of nicotine gum was cited as the reason for not using it.

Rather lick an ashtray than that bloody gum. (KN7W)

It's yuck ... It's gross. (14W)

It tastes like an ashtray. (24M)

It would be alright if it tasted like Extra. (24M)

It's disgusting. (KN2M)

Despite the taste a number of participants had used or knew someone who had used the gum to successfully quit smoking although most ended up relapsing.

That's what I gave up with the first time. It really works well. I'm not right into it this time. (25W)

*My brother tried it for about a couple of months, but he went back on it again. (KN1M)...**Do you think it works or not?** I think it does. I know people who've quit on that. (KN1M) ...I don't know. (KN1W) I've tried it too. (KN1W)...Well I've known*

some kid that's actually used it now, but so far so good. She's actually stopped for about a month now, so I guess it's working for now. (KN1M)

I saw a mate on it, it sorta worked, but I think he just gave up on it. (13M)

Participants who had not used the gum before were willing to “try some to see if it would help” them. (25W)

One woman's doctor had told her to “just quit” (25W) and this made her reluctant to try other cessation products.

No, I'll stick to the gum. All these different ways, I'll just do it. (25W)

Patches

In most cases, participants knew about nicotine patches, but did not know about the mechanisms of them.

Are there different steps? (8W) ...What? It's got nicotine in it? (8W)

One participant demonstrated personal knowledge about her use of the nicotine patch.

You can feel it aye, when you wear the patch, and have a cigarette. It's no good. (23aW)

A few participants reported that patches were an effective cessation method. One commented that “the patches are alright” (8W) and another “used it to get the edge off... and it did work.” (KN7W) One participant was resistant to nicotine patches because “I don't think it pumps enough nicotine into you.” (24M) The patches worked for some participants but not for all. Overall most participants did not perceive patches to be an effective quit method.

I gave up for 6 months and then I had to have a smoke outside the marae ...they were okay for 6 months and then it just... (KN2W)

They don't work. (14W)

Those nicotine patches are crap. (24M)

It doesn't do much because my cousin had it on, she had about two of them and she was still puffing on a cigarette. (24M)

They didn't work ...I just felt the same ...Yeah, I still craved for one. But I only tried it for like a couple of days and I was like, oh nah this isn't working. Waste of my time. (13W)

One participant had only just got some patches and was yet to get started on using them.

I got those patches last week, and I haven't even started yet. ... All I'm doing is shifting them around the room and walking past them. (8M)

A discussion among participants in one focus group highlighted the lack of knowledge regarding where to source gum or patches and how much they cost. Not having the time to try and the inaccessibility of the product were also seen as barriers. Furthermore one participant believed the product would not be useful for people who were already conditioned to smoke.

Heard of them ...Never knew how to get them (23aW) ... I've just never had the time to use any of them. (23aM) ...I used to work from dark in the morning till night, yea. (23aM)... No time to do anything, just to smoke, go to sleep. Back up to work, go to sleep ...getting all these kind of services and that and it all costs money and we haven't got money to spend on that. It's easier to go to the shop and buy some smokes. (23aW)

I think it's a bit late for other generations that are already conditioned into... smoking. (23aM)

There was also some negative attribution from previous failed attempts:

Yeah and it didn't work. [Laughs] (23aW)

Many participants reported that they had had a bad experience or had heard of people reacting badly to the patches and this caused them to stop using patches or stopped them from trying patches. Adverse effects included “hot and cold flushes” (11W), feeling “tingling” (11M), “itchy” (25W) and “just felt sick” (25W). One participant who “got the itches” overcame this by cutting the patch in half so they “only got half the dose” (7W). Twice participants brought up having “real bad dreams” (KN2M), which made one person “too scared to use them” (7W).

I had a real bad reaction to the patches. My arm all blistered up within 3 hours of having it on. And I went to the doctor and they said don't ever use those again. (KN7W)

It made my arm sore. (KN7W)

I didn't like it. It gave you that racing heart kind of thing ...everything goes pump, pump, pump. (11W)

Tried patches and he got really sick. (11W)

One participant complained that their “patch kept falling off” (10W) while another reported that they “had issues getting them off” (10W). There was also concern that patches do not interact well with other medications.

The only reason why I stopped using patches was because it reacted to my Metformin. (23bW)

The patches, if you're diabetic, don't use them, because they react with your insulin. (23bW)

At times the benefits of patches were compared favourably to smoking and to using nicotine gum.

You don't get the yellow fingers. (7W)

I'll give it a try. I'm sure it'll be better than the gum. (KN1M)

I'd try these any time... (23aM) ...I wouldn't try the gum again... but I'd try the patch. (23aM)

Lozenges

Not all participants were aware that a nicotine lozenge is available. One participant asked “can you get stop smoking lozenges?” (KN7W) whilst another referred to them as “the lollies.” (23aM) Hence, there were lots of questions about the lozenge.

Is that those cough lollies?(24M)

I didn't know about the lozenge. (14W)

Where would we get them from? (23aW) ...Can you get them from the doctors? (23aW) ...Does it get dearer after 4 weeks? (23aW) ...I think that's expensive. That's a loaf of bread right there. (23aM)

Participants were curious about the success rates of nicotine lozenges.

Have they been successful amongst people quitting? (KN7W)

Nicotine lozenges like nicotine gum were seen to be counter-intuitive because some participants lacked an understanding about how they worked to deliver nicotine. This resulted in one participant dismissing the product because “I don't want to suck on them all day. I'd rather the gum than that.” (KN1W)

One participant valued the nicotine lozenge not because it delivered nicotine to the body efficiently, but because it kept them preoccupied.

It keeps you busy. Sucking on something. (11W) ...The lozenges are better than the gum. (11M)

Not everyone viewed the nicotine lozenge favourably and this was commonly attributed to the taste of the lozenge.

The lozenges are horrible. (8W)

Taste like ashtray ...They're horrible. I'd rather the gum than the lozenges. (8W)

Those are the disgusting, creepiest, ugliest... (KN2W) Somebody should make those taste better. (KN2W)...That's what they said about the chewing gum too. But they're ashtray flavoured. (KN2W)

Microtab

A few participants had heard of Microtab through friends and could accurately describe the Microtab packaging, but many had not utilized this cessation method for themselves.

That's what [name] and them were having... they had their wee thing? Their wee cases and they pills in them. (11W)

The name is similar to microchip so there was some confusion about how it works with microchip qualities inferred to the Microtab.

I like that microchip one. (23aM) ...Yeah, because you put it in your mouth, and it dissolves. (23aM)

Some participants were impressed with the novelty of the Microtab and were keen to try it.

Wicked. I didn't know there was anything else. (KN7W)

Would you try it? *Yeah, of course. (KN1W) Yeah. (KN1M) Yeah, maybe. (KN1W)*

Others were more reluctant, with some asking about the cost and taste.

What does it taste like? (KN1W)

There were some participants who were not at all interested in trying the Microtab.

*Far out. (24M) **Sound appealing?** ...Nah. (24W)*

The microtablets too. I don't like them. (KN7W)

Another way of smoking, I guess. (14W)

The Microtab packaging reminded some participants of female contraception pill packaging.

That looks like the... contraception pill. (KN2W)

Nicotine inhaler

Most of the participants had not heard of the nicotine inhaler before and many were guarded about trialling this product.

An inhaler? (23bW) ...I'm going to stick to smoking. (23bW)

That sounds pretty scary eh? (11W) ...Like an asthma pump? (11W)

Some of the questions which participants asked imply they do not fully understand the mechanism behind NRT's or the nicotine inhaler.

What is actually in these products? (13M)

Interested in trying that one?...No. (25W) ...No. (25W) ...I would. (25W) ...It'd be just like smoking. It would remind me of smoking. (25W) ...But it wouldn't be smoking. I would hope. (25W) ...But then how do you stop getting off it? Like, I don't know, you're not stopping it. (25W) ...it won't work for me, I'm pretty sure. (25W)

Despite this some people did see value in the nicotine inhaler.

I reckon something that might replace it, like those inhalers would be good, I reckon they would be good. Because cigarettes is yuck. (KN2M)

One focus group in particular was keen to use this product but there was some joking about it being similar to smoking marijuana.

Anyone be willing to try a Nicotine inhaler?...Me. (24M) ...Me. (24M) ...It looks fun to use. (24W) ...Yeah, it'll be like a little pipe. (24M) ...That would be mean. (24M).

Talk about the inhaler also uncovered more myths regarding nicotine namely that nicotine is the most harmful drug in cigarettes and that cessation products with nicotine were unsafe.

Heard of that? ...No. (22W) ...I don't like the sound of that? (22W) ...If I wanted to quit I wouldn't want nicotine in me. Because that's the worst part of the cigarette. (22W)

Once in one focus group the nicotine inhaler was confused with an electric cigarette (e-cigarette). In another, the inhaler prompted talk about the e-cigarette.

...a little bit comes out ay? (23aM) ...I saw that on TV the other day... when the smoke comes out. (23aM) ...The electric cigarette? It looks like a bullet. (23aW) ...It looks like one of those guns. (23aM)

There's one that's like a plastic container and you put the thing in the end, the capsule, and you smoke it and it gives you something, like nicotine. (KN2W)

*And you light it? (KN2M) **Not that one, there's another one that does.** It actually looks like smoke. (KN2W) A little plastic thing – (KN2W)*

One of the appeals of the inhaler and the e-cigarette is that the hand motion used for both imitates the hand actions of cigarette smoking.

I want it [e-cig]. (KN7W) Yeah, me too. I wanna try. (KN7W) So you've got the hand habit covered if you can't break that. Because that's why I fail. (KN7W)

I think that inhaler one isn't too bad because you're still getting that, sitting there with it in your hand. (KN2W)

Participants asked specific questions as they tried to work out the cost of the inhaler compared with the cost of cigarettes.

Oh that's dearer than cigarettes. (KN2M)

If the product worked out to be dearer than smoking, participants concluded that people would give up using the product and go back to smoking. If the inhaler was subsidised however then they thought it would be an attractive quitting aid.

People might get put off by the price and not want to give up. (KN2W) ...Give up because it's too dear ...why buy those when they can buy a packet of smokes for cheaper. (KN2M)

Participants wanted to know where to get the inhaler from and if they could be prescribed on a Quitcard.

Where do you get the inhalers and that from? (KN7W)

Do you know if they provide those inhalers? Because I wouldn't mind getting those. Mum uses those. (KN2M)

The inhalers reminded a few participants of cigarette holders and other devices that purported to reduce inhalation of toxins from smoking.

I remember the tubes that we used to put our cigarettes in and it stops the nicotine from going into, inside your system. I biffed it because I wasn't getting enough nicotine, you know? (KN1M)

It's like one of those old fashioned cigarette holders. (KN7W) ...that just goes over the filter butt (KN7W) ... he's 60 ... he used to roll up dummy cigarettes so the filter was paper and just have it in his hand driving and stuff. He loves it. (KN7W)

Prescription and/or nicotine-free medicines

Pills

Some participants had knowledge of medication that could be used to quit smoking, however this wasn't complete. Without prompts about possible side effects some participants seemed open to them.

We all do it actually to fill that little boring 15 minute break that we have, or like that next 5 minutes we have. And if you just take the pill it's like, 'well I've got another 5 minutes of sitting here'. But then again that could be in a good way because then you could do that and then I could carry on with my work or I can use the next 5 minutes of my break to read a book or. So it could be good or bad. I don't know, give me some. I'll try them. (KN2W)

Some participants were amazed to learn that there were so many stop smoking medications.

Amazed how much tablets there are. (24M)

Many had heard of "pills" but struggled to remember what they were called.

There's another one too aye, it starts with T. Tolonol or something, I don't know. (25W)

I know there's a pill out now, I don't know what it's called though. (KN2W)... Are you just taking a powder or something? (KN2M) Something like that. (KN2W) Because it's the look for young people. (KN2W) And it's the whole action thing. (KN2W) We're cool. (KN2W)

Medications implied that quitting was too hard to achieve without medications. Some participants didn't like the implication that smokers are sick, that they are pathologised. The assertion that they needed medication to quit was seen to undermine self-efficacy.

Looking at all these different pills and stuff, it makes you kind of put that thing in your head like 'oh you need to have a pill or something to quit'. You can't do it by yourself maybe. (KN2W) You're sick. (KN2W) It's going to be so hard to do it. (KN2M) I'd only turn to a pill if it was extreme, but, like if I was smoking heaps and heaps then I'd go like that, but now I'm thinking I'll just leave it. (KN2W)

Some participants were sceptical about the good intentions of pharmaceutical companies. They questioned their profit motive.

Are they money-making products or are they actually there to try and help us quit? (KN2W)

Champix

Participants did not know about Champix.

Sounds like a dog medicine. (KN7W)

*What is it? Medicine?(23aW) ...Drugs? (23aM) ... That's what I need. (23aW) ...
And what does that one cost! (23aW)*

When informed of the cost of accessing Champix, one participant said. “*They can keep those*” (8W). Some participants wanted to know which would be the most effective quit smoking aid and displayed disappointment and shock that Champix, which is one of the most effective, was not affordable for them. Some participants thought that the expense in the short term for a chance at greater success to quit, could be worth it.

That's expensive! (23aW) ...That might work actually. (23aM)... \$50 for stopping smoking for life though, that would be well worth it. (23aM)

So it must work. It must do for that price. (KN1W)

As well as exhibiting apprehension regarding the cost of the product, participants were worried about possible side effects.

Does it have any side affects? (23aW)

Some participants were concerned about getting addicted to the cessation medication.

What? You're getting addicted to something else. So they'll un-addict us from tobacco and get us addicted to whatever that is. (KN2W)

Others were put off by the product and its “*plain Jane*” (KN2W) packaging which made quitting look “*boring*” (KN2W).

No, it doesn't look appealing aye? It actually... (KN2W) It looks like doctors, like you want to go to the doctors and get pills like that. Like prescription meds. (KN2M) ...I think the colour and the box. (KN2M) Plain Jane. (KN2W) It looks like giving up smoking is going to be boring. (KN2W) Even with a name like that, it's still – (KN2W) It doesn't jump out at you. (KN2W)

Some participants were curious to learn more about the product, such as, how it is taken, how many times a day, for how long etc. Some participants, however, were opposed to the idea of taking so many pills and some were concerned about the chemicals in them. One person thought they would just forget to take the tablets.

Does it have chemicals in it? (KN1W) I get put off by even looking at that many points, to have to take those over a week, that dosage. That just puts me off. (KN1W) I'm not sure. (KN1W) I see enough of old people taking pills. How many pills do you take of that a day? (KN1W)

No, I'd forget. (24M)

Other participants raised questions about Champix interfering with pre-existing medical conditions or possible interactions with other medications they might be on.

I can't take pills much. (KN7W) No, neither. (KN7W)

I'd probably go through my doctors if I was to go on that, because I'm a diabetic. (KN1W)

The name of the product came up a few times. The use of medical jargon such as varenicline (pharmaceutical name for Champix) – “*Quite fancy words*” (14W) could make this medication less accessible or appealing to some.

Zyban

A few people recognized Zyban as a smoking cessation product but for the most part Zyban was not widely known by the participants.

Is that that Nicobrevin? (7W)

That Z one? What's that pill called? Z-blah blah? (11M)

Oh! That's on TV aye? (8W)

Zyban. (24F) ...Is that a dissolving one? (24M)

*That's pretty. (KN2W) That's been around for a long time aye? Zyban. (KN2W)
I've heard that name before. (KN2M) Zumba. (KN2W)*

Participants were interested in Zyban though and wanted to know more about what was in it, how it worked, where to get it etc.

Have you got a camera we could take some photo's of those? (23aM)

So you have to have a community services card to get subsidised? (23aW) ...You go to the doctor to get those? (23aM)

Some participants, who did know about it, saw Zyban as an effective smoking cessation product. One whom had recently started on Zyban commented that *"the taste isn't quite as nice"* (25W).

All we have is hope. And Zyban. (25W)

It does take away the craving for a smoke. (25W)

I don't know what it does. It just helps you stop smoking. (11M)

The Zyban name was similar to a weight loss medication which caused some confusion and there was also a lack of knowledge about access to NRT medication.

I thought that was to lose weight? Oh no that's Zenical. (23aW) They don't know about all those drugs you got. (23aW)

Wasn't Zyban done for, like if you were giving up smoking, that you didn't pick up the habit of... eating. Wasn't it? I'm sure it had something to do with that, so you didn't pack on the extra pounds while you were trying to give up. (KN2W) Oh, give me some of that. (KN2W) ...You know how when you stop smoking you eat more? Well mine's extreme because I eat heaps anyway and so I eat a lot. (KN2W)

I've been on that. (KN7W) Have they got one for food? (KN7W) So what are the side affects of that? (KN7W) It's gonna cut down your appetite. That's what it did to me. (KN7W) Mean. I'll have a go. (KN7W) I think it did interfere with my sleeping a bit. But I like that, I'm going on that. When I decide I'm going to the doctor. And it's subsidised now. It used to be like \$90 so it was really dear for me back then. (KN7W)

That Zyban slows weight gain after smoking cessation was mentioned several times, during which it emerged that a few participants would wait until they were sick to go to the doctor, thus delaying their accessing Zyban or GP delivered smoking cessation support.

*I actually had a friend who told me about it. She lost piles of weight and quit smoking. But she'd had it prescribed to her as an antidepressant. (10W) ...**So if you're at the doctor for something, it would be a good opportunity to say well can you tell me about Zyban.** That's what I did. I was there for something else and I went oh, actually, about that Zyban stuff. Tell me about that stuff. And he was like blah, blah, blah – here. (10W)*

Some people were sceptical about the safety of using pills. They did not think they would try Zyban because they were generally anti-pharmaceuticals.

Because they're pills... I'd rather just use a homeopathic alternative as opposed to, like, shoving chemicals in my body. Even if it costs \$50 or \$3, I think that's the difference. (KN1W)

In particular, participants were concerned about the side effects, and the possibility of becoming addicted to the medication.

When you come to all these medicines and drugs and stuff. (23aW) ... It's kind of scary because would that mean that, or is there any chance that you would become addicted to those drugs? (23aW) ...So, instead of taking the time out to smoke, you're taking your time out to take a pill? (23aM)

Participants were sceptical of Zyban given its original use as an anti-depressant. They seemed to think that using anti-depressant medication is more dangerous than smoking.

I've never heard of that. (23bW) ...Nah, that's dumb. (23bW) ...I'm not bloody depressed. (23bW)

Do people know that? That they're getting hooked on prescription drugs? (11W) ...That's dangerous though isn't it? (11W) ...Is that widely known that that was their original bloody use? I bet most people don't know that. (11W) ...I'd say to them do you know that's an antidepressant. (11W) ...Geez no. Keep smoking. Leave that shit alone. (11W) [Laughter] ...Yeah, do you know what you're doing? Put the drugs down and keep puffing. (11W)

Most participants did not know Zyban was subsidised and they were somewhat surprised at the low cost. Because it was low cost, participants were open to trying the product.

For \$3, what have you got to lose? (25W) ...Yeah, that's what I thought. (25W) ...Give it a go. (25W) I was thinking maybe I should try that. (25W) ... I was wondering if it would work better now because I'm not that long into smoking maybe? (25W)

But it was not perceived as low cost to some participants who factored in the cost to go to a GP for the prescription. The costs involved in accessing Zyban were identified as a barrier. Some participants wanted the product to be free.

You can get it free from your GP now. (11M) ...On top of the \$60. (11W)

Is that the acupuncture one? (14W) ...And you need money to get that one? (14W)

Is that one free? (23aM)

Overall when asked about doctor prescribed medication a number of participants were open to the idea "if it works, yeah" (KN1M) as long as "they don't make me go crazy" (8W).

Norpress

Very few participants had heard of Norpress before, a standard response was "never seen this." (7W) One person described the packaging as looking "the same as plain tea." (KN2W) Furthermore, participants who had heard of Norpress confused it with sleeping medication.

It's sleeping medication. (KN7W) No, don't need that. (KN7W)

What's that – how much are those? Are they subsidised? (KN7W)

It was confusing for participants to be told that Norpress was an anti-depressant being used also for smoking cessation medication.

What's an antidepressant? (23aW) ...Is that why we smoke? Because we're depressed? (23aW) ...That makes me happy, not depressed. [Laughs] (23aW) I don't. I find it easier when I smoke. (23aM)

E-Cigarette

None of our participants had used an electric cigarette but some of them had very good knowledge of what the electric cigarette was and how it worked.

There's like fake smokes too ...they've got nicotine in them. (25W)

An electronic one. (23bW) ...Made in China. (23bW) ...it's like you're holding a cigarette, but you're doing it with the batteries. (23bW)

The smoke you're having when you're not having a smoke. (11W)

The e-cigarette was perceived as 'cool', used by 'chicks', and had humorous uses; this was viewed favourably by participants. It was sometimes referred to as a 'fake smoke' or a 'smokeless cigarette'.

I've heard about it. (KN7W) Gives you a shock every time you puff it. [Laughing]. (KN7W) It's a smokeless cigarette. (KN7W) It has a little red glowing light at the end so it can even look real if you're trying to trick people, you know. (KN7W)

Participants found it amusing that the e-cigarette was battery powered but mixed in with this were also serious questions about cost and how long it would last for.

Oh, so you only get a little bit of nicotine, but not the tar and all that stuff? (14W) ...Cool. (14W) [Laughter] Can we get those too? (14W) ...Nice. (14W) How much are they? (14W) ...Do they last as long as an (ordinary smoke)? (14W)

A major draw card for the e-cigarette was that it would allow smokers to socialise as they did before smokefree laws came into effect.

Yeah, you can go into a pub and have it and they can't kick you out. (KN7W) If it's raining outside. (KN7W) Oh wow. (KN7W) It's mainly when you're socially – (KN7W) Yeah, you could have it on an aeroplane couldn't you. (KN7W)

It would be good to smoke in the clubs. (22W) ...Just to stir some trouble. Watching the bar manager's face as he comes running towards you. (22W) [Laughter]

That looks like something that I would hang out with... (23aW) ...And I can sit in the smoking circle. (23aW) ...And they look at you and go your smokes not going down! (23aM) ...That would be cool. (23aM)

Often throughout the discussions participants talked about the five senses and how the e-cigarette appealed to sight, smell, taste and touch.

They look like a cigarette. And I guess that's part of the appeal. (11W) ...So it would be the same as that inhaler thing. (11W) ...You're just not blowing out smoke. (11W) ...No you're just coating your tongue with it. (11W) ...Yeah. (11W)

Are they actual, taste like smokes or? (KN2M) I've seen close to one. (KN2W) It tasted like some herbal thing. (KN2W)

That's part of the addiction, having it in your hand. (KN7W2)

Because it looks like a real cigarette and it'd just be a tease. (KN1W)

It looks the part and gives you that hit. (24M) ...That's what we want. (24M)

The interest in the e-cigarette resulted in lots of questions regarding how to use it, how much it cost, was it addictive, should you share it and so on:

So what do they do? (11W)

Does that get you addicted? ...Do you light it? (KN2W) ...Do you smoke it outside? (KN2M) ...And how long does it last? Is that reusable or do you get it in packs? (KN2W) ...If you have a e-cigarette, should you only smoke it, not anybody else? Because, you know, germs or something. You know with smokes we share, is there, like, certain things you shouldn't do with it like share it or stick it in anyone? (KN2W) ...I'd use that. (KN2W) ...Same. (KN2W) ...Didn't someone say at the grocery store you can get those, but it's the actual tablets you have to order online aye? Because they don't sell them. (KN2M) ...You'd look cool with a plastic

smoke. (KN2W)...I'm still cool. (KN2W)...Do you know how much those cost? (KN2M)

How do you work it? ...So, it's not a real smoke? ...It looks like a real smoke. ...And can you smoke on that as much times as you want, or do you get like a packet of twenties or something? (7W)

Do you chuck a cigarette in there? ...Oh that looks way better. ...But does it go down or does it stay like that? ...What's the smell that comes off? ...But the smoke comes out of your mouth? (24M)

Many participants were interested in trying this product but were cautious of how much it might cost. A few indicated they would be more likely to try it if it fell into the same price range as subsidised NRT products.

I would try it. (KN1W)...I think I'll try it. ...It looks like a cigarette and it depends what you stuck in it. (KN1M)...Never seen it, never heard about it. ...Interesting. (KN1W)...But what do they cost? (KN1W)

How much would you guys be willing to pay for one? ...Not much. ...A dollar. ...50 cents. ...\$3 ...Yeah, \$3 like you said. Like those patches and gum. ...Would it come that cheap? ...Yeah, man, I want it. ...I really need it. (24M)

There were references to possibly using an e-cigarette as a pipe for cannabis.

Oh, that's like a pipe, I know what that is. That's what we use. Oh nah, never mind. (24M)

One participant mentioned that some children had possibly obtained and used an e-cigarette.

There was some kids saying this morning that they were smoking back on one of those cigarettes. It wasn't real. (KN2W)

A small number of participants perceived the e-cigarette to be uncool which seemed to influence their decision to not use an e-cigarette. One participant had concluded, based on what they had heard, that electric cigarettes are “apparently they're a waste of friggin time.” (25W)

Never heard of anything so ridiculous! (23aW) ...If it works hey, why not! (23aW) ...Ew, that could give you an electric shock. (23aW) ...That couldn't be very popular could it? It would be very uncool ...Is it very popular with people giving up? (23aW)

Would you guys consider using that? ...No. (25W) ...No, you'll look stupid. (25W) ...Yeah, that would be silly. (25W)

Cessation services

One participant responded “nah, I don't know any of them” (14W) regarding organisations that help however, groups had discussed Quitline and AKP in unprompted discussions.

Quitline

Most participants appeared to have heard of Quitline referring to it as “that thing on TV” (8W) or “that number on the cigarette packet.” (8M). Though not all participants knew that Quitline was specifically for helping smokers stop smoking. One participant for example thought it might be for alcohol consumers.

Quitline. Is that for smokes or alcohol? (11W)

Two participants said that they had heard of Quitline but “I haven't tried any of it.” (23bW) Some participants were aware that Quitline provided personal coaching for people who were giving up smoking, though were not aware of the other benefits, like being able to access smoking cessation products.

You ring them up when you want a smoke and they help you get through it, don't they? (8W) ...Do they just talk? (8M) They've got a book too. (8W)

One participant had vague recollections of a Quitline resource which encouraged recent quitters to delay, deep breathe, drink water and do something else, but they still required prompting from the facilitator to recall details.

*I just remember one of the other things that you had on that was that card with the four Rs. That was really good. (11W) **Four Ds?** I haven't looked at it for a long time. (11W) **Do you remember what the Ds were?** Don't, don't, don't, don't? (11W) No. It was a plan of action on each of the Ds. (11W) Dehydrate? (11M). **Do something else. Drink water.** Yeah, that's it. (11W) **Deep breathe.** Was there something about just walking around? Taking some time out. (11W) **Delay.** Delay. (11W) Delay, that was it. That was the first one. Delay. (11W) ... It was just kind of a little card. And it was kind of like oh just delay for another 5 minutes. Have a drink of water. ...That's good. It's a good distraction. (11W)*

Another participant had not used Quitline but were thankful that there was such a service in place.

I'm not using it but I'm glad it's there. (25W)

A number of participants had used Quitline and they particularly liked that Quitline were regular people.

It was good. It worked, for 3 years. I think I was actually, like up here, I was right with it. Yeah. (25W)

They're actually, I found them really good because they're sort of just people like us. (25W)

Like the Quitline ads, you know, just their voices are really friendly and they make you kind of want to ring. (KN2W)

But another participant recounted that when they rung, they had been told to ring back which made them think Quitline was too busy to help them.

I rang up once and they said to ring back the next day. So, I thought, they're busy. (KN7W)

One area of confusion was around whether Quitline was “for people who have given up already?” (11W) One participant suggested Quitline would have worked better for them “if it was towards the end of my quitting rather than the beginning.” (KN7W) Other participants indicated that they wouldn't ring until they had decided to quit. They didn't see how the service could be of help to them prior to that.

***So why haven't you ever rung Quitline?** ...I don't have no reason why, I just haven't. (23aW) ...Yea, because I probably haven't decided to give up. (23aW)*

If I was planning to stop, yeah, I'd call them. (KN1M)

One participant did not think Quitline was relevant to him because he had only “just started smoking a couple of years ago.” (22M) Another reported that “they didn't ring me back” (13W) to which someone joked “Quitline, were having a smoko break.” (13M)

A few participants felt that “Quitline don't provide such a personal touch” (10W) and this put them off ringing.

***What puts you off?** Yeah, having someone telling me what to do on the other end of the call. And I can't even see them. That's probably the biggest. (KN1W)*

When asked if they were comfortable with talking to people over the phone one participant replied:

No, not really because I think when I needed the support I forgot to ring ...They'd ring you like once a month, but by the time that month come I forgot what I said to them that month. (KN7W)

One barrier was the perceived time it would take.

I've seen those ads (23aW) ...yea if you've got 25 minutes spare or something...yea. (23aW)

Another barrier to use was that Quitline asked too many questions and the experience was altogether boring. One participant had rung, they said 'just for fun'.

Yeah, just for fun. ...it's pretty good. They asked how much questions man. ...Yeah, that's why I hung up, too many questions. ...they were nice, but they're boring. (24M).

Awareness of the Quitcard amongst participants was fairly poor.

Aukati Kai Paipa

When participants were prompted about Aukati Kai Paipa a number of participants said they had "never heard of it" (23aM) or had "just heard of Kai Paipa" (24M). However, earlier when talking about their quit histories participants spoke favourably about their local Māori stop smoking service. Participants were not aware of the name of the service, or the design of the logo, or 'branding'. The attribution for the success of the service was made about the people involved and the location it was held at.

A few times participants were aware of the services, but did not know it was an AKP service:

***Has [name] seen you?** [former AKP quit coach] Oh, that fella with the smoking machine? [smokerlyzer to measure Co2] (8M)*

***What's AKP?** (8W) **The Whaiora programme. Here.** Oh. Oh Okay. (8W)*

When asked about other services that had helped, participants mentioned AKP, but not when prompted by the logo.

There was both positive and negative feedback about AKP services among participants who had used AKP. For example, one women who accessed the service through a doctor described her quit coach as "quite good" (14W) but another said that quit smoking services were just "too hard" (23aM).

The thing I like about the Aukati Kai Paipa one is that you're not pressured to give up. (11W) ...And didn't even look disappointed when we were bad. (11W) [Laughter] I actually quite liked the quit group though. It was good. (11W) ...Just because we didn't give up doesn't mean it wasn't good though. (11W)

When I first quit smoking through Whaiora I went on a chart thing. And you give a date when you want to finish. And your helper came and saw you each week and you wrote down everything. How many smokes you had, what time and everything. And that helped me better than ...It was a timetable. And you just wrote down when you had your first smoke. (8W) Within two weeks I had gone from twenty smokes down to ten. (8W)

Some younger participants showed an interest in te wairua and learning ways of stopping smoking that are particular to Māori but, AKP was not appealing to some youth who were not confident in te ao/te reo Māori.

*So you're talking to a Māori? (24M) ...**Yep** ...Oh rich. (24M) ... **So would you guys consider using them or not?** ...No. (24M) ...Not really. ...I won't understand, won't know what they're on about. (24M) ... **So you see them as,***

like, they'd be speaking Māori and stuff like that ...Don't know what they're saying. (24M) ... It would be all good if they translated it. (24M) ...Haere atu. (24M) ...So you ring in Māori and then English. (24M) ...Probably 'cos they would have different ways of stopping. (24M) ...As long as there's some people that speak English, not only Māori. (24M) ...And there's someone who can do the Māori spells. (24M)

Some participants were reluctant to try AKP if the people running the service were smokers themselves.

The one here smokes. ...pretty hard to listen to someone who's still doing it. (KN7W).

There was confusion regarding branding with the AKP smoking cessation service sometimes being confused with the Auahi Kore sponsorship and health promotions.

Aukati Kai Paipa? (10W) ...Is that the same as Auahi Kore? (10W)

...Auahi Kore ...That's just the smokefree environment thing isn't it? ...They have promotions at community days. ...At hui-ā-taus. ...They provide sponsorship too eh? ...and they have like a sports programme? ...Lots of products... the bottles. I mean they turn out lots of things with the brand on. Branding. (11W)

One of the participants expressed that they would prefer a Māori stop smoking service over a Pākehā service because they felt the Pākehā service was judgmental.

Would you use a Māori approach to stop smoking. Oh yeah, I'd go to that service. (KN7W) ...They [Pākehā service] come from a different approach. They're judgmental. (KN7W) ...I'd use the Māori one. (KN7W)

Unknown service

One participant had the perception of quit coaches being "evil salespeople" who pestered them but it was not clear who these people might have worked for.

I don't think it was Quitline. It was some thing I did on the internet... Just to try and stop smoking. But they just became really annoying so I just told them never mind. I've given up I'm fine thanks ...they just kept ringing up everyday ...I seen it somewhere and I called though and they're just like the evil salespeople [laughs] (23aW) ...Won't go away! (23aW) ...A quitline? (23aW) ...Yeah, a quitline. (23aW)

Other cessation programmes (school/work based etc) or agencies that provide cessation support (family planning, pharmacies)

Participants also cited school based quit programs such as a "smoking counsellor." (10W)

It's helped heaps of people at our school. Especially because she gives out the prescription for the gum and stuff. Like she would just tell us and we wouldn't go and get it. But she gives the prescription so people just pretty much motivate themselves to go and get it themselves. And try it out... And, it costs nothing. We get it for free. ...she gives it to us. ...No, she gives us prescriptions. (10W)

One of the strengths identified by this younger focus group was having a cessation support person with a past history of smoking because this gave the person credibility and the ability to empathize.

But because I knew you [quit coach] smoked and that you don't smoke now, that helped me a wee bit as well. To know that you know what the craving's like. ...They've been through it... To have a smoking cessation coach who has never smoked would be like a midwife that never had a baby. Don't you tell me it doesn't hurt! (10W)

In another focus group participants described a programme which came in a school and told all the kids to go home and nag their parents to quit smoking.

...went to the schools and all the kids were told to go home and tell their parents to stop smoking and to nag them constantly. (11W)

One participant was aware of a workplace based program.

The whole workplace went smokefree ...they have incentives for the staff to give up. ...Gave up and then they all went to the gym... so I suppose it worked great. (11W)

Action on Smoking and Health (ASH), He Oranga Pounamu and Family Planning were also recognized as agencies which provided smoking cessation support.

Internet and books

The internet

Only one participant referred to the internet as a smoking cessation tool suggesting that people “Google it.” (7W) The internet was described by another participant as “just boring.” (24W) Another indicated that the time and effort to search for cessation information on the internet was a barrier – “can’t really be bothered” (23aM) and another said it was “too dear.” (8M) One woman thought the internet as a quit method would be utilised mostly by young people.

Maybe younger people do, like on their Facebook and all that. You know, they live on the internet don’t they. (KN7W)

Participants identified two ways which the internet could be used. One was to search for information and the other was to link up with an online support network or forum of smokers trying to quit. Social networking sites such as Facebook, YouTube and Bebo were occasionally mentioned as good web locations for this to occur:

We just like to research more information and stuff like that. (13W) ...You can just type in a few key words and you come up with heaps of different options. (13W)

I might use it to buddy up with someone else that’s trying. (25W)

I’m just thinking off the top of my head, maybe there could be like a Facebook thing where everyone jumps on there and it’s like a support system. And you jump on there during the day and you go ‘how’s it going’, ‘oh man, I’ve been hanging out for a smoke today’. And then somebody who’s along the same lines as me could jump in and say ‘be strong... I was feeling like that this morning too. Now I’ve gone and had a run around the block’. (KN2W)

Self help books

A few participants were familiar with Allen Carr’s book to quit smoking:

That smoking book that everyone says you read it and it makes you quit. (KN7W)
Allen Carr is it? (KN7W)

One participant said they “enjoyed it” (KN7W) but did not comment on whether or not it had been successful. One woman was currently reading Allen Carr’s book at the time of data collection. A number of participants knew of people who had quit using this method and despite some having relapsed since then, participants were overall, fairly positive about this cessation method.

So has anybody used any books? I know someone that has. ...He doesn’t smoke to this day. (13W)

We used to have a work mate who tried a book aye? ...She smoked the whole time and it encouraged you to smoke the whole time you read it and once you finished reading the book you actually gave up ...once she'd read it she stopped. She stopped for ages aye? She did restart though, but she had a significant amount of time where she actually stopped. (KN2W) Which is good. (KN2W)

The Allen Carr book was seen to assist with self-motivation. There was however some stigma around people who read self-help books and scepticism about their efficacy.

That guy. Allen – ...Self motivation. ...You read the book. And it says keep smoking all the way through it. ...And then as you read it you just slowly turn yourself off? (11W) ...I don't know how it works. (11W) Wouldn't drive me not to smoke. It'd drive me to smoke. (11W) But he has seminars and things as well. (11W) I can't see myself with ra ra bloody types. (11W)

In another account of Allen Carr's seminar, the participants believed focus was put on teaching people the psychology behind smoking.

...they talked to her and they talked to the group all about how people that are non-smokers don't envy smokers and how, like, the psychology behind it and all that stuff ...just making up your mind, getting your mind into the right space sort of thing. (25W) ...It's all in your mind aye. (25W)

The participants were open to attending these kinds of seminars but they assumed they would be unaffordable for them.

But it was, like, eight hundred bucks or something like that ...But you wouldn't pay eight hundred bucks and sit in a room full of people if you weren't really kind of into it. ...but you would if you knew you were getting your money back. ...And if you have a spare eight hundred. (25W)

Our participants were able to identify a range of self-help resources to help people stop smoking including a Ministry of Health pamphlet – “it's kind of like a tool kit on how to quit” (KN2W); Tony Robbins' products “that empower thing ...he has tapes which you can listen to” (KN2W); “CDs” (KN2W); and, “the bible”. (KN2W)

Two participants had access to a quitting book but had not read it therefore it had no impact:

I've been given lots of self help books from my girlfriends that have quit. Yeah, they're still sitting on my bookshelf. (KN1W)

You read the book and it says that you can smoke until the end or something. (8W) ...I just looked at it. (8W)

For some this approach was “boring.” (24M) If people did not read for leisure it was unlikely they would read to quit smoking.

Oh no, there you go, that's boring. (24M) ...No, don't do reading. (24M) ...I'll probably look at the cover and walk past it. (24M) ...If there's pictures. (24M) ...Yeah, I'd look at these pictures. (24M)) ...Can't read, man. Can't read books. (24M) ...It sucks, it's boring. (24M)

There was also mention of the bible. None of the participants had used the bible as a quitting aide but they referenced a former mongrel mob member who read the bible and consequently quit smoking and became a bishop.

I know someone that stopped for a book as well, but his whole life has changed. He read the bible and now he's a bishop ... before that, like he was a mongrel mob patch member and everything. (KN2M)

Participants said that “for some people the bible would work and for some people it wouldn’t” (KN2W) but participants also suggested that the bible could be used to rationalise smoking depending on one’s interpretation of bible passage.

But doesn’t it say somewhere in the bible that, like how God talks about partaking in the herbs of the land? (KN2W) [Laughter] Yeah. (KN2W) What could that be? Partaking of the herbs of the land? I mean herbs could mean natural herbs, but they’re all natural. They’re all natural. (KN2W)

Alternative therapies

Hypnotherapy

Hypnosis was described as effective for “some people” (8M) but not everyone. Participants saw hypnosis as a theory requiring belief in its principles for it to be effective. Its qualities were very similar to cold turkey - failure to quit was not blamed on hypnosis but the person’s poor self-discipline. Others thought hypnosis doesn’t remove the desire and people would still want to smoke – they would just have to use willpower to overcome cravings.

It’s quite successful, that is, yeah. (KN1W)

It just proves the point that it’s all in your head. ...but you’ve still got to apply a lot of discipline to it anyway. ...I think you’ve really got to make your mind up that you want to do it. It’s not going to happen by chance. I think you’ve got to really work at it. ...So the desire really has to be there [points to head] to give up. (11W)

Despite the scepticism a number of participants knew of people who had successfully quit smoking using hypnosis.

I think it does because [name] got it done. And she was a – what – packet a week? Couple of packets a week? ...Yeah, she wasn’t a very heavy smoker. ...she paid two hundred and something to get hypnotised. And she hasn’t picked up a smoke since. And that’s been a few months now eh? ...it’s been a year hasn’t it? (11W)

My aunty tried to give up smoking? She was a 15 year chain smoker, then she stopped ...I don’t know how they done it, but she said they had trained her mind into making her believe that she was never going to smoke again ...it was just like an hour thing and now she is a non smoker. (KN2W)

There were two references to hypnotherapy tapes, the rest of the comments referred to hypnotherapy seminars.

The hypnotherapy tapes that you play while you’re sleeping, they’re really good. They helped when I gave up the second time. But hypnotherapy with somebody – (25W) Talking? (25W) Talking didn’t work for me, at all. (25W)

Mostly participants were interested in hypnotherapy and believed in its efficacy as a smoking cessation tool. Hypnotherapy was believed to have a fairly simple mechanism which was appealing. The greatest barrier to accessing hypnotherapy was cost.

If you pay for us to get hypnotised, I’ll get it done. (11W)

Yeah just don’t want to pay. (8M)

Hypnotists! ...I don’t know if they work but they take the money. (13W)

That’s probably worth a try. (23aM) ...Yea I’ve heard about that, costs a lot of money. I reckon that would help me. (23aW)

Where’s your money?! (8M) [Laughter] ...Is it subsidised? ...My friend has just done that actually. (8M) ...He hasn’t had a smoke for the last five months. He

hasn't even thought of it. One session. (8M) If a hypnotist was free, I'd go. I'd go today. (8W) ...We'd all go! (8W)

Hypnosis. ...They charge a lot. (13W)

I would try if it I knew it wasn't so expensive, because I know it's not cheap. (KN2W)

One participant mentioned that hypnotherapy had a limited time span of effectiveness.

My cousin's had one before. (14W) ...It only lasts about a couple of weeks, aye, like a week. (14W)

Only a few participants had tried hypnotherapy themselves therefore many of the participants' attitude towards hypnosis was based on the experiences of friends, family and acquaintances.

I reckon that would help me too miss. (23aM) ...I knew this old lady up north and she did it and it only cost \$50 and she's like a, you know and she's like old, she'd been smoking for years and she was a real heavy smoker and then she went to do this hypnotherapy cause she decided that she wasn't going to smoke anymore and she just stopped! And she's still stopped to this day. That was pretty cool, under hypnosis for \$50. (23aW) ...So if you can get a hypnotist here, we'll be standing in line for them. (23aW)

I want to try that. That looks mean. (7W) I really want to do that. ...Because it seemed to work for my aunty. (7W) Yeah, half of my step-mum's netball team went to a hypnotist and now her netball team's all smokefree. (7W)

My friends did, he gave up and mum gave up after being hypnotised. And I think the dad just started but he stopped smoking for 15 years. That was pretty good. (25W)

Participants in focus group 23 were very interested in having a group session run for them.

*How about a hypnotist, would it be hard to get a hypnotist in? (23aW) **Do you guys want to have a group session?** ...Yea (23aW) ...When's that? (23aM) ...When is that possible? (23aM) So the ones that are missing from home can join us. (23aW)*

It was widely accepted that being hypnotised required a certain degree of trust in the hypnotist and even though many participants thought hypnosis could be an effective method, some were uncomfortable with trusting a stranger. Programmes on television propagated a common misunderstanding of hypnotherapy that it was about making people “bark like a dog” (24M) and “do stupid things.” (24W)

As long as they don't make me cluck like a chicken! I'll be just fine. (23aM)

I think perhaps there was a consciousness I couldn't let go. (25W)

I heard that's good. I heard about it, but that's so scary. (22W) ...That's head doing. That's fucking with your brain. That would be scary. (22W) ...You don't know what he's capable of doing to you. I don't trust those people. (22W)

I've heard that works. (KN2W) Cluck like a chicken. (KN2W) You are in a deep sleep. (KN2W) My aunty, she's had, her life has just changed, it's just so quiet now. She doesn't want to come around. (KN2M) Personally I don't think I'd do something like that, because of the fact I'd probably like to know what I'm doing. (KN2W) I'd probably laugh at him if he told me to go to sleep. (KN2W)

There were one or two doubters among the believers and one participant who had tried hypnotherapy without any success.

Didn't work for me. It left me in a state – that was the adverse reaction. It left me in a state of depression afterwards. (KN7W) My dad done that. (KN7W) And it

worked for him. (KN7W) It worked for him for about seven years and he's a chronic smoker now. (KN7W) I'd never go back there. (KN7W)

Acupuncture

Not all participants knew what acupuncture was – “Acupuncture ... What's that one?” (11W) In general needles were seen as unpleasant and “sore.” (25W)

I'm scared of needles. (KN2W) I would never.... I'd be scared they'd stab my brain. (KN2W) That just looks sore. (KN2M) A bit of a vulnerable place. (KN2W)

Participants seemed repulsed and confused about the mechanism and generally unconvinced that acupuncture would be effective. There was, however, some interest in the method.

What does that do? Like, what do you do with that? (14W) ...Are they addiction points? (14W) ...Take the stress out of you aye? (14W)

How long do they leave the needles in there? (8M) ...It's like in and out. (8W) ...Oh yeah. A session? Yeah. (8M) ...And then play with your ear when you want a smoke. (8W)

Why in the ear, we don't smoke through our ears? (23aW)

Aye? [Referring to picture of needles in the ear] (23aW) Is that where they stick it? (23aW) I didn't know that they stick it in your ear. (23aM) ...Oh that could work, yea. But I've never tried it. (23aW)

Some people knew about acupuncture through family members who had used this technique, and others had heard of acupuncture before but “not for smokers.” (24M) One participant talked about a ‘staple’ being used rather than a needle.

...And they have like this staple in their ear. And they go, oh I need a cigarette, and it goes away. ...Give it a wriggle. She'll be right. (10W)

Another participant was well informed about acupuncture and went on to tell fellow focus group members about recent developments in acupuncture smoking cessation.

There's actually this new thing now that's exactly like acupuncture. And it's called, it's a patch... that helps you give up smoking. It's exactly like acupuncture where you put it on the pressure points. 11M) ...The chakras and all that sort of stuff. (11W) ...I think they used to put a staple somewhere in your ear. And when you're wanting a smoke you used to rub it ...I did that years ago. I remember now... It was good for about a week. (11W)

One woman in focus group 23 was less enthusiastic about acupuncture and explained her mistrust of new medical treatments:

See the thing with Māori is that we can be quite untrusting. I'm really untrusting, especially of new medical treatments. ...I'm a real control freak as well. I need that control. (23bW)

A small number of respondents had tried acupuncture in the past, one of whom had tried it twice. Based on their experience acupuncture “didn't work ...I don't mind needles at all but it didn't take the edge off. It just felt like nothing.” (KN7W)

Alternative non-tobacco products (Chinese herbals, powder inhaler, herbal cigarettes and Nicobrevin)

There was a brief mention of Nicobrevin by a female participant but no further discussion. This participant recalled having tried brown capsules, probably Nicobrevin, but they could not recall the name of the product.

They were brown capsules....They had kind of like a bad odour to it. (KN1W)

One participant talked about a powder inhaler but her knowledge of the product was very low.

*...she had a thing, it looked like a cigarette but it was a powder that you inhaled.
...It was pretty cool too ...It's the same size as a smoke and you hold it like a
smoke. (7W)*

Some participants were also aware of herbal cigarettes but again they demonstrated poor understanding of how the product worked.

Oh, those healthy smokes you can get? (7W)

*There's those herbal smokes too eh? (11M) ...That's called marijuana. (11W)
...No ...Legal ones. (11W)...They're just substitutes. (11M) ...It's something to do
with your hands (11W) ...that's why I fidget. (11W) ...Isn't there that stuff that you
could spray in your mouth and it makes cigarettes taste disgusting?*

*You give up smoking and take up eating. (8W) ...You need another thing to do.
(8W)*

*Can't you buy smokes without nicotine in them? I'm sure you can. (10W) ...You
can get herbal ones I think. (10W) Clove cigarettes. I've smoked a whole packet of
them before, and they make your tongue go a bit bung. Not very nice. But the
outside of it, this is the way they rope you in, because the filter tastes like sugar.
They smell kind of weird. They smell quite a lot like cigars actually. What are
those leaves that those cigars, the expensive ones, are wrapped in? They have
leaves wrapped around them. (10W)*

Cold turkey

Stopping cold turkey was also referred to as willpower, mind over matter and 'cold chicken' by our participants. There were nearly as many different variations of this method as there were participants. One person for example avoided triggers therefore they "*just refused to go to the shop.*" (8M) Another participant "*just stopped*" (24W) but was not sure what to call this method. Another talked about using willpower after every other method had failed them:

*You've tried all the methods and then you're just like you have the willpower to
say 'it's time to quit'. (24M)*

One person shared advice they had heard about:

*I can't even remember who told me this. But to set a goal on a certain date, it's a
lot easier ...if you make a date it makes it a lot more achievable. You've made that
date. That's it ...But you've got to make little steps towards it ...If you write goals
down, for some reason they seem more achievable. (10W)*

One man tried to quit unaided and described his experience in this way:

*I kept on putting it in my head "I'm not going to smoke; I'm not going to smoke.
These are disgusting". ... After a week or a couple of weeks it started getting
harder. (8M) ...Get the withdrawal symptoms. (8W)*

Participants who commented on unaided quitting found quitting this way much harder to achieve than they expected. None of the participants reported successfully quitting using cold turkey and one attributed this to not getting the support and guidance she needed.

*Didn't use anything. (24M) That's the best thing. (24M) ... **How did you guys find
just stopping?** Oh yeah, started up again. (24W)...It worked for a little while.
(24W)*

*It hasn't worked. You need help and support, someone to guide you. That was ten
years ago and I'm still smoking. (10W)*

There was a commonly held 'smoker's myth' that willpower alone was enough to quit smoking. So if someone was unable to quit using whatever method, the conclusion follows that their willpower was insufficient.

Didn't work. (22W) ...Mind over matter, that's why. (22W)

The willpower. It's the mind you need to trick. (10W) ...The power of the mind is amazing. If you implant something in your brain, you will achieve it. It's just whether you keep it there or not. (10W) ...The goals. Like you were saying, setting goals. You can't say I'm going to quit tomorrow and then all the kids are running round. Oh, you're going to have a cigarette. (10W)

As the following excerpts show, stories about people who "just stopped like that" (KN2) are freely shared among smokers and help perpetuate 'smokers' myths' about cold turkey being an easy way to quit. By implication, cessation aids and services are therefore unnecessary.

Every drinker in the pub's got a story like that. I took the smoke out of my mouth and said that's the last one I'm going to have. And he's never had another one since. And you kind of feel just like going slap. ...My step dad. He had a pouch a day. ...Wow. ... Wicked. ...He was a huge smoker. ... But he was constantly rolling and smoking and doing. And he was an active fella. And then he just went to the pub one night and went egh! And the next day, just away he goes. No symptoms, no grumpiness. No nothing. Geez he was annoying. ...My ex did that too. Just stopped. And he stayed the same weight. Not fair. (11W)

Nah I've never met anyone who just stopped because they wanted to. (7W) ...My step mum did. (7W) ...You did. (7W)

I think it was just easy for me because it, I don't know, I'm not a big smoker anyway. ...my friend's dad, he smoked for like 30 years and he just stopped. I mean he brought in like heaps of nuts and peanuts and that was his substitute, lollies and, but yeah, he was smoking for 30 years and just stopped like that. ...It just works for some and doesn't work for others I think. (KN2W)

Participants knew of people or had heard of people who had just stopped unaided, but they also had not been able to do this themselves and knew of others who similarly had not been able to 'just stop.' The successful mechanism was a mental process of psyching up. But as the following quotes suggest, participants believed, willpower has to reach a particular level of strength for cessation to be achieved.

Just psyche yourself up really. Just, nah, that's it. That's what I did. (25W)

How do you make sense of some people being able to give up? ...I guess they were just at a place in their lives where they felt strongly enough about it that they could give it up. (11W)

Believing that cessation is just a matter of deciding to stop and therefore that cessation aid is not necessary, was supported also by a disbelief in the addictiveness of nicotine/smoking. Some participants thought that smoking was a socialising tool, not a behaviour they engaged in because they were addicted to nicotine.

*I always believed that when you want to stop smoking, you just stop. I mean, getting all gum and things like that is sort of just carrying on, your pretty much still smoking. That's how I've like thought about it. ... **Don't you see it as an addiction?** No, not really. I don't see it as an addiction I see it as a um, a socialising tool. [Laughs] ...No I actually don't really look at it like an addiction, it's just something that you do. (23aW)*

Not all the participants in focus group 23 saw smoking as an addiction but they believed heroin to be addictive which prompted a discussion around the participant's understanding of addiction, and how nicotine addiction compared to other drug addictions.

Do you think heroin is addictive? Yeah hard out. (23aM) ...Yep, it's addictive. (23aM) ...I think smoking is addictive. (23aW) **Alcohol, is alcohol addictive?** No (23aW) Yeah, I reckon it is. (23aM) ...Alcohol's like smoking. (23aW) It's like a socialising thing when you drink, so yeah it's pretty much the same thing as cigarettes. (23aM) And quitting too. (23aW) Yeah, so, much like smoking. (23aM) ...And you stand out in the cold freezing for your cigarette! (23aW) ...You make time for that. (23aM) ...Is the medicine to attack the nicotine or the feeling of how you are thinking about it? (23aW)

One participant tried not carrying cigarettes without any luck and another stopped buying cigarettes but even this was not enough to stop smoking completely.

I can't do that now. (KN7W) Leave them in your car. (KN7W) The first two times I did, but I couldn't. (KN7W)

I don't buy my own smokes anymore, I've stopped buying them because then I know I'll just be like, 'oh I'll have 3, I'll have 5' and then I'll be a smoker again. So I've just stopped buying and I'm trying not to ask people and not to accept them. But when I do need them I do ask for them, if I feel like one. (KN2W)

Two women in one focus group referred to how withdrawal symptoms affected their behaviour, making it difficult to quit smoking without assistance:

When I give up smoking I'm just like ...Nasty. (11W)

I'd have to take a month off work for it. Otherwise I'd be up on a murder charge. (11W) [Laughter]

Substitution was a common method used to quit smoking across all focus groups. Several participants made reference to keeping busy for example "give your hands something to do" (23aM). Others substituted another behaviour for smoking, such as "If she felt like a smoke she brushed her teeth ...it washes the taste away." (24W) Others swapped "one bad habit for another" (23aW) including:

Smoking for over-exercising. (23aW)

Change it to drinking ... alcohol. (24M)

You eat heaps of food. (24M)

A number of participants stopped smoking only to take up eating instead, which resulted in unwanted weight gain.

I think I definitely gained a bit of weight. (25W) ...But yeah, life was just normal. It wasn't like looking for something to have in my hands, or whatever, you know. (25W)

Participants also replaced a cigarette with a lollipop because it mimicked the same hand motion as smoking.

There's another way too ...Lollipops, yeah because it's the same action as a smoke. (24M)

Chewing gum was another common substitute because it kept the mouth occupied.

My grandfather gave up by just not using anything and just chewing chewing gum and sleeping with chewing gum in his mouth. (23aW)

Many participants talked about keeping themselves busy "getting your mind off it" (KN1W), so that their attention was diverted from wanting to smoke.

Because I've noticed when I'm busy, or when we're busy, we don't even think about smoking until we've finished. But it's got to be, like, a constant busyness, like 'do this, do this, do this'. (KN2M) But it's always at the back of my head, like if I know that

there is a place, a time in that day where I can jam in a smoke, I will so jam it in. And I'm pretty good at finding that time in the day. (KN2W)

Cutting down/Reduction

Two participants were “cutting down” (23aW), that is, reducing the number of cigarettes they smoked as a quitting method.

I've started going to a gym and so forth, etc. So I'm down to about 5 a day. And that works for me - the reduction stuff. (11W)

Pregnancy

Pregnancy was cited as a quit method because of the frequency with which it had caused women to stop smoking.

...because I wanted to give up. Because you know everyone knows you don't smoke when you're pregnant. (23bW)

One woman's attempt to quit cold turkey coincided with her pregnancy, and it would seem that she incorrectly attributed her morning sickness to nicotine withdrawal.

I was put off it ...It wasn't even that bad, I didn't have bad symptoms or anything. I just woke up, and thought I don't want to do it anymore. Yuck. Every time I tried to smoke it just made me vomit. (22W)

A number of female participants gave up cold turkey when they fell pregnant and found themselves replacing smoking with “substitute eating” (11W) to compensate but without any cessation products or services to support them, they returned to smoking shortly after having baby or finishing breastfeeding.

The drinking just stopped like that. That was easy. But smoking was still really hard. ... how did you get through that? I don't know. ...I eat. ...It's just swapping one addiction for another isn't it? You just ate. I don't know. It wasn't hard though. ...As soon as I found out I was hapū I just stopped. Drinking and smoking. That was the end of it. And then, I was all good right up until I finished breastfeeding. (11W)

Smokefree social marketing and advertising

Some participants cited smokefree promotions and sponsorship of events as quit methods, meaning perhaps that these initiatives prompt and support quit attempts.

Participants recruited from Hawkes Bay cited “a competition” (13W), it was later established that a Quit and Win competition had been run in the area.

The smokefree advertising when there's, like, promotions on music festivals and stuff like that. And I think they're cool. (25W)

There were references to what was probably World Smokefree Day.

*Is there like a national day, like they have that white ribbon day? (13M)
...Smokefree day (13W) Do they have like a march, and stuff like that? Like what they do for breast cancer? (13W)*

And one participant also drew attention to the graphic warnings on cigarette packets as being a useful prompt.

Do you count those pictures? [Shows pictures on cigarette packet] (25W) ...the teeth bug the crap out of me. (25W)

Some participants did recall advertising on TV about smoking cessation, namely ones with “movie stars” (KN2W). One participant was especially moved by a Quitline TVC featuring an emphysema sufferer.

The only ad that ever put me off and even seeing the advertising on the cartons, the only one that's ever put me off is that old koroua. The one with the emphysema. Yeah, when he has to get his kai aye? (KN2W) And because he passed away aye? Scare tactics. (KN2W) He put me off, he so put me off. He nearly made me quit. (KN2W)

Another suggested that what they really needed was not medical intervention but “someone famous saying ‘oh smoking’s bad for you!’” (23aM).

Whānau and friends support

One participant referred to the support of whānau and friends in helping them give up smoking:

Whānau support... Encouragement really... Not people telling you when to quit or that you should give up ...Just support. (10W)

Aversion therapy

Others talked about using aversion tactics to put themselves off smoking.

Get a whole packet of 30 grams and smoke the lot until it's over. ...Makes you sick! ...power smoke. (23aW)

I'm standing there with my big fat belly [pregnant participant] I think it's sort of put me off, trying to quit smoking. (23bW)

Doctor

A common theme across all the focus groups was the lack of knowledge about antidepressant medication and a lack of information or questioning from GPs. Further, participants who did not visit their doctor often did not get access to smoking cessation medication.

***You go to the doctor?** No, not unless I'm nearly half dead. (23aW) I do. (23aM) I just came back. (23aM) **Does the doctor ever tell you about any of these or?** Not for smoking, cause you have to tell the doctor your problem. (23aM) No, she just asks if I've stopped already...No. (23aM) **But she could write a prescription** ... I'll tell her next time. (23aM) **Have you had the doctor offer?** Nah, I've never asked. (23aW) I haven't been to the doctor in years. (23aM)*

One participant shared how they had sought cessation advice from a Doctor who did not offer the opportunity to utilise NRT. He just told to her stop.

The doctor's no good as a service because I went to get that [pointed to a product on the sheet] and he said just stop doing it. It's not going to work. ...I went to him because I was fat and then he said 'stop eating'. So that's all he ever tells you. But he reckons that, yeah, that's just a drug company thing and I'm better off to just cut down. (25W)

Reasons for relapse

Table 10 shows the reasons and frequency by category for relapsing after past quit attempts. Negative affect, mainly stress, and social inclusion and identity related reasons were the most frequently cited. Behavioural and physical associations and restrictions on smoking being lifted were the next largest category of reasons cited for relapsing in the past, although these were cited less frequently. Alcohol and 'wanting to smoke' were other less frequently cited reasons for relapsing.

Variation by age

Relapse reasons within the category of negative affect were cited relatively frequently across age ranges, although cited most for participants in the 16-20 age range. Under 20 years of age, relapsing for reasons related to social inclusion and identity were common. Behavioural and physical associations were a fairly consistent reason for relapse across age ranges.

Table 10: Māori reasons for relapsing by age at relapse

Reason for relapsing	Age Group									Total
	≥15 Yrs	16- 20Yrs	21- 25Yrs	26- 30Yrs	31- 35Yrs	36- 40Yrs	41- 45Yrs	46- 50Yrs	51+ Yrs	
Negative affect	5	16	8	3	3	3	0	2	1	41
Social inclusion or identity	19	15	2	1	3	0	0	0	0	40
Behavioural and physical association	2	4	2	3	4	1	1	4	0	21
Reason for stopping no longer relevant	4	6	5	4	0	0	0	0	1	20
Wanted to smoke	4	4	1	2	0	2	0	0	0	13
Alcohol	2	4	2	2	1	0	0	0	0	11
Whānau	3	1	0	0	1	0	0	0	0	5
Employment	0	0	0	2	2	0	0	0	0	4
No reason	1	2	0	1	0	0	0	0	0	4
Financially able to smoke	1	2	0	0	0	0	0	0	0	3
Location	0	2	0	0	0	1	0	0	0	3
Appearance	0	0	0	0	0	1	0	0	0	1
	41	56	20	18	14	8	1	6	2	166

See Appendix C for full details

Motivational forces to relapse

Te Taha Hinengaro

Negative affect, that is, experiencing negative emotions, was the most commonly cited reason for having relapsed in the past. Negative emotions included: stress, grief, anxiety, boredom, sadness and depression.

Stress

Stress was a common term used for the emotional state people recalled led them to restart smoking. Stress associated with relationship problems with partners, children and other whānau was particularly hard to cope with.

I think that makes us smoke more. (23aM)

My boyfriend pissed me off. (7W)

Just relationship problems with hoha, and they always make me smoke. Well not the actual person but if something goes hoha, then I'm like 'oh give me a smoke' ...apparently I have a temper so if I can't let it out I have to smoke or else I'll be punching things and it's not very fun. So just something to calm me down instead of letting it out in bad ways. (KN2W)

Stress was caused by worrying about children getting into trouble.

My son. Yeah my oldest one was just getting into too much trouble and running away. So it was like sitting at home and wondering what to do, so... (KN7W)

For some participants, their occupation or work, or studying was a source of stress.

It's called being a teacher. (22W)

I work in the TV industry. And it's a bit of a high demand. My whole life was wrapped around my job. (22M)

When I first started work and I wasn't used to all the hard-outness of it. Not hard-out, but like, not used to it yet. I just needed something to calm the nerves. (KN2W)

It's a stress relief in the way that when you have four assignments to get out, the best thing you can do, and because I'm not a person who, weeks on end, you have about a month or so to do your assignments. I'm like 'hell no', mine's got to be the last night. That's how I think, and that's how I do my work. It's the last night and then I'll just go hard out and then hand it in. (KN2W)

Being unhappy with one's life circumstances was a source of stress, for example, being single, not having enough money, being or becoming unemployed.

No partner. (25W)

Bills. (25W)

Running out of work. (23aM)

No work. (23aM)

Smoking was a way of taking a break, for example from the stress some participants experienced looking after moko (grandchildren). Another participant liked the calming effect they got from smoking.

They stress you... Yeah it gives me a break. (8W)

A calming effect. I'm really a nice person after I've had a cigarette. ...The time out is a huge factor. (22W)

In the height of the stress it allowed you to have some time out. ...When there's crisis going round, okay, I just need to go away and have five minutes. And it just allowed me to do that. (11W)

Boredom or ennui is not experienced as a negative emotion as such but it is like a flat-lining of emotion, that is, it's like the brain signalling the need for stimulation, which for smokers is quickly obtained from nicotine.

*Hard out bored. (24M) ...**And what is it about being bored that makes you feel like you want to smoke?** ...Doing nothing. (24M) ...It kinda, relieves it. (24M)*

Similarly, participants re-turned to smoking when they felt tired and needed something stimulating to keep them going when studying or after sports/fitness training.

Tired. Too tired from training. (24M)

One participant said that even watching a sad movie on television could trigger enough discomfort to restart her smoking.

And you're watching a tear jerker or something. (7W)

General stress was cited, as was stressful life events, like having a baby.

I actually had two cigarettes when I was in labour with my first. Because I was six months pregnant, when I gave birth to my oldest. So I was freaking out. Because I knew that the baby wasn't ready. And I didn't smoke during that pregnancy. So when I had my first contraction and started bleeding, that was me. I was just smoking right outside the ambulance waiting for the paramedics to get the stretcher ready. (22W)

Some participants detailed an onslaught of multiple stressors, such as in the following quote:

I went to work, straight after giving birth. And it just got too much. Being young, being a mum and working all at the same time - did my head in. (22W)

Death, coping with the loss of someone, experiencing grief and sadness, is negative affect in the extreme. Two participants restarted smoking when they encountered this experience for the first time.

I'd never been through that before, because she was the first person that passed away in my life, where I was old enough to understand what it meant. Like I had other family members pass away... so I started smoking again. (KN2W).

People passing away, the pressures of not understanding the umm... how to grow up, couldn't handle it. No adult figure around. ...I had to sort stuff out by myself. That's it. (23aM)

The following quote talks about how pervasive smoking is at tangihanga.

I've never stopped at a tangi ...You see everyone smoking at a tangi. ...You socialise. Because if they're having a smoke then you're going to go over there to stand by them. So... (8W)

Depression as a more enduring state of negative affect, meant that for one participant giving up smoking on top of how miserable she felt was just too depressing.

At that time of my life I suppose it just felt like the only one thing I enjoyed I was trying to give up. So it was like, 'nah', so I just went back to it. Yeah, it just felt depressing to not, so I did again. (25W)

There was some stress that could have been exacerbated by nicotine withdrawal, but this was not always clear. Some of the examples sounded like the sort of irritability and annoyance that occurs with nicotine withdrawal. For example, in the following excerpt 'things' just 'stupid stuff' and different people annoyed the participant.

Things just happened around me, like stupid stuff. It just pissed me off. The stress... Someone on this course. ...Sometimes my mother ...Girlfriends. (24M)

Just getting stressed out over little things, like partner. (8M)

Reason for quitting no longer an issue

Some participants simply started smoking again because the reason for not smoking was no longer. For instance, for young people, they move out of their parents house.

I left home. (22M)

Starting again after an unintended quit attempt due to illness was common across all age groups.

Got drunk. Felt better. (7W)

I smoked as soon as I got out of hospital ...I couldn't wait. [Laughs] (23aM)

Got better. (11W)

Similarly, many women who stopped smoking unintentionally because of morning sickness in pregnancy or intentionally for pregnancy, started again as soon after they'd had the child, or stopped breastfeeding. One woman, got a craving 2 weeks before birth and started then.

Went back after the kids were born. (8W)

Once I had them, well, "where's the cigarettes?" (23aW)

After I had the child, as soon as, I had two things in my hand. One was a coffee and one was a cigarette. (22W)

I breastfed for a while so I didn't smoke while I was breastfeeding but as soon as they came off... (25W)

A couple of weeks before I had my daughter. Oh, I feel like a cigarette... For some unknown reason I started smoking again. (KN7W)

People who unintentionally stop smoking because they temporarily can't afford cigarettes, are similarly likely to start smoking again as soon as they have enough money to do so.

Two days later I got some money. (8W)

Te Taha Whānau

There was a lot of negative affect associated with relapsing occurring while socialising, for example: feeling left out or excluded, shy or insecure.

I felt left out. (24M)

When I started this course I was, like, shy and just wanted to talk with them and just asked for a lighter. (24W) ...Like asking someone for a lighter? ...Yeah (24W) ...Have you got a spare ciggie bro? (24M)

These appear to be triggers to relapse as they occurred somewhere or while at some whānau gathering or social event. They appear to be spontaneous, sudden slip ups. Participants seemed particularly vulnerable to re-starting smoking when drinking alcohol.

It was a social thing. (24W)

At the pub, yeah socialising. (8M)

When I play sports, or when I drink. ...Like, every time we have sports, then there's a function! ...There's alcohol and smoking! Or after I play sport, or before I play. (23bW)

When everybody in the peer group smokes, there's a powerful force to just do what everyone else is doing. This is described in the following quote:

It wasn't that I wanted it, it was just watching other people ...I didn't know what to do .. watching other people smoke. Most of my friends smoke. (25W)

Yeah, social. That's it. When everyone around you smokes. (8M)

When you're young you do what your mates do.(23aM) ...That's my life story. 23aW)

Peer pressure. (8W)

Part of the 'pressure' experienced could be a wanting to avoid feeling excluded. Like one participant said, if they didn't join in and smoke, they'd have no friends. This was especially so on the marae.

You'd look funny sitting over there – and can smell the smoke and then you'd think, shit I want a smoke. ...You'd have no friends. (8W)

On the marae. (23aW)

Because everyone else was doing it. (23W) ...Cos it's cool. [Laughs] (23W)

Everyone was coming up and chain smoking. (14W)

Watching everyone else. (25W)

Everyone was smoking. (KN1M)

I tried to stop and had stopped for quite a while. And then we were in a band and there was 3 major smokers and I was always like a 'can I have a puff after you' smoker. I was like a hoha smoker that hoha'd everybody else, but it kind of became 'oh I'm sick of puffing off theirs because I want one when they're not around so I'm going to buy my own packets and I'm going to start smoking'. And because I had a job now, at that time, I was able to just buy me a packet and, like, didn't smoke as much but at least I didn't have to inconvenience others by going 'oh can I have a smoke' and waiting around to get them to roll it for me. Because then I had my own pack, I could just do that. (KN2W)

One man re-started smoking because he was feeling left out at work - there was no one else there his age that he could 'click' with.

The majority of my mates that work in the industry, are adults. So there was no one my age that I could really click with. So most of the workers in our area are smokers. (22M)

Wanting to be accepted in to the 'cool' crowd or by new friends was a reason to restart for several participants.

I wanted to fit in again. ...I wanted to be cool. (13M)

Just do what everyone else is doing. ...Because I felt left out. (24M)

Everyone I studied with smoked, that I liked, so I just smoked with them. (25W)

Young people did report restarting smoking due to peer pressure.

Pressured in high school. By friends. (22M)

Te Taha Tinana

Weight gain

Fear of weight gain, probably based on gradual weight gain experienced after quitting was noted as a background reason for starting to smoke again. This was talked about more in terms of it being an undermining tension rather than a sudden slip.

And then I was driving home one day and this thought come in my head. It's like I wonder what it'd be like to have a smoke and that was it. (KN7W)

But then, you know you start growing in other ways when you give up cigarettes. I think I grew about 3 or 4 dress sizes. I was huge. And I suppose that was a thought in the back of my mind when I decided to put that cigarette back in my mouth. (KN7W)

And then I started again when I ate all the food in the cupboards. (24M)

Wanted to smoke

Some participants said they started smoking again because they just wanted to smoke, for example, for the satisfaction it used to give them or the reward, or break from work that it used to allow them.

There's satisfaction out of it for me – done that bit for the car and it's parked up so then you have a cigarette and think what's next. (8M)

Behavioural and physical associations

Smoking was habitually associated with so many contexts, actions and people that were reminders of smoking and these would trigger a craving – which participants would manage to transcend sometimes but not all times. There was some recognition of this among some participants. They said they relapsed because of the habits and because they were addicted.

Probably mainly the habit really, I think habit would be more accurate. (8M)

I still have those habits, like when I'm really full I need a smoke or just after I've had a coffee I need a smoke. And it's still the habits I've got to break before I think I can stop fully and then I'll be all good. (KN2W)

I'm addicted to cigarettes like I am to food. I'm an addictive person. (KN7W)

The smell of smoke was mentioned as a trigger to relapse.

When you guys are having a smoke and stuff, and I come and see yous, I can smell it. (KN7W)

Even a car driving past and someone smoking in that car and I'd be like oh, yeah. That smells good. (10W)

Some participants believed that it was possible to smoke just socially, that is, occasionally without becoming addicted leading to having to smoke regularly. They would subsequently think that they could have 'just one puff.' This made them vulnerable when faced with the temptation or a craving to smoke, as the following quotes show:

They said do you want a puff and I said yeah. [Laughs] And then I couldn't quit it. (13W)

I just thought I'd beaten it, that's all. (25W) ...I had a couple of cigarettes when I went out and that was it. (25W)

Some participants had beliefs that smoking takes a specified amount of time to get out of your system, that there is a trajectory of the habit, so to speak. So, when they went back to smoking, it felt like they'd never given up.

Like I gave up for five years. And then I got back into cars and that. Started working on cars and that again and I just was smoking and it was like I never gave it up. (8M)

Alcohol was one behaviour strongly associated with smoking for some participants.

Because you crave for one when you're drinking. (7W)

Alcohol and smokes go together. (22W) ...They just complement each other. You get a better, I don't know, you get a better kick out of it. (22W)

One person said she smoked less when she drank.

I smoke less when I drink. I could spend 8 hours in a club and not go outside for a smoke. (22W)

No Reason

Not all participants could recall a reason for why they started again. One participant said she started smoking again because she didn't know any better.

I can't even remember why I started up again. (23W)

Oh I was ignorant, young and dumb. (KN1W)

For some people, it's just easy to get started smoking again.

It's easy to get started. (KN7W)

Things that made it hard to stay smokefree

The reasons for relapse reveal some of the perceived triggers to return to smoking. The things that make it hard to stay smokefree are the pressures (tensions) opposing not smoking, pushing people back to smoking. They are the things that undermine people's motivations to stay smokefree.

Many of the undermining factors are the same as the above perceived triggers to relapse, suggesting that there is a certain level of intensity that tips the motivational balance away from staying smokefree. This can be experienced suddenly and surprisingly, as when an unexpected stressful life event occurs, or there can be a cumulative build up. Or, as some of the quotes suggest, the triggering of cravings, the pressure to smoke is almost constant requiring an equal or stronger constant source of motivation to stay smokefree. Thus, stress, boredom, socialising, relationship problems, depressing life circumstances – all the same reasons that cause relapse, exist and exert pressure to return to smoking.

Stress. Work. Boredom. (23aW)

Socialising can be as much of a trigger as stress. (11W)

Boyfriends, kids, stress. ...If there were no kids in the house I'd be alright. But kids stress me out. Like my little brother. (7W)

The pain in the arse husband. (8W) ...Wife! (8M)

Having kids, working, solo mum. No life. (22W)

Family disputes. Dramas. Problems. (22W)

Because all the men stress them [the women] out, that's why. (10W)

Hard day at work. (24M)

If you've got too much spare time. (8W)

Having nothing to do. (22W)

When you're worried about how you look. When you're insecure. (22W)

In times of stress, smoking was remembered as a coping strategy, as something participants could rely on.

It just calms you down ...If the kids are having a go or whatever, be it your own or not, they just – yeah, oh my God I need a smoke. (10W)

It sounds a bit deep, but I think emotionally what feeds the addiction for me is that I'm fearful of being dependent on myself so I need something to be dependent on. (25W)

Some participants were even aware of the strong use of smoking to cope with negative emotions and fatigue, as the following excerpt shows.

Anger. ...I'll smoke more when I've got more negative emotions. So if it's anger, resentment, frustration, annoyance, whatever, I'll smoke more. ...If I'm tired I'll smoke more too because I think it's a stimulant, I just smoke more. (25W)

Te Taha Whānau

Whānau members smoking made it hard to stop and stay smokefree.

Family members ...Whānau, hanging out with whānau. (23aW)

If people's partners, husbands, wives, boyfriends or girlfriends smoked then it was hard for them to give up or stay stopped.

My partner doesn't care whether I smoke or not. (7W) ...Because he smokes too? (7W) ...Yeah. (7W) ...They pretty much all smoked so they didn't care if I gave up or not [talking about her previous boyfriends] (7W)

The Mrs smokes. (8M)

Older participants recalled that when they were younger everyone smoked, everywhere. Whānau, the whole of society was permissive of smoking.

When I grew up, I don't know about you, but probably everyone's similar, everyone smoked. Parents smoked. Family smoked. Doctors when you went to hospital, they smoked. You smoked at your desk. (11W) ...I can go for like a week without smoking. ...If I'm with non-smokers I won't smoke. But if I'm with smokers I'll smoke. (11W) ...Everyone did it in the era I grew up in. (11W)

If the whānau are permissive of smoking, they may go so far as to be dismissive and disruptive when whānau members try to quit, as happened for one participant.

...made them angry cos they said. "Oh, I have to stand there by myself." (8W)

Given all the above things that trigger cravings, it is not surprising that living with smokers makes it hard to stay smokefree.

It's hard when you live with bloody smokers. (10W)

Te Taha Tinana

Some participants were scared to stop smoking in case they put on weight. Others had had this happen to them and it was what made it hard for them to stay smokefree. The desire to maintain a certain body weight and image, using smoking to lose weight and or wanting to avoid putting on more weight when they already had unhealthy levels of excess weight was a real problem of competing motivations – both health focused.

Weight loss ...Not that it worked! [Laughs] ...Weight gain more like it - what made it hard to stay smokefree? Weight gain! ...Stopped smoking and you get fat cause you go to the fridge. (23aW)

I'm scared I'll, because you know, I'll always carry weight. I'm trying to lose that and it's not happening. I'm scared too, that if I stop smoking, I'm going to start eating. I don't eat a lot, but I'm still carrying weight. So I won't give up smoking. (23bW).

Seeing other people too who have given up smoking, and suddenly they put on... They get fat. ...20 or 30k ...Yeah well you start off as skinny and you end up fat. I learned really fast eh. It was like, I put on how many kilos... My God! (11W)

I used to smoke when I thought it helped me lose weight after giving birth. (22W)

But that's what smoking does. It doesn't make you crave food. Like eat. Well, for me. I don't really eat much. (10W)

One woman quipped that smoking made her eat more.

I reckon smoking makes me hungrier ...I have a cigarette after every meal. (10W)

Smoking was used by some participants as an appetite suppressant, for example, if they didn't have time to eat.

Or if you just don't have time. It's faster to have a smoke and a coffee than it is to go and make anything. (11W)

For some participants smoking was engrained in their idea of and experience of socialising. Smoking was an aide to meeting people, making conversation...

*Being in really good conversations makes you feel like you want a puff eh. (22M)
...You don't even realise aye, you've already had three. And one glass of wine. (22W)*

*You smoke more when you're drinking and socialising at a pub. (11W) ...Even with smokefree pubs. (11W) ...Go out to have a game of pool and then – (11W)
...Like I smoke about only four or five a day now. But, like you're saying if someone says oh let's go to the pub for a drink, which is very rare, but as soon as I do, I can go through a pack in a night. And it takes me about a week to get over it. Because I'm such a light smoker. I hardly bloody drink. But everybody's popping out for a fag and I'm right there. (11W) ...And you suffer aye? The next couple of – it takes you a week to get over it. (11W) ...I can hardly breathe, literally. (11W) ...But socialising can be as much of a trigger as stress. (11W)*

Watching everyone else have a cigarette and they make it look so yummy. (23aW) ...If you go to a party, and someone lights up... (23aM)

I really wanted to stop at 23 because everything else, what I had like a lifestyle, job. It was hard, and that age of 23, 24, I really wanted to stop but I just had mates coming around and they were drinking and all this other stuff. (KN1M)

Smoking was also seen to be bound to cultural identity as Māori, and Māori environments were permissive of smoking, for example, wānanga, marae. Smoking was seen as a Māori thing to do.

Going to the marae (23aW) ...Going to wānanga's. Anything Māori. (23aW) ...Is anyone going to the kapu ti [cup of tea]? ...Don't be a Māori! (23aW)

Everyone else is doing it. (22W) ...Work. Other commitments. Might be in a sport team that do smoke. And it's just a habit of you picking it up. Or something cultural and everyone's smoking. (22M)

The other thing that was a little bit freaky is like at our, at our marae is that people smoke out where you cook. They smoke while they cook and they smoke inside the cooking, where you eat, like the dining and that. Which I thought was pretty bizarre. (25W) ... when they have their little after functions but it's still sort of like weird. (25W) ... they've got that big roller door open but they're in there, you know, and they're cooking and they walk around with fags in their hand. (25W)

The craving. (14W)

Coping with cravings was one of the hard things about trying to stay smokefree and for some participants this went on and on.

I still crave cigarettes. But I'd die if I puffed one though. (10W) ...Have you quit smoking? (10W) ...No, no. I've done it a couple of times, but when I did restart it, it did take me a wee while to get back to it. I'm so dedicated. I'm just not a quitter. (10W)

Cravings were triggered by smelling smoke, the smell of it on family and friends, and all the behaviours that were part of the routine, that were habitually followed by a cigarette.

Being able to smell it on your friends or family, if they smoke. (10W)

It's about your eating and your drinking and your socialising and your – it's a lifestyle really. ...It's association too isn't it. Coffee, smoke. Have a feed. Finish it. Have a smoke. Go outside, have to have a smoke. Stressed. Have a smoke. (11W)

Drinking alcohol and playing pokies were for some participants inseparable.

Drinking just makes you want to smoke heaps and heaps. (24W)

Pokies. ...All the vices. Yeeha. (11W) ...And you can smoke a whole packet eh. (11W).

Drinking makes it hard. (22W) ...It doesn't work when you're just drinking. I don't know why. It doesn't happen without a cigarette in your hand. (22M)

I need a cigarette when I drink. (10W) I don't even think it is the movement either. (10W) ...It all runs together. (10W)

Tonight I want to have a drink and I'm like, oh my God, I've got to buy a packet of cigarettes. Can't just buy the four pack. I've got to buy the packet of cigarettes too. (10W)

Feeding the smokers'-myth about social smoking, the following quote includes a story about how even non-smokers have to smoke when they're drinking.

Even non-smokers, umm, a few non-smokers smoke while they're drinking. (14W) ...Yeah, they've quit. But they don't always give up. (14W)

Treatments

Poor access to NRT products and cessation services

Another theme on what made it hard to stop smoking and stay stopped had to do with having poor access to smoking cessation aids, services and support.

The cost of accessing cessation support was the most cited barrier. For example, some cessation aids or support requires people to see a GP. For some participants visiting a GP was cost prohibitive.

You have to be pretty rich to go to a doctor. (23aM)

Some participants firmly believed that even \$3 for a supply of NRT was beyond the financial resources of some people who smoke. In one of the KwitNeeds focus groups some strong resentment was expressed about the having to pay for cessation support, when the tax on tobacco was so high and when the pressure on smokers to give up was so consistent and strong.

What gets me... is how you have to pay for all of this sort of stuff. If you really want our people to give up, then give them the opportunity to actually be able to have access to it, instead of giving them, 'oh five bucks for that cuz, three bucks for that cuz'. They can't even afford five or three bucks. ... Well the younger ones are probably pohara [poor] too but the older ones can't afford it because they've got children to think of and other expense, yeah. So why don't they do that? They harp on and on about smokers, you know, smokers, smokers, smokers all the time...(KN2W) Find the cure...(KN2M) Yeah, and then make people have to pay for it... Give it to them where it's accessible, it's not going to cost. (KN2W)

A further effective psychological barrier, according to this group, was having cessation aids cost more than tobacco. Neither did it help that tobacco retailers sold packs of 10 to keep cigarettes affordable.

Especially being dearer than the normal packet of smokes. You know, people would just ordinarily choose a packet of 20s, of tobacco... who would want to choose that over a packet of smokes? (KN2M) And I've noticed a trend with our nannies now. Our nannies go in and they'll buy the packets of 10 cigarettes that they have. I don't know whether it's the affordability or they just have one smoke now and then, but yeah ...because the Indian sells the packets of 10s. (KN2W)

This group felt that cessation support and products should be free, because they felt they had paid for them already via the tax on tobacco. The more sceptical in the group concluded that the Government actually wanted them to keep smoking.

With the amount of tax that's on our blimmin' cigarettes at the moment, we are paying for these things anyway, so they should be free. Because I know how much money the Government's making off the tax that's on the cigarettes. So it's not like it's not paid for. We're paying for it ourselves ... (KN2W) ...May as well get something out of it. ... because they want us to keep buying them really. ... They want to get their, yeah, well they get a huge cut out of it.(KN2W) They get a huge cut out of the cigarette, the whole industry. ...(KN2M) And then they say 'oh well we're paying for you guys to go to the hospital' and all that, but that's only this much of the money that you're spending on us, you know?... And more Māori and PI are dying, and blah blah. (KN2W)

And they, Government, will keep it that way because ... They earn money ... And they make shitloads off it ... So it's in any government's interest to keep the people smoking... (23bW)

If support was only accessible during, for example, normal working hours and participants also worked during those hours, then they found it hard to access cessation support. Location of

cessation support could also be a barrier to access, if the location was not convenient for participants.

I work nights and weekends too so it's a bit hard. (23aM; & 23aW)

Some participants thought stopping smoking just required too much time. Particularly, it was seen that women would often put their health after the health needs of their children, so they never got around to having time and money left over to undertake what was perceived to be a serious effort and time-consuming commitment.

I'd love to give up smoking. I really would. But I just don't, see, you know especially from my side I'm just constantly on the move. Like I don't see. Like, I think, for a lot of women, there's very little time in the day, for you. So, you come last. ...So you sort out everyone else, and everybody else is ready for that day, and then you sort yourself out. And by the time you've sorted yourself out you've got no energy to stop smoking. (23bW)

I'm not prepared to go to all the, you know, things like, drug rehab. (23bW)

Different pressure on women. (11W)

Some participants gave the impression that where they lived, smoking prevalence was so high as to be the norm.

Look around where you live, man. It's like the middle of the ghetto in Tokoroa man. ...Most of them smoke something. (24M)

In some focus groups there was talk that suggested some participants believed it was possible to smoke 'socially' that is to not be addicted and have to smoke every day. They believed there were lots of people who no longer smoked daily, but who would only smoke when socialising. That is, they would only smoke when in environments that were permissive of smoking, where it was socially acceptable to smoke.

So I think there's a lot of people out there like that. ...Yeah, well they'd only smoke socially aye, when they're around other people that smoke, but can go during the weekdays when they're at home with their kids. ...Why smoke when other people are around smoking? (25W) ...Pressure. (25W) ...Yeah. (25W)

When all your friends and work colleagues smoke – it makes it hard to stop smoking and to stay smokefree. Friends and work colleagues could make it hard also, by continuing to encourage participants to smoke, for example, by asking them to go outside for a smoke with them.

One of them will walk up to me the day after I've just finished smoking and say do you want a smoke? (KN2W)

Come on let's go for a smoke. (11W) ...That whole eyebrow thing. (11W) ...Everything can be unspoken eh. (11W) [Laughter]...I get emails now and it's just a question mark. (11W) [Laughter]

When your mates smoke. ...When you go outside with your mates, and they all smoke. (7W)

And it didn't help that the people that came [to a cessation course] to quit smoking with us would go back to course and go have a smoke. ...Or as soon as we got out the door! (7W)

One participant reported that at one of their workplaces, they worked with a lot of Asians, who were very generous with their cigarettes and this was one thing that made it harder to not smoke.

Lot of Asians they go "here have a smoke, have a smoke". ...Even though no one smokes, they can sit there for hours [smoking] (23aM) ...someone comes along with a smoke and lights up. (23aM) I used to work with a lot of Asians and they just give you smokes like nothing. (23aM)

Peers were even perceived to pressure friends to smoke with them.

Pressure. ...like you're trying to tell your mates that you're going to stop and they pressure you to stay, like, keep smoking. ...Yeah keep encouraging you. ...Yeah, keep asking you if you want a smoke. (24M)

Being around other smokers was generally unhelpful to staying smokefree.

Being around other smokers. (25W) ...Yeah, that's definitely. (25W)

Give me a smoker and I've got a buddy. Come on let's go out. (11W)

Some participants had learned from relapsing that it's not safe to have even 'just a puff' and that it's not so easy to be just a 'social smoker.' One participant warned that you have to realise you're still a smoker – that the addiction lies in wait.

*One of the things when you give up is that you have to realise that you're still a smoker. It's just there, it's just in the back. See, I believed I was a non-smoker after 3 years and it was like, nah, it was still there. Just step back into those shoes, just like that. (25W) ...It's like you can always be an alcoholic. (25W) ...**So you could relapse at any stage?** Yeah, it's just sitting in the background. (25W) ...Waiting to happen. (25W)*

The group then talked about a person they knew who had been smokefree for years and he had just relapsed.

It's like [name] the other day, you know, he's 35, 39 years. It's like - (25W) ...Yeah, that's sad. (25W) ...I know for the next time when I give up, that's it, I am not going to touch it. Because that's all it took. (25W)

Being able to afford to smoke was an enabler, a thing that made it easier to keep smoking. Conversely, if tobacco products are affordable it was one less reason motivating people to give up. One focus group dismissed that only lower socio-economic people smoked or that smoking was unaffordable even for the poor.

Honestly, because, excuse me, most of the people who are hard out smokers, are supposedly poor. (23bW) ...And they're still smoking. (23bW) ...Well they can't be poor. (23bW) ...Well I'm not poor. (23bW) ...I'm not poor. (23bW) ...I know what poor means. (23bW) ...I'm not poor, I've got whānau. (23bW)

When asked where they get their money for smokes, participants in one focus group said they got it from their benefit or from savings.

Benefit. (24M) ...WINZ, yeah. (24M) ...Savings. (24M)

Parents were reported to help out by supplying tobacco when required also.

When I was on the DPB my dad went out and bought my cigarettes. Yeah. Cos he's a smoker, so you know. He bought me cigarettes. (23bW) ...When I was broke and had no money, there would be cigarettes in the mailbox. Because he knows. It was probably for the benefit of his mokopuna, that I would have a smoke. (23bW)

Smoking was made easy also by having easy access to tobacco.

Ah, easy accessibility. (23aW)

Some participants found it hard to stop or stay smokefree because they really enjoyed smoking and the benefits they perceived that they derived from smoking.

I liked smoking. I love smoking. I really do. (23bW)

And I'm like measuring tasks in between smokes. I'm going to do this and this and then have a smoke. (11W) ...Like you reward yourself. (11W)

And it made me look cool. (23aM)

One participant said she smoked because it justified her taking extra breaks like the smokers at her work were allowed to do.

I work at the pub but then the chicks that don't smoke don't get a break. So it's a cop out. So, I go "oh smoke", so I can go have a break. (7W)

Te Taha Hinengaro

What made it hard to stay smokefree? Being addicted to it. (10W)

Smoking is a legally sanctioned addiction, which allowed one participant to rationalise that whilst she didn't like being addicted, at least she was only addicted to a legal drug.

I'm addicted. But there are a lot of worse things I could be addicted to. Umm, I weigh up and I think well, I could be a P-head, or I could be a coke-head. I'm a tobacco head, and until it becomes – you know, against the law... So if one day the law says it's illegal then I'll give up because I do not - if that's why my children do that, they actually practice what they, you know, you're showing your kids, okay, well. But at this stage in my life, and I'm sure for many years to come, I'll God damn smoke, unless it's become, you know, against the law. ...It's a legal drug. (23bW)

Some participants felt powerless over the addiction. As one participant said, she felt like she needed something that could switch off the addiction in her head.

If someone could go into my brain and switch off the switch that was the smoking switch, I'd do it. But they can't. (8W) ...I'd have to pay two hundred and something dollars to go to the hypnotist. And have them say "stop thinking of smoking" and you do. (8W)

One man expressed amazement at how powerful the addiction was, that people would go to great lengths and discomfort to still have a smoke.

...it's quite amazing actually how we all, if you're not allowed to smoke in an area, how far we'd travel out that door to go and have one. Bloody hell. That's what pisses me off a bit. It annoys you aye because you're dragging out to go and have a smoke. (8M) ...Freezing cold and the rain. (8W)

This creates cognitive dissonance, that is, this participant was quite annoyed about going through the motions of going out in to the freezing cold to smoke and yet he couldn't stop himself from doing it. The following quote also illustrates cognitive dissonance. The woman says she likes to smoke, but she also knows it's doing damage. To assuage the guilt she feels, she rationalises that 'it's an addiction anyhow' thus attributing blame to the addiction and not herself.

I like to smoke. (8W) ... But in the meantime I know I'm doing damage too. Maybe that's just an excuse for me. I don't know. It's an addiction anyhow. (8M)

Addiction, or rather nicotine dependency, was not well understood. The following discussion from one focus group presents the group with a range of behaviours that the term addiction is supposed to explain. First, there is a story (like an urban-myth or smokers'-myth) that is shared of a long-term ex-smoker who still craves for a smoke after 39 years. Another participant says smoking is a habit, and then another woman suggests instead that it's an addiction. This is disputed. The previous speaker goes on to explain that she's only 'emotionally addicted' not physiologically or psychologically addicted. The confusion over the term addiction is added to by the way the term is applied to alcohol use, that is, it's only an addiction once drinking becomes problematic. The group then spins off on to eating and say that not being able to stop eating is because it's an addiction.

That's actually what's quite scary about it. I was talking to someone on Tuesday and they've given up for 39 years, stopped smoking, and he said he still wants to smoke. (25W) ...Still has the urge. (25W) ...It is a habit. (25W) ...But you must be addicted aye? (25W) ...No. I talked to ... a psychologist. (25W) ...And I believe that I'm emotionally addicted to smoking but not physiologically or psychologically addicted to smoking. I'm emotionally addicted to it. (25W) ...It's a make me feel good thing, is it? (25W) ...Yeah, like a friend little thing, you can lean on when nothing else is. Yeah, when no-one else cares. (25W)...I think it might be emotionally psychologically for me, but everyone would be different. And I haven't, it's the first time I've sort of thought a bit like that and I think it's going to take a while for me to figure out exactly where I sit with that, though. (25W) ...People who drink don't see it as an addiction until it's a problem aye? (25W) ...But that's a bit like food in that sense. (25W) ...Yeah. (25W) ...Like a lot of people think, 'oh I'll stop eating', but it's actually an addictive behaviour. (25W) ...It's an addiction. (25W)

An interesting discussion about addiction occurred in response to the question 'Is it harder to quit when you're older?' This showed that some participants think that the longer a person smokes the more addicted they become.

I think we just assume that... (KN2W) I think it is. (KN2W) Because the longer you've been smoking the more addicted you get. (KN2W) Yeah, it is more addictive. (KN2W)

One participant said that "as you get older...your priorities change" (11W), implying that quitting gets easier as you age because there are new reasons to quit smoking that were less relevant during youth.

Smokers myths about quitting smoking

Some of the 'smokers' myths' about smoking and quitting smoking possibly undermine motivation to quit and self-efficacy (confidence in quitting). Some of these were: not believing that smoking does harm; thinking that quitting can be worse for health; that smoking is a choice and success at quitting is dependent on willpower; and, not believing that smoking is addictive and that it is possible to just smoke occasionally.

Seeing elderly people who have smoked for a long time who are seemingly unaffected by their history of smoking undermined people's acceptance of the health risks of smoking.

An old lady used to live next door to us said, and she reckoned smoked meat lasts longer than raw meat so she was going to keep smoking. [Laughter] ... And she was like 82 man. Fit as a fiddle. (25W)

Then, seeing friends and family stop smoking and promptly get sick or soon after die from a heart attack anyway, scared people. They incorrectly concluded that quitting was responsible for the worsening health and death.

I think it's a nice idea, but I have so many friends of my age group, who have given up smoking, and gone the total opposite gone quit, and then had a heart attack. (23bW)

Waiting for their planets to align, so-to-speak, that is, believing that at some particular (but unknown) 'time' they would make 'the' decision to quit and that would be enough to ensure a successful quit attempt – left people incorrectly waiting for something that might never come in the absence of more direct action to exert change.

I feel it's something I need to do on my own. It's a decision I have to make. I chose to smoke so it's something that I need to do. Yeah, so. ... When the time's right. (KN2W)

Some participants thought they could smoke intermittently, like they had when they started smoking, as illustrated below. Or, they tried to smoke occasionally, that is, 'socially' thinking they weren't going to relapse to regular/daily smoking. This made participants vulnerable to relapse.

I thought I could be a social smoker. So I still saw smoking as desirable. But I thought, oh, I can do this socially. (11W)

I honestly thought for about three months that I had the whole thing under control because I wasn't smoking here and there, and it didn't really matter. And then bang. (25W)

I started as a social... I used to smoke when I used to get drunk with my friends because they were all, and then it became to the point, like, we used to always do it with other people's smokes and then the next day we wouldn't even think about smoking, we'd think it's disgusting. And then it became to a point where we started getting a box and a cigarette packet before we'd go out and then it just kept going like that for a while... (KN2M)

Some people had no reason that they could think of for stopping smoking. As one participant said they just couldn't get that motivated about quitting.

Just you can't get that motivated. (KN7W)

I was a heavy smoker and that's, there's no reason for me for stopping. (KN1W)

One thing that made it hard to even contemplate quitting was having negative expectations about how bad the withdrawals would be.

I viewed my father when he gave up and he was like a bear with a sore head 99.9% of the time. He had 300 staff and about 20 staff came to us and said get your father to take up smoking again. He was so bad. He was unbearable to live with. (11W)

Focusing on the losses rather than the gains also made it hard to stay smokefree.

We do, you do lose, that special time that we should have with our friends, and whānau, umm, we do create stress for your whānau because I believe that without them I go through horrible up's and down's. Up's and down's in terms of emotional. I've got kids most of the time. (23bW)

Te Ao Turoa

Promotion of smoking and tobacco products

In one focus group they said the tobacco displays in shops and seeing smoking on television triggered cravings.

Walking into a shop and seeing a packet. (7W)

Outrageous Fortune is the worst time I smoke. When you watch Outrageous Fortune and it comes up to a really good bit, and then the ad comes on and you quickly run out for a smoke. (11M)

I crave a smoke when I watch Cheryl in Outrageous Fortune. She smokes like a train. And when she's inhaling it, it looks really enjoyable. (10W) ...When you see people smoking on the TV you want to have a cigarette. (10W) ...Yeah. (10W) ...Influence of other people. (10W) ... I tell you what, Robyn Malcolm doesn't even smoke though, does she? (10W) ...She does it well. (10W) ...She's inhaling it really deep. (10W) ...She does heaps of stuff for animals and the environment and stuff like that. (10W) ...She's on that Quitline ad, eh. That smokefree ad. (10W) ... She is too. All of the actors are. (10W)

Māori discussion

Consistent with other studies there was a high percentage of loose tobacco use among Māori participants (Ministry of Health 2006; Health Sponsorship Council 2008; Nosa, Glover et al. 2009; Wilson, Young et al. 2009). Only 20% reported smoking exclusively factory-mades. Cigarettes per day was low with about half of Māori participants smoking up to ten cigarettes a day. This contrasts with time to first cigarette, an established indicator of nicotine dependency which suggests that about 60% experience a high level of nicotine dependency requiring that they smoke within half an hour of waking. Smokers can adapt the way they smoke in a variety of ways in response to increasing tobacco prices – switching to RYO, switching to cheaper brands, smoking cigarettes more intensively and smoking closer to the butt (Wilson and Thomson 2005; Thomson, Wilson et al. 2008; Wilson, Young et al. 2009).

Māori women were over represented among the Māori participants but this is acceptable given the high priority that needs to be given to reduce smoking among Māori women, especially of child-bearing age (United Nations 2010). Almost 18% of Māori girls aged 14-15 were daily smokers in 2009 (Paynter 2010); and 49.7% of Māori women aged 15-64 surveyed in the NZTUS 2008 were daily smokers (Ministry of Health 2009).

More than 90% of the Māori participants wanted to stop smoking sometime which is higher than the commonly cited 80% of smokers who are said to regret and or wish they had not started smoking (Ministry of Health 2009).

Almost half were intending to stop within the next three months from the date of data collection indicating a high level of need for cessation support to be delivered to this demographic group, if the efficacy of their cessation attempts are to be improved as desired by the Ministry of Health. Actually, by the end of the focus group exercise, more than a third of participants wanted to take a Quitcard away with them so they could try quitting again with NRT.

- ***It is recommended that the Ministry of Health review the current capacity to provide cessation support to Māori, against this possible scenario: that a third of Māori smokers need cessation support delivered to them right now.***

Motivation to Stop Smoking

Actual reasons for quitting based upon reasons given for stopping at past quit attempts varied slightly from the ranked perceived reasons, that is, the reasons participants thought should prompt Māori to quit. Previous quit attempts were largely (39%) attributed to broadly health reasons. But quitting for children's' health and to be a smokefree role model for children was ranked as the most important perceived reason prompting Māori to quit. Quitting for pregnancy was also ranked highly. The range of reasons grouped as health were ranked as less important reasons for Māori to quit.

This suggests that there are reasons that are perceived to be very important motivators to quit but they are not translating through to triggering actual quit attempts. As seen in the tables of relative ranking of reasons to stop stopping and the reasons given *for* stopping, there is a mismatch between what could be termed reasons why Māori should quit versus what actually triggers them to quit.

Quitting to protect children from the ill-effects of second-hand smoke (SHS) just did not feature as a trigger of past quit attempts. Yet, Māori participants clearly believed protecting children and not smoking in pregnancy were important values for Māori. Valuing tamariki and protecting tamariki from preventable illness is a tension, but for our participants, it had not been strong enough to trigger quitting. This assumes the recalled data is sound. It could be that participants recalled simply

commonly cited reasons or one proximal factor only, rather than recalling contributing but distal factors also. It may not be an either/or, as West's (2006) theory proposes multiple factors contribute to building tension to quit.

A bout of illness and pregnancy are 'events' that crop up and provide sufficient force to trigger a quit attempt. These events could be capitalised on by tobacco control initiatives.

- ***It is recommended that public health, primary and secondary healthcare providers ensure that patients who are ill or pregnant and who smoke are informed at each consultation of the availability of cessation support, and offered cessation support.***

Tobacco control also however needs to build the tension to quit, which with Māori can be done by positively supporting Māori valuing of tamariki me te whare tangata and hapungatanga and linking not smoking with practice of these important tikanga (i.e. lived tikanga). "It's About Whānau" is still a highly relevant theme for tobacco control initiatives to capitalise on.

Simply wanting to quit and not liking smoking, because it is a "bad", "dirty", "disgusting habit" that stinks, tastes bad and stains your teeth featured quite highly as a category of triggers to quit, but was not ranked highly as an important reason prompting Māori to quit. As smoking becomes more and more socially unacceptable more could be made of the offensiveness of the smell of tobacco smoke, not to non-smokers and children, but to smokers themselves. Enjoying that their room and clothes no longer smelt of smoke was also one of the benefits that helped people in their resolve to stay smokefree.

Nearly all of the Māori participants wanted to quit sometime. Tobacco control initiatives should regularly remind smokers of this desire and make it easier for them to quit. The saying 'you can lead a horse to water, but you cannot make it drink' does not apply here. We are in an enviable position: the horse wants to drink; all we need do is lead it to water, or better yet – take the water to the horse!

Cost was minimised in the ranking exercise and was not seen as a strong motivator to quit for Māori. But it did feature as a reasonably frequent trigger prompting past quit attempts. However, some of these past quit attempts especially among younger participants were by necessity rather than intent. That is, people stopped smoking because they had no money to buy tobacco, but as soon as they had money they smoke again. This highlights the distinction that needs to be made between intended and unintended quit attempts. We wanted to identify all triggers of any quit attempt, as according to West's theory any quit attempt could unexpectedly become a person's final quit catapulting them permanently to a smokefree status.

Is Smoking Still a Māori Cultural Norm?

There was a stream of comments that linked being Māori and smoking, as if they go together. Being Māori brought with it a level of stress that contributed to smoking. Māori environments, like marae and wānanga, were perceived to be largely permissive of smoking. So permissive of smoking, so normalised was smoking, for example at tangi on marae that even non-smokers smoked there. Going to Māori environments was a sure way to relapse. Smoking was so prevalent in some whānau and areas, along with stress (relationship problems, caring for tamariki, kids getting into trouble) that smoking was universal almost. Additionally, Māori never isolated you for smoking – there was no negative consequence in terms of belonging. As one participant said, smoking in Māori society is acceptable.

Māori tensions not to smoke need to be strengthened.

Māori environments, marae, wānanga and workplaces need to be assisted to reduce the smoking-permissive culture reportedly still engrained there. More Māori leaders need to speak against

smoking to challenge the perceived acceptability of smoking in Māori society reported here. Māori leaders and role models who have suffered smoking-related illnesses, like MP Tau Hanare, could usefully share their experiences with cessation to help redress some of the 'smokers myths' and to encourage other Māori smokers to quit before they too have a heart attack. Particularly, strong hapū, iwi and urban Māori leaders need to be enlisted to re-set tikanga/kawa around te whare tangata, NOT smoking while pregnant, and Māori infant care practices (hoki ki te ūkaipo/breast feeding, he pepi he rangatira, kua e patu ngā tamariki). Māori society, especially lower SES, urbanised and rurally isolated Māori need clear and strong Māori guidance to improve the health and safety of tamariki Māori.

What cessation service?

Aukati Kai Paipa as a programme brand was not well known. This study suggests that even when such a service exists in the local area, and even when people have been assisted by such a service, there was still poor knowledge of the existence of Māori specific cessation support services. Cessation services delivered by Māori providers or designed for Māori smokers need to be reviewed and assisted with branding and marketing.

Chapter Two: Pacific data

Dr Vili Nosa, Donna Watson, Jane Stephen, & Raina Tutini

Participants

Demographics

Eighty-nine participants took part in focus groups for Pacific peoples who smoke. See Table 11 for a summary of participants' demographic data. Forty-seven percent of participants were female, and most participants were of Samoan, Tongan or Cook Island ethnicity. Fifty-one percent of participants were under 26 years of age, and just under half (49%) were born in New Zealand (NZ). Of those participants not born in NZ, most (67%) had resided in NZ for more than 20 years. Thirty-seven percent of participants were in paid employment, and greater than half (54%) were eligible for a Community Services Card thus indicating lower socio-economic status (SES).

Smoking Behaviour

Age of smoking initiation

Table 12 shows participants' smoking history data. Almost half (42%) the participants smoked their first cigarette between the ages of 11-15 years. Almost half (43%) the Pacific participants progressed to regular smoking between the ages of 16-20. Most (60%) were daily smokers by the age of 20.

Current tobacco use

Thirty-seven percent of Pacific participants smoked factory-made cigarettes, 8% rolled their own cigarettes, and 39% smoked both factory-made cigarettes and loose tobacco. Sixty percent of participants smoked 10 or fewer cigarettes per day, while 12% smoked more than 20 cigarettes daily.

More than half (56%) of participants reported smoking their first cigarette within half hour of waking, thus indicating high nicotine dependency

Table 11: Socio-demographic characteristics of WhyKwit and KwitNeeds Pacific group participants (N=89)

		N	%
Gender	Female	42	47.2
	Male	47	53.8
Ethnicity*	Samoan	31	34.8
	Tongan	28	31.5
	Cook Island	24	27.0
	Niuean	10	11.2
	Māori	5	6.6
Age (years)	16-20	25	28.1
	21-25	20	22.5
	26-30	7	7.9
	31-35	3	3.4
	36-40	3	3.4
	41-45	8	9.0
	46-50	10	11.2
	51-55	7	7.9
	56-60	2	2.2
	61+	4	4.5
NZ born	Yes	44	49.4
	No	43	48.3
	Missing	2	2.2
Length of time in NZ if not NZ born (n=43)	5-10 yrs	7	16.3
	11-20yrs	4	9.3
	>20yrs	29	67.4
	Missing	3	7.0
Employed outside the home	Yes	47	52.8
	No	31	34.8
	On leave	2	2.2
	Missing	9	10.1
In paid employment	Yes	33	37.0
	Unpaid	4	4.4
	On a course	8	9.0
	Missing	2	2.2
Terms of employment	Full time	28	31.4
	Part time	5	5.6
Eligible for a Community Services Card	Yes	48	53.9
	No	35	39.3
	Missing	6	6.7

*Ethnicity is reported here as multiple response, therefore percentages total more than 100%.

Table 12: Smoking history and behaviour (N=89)

		N	%
Age (years) at first cigarette	<10	6	6.7
	11-15yrs	37	41.6
	16-20	32	36.0
	21-25	9	10.1
	>25	4	4.5
	Missing	1	1.1
Age (years) when started regular smoking	<10	2	2.2
	11-15yrs	16	18.2
	16-20	38	42.7
	21-25	10	11.2
	>25	7	7.9
	Missing	16	18.0
How do you smoke tobacco?	I don't smoke	6	6.7
	Roll my own	7	7.9
	Factory-made	33	37.1
	Rollies and factory made	35	39.3
	Cigars/pipes	4	4.5
	Other	5	5.6
	Missing	2	2.2
Cigarettes smoked per day	1-5	29	32.6
	6-10	24	27.0
	11-15	9	10.1
	16-20	10	11.2
	21-25	2	2.2
	26-30	6	6.7
	More than 30	3	3.4
	Missing	6	6.7
Time to first cigarette	Within 5 mins	17	19.1
	6-30 mins	33	37.1
	31-60 mins	7	7.9
	After 60 mins	20	22.5
	Missing	12	13.5

Quitting Behaviour

Most (79%) Pacific participants indicated that they intend to stop smoking sometime (see Table 13). Just over half (52%) reported that they intended to stop “in the next 6 months.”

Table 14 shows the average and range of number of attempts to stop smoking by participants in the Pacific focus groups. Younger Pacific participants averaged more quit attempts than older participants. Overall, the number of quit attempts per participant ranged from none to six.

Table 13: Intention to stop smoking (WhyKwit participants only) (n=66)

		n	%
Intend to stop ever?	Yes	52	78.8
	No	8	12.1
	Missing	6	9.1
Intend to stop next 6mths	Yes	34	51.5
	No	20	30.3
	Missing	12	18.2
Intend to stop next 3mths	Yes	24	36.4
	No	30	45.5
	Missing	12	18.2

Table 14: Average and range of number of quit attempts

	Average	Range
16-26yrs (n=28)	2.9	1-6
≥27 (n=32)	2.2	1-6
Mixed age (n=19)	1.1	0-2
Total	2.2	0-6

Reasons for stopping smoking

The frequency of reasons for stopping smoking in the past is summarised in Table 15. Health-related reasons were the most frequently cited reasons for stopping. Family and cost were the next most often nominated reasons, followed by not liking smoking and wanting to stop.

Variation by age

Quitting reasons related to health, family and cost were most relevant for participants at 16-25 years of age. The frequency of health reasons was largely explained by quit attempts due to ill health or because of sports performance. Not being permitted to smoke by parents accounted for the spike in family-related reasons during this age group. Being unable to afford to smoke or having an awareness of the financial implications of smoking were associated with this age grouping and contributed to the high number of reasons cited within the category of cost.

Reasons for relapsing

Participants were asked to record their cessation history, including the age at and reason for each relapse. The reasons for past relapses are summarised in Table 16. Negative reasons, mainly stress and boredom, were cited most frequently. Reasons relating to social inclusion and identity were the next most cited reason for resuming smoking. Behavioural and physical association was also cited frequently. This was mainly related to craving and temptation. The lifting of restrictions on smoking also featured as a dominant reason for relapsing.

Variation by age

Stress related negative affect was a particularly relevant trigger to relapse for participants between the ages of 16-25 years. Social inclusion reasons such as prompts by friends to smoke, were also highly applicable for participants between the ages of 10-25 years. Family members smoking influenced participants to smoke. This reason was most relevant for participants between 16-20 years of age. A restriction on smoking being lifted was an oft cited reason for relapse for participants between ages 16-25 years.

Table 15: Pacific reasons for stopping smoking by age quit attempted

Reason for stopping smoking	Age Group									Total
	11-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	
Health	8	31	15	6	1	5	5	3	4	78
Family	6	15	9	2	4	0	4	2	2	44
Cost	3	14	7	2	1	3	5	3	1	39
Don't like it/want to quit	2	6	2	1	2	2	0	0	0	15
Pregnancy	0	6	4	2	2	0	0	0	0	14
Social inclusion or identity	2	2	1	1	0	0	1	0	1	8
It's time	0	2	4	1	0	0	0	0	0	7
No reason	1	4	2	0	0	0	0	0	0	7
Smokefree policies	0	4	1	0	0	0	0	0	0	5
TV ads	0	1	3	0	0	0	0	0	0	4
Church	1	0	1	1	0	0	0	0	0	3
Career	0	0	0	0	0	0	0	0	1	1
	23	85	49	16	10	10	15	8	9	225

See Appendix D for full details

Table 16: Pacific reasons for relapsing by age at relapse

Reason for relapsing	Age Group									Total
	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	
Negative affect	1	10	21	8	1	3	5	0	4	53
Social inclusion or identity	9	19	8	1	0	0	3	0	1	41
Behavioural and physical association	0	7	7	2	2	1	2	2	2	25
Reason for stopping no longer relevant	1	9	7	2	0	1	0	1	3	24
Alcohol	0	5	4	2	2	0	1	0	0	14
Family	0	11	0	0	1	1	0	0	0	13
Wanted to smoke	3	1	1	1	0	0	0	0	1	7
Financially able to smoke	1	3	1	0	0	0	0	0	0	5
Appearance	0	1	1	0	0	1	0	0	0	3
Employment	0	0	0	0	0	0	1	0	0	1
Location	0	0	1	0	0	0	0	0	0	1
	15	66	51	16	6	7	12	3	11	187

See Appendix E for full details

Reasons to stop smoking or to relapse

This section outlines the key findings related to Pacific participants' talk about stopping or resuming smoking. The results are organised according to the framework provided by the Fonofale model; that is, under the headings of Family, Physical, Mental, Environment, Spiritual and Culture. Pregnancy is also included as a key component.

Family

Family forms an important part of Pacific communities for most Pacific peoples, and is the foundation for health and well-being. A number of participants identified the role of family members in motivating them to stop smoking. Being there for family, and when participants were young, the fear of family finding out they smoked, being told to stop or lectured by family, and/or not getting money to buy cigarettes from family were talked about as providing motivation for stopping smoking.

Because I love my children. ...If I die now, who will take care of my children? (4M)

My mother told me if I stopped she won't give me a hiding. (KN4M)

Your parents? Yeah got snapped, so I stopped. (3M)

[I stopped at age] 18, 'cos mum said. (16W) [Laughter] ...Dad caught me. (16M)

*Could you say a family member? (5W1) **Yep. So what did they do?** Don't give us the money aye? (5W2) No money, no smokes. (5W3) Hiding. (5M) Yeah. The long, you know, all the lectures. (5W3)*

***What's up with the parents?** When I was young I used to smoke behind their back and stuff but when I got caught I was shamed. We'd get growlings and stuff. Get in trouble. (6W1) ...Get a hiding and lectures. (6W2)*

Elsewhere, participants raised the role of "parent intervention" (16M1) in keeping them smokefree. Participants noted that they were no longer subject to such intervention, but one thought that this would provide a tension to be smokefree.

*Like when, if your parents tell you not to smoke. Would that even count? (16M1) Maybe back in the day. (16M2) **Do you have ...parent intervention?** Nah, they've given up. (16M2) **They've given up on you? So, if, you have parent intervention now, as a motivator to quit – ...it would work for you?** Yeah, like I would consider, it would always be in the back of my head. (16M1)*

In some cases, children's 'pester power', that is, children prompting their parents to stop smoking, was evident.

My daughter begs me to stop smoking because she doesn't want to see me like other people on T.V. (2W)

There are some people who have stopped smoking because their children have said something to them. (17M)

Family/social support was nominated as useful for those making quit attempts.

I think it was the support from people around me. (17bW)

An ex-smoker. She gave me a teddie. I get a hug every time I want a smoke, just to get the moment past. (19W)

In contrast to the support to quit offered by some, other participants noted how they were discouraged from stopping smoking by people around them.

Lack of support. Because you do get some people who say, you know, what's the point of you stopping smoking now? (6bM)

Having people discourage you, you know saying that you can't do it. (17bW)

Similarly, in opposition to the role of family in creating tensions or triggers not to smoke, older smokers recalled being allowed to smoke by family as a rite of passage. One participant commented that his father gave him a cigarette when he turned 21 years of age.

I started smoke when I was 21, my father, that was his present to me, gave me a packet of cigarettes, I remember that day, so he allow me to start smoking. (4M)

One young woman described her reason for relapsing as being “because I got my license from my parents.” (1W) When asked if this meant she was permitted to smoke, her friend elaborated.

She wasn't allowed and then she got older and she got her... [smoking] license. Her key to her freedom and she could buy her own smokes. (1W)

Another participant considered her son's smoking to be permissible because “he's old enough, he works hard, he can buy his own smokes.” (2W)

One participant from this focus group talked about how she guided her children not to smoke.

We tell them not to follow our footsteps because we know it's bad but we just can't quit. So we tell them as an example not to touch it because we know it's bad for them. (2W)

Another participant thought that parental and elder influence, in the form of telling young people to stop smoking should be sufficient motivation for young people to stop.

*Yes, its parents, parents influence, I think when they were told by parents, kaumatua or authority to stop then they will stop, they respect and in that sense they stop. (17W) **So kaumatua or parental intervention?** But I think in respect and obedience, I think. In the Tongan way, if they still maintain that. (17W)*

Concern for children and young people smoking was echoed by other older participants, “I hate when I see the young ones smoke. I hate that. If I see them smoking it makes me angry.” (KN4bM) Of these, one believed parents should role model smokefree behaviour if at all possible.

It's a good thing, a very good thing if the parents can set an example but only if they can. ...It's a very good thing in that it will be a way for the children to turn their own lives around, so that there won't be a time where they would have to suffer. (4M1)

Elsewhere, the influence of parental smoking on children's uptake was strongly disputed.

So if the child is watching me smoke then there's nothing I can do, because it's up to the child what he wants to do. (4M2)

*I don't believe that. For one minute. I don't believe that. (2W1) **Why's that?** I don't perceive everybody's doing that. (2W1) Because we are smokers. We are drinkers. None of my kids touch anything like that. They're hard, hard core that's why I tell you now, I don't believe that. I know it, I'm a role model for my kids but they can't do what the parents do. (2W2) ...It happens to other parents but you know I've heard a lot about that but you know, I'm against what they say about parents being the role models for their kids ...as bad role models. No. It's different people. You know, different people, different environment. (2W3)*

There was resentment from some younger participants at being told not to smoke by parents who themselves smoked.

Our parents tell us not to smoke, yeah. But when I see them smoke, it makes me want to smoke more. (3M)

The following example conflates some of the previous themes, that is, a young person reports being caught smoking by her parents, one of whom was a smoker who did not tell her to stop, and whom went on to provide her with cigarettes.

*Actually my Dad snapped me [caught me smoking], and then my Mum told me to stop, but because my Dad smoked, he didn't tell me to stop. It was like, oh it was up to you, kind of thing. Like, 'you know what's wrong'. (16W) **So, you went away and thought about it?** And then starting scabbing off Dad. (16W)*

Despite disputing the effect of role modelling and imitation on smoking initiation, one of the participants in focus group two acknowledged that peer pressure had triggered her uptake of smoking.

I was smoking at a very young age because I was very cheeky because I wanted to try what the other kids were doing so I wanted to try it that's why I started smoking. I picked up smoking here in NZ since 1976 not long after we arrived here from Samoa. So you know it's true about copying other people. (2W2)

Spouses, friends, and workmates were also implicated in smoking uptake, as in the following conversation.

*For me it started from work. One of my team mates, he came and asked me if I got a light and I said what do you mean have I got a light? And he told me to go and light up his smoke for the other friend and that's how I started. I'd just go and have a little puff, you know, and then puff, puff, puff. [Laughs] (2W1) **What about yourself?** There was a party held at my house. ...And one of the guys, my husband's friend, you know, gave me a smoke. That's how I started, I think, yeah. I was coughing at the smoke the first time. [Laughs] (2W2) ...My husband gave me a smoke and so I smoked it and it started from there. (2W3) ...Here in New Zealand? (2W2) Started here in NZ. (2W3) Yeah, if the husband smokes then the wife just follows. (2W4)*

Where smoking was widespread among communities, the behaviour was normalised, and strong pro-smoking norms made smokefree attempts difficult.

Yeah, like all my uncles and that all smoke and drink. That was normal. (16W)

My brothers and sisters, and also our parents, we are all smokers. There isn't anyone that doesn't smoke. (4M)

And meeting friends. ...When you see someone smoking you feel like smoking too. (17M)

Most of my friends all smoke. And I'm around them. And if they start smoking, then I started back smoking again. (18W)

Physical

Physical health and well-being featured strongly amongst participants' reasons for stopping smoking. This mainly manifested as a tension or trigger for quitting due to ill-health. In these situations, quitting was often temporary, for the duration of the illness.

I was sick for a month with a chesty cough. (5W)

I was in hospital and the doctor said to me that if I wanted to live longer then I should stop smoking. But it was about a week after I was discharged from hospital that I went back to smoking again. (4M)

*I gave it up for the day, only because I was sick and I couldn't take it. (17bW1)
...Like if we got sick, of course we would stop smoking to get better. (17bW2)*

There was a prevailing health-related myth around the disbelief that smoking really was hazardous to one's health. One participant sought confirmation that smoking could cause death.

Is it already confirmed that people are dying from smoking? (17M)

In contrast to the value participants placed on the importance of stopping smoking for health reasons, there was much to suggest participants felt conflicted about this. The following quote by an older male illustrates this conflict.

I do know that it's a cause of a lot of diseases, a lot of cancers but I remember my grandfather was the heaviest smoker in the whole village and he died when he was 98 years old. (4M)

There was the suggestion that long-time smokers were evidence that smoking didn't impose a threat to longevity.

I've got an aunty who's been smoking ever since she was probably like young, and she's like oh 60. (17bW)

How long have you been smoking? 33 years until now. See I have no cancer and I'm healthy except for the cough I get. [Laughing] ...I've never been sick. I don't have diabetes, just the cough. (2W2)

The health risks of smoking were openly disputed in the following conversation between three participants.

There's no real reason linking someone's death to smoking. They're all correlated research. ...A doctor cannot say 'Oh she died of lung cancer because she smoked for 15 years', they can't say that. (19W1) I know, you can't say that because there are people who don't smoke and they still have lung cancer, so... (19W2) Yeah, true. ...There's no real evidence that it's got to do with smoking. (19W1) ...The lung cancer can be caused by something else. (19W2) If you see them struggle with breathing, but then so can somebody else who's never smoked. ...They have the same respiratory problems. ...It could be from having salt in the morning for breakfast that my body's allergic to. (19W1)

This scepticism was summarised thus:

You've got a better chance of getting hit by a bus on the road than from dying from smoking. (19W)

Fitness

Poor fitness was cited by some participants as a reason to stop smoking. These participants were aware of the impact of smoking on their fitness.

No, just letting me down in my usual – if I go exercising or dancing I get tired faster. (18W)

First one's about 3 months, because that's how long waka racing lasts, and the next one was, like, a month and a half. (5W)

I started noticing that when I play touch with the boys, I started puffing. And when I walk up stairs, I run out of breath. (3M)

Fitness, health and longevity were conflated in the following comment, where the participant considered her daily run, in spite of her smoking, kept her fit and healthy. This seemed to counter any threat to her longevity that smoking may cause.

Whether you smoke or don't smoke, you still don't live longer. Man, I still go for a run every morning, 20 minutes, so I'm still healthy. (19W)

Smoking as a stimulus

In contrast to stopping smoking due to lack of energy, some participants said that smoking gave them energy. Participants who expressed this attitude were mostly male and/or in the older focus groups.

To me, I reckon smoking gives me energy. ...Because when I'm like puffed out, I need a smoke. (3M)

There is one point that I know that I can't leave the smoke and that is the time when I read a book, when I feel like I want to sleep it is the cigarette that will wake me up, so if I feel sleepy I smoke a cigarette to keep my eyes awake. ...So I think that's the reason why I can't stop smoking. (4M1)

I gain strength from smoking. Like the times I am work, the smokes get me through the daily hardship of work and the same goes for the home like if I do some work around the house then I have a smoke and drink a beer, so to me if I don't have any of these things then I feel weak. ...So that's what I'm telling you straight, that I can't stop smoking. (4M2)

The belief that smoking gave people energy, expressed by a female elder in one group, was challenged by a younger male participant. He said that another of the participants had refrained from smoking while participating in an exercise programme.

They have more energy when they smoke. (6bW2) Actually I would debate about that because when we did our fitness together, [name of fellow participant] didn't want a smoke, eh? (6bM)

Pregnancy

Smoking during pregnancy was not uncommon.

I didn't make the decision [to stop smoking] while I was pregnant. (17W)

There's so many pregnant Tongan ladies that smoke. (17bW)

Of the participants who did stop smoking, some were motivated to stop for the health of their unborn child, while for others, stopping during pregnancy was due to experiencing morning sickness.

All the ads about smoking during pregnancy kind of put me off. I didn't want my kid, my son, to come out deformed or something, with something wrong with him. (16W)

With some pregnancies you could smoke because baby didn't react, or you don't get sick. And then other pregnancies where you'd get sick and just throw the cigarette away. Can't smoke. (18W)

I stopped smoking when, when I was pregnant with my son actually. (19W1) Me, [I stopped] for eight months. (19W2)

Yeah, my first pregnancy I just stopped, 'cos I didn't want to smoke while being pregnant, just for health reasons for the child. And then I started again, and got pregnant again. Before I knew I was pregnant I was still smoking until I felt sick, and then I stopped again for another year. (16W)

Many women who stopped smoking because they were pregnant indicated that they restarted following the birth of their child.

So why did you start smoking again?... *Oh, after my pregnancy? Because baby was out. (1W)*

When [name] was born, three months, and then I got back to smoking because my brother was fussy with the house. And he was vale [moaning] all the time. (19W)

When asked whether he stopped smoking when his wife was pregnant, one older male participant did not think this was necessary. He said:

Pregnant women, they got their own protector inside to protect the newborn...so it's no worry about it. (4M)

Environment

Smokefree legislation, TV ads and social marketing campaigns

Participants acknowledged the role of smokefree legislation. Smokefree restrictions caused one participant to stop smoking at school.

The reason I gave up at school was because I was stressing myself out finding time for me to step out of the gate for a smoke. (19W)

Reducing areas where people can smoke created a tension for another participant to think about her smoking behaviour.

Sometimes I think like "I wish I don't smoke" because you're always looking for somewhere to smoke, wherever you go. (19W)

Similarly there was evidence that social marketing campaigns produced tensions for people to think about the risks to smoking. These comments were about the graphic images on cigarette packets:

It's important to have those messages, because when you look at it you think "oh maybe it's not worth to smoke..." (4M)

I think, oh that could happen to me. I could have my tooth chopped off or something. (6W)

The following quotes describe how the cognitive dissonance created by smokefree graphic warnings is resolved.

*I look at it [the graphic warning] and see how gross it is, but then it's just - (16W1)
I think you just laugh at them. (16W2) [Laughter] ...It's true. ...Because this is extreme. (16M) It's like worst case scenario and you never think that it's gonna happen to you. (16W3)*

Just turn the packet over, and open it, don't look at it. (5M)

Another participant who confessed that she doesn't "even look at [them]" (16W), went on to say:

Yeah, the one that, the warning that affects me is probably the one that has kids on it, and the pregnant lady. (16W)

Cognitive dissonance in relation to the smokefree TV ads was also evident. The following participant initially suggests the ads create a tension for being smokefree, but then goes on to say that any perceived threat of smoking will “not happen to us.”

It [TV ad about the risks of smoking] makes you think, but in the end you think it's self righteous and that's not going to happen to us. (5W)

The Adrian TVCs were recognised by participants, and created a momentary tension to think about the risks of smoking for the duration of the ad.

It's not worth it, mate. ...Because that guy. You know. That guy with the throat on the TV. (6M) He was addicted. (6W1) Oh yeah. That TV ad. (6W2) ...It's like that ten second think about quitting but then it goes away. (6M) Yeah, because the ad's gone. (6W1)

Smokefree TV ads were perceived by others to be ineffective. For some, the ads inadequately relayed necessary detail, while in others the ads triggered the desire to smoke.

I think on the ad, it doesn't really explain the whole details. (17bW1) So the little 30 second ad on TV's not enough. (17bW2) I've seen quite a few of them TV ads, just made me want to have another cigarette. ...Yeah, for me. I'm not too sure about the rest, but for me, just seeing someone draw on a cigarette. I went outside and had a smoke. (6bM)

Seeing people smoking in TV programmes was a strong trigger to smoke for others.

There's a lot of options that can trigger you to have a smoke. ...My worse one is when I'm watching a movie. I can be trying to quit smoking but when you watch a movie and you see someone puffing on it. You've got no cigarette so you go hunting for it. Or go jump in the van and go buy some. Just because one person smoked on the TV. (6W)

Some participants, who were reluctant to stop smoking, smoked outside and away from their families.

*I think none of us [smoke around our children]. (2W1) We've got children in our house, but we all go outside and smoke and make sure. (2W2) ...**Do you smoke in your garage?** No. (2W3) Sometimes. (2W1; 2W2) But the garage ...with no kids around, just me. [Laughter] (2W1) **Do you think your smoking effects the kids?** Well, it depends which side the air is blowing. [Laughter] (2W1)*

I don't smoke in the house. Keep my house nice and fresh for my children. But I smoke outside. When my family comes home, sorry you don't smoke in the house. Every time you smoke, you go outside. Don't smoke in the house. (KN4bM)

I personally have this rule with me and my family that I will never smoke inside. I will go outside despite how cold it is and I will smoke outside to avoid my family saying that it stinks. (4M)

Access to smoking and tobacco

While smokefree policies and social marketing about the risks of smoking made smoking less easy, avoiding environments and people who smoked helped reduce the chance of relapsing.

Just not to be around people that smoke. (6bM)

Similarly, retail displays of tobacco and easy access triggered the desire to smoke in some participants.

Like when you go into a shop, there's been times when I don't want to buy a pack of smokes but I just do. (19M1) You look up and 'oh yeah, yeah'. (19W1) ...Yeah,

get me a pack of smokes. It's just easy. (19M1) And any shop really. In your face. When you walk in, you see them. (19M2) ...Liquor stores. Dairies, bars. (19W2)

It's like gold bullions in the shop. (6bM1) Woah. (6bM2) Wait a minute – can I have one of those? (6bM1)

It is a struggle, yeah, yeah. Because the urge is still there. ...It's easier to get hold of a cigarette than to go to a bar or a liquor store, you know, yeah. (17bW)

Cost of smoking

A number of participants discussed the financial implications of smoking. Financial shortfalls were a reason to stop smoking or reduce tobacco consumption.

But there was a time when I did stop smoking. I stopped because there were too many children and it was hard with my income, so it was hard to smoke. (4M)

No money. (3M)

I wasn't saving, I just, and I was just not meeting the rent. Just that risk of losing the house if you don't cut down on it. (19W)

You know when you have a new family, trying to make ends meet. (19W)

Cost is a big factor. (KN4M)

While cost was mentioned often by Pacific participants as a reason for not smoking, this was generally a temporary measure until the costs of smoking could be met again.

The other thing is financial, there are times when there's not enough finance to buy the smokes. (4M)

Some participants sourced cigarettes from others when they didn't have their own. As the following comment indicates, not smoking in the short term when you don't have cigarettes does not necessarily suggest a quit attempt.

I can stop when there's no smokes, but I know my next door neighbour will give us some. We weren't trying to quit aye, it's just we didn't have smokes at the time. (KN4M)

Some participants did not believe that price increases work to stop smoking.

If the price of cigarettes went up to a hundred dollars, smokers will still keep smoking. (17M)

If I think about it some families wouldn't eat but yet they would have money to buy smokes. Sometimes it's difficult to ignore the cravings. You know the saying, whatever your heart desires what you will do. (4M)

Kava sessions

Several of the Tongan participant's spoke about how smoking occurred at kava parties and clubs. Smoking was considered to be an entrenched aspect of the kava sessions.

Usually when they have those sessions, like people come around and some people come along and have three packets and you just share it around the circle. (16W)

I was sitting there serving them, and they would go through a whole packet within like half an hour. Just sitting there drinking kava, smoke after smoke after smoke. And everyone's sharing their smokes. (16W1) ...Well, yeah, 'cos my Dad was like that, too. He drank kava every weekend, and he went through smokes like no tomorrow. (16W2)

Like now kava, a kava party. When we drink this, we feel we need something to release some of the kava taste. To turn around the taste of the kava. (17M)

Probably sometimes, some people like the Tongans. Some Tongans, when they drink kava they need to smoke. (17W)

Health professionals

There was a gamut of comments about receiving advice to stop smoking from a HP. Some participants spoke about how HPs had advised them to stop smoking. This was a trigger to stop smoking for some and a tension to think about stopping for others.

There are those time you stop because it's the doctor's orders. (17M)

Getting sick all the time, [and] the doctor, the doctor told me to. (1W)

It was the doctor's advice to stop smoking. (6M)

When my wife was pregnant, we would go to the doctors and the doctor would say to both of us that we shouldn't be smoking. So, I think that was the only time when we thought that it was important that we both stop smoking. (4M)

The Tongan people... the thing that I know that stops them from smoking is number one, getting sick and orders from the doctor. That's a really important reason as to why they stop smoking. (17M)

The last two years I stopped. I took my son to the hospital, they asked me if I wanted to quit and then I tried it, at Auckland Hospital. (17W)

One participant who had asked her GP for a script for NRT, had never filled the script, suggesting that follow-up is required.

I've got the prescription. ...because I asked for it. And then I didn't go and get it. (6W)

Doctor's advice to stop smoking was disregarded by some participants.

Well my doctor has been advising me for the last how many years and I never listen. (17bW)

Every time [my mum] goes to a doctor, the doctor tells her to stop smoking. [But] it's like she's saying 'who the hell do you think you are'. (6bM)

Well, the doctors keep trying to tell me stop but I just keep on smoking. (4M)

To avoid censure, one participant said:

You just lie to the doctor that you don't smoke. (2W)

Another participant was dismissive of advice to stop smoking from HPs who also smoke.

The doctors and the nurses are the worst smokers so how can you listen to their advice when they're not being good role models. (19W)

Some participants did not visit the doctor, "I don't go and see the doctor". (6bW) Others who did, had not received advice to stop smoking.

My doctor never tells me to stop. (16W)

Oh well I haven't seen [a doctor] for smoking. (3M)

Not receiving such advice was a missed opportunity for at least the two preceding participants.

If a Doctor told me to stop I would try to stop. (16W)

I am just saying that, probably, if he told me to stop smoking, I would stop. (3M)

One participant indicated that he should stop smoking on his GPs advice out of love and concern for his children. His comment below implies that the advice he says he should heed would be conditional upon having a serious illness.

When the doctor says “stop smoking ‘cause you got cancer” then I should stop because I care about my children. (4M)

The following extract combines some of the themes discussed previously. This participant talks about her family, health issues, a HP’s recognition of the risks of third-hand smoke (i.e. smoke on clothing) which prevented her from visiting her sick grandchild in the hospital, and smokefree restrictions. Taken together, these caused the participant to think about stopping smoking.

I went down to my granddaughter’s when she was in hospital. ... I got off the plane and I had a smoke straightaway walking down to meet my kids.On our way to the hospital before I get in to see my granddaughter, I was told at the door ‘did you have a smoke’, because I think they can smell me. And the doctor or the nurse told me, ‘Oh, you’re not allowed to go and see your granddaughter.’ .. Yeah, I was so angry. I said ‘I can go and have a shower, I can go and do anything for me to go and see my granddaughter’ because she was really, really sick. ... I was so confused. ...Because I was thinking my granddaughter’s dying, and here I am, they wouldn’t let me in to have a look at her. And I end up having a shower at the hospital. My daughter had to go home, grab some clothes and something for me. ...She was in an ICU. ...And they were really, really strict. And I think from that time, I always sit and think, ‘Oh here I am, an old lady, 50-something years and look at my granddaughter and look at my other grandchildren, and am I going to continue smoking or am I going to stop’. And I think today I’m thinking really hard.I’m going to think really, really hard to quit smoking... That is my promise for today. (19W)

Culture

Culture was cited by one participant as a barrier to becoming smokefree.

The way that I’ve experienced, throughout the times, you know especially with my own parent, their only weak point were the culture itself. Because, the reason why I say that, because everybody knows each other in the community. Now if anybody found out that you were doing this [becoming smokefree], you know, you try and pick yourself up here, but somebody’s down there, trying to grab you and pull you back down. ...Tall poppy syndrome type of thing. (6bM)

Another participant spoke about the strict environment in the Pacific that made it very difficult for young people to smoke. However, once they had migrated to New Zealand smoking was available. Cigarettes were more accessible for young people in New Zealand than the Pacific Island countries.

Families in Sa[moa] are more strict, like, on girls. The girls can’t even leave the house. ...So they probably think they’ve got their licence to smoke for them here. So it’s easier for women, young PI women to come here and smoke, more than Samoa. (1W)

Some of the participants commented on the issue of being caught up in the New Zealand smoking culture where smoking was an important lifestyle behaviour. For example, the following quote indicates smoking was seen as “a rite of passage.”

My little sister... is like dying, wants to become a smoker. She thinks it’s a rite of passage. (5M1)

This conversation was pursued by the group. The concept of “culture” carried various meanings. Culture, in terms of its association with smoking, most often referred to people coming together and bound by a commonality, such as their youth or university attendance.

*Smoking is not cultural to me, it's just a habit. (5M2) Like they have all these stats, like, for me it's all about personal choice not actually culture. Because my parents, oh my Dad doesn't smoke, and neither does my Step-Mum and the only person that smokes in my house is just me and my stepsister. (5M3) ... **And you were saying you think culture does influence that?** Yeah, I'm not, like, “the culture”, like, our culture about, like, when heaps of people come together – (5M1) Youth culture. (5M2) - and therefore they influence other people. It's like a chain effect. (5M1) ...**Did you mean Pacific culture or youth culture or church culture?** Pacific and uni. (5M1)*

Spiritual

The church, religion, and spirituality were intrinsically linked for Pacific participants. Some participants recognised that smoking conflicted with church doctrine. Spirituality had the capacity to act as a trigger to stop smoking.

That's the guilt in me, always, to just really stop [smoking] because I feel that I am a second best Christian, so religion is another reason. (17W)

Like Jehovah gave the nation of Israel guides about eating and drinking in the body. The temple of the body. Because like, our bodies are sacred temples so you want to keep (it) that way. (19M)

My dad was smoking for ages and then he found the Lord and then now he has just stopped smoking, he's a different man. (3M)

Church

As a community venue where social interactions occurred, the church was frequently mentioned as a site for smoking behaviour. As accepted, legitimised behaviour in this context, smoking was ‘made easy.’

At our church, if there's a feed after it, straight after church all the women in the church and all the men are outside drinking and smoking. So, like I kind of grew up being surrounded with my whole family just drinking and smoking, and that's what I grew up knowing. (16W)

When I would come here [church venue], I would see people smoking and then I would smell the smoke and how good the smell was ...so it sort of made it easy for me to smoke again. (4M)

Mental

Many participants identified a more positive mental state as being conducive to stopping smoking. Cognitive and behavioural strategies were proposed that help support quit attempts.

A happier lifestyle. Got me a new man. (18W)

Being relaxed. (6bM)

There's a book I was reading on relationships which didn't talk about smoking. But I used the techniques to stop smoking. About relationships. Kind of like intertwine each other. (6bM)

When you stopped smoking it was food. Food was a comfort. (18W)

Negative affect, that is negative emotions such as stress, worry, loneliness and boredom were identified as triggers to smoke and/or relapse.

Sometimes you feel stressed, sometimes you feel worried sometimes you feel lonely, so that's the only way you can forget it, just relax get a smoke and relax. So I don't think I can stop smoking. (4M)

She was in the hospital for one and a half weeks. ...It made me think, her in hospital that really motivated me to stop (smoking) for that week until she passed away and then I just felt really stressed and then I got back into it. (19W)

We all get stressed out that's why we smoke. (2W)

I go through a packet a day man, and it's because I've got nothing to do the whole day. (1W)

It becomes a reflex. (5M1) Yeah. It's like when you have nothing to do then you end up doing it. (5M2)

Like sometimes when I smoke, I don't want the smoke, but I just try kill time, like if I'm waiting for something and if I've got like what 5 minutes then I'll have a smoke 'cos it would take away half of that time. (17bW)

Paired associations

Like the association of the kava-ceremony environment, smoking was frequently associated with other behaviours, to the point smoking became almost involuntary. For many, smoking had become part of the rhythm of their everyday routine.

The activity you do while you're smoking. And when you stop smoking, you're used to having your coffee with a cigarette. And when you just drink your coffee you want a cigarette. It becomes like a routine. (6bM)

But the coffee usually goes with the smoke. That's usually hand in hand. (18W1)

If you finish washing the dishes, you have a smoke. If you finish bathing the kids, you're having a smoke. After the computer, you're having a smoke. (18W2)

Like my habit now, when I go home after work, the first thing I do, I turn the kettle on, I get a magazine and sit outside, have a smoke. By the time the kettle boils I make another one, have another cigarette before I start dinner. (19W1) ...I like getting my coffee and I sit all by myself and relax. (19W2)

And when I'm at work, every sort of like 15 minutes, I pop outside and have a puff or a smoke, and then I come back. (17bW)

One participant, who didn't smoke during the day due to smokefree restrictions, associated returning home after work with binge-smoking.

My job is working as a truckee. ...From the time when I go to work, ...like from 6 in the morning till about 7 at night I don't smoke a cigarette. ...It's only when I arrive back home, that's when I start smoking. I probably have about 3 or 4, one after the other. I'll just stand outside the house and smoke the cigarettes when I get home. (4M)

Participants struggled with the notion of relinquishing this habitual behaviour, and 'filling the gap' that smoking provides.

Now I don't have that gap filler, the 15 minutes or half an hour time, something else to do during that time before I start dinner. I was so used to that. (19W1)

It's alright, but it is, what I'm struggling with is a replacement of the habit, yeah. So mentally and things that I'm used to, you know, this is what I do; I smoke. So what I struggle with is a replacement for all those bad habits. [Laughter] (17bW)

Alcohol and smoking

Participants across all Pacific groups spoke about how alcohol and smoking were strongly linked. Many said that when they were consuming alcohol they would also smoke, and this association often meant they relapsed upon drinking, after a period of being smokefree.

Hey, I guess it's kind of like alcohol. When I drink, I smoke a lot. (16W1) ... Yeah, like I don't smoke as much, but when I'm drinking I smoke a lot. (16W2)

Well there's smoke and there's drink. (19W) ... They're husband and wife aye. (19M)

That's the other thing, you quit and then you drink. You're used to the habit of having a smoke when you drink. Even when you're not smoking. It goes hand in hand. When you're a non-smoker you have a drink when you smoke. Oh, a smoke when you drink. Just to kick in the buzz. (KN4M)

Fatalism

Some of the participants were not interested in stopping smoking, and expressed a fatalistic attitude towards their continued smoking. That is, that death is inevitable, and any attempt to try to avoid it, such as stopping smoking, is futile. This was mostly evident amongst the groups of older participants, some of whom indicated that they had reached an age where stopping smoking seemed redundant.

If you give up or you don't give up, you still gonna die right? [Laughter] (4M1) With death you know it will happen to everyone aye. ... For us older people, I can't stop smoking. We have been doing it for years and it's too hard and too late to stop. (4M2) ... We are over 50 years. (4M3)

Because my point of view is that we are going to die anyway. (2W1) I don't think any of these older ladies want to quit smoking now because they're old now, so what the hell. [Laughing] (2W2)

I'm like, I might get run over by a bus and I might not. (17bW)

Fatalistic attitudes such as these may interfere with quit attempts and allow people to justify their smoking behaviour, and/or may suggest that people feel helpless to control their future.

Myths about smoking and stopping smoking

Other barriers to quitting were the host of myths surrounding smoking and stopping smoking. For example, some participants held strong beliefs about the critical role of 'willpower' in stopping smoking. Moreover, smoking was perceived to be a personal choice, a matter of "your own rights." (4M) Following on from the latter myth, there was a perception that if someone really wanted to stop, they would do so.

It's really up to the person's willpower to do anything that they want to do. Including smoking and being pregnant. People are not going to do it because they're pregnant. Really. I mean that's the reality of it. Either they've got the willpower to think of the child and stop smoking. Or they don't. (18W)

I think we actually have the willpower to quit. ... It's like mental strength. (5M)

So it's my health. ... It's my own body, it's my own health. (2W)

It's people's choice, it's their own right to smoke or to stop smoking. (4M)

It's my choice to stop. (17M)

Don't forget it's an individual personal preference ...[Smoking] is my personal thing. (19W)

If you feel you wanna stop you can stop. People have different choices. (4M)

Honestly, if I really wanted to, I know I can do it, but I kind of just don't want to. (16W)

Smoking was perceived to be relatively less hazardous than alcohol, and one participant was surprised that there are so few alcohol compared to smoking related deaths.

Some smokers felt victimised, and there was resentment among the participants in focus group 19 that smokers were being unjustly targeted with “*in your face*” messages about the risks of smoking.

So what are the statistics, in regards to alcohol and sickness? Only a few hundred people die from alcohol, but what are the side effects of alcohol in the family? (17W)

Alcohol has a lot more damage on the roads than the person who sits at home and has a cigarette, you know? ...So for a lot of smokers, that really gets their backs up. And some of them will just continue on smoking, and you have the hard core, die-hard smokers who want to quit but won't admit it because they're sick of all this in your face kind of messages coming across. And yet a drunk driver down the road will kill 4 in a car accident. (19W)

Finally, *stopping* smoking was imbued with risk for some.

There's a lady at our church, her husband just passed away and he was a heavy smoker. But once he stopped smoking, then his sickness started getting worse. (2W)

Relative Ranking of Reasons for Quitting

The groups' ranking of relative reasons for quitting are presented in Table 17. Five groups of Pacific participants aged between 16 and 26 years of age, and five groups of participants aged 27 years and over completed the ranking task. Two groups of Pacific participants aged 27 years and over did not complete this task. The mean is calculated based upon 1 as the highest ranked position, and 20 is the lowest possible ranked position.

Table 17: Relative ranking for reasons for stopping smoking (n=58)

Reasons	Rank order (Mean)		
	16-26yrs (n=27)	27yrs+ (n=31)	Total (n=58)
To stay healthy	2 (2.4)	1 (3.2)	1 (2.8)
Cost	1 (2.0)	3 (4.6)	2 (3.4)
To live longer	1 (2.0)	4 (4.8)	2 (3.4)
For my children's health	4 (3.6)	2 (3.4)	3 (3.5)
To be a positive role model to my children	3 (3.4)	3 (4.6)	4 (4.0)
To not grow old early	5 (4.2)	5 (6.2)	5 (5.2)
To have a healthier pregnancy	3 (3.4)	6 (7.7)	6 (5.5)
Fitness	4 (3.6)	7 (8.0)	7 (5.8)
To have more energy to do things	6 (4.4)	7 (8.0)	8 (6.2)
To get better	7 (5.0)	8 (8.4)	9 (6.7)
Seeing what smoking does to someone close	7 (5.0)	9 (9.9)	10 (7.4)
Getting pregnant	7 (5.0)	11 (10.2)	11 (7.6)
Doctor told me to stop	9 (5.8)	12 (10.3)	12 (8.0)
If they can, I can	10 (7.2)	11 (10.2)	13 (8.7)
Smokefree environments	12 (7.8)	10 (10.1)	14 (8.9)
It's time	11 (7.4)	13 (10.8)	15 (9.1)
Making one's own choices	8 (5.6)	15 (12.6)	15 (9.1)
It's not cool anymore	15 (9.8)	14 (11.9)	16 (10.9)
It stinks	14 (8.4)	16 (14.0)	17 (11.2)
TV ads about smoking	13 (8.2)	17 (15.0)	18 (11.6)

Health

Many of the participants highlighted staying healthy as an important trigger to quit smoking.

Yeah, it should be for your own personal health and wellbeing. So to stay healthy should be first? (18W)

Because you've got to think about yourself first. As in wellbeing. So it's time can be at the bottom because nobody really thinks about when it's time. If it's time, it's time. But it's not as important as your own wellbeing. (18W)

The relative importance of longevity was keenly discussed by one group of younger participants as a motive for stopping smoking. This discussion again illustrates how different tensions and triggers operate for different people at different points. Further, it highlights the role of addiction in blocking people from acting on tensions and triggers to quit.

I would think 'to live longer' would be up there. (16W1) Yeah, same. (16W2) Because it's in the back of our mind. (16W3) Because when I think about, I think about quitting. (16W1) ...But then, nobody's even making an attempt...Because nobody's been thinking about living longer, right now. (16M1) Sometimes I do. (16W2) ...But is it enough to make you wanna stop? (16M2) ...Do you think that far forward? Do you think that far ahead? (16W3) I do. (16W1) ...Every time you pull a cigarette? (16M2) [Laughter] Yes, I do. (16W1) ...Do you think that far into the future? (16W3) Yes I do. (16W1) And then how come you carry on smoking? (16M2) ...Because it's addictive. (16W2) Exactly, it's addictive. It's an addiction. (16W1)

Cost

The cost of smoking was ranked by Pacific participants as a significant reason for stopping. Cost was ranked as the main reason by participants aged 16-26 years, and as the second highest reason overall to stop smoking.

No money, no lunch money or anything, I was at school. (3M)

Grandchildren

A number of the older Pacific parents stated that they would quit smoking so they can live longer to see their grandchildren.

Well if you haven't got any grandchildren, then you might want to see your grandchildren. (19M)

I'd like to live longer to see my grandchildren. (19W) But it's just increasing the chances. It's not, you stop smoking you live longer. (19M)

Children

Stopping smoking for children and for children's health was ranked as an important motive for many parents.

For my children's health, because that's where it starts. (19M1) Yeah, because it may not be for us, but for our children. (19W) That's for the mums, that's for the mum up here. Yeah. For my children's health, that's where it's beginning aye? For the mother. (19M1) ...Yeah... [you want]... the nicotine away from your child. (19M2)

Yep. I think that it's really important [to stop smoking for my children's health.] (17bW)

Positive role models

Some participants thought stopping so they could be a positive role model for their children or younger relatives was important. One participant saw this as being linked more generally to the reason "children's health."

Because I want to like be a positive role model. ...To sisters and cousins and people that might see me smoking and I don't want them to start smoking too. ...I can see that they're already like, you know, I'm the oldest so they're doing things that I already do. And if they see me smoking, they will. (3M)

For my children's health. (18W) Well, that's to be a positive role model and the children together. (18W)

Stopping smoking for other people

Participants stated that they would quit smoking for others rather than themselves.

Well for me, most of the reasons that I have for why I would stop is for other people. So all these [other-related reasons] like pregnancy, they would be up the top for me. I would stop for other people. That's the main reasons why I have tried to stop before. Umm they haven't been really working but those are what I see are the most important. And the second ones are the ones that relate to my own health. (3M)

Seeing what smoking does to someone close

This did not rank highly as a reason for stopping smoking, despite smoking being a factor in some of the premature deaths of close family members that our participants experienced. Where participants did stop smoking following the smoking-related death of someone close, it was usually a short-term quit attempt.

My grandpa died. He had emphysema. Yeah. He passed away from lung cancer. ...Seeing him die didn't really affect me. (3M)

That would probably go last as well. Because we've seen so many and we still don't stop. (6W)

Yeah, that's how [name] passed away. (1W1) Yeah, heaps of people have. (1W2) ...Like because when my aunty passed away I ...stopped for... three weeks. (1W3)

The following quote suggests that the role of smoking in some premature deaths was downplayed.

*Yeah, 'cos my Dad smoked like a chimney and his death was sudden. (16W). **Was it due to smoking?** Nah, he had a heart condition, but it was like unexpected. But the Doctor said that smoking didn't help. (16W)*

Smoking cessation methods

This section gives an account of the cessation methods used by participants in previous quit attempts, and their unprompted and prompted awareness of cessation products and services.

Smoking cessation methods used in past attempts

Participants were asked to identify smoking methods that were used in the past to quit smoking (see Table 18). Across all Pacific groups regardless of age, stopping smoking without formal help was most common. Stopping unaided included 'cold turkey,' 'just stopped,' and where participants had cited 'determination' or 'willpower'.

Less frequently, substitution, family/social environment, NRT, reduced tobacco consumption or purchase, and lack of access were also cited.

Table 18: Cessation methods and age used

Quit method	Age Group									Total
	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+	
Unaided	7	23	17	4	4	2	5	1	3	66
Substitution	1	6	5	1	0	0	2	2	1	18
Family/ social environment	2	5	5	2	1	1	0	0	0	16
Nicotine replacement therapy	0	2	5	2	0	1	2	3	0	15
Reduced consumption or purchase of tobacco	1	5	4	0	1	0	0	0	0	11
Lack of access	2	7	1	0	0	0	0	0	0	10
Nicotine free prescription and GP's advice	1	2	2	1	1	0	1	0	0	8
Smoking cessation programmes and services	0	0	0	1	0	0	1	0	0	2
Pregnancy	0	0	1	1	0	0	0	0	0	2
Alternative therapies	0	0	0	1	0	0	0	0	0	1
Can't remember	0	0	1	0	0	0	0	0	0	1
Stop smoking books or internet	0	0	0	0	0	0	0	0	0	0
	14	50	41	13	7	4	11	6	4	150

Unprompted awareness of cessation products and services

Participants were asked to identify methods for stopping smoking. Data about unprompted awareness of cessation products and services were collated across all groups (see Table 19). There was a high awareness of nicotine gum and patches, and of Quitline. Unprompted awareness of other smoking cessation products or services was relatively poor.

Table 19: Unprompted awareness of cessation products and services (n = 12 groups*)

	Focus group no.												
	1	5	6	6b	16	17	17b	18	19	KN 3	KN 4	KN 4b	Total
Patches	√	√	√	√	√		√	√	√	√	√		10
Quitline	√	√	√	√	√		√	√	√	√		√	10
Gum	√	√	√	√	√		√	√			√		8
Fear of parents		√					√						8
Cold Turkey	√		√	√	√		√		√		√		7
TV ads	√				√			√		√		√	5
Church/prayer			√	√	√					√			4
Graphic labels	√		√							√		√	4
Lozenges			√				√		√				3
E-Cigarette		√								√			2
Pacific Services/Programmes						√			√				2
GP "pills" or "advice"	√		√										2
Hypnotherapy					√				√				2
Books or internet				√						√			2
Smokefree legislation		√				√							2
"Smokefree groups"				√						√			2
Chewing gum									√	√			2
Sweets or lollies			√						√				2
"Nicorette capsules"								√					1
Pharmacist/Chemist												√	1
Text to quit	√												1
Unable to afford cigarettes		√											1
Family support								√					1
Other support person									√				1
Group quitting				√									1
Physical activity			√										1
Substitute other activity			√										1
Eat more food	√												1
Nasal spray													0
Nicotine inhaler													0
Zyban/Champix/Norpress													0
Acupuncture													0

*Three groups did not complete this exercise

Discussion of products and services

When prompted, participants had some knowledge of some of the presented products and services, while other products and services were not well known. Some of the participants did not know how to stop smoking, and indicated a desire to discuss this further.

I don't know how to stop smoking. ...For me personally I don't know how to stop. (4M1) ...But if there is a way that I can stop then, you know just something to think about for the future. (4M2)

For at least one participant, the focus group process provided a trigger to make a quit attempt, demonstrating the need for wider dissemination of cessation services.

Please, do you order the patches and gum for people who want to stop smoking? Because I want to try it. ...I want to try to see if it works for me or not. Yeah, 'cos you never know, I might like it (2W)

Nicotine replacement therapy

The nicotine gum and patches were the most well known products.

There is a nicotine gum and patches. (16M)

And then they've got those patches and tablets. (18W)

Gum

A number of participants had used the gum. For others they had heard about it. There were mixed reviews on the effectiveness of the gum, and participants also confused nicotine gum with ordinary chewing gum.

Chewing gum. (KN3W) ...I've tried it. But yeah...(KN3W) ...I've never tried it, just heard of it. (KN3W)

I think the chewing gum's better. The way I look at it. (KN4bM)

I used to use the gum and stuff like that, but it didn't work. (KN4M)

It actually works, but I just always forget to take it with me. (16W)

The taste of the gum was considered to be unpleasant, and in some cases this was a barrier to use.

There's no taste eh. It's just like you're burning your mouth off. It's like eating rubber. (16W1) ...If you suck on it in the beginning it's alright, but then once you start chewing ... I don't like it. (16W2)

Yeah, I've tried it, and it's got a foul taste afterwards if you start smoking. (KN3W)

The nicotine gum, it tastes like shit. (5M) Like your smoking ten smokes at once. Yeah, it makes you want to vomit. (5M)

The gum? I've tried that but it's, oh it's disgusting. (17bW)

It was apparent that some participants had not been shown how to use the gum correctly, while others were familiar with the 'chew, chew, park' (17bW) method, and shared their knowledge of how the dosage was prescribed.

I just chewed one. Mate, he just said it's nicotine gum and you chew on it. (3M)

Yeah, you can get it from the pharmacy. ... Is it subsidised, to get it? ...I got, you know the free stuff that you can get from the net, yeah, my sister did that. Yeah, she really got into it at one stage and she got nicotine gum. (5M)

Yeah, it gives you like a tingling feeling, and then they say when you have a tingling feeling you've got to tuck it between your teeth and your gums, and then wait. And then, when you feel the urge again to chew another couple of times... They gave me the 4mg first. I think it depends on what you answer – how many smokes you take per day, and they decide when, how much they should give you. (16W)

Patches

Patches had been used by a few participants, and one participant was well informed about their function.

So these supply me with the nicotine and probably help me fight my habit. It does help a lot. If you wear two, it doubles the nicotine. You wear it for 24hrs. (17W)

Another participant indicated the side-effects of using the patches.

Yeah, I know. Yeah, so I just had the one in the morning, one at night. Yep I've tried it. It sort of makes me hallucinate. (KN3W)

Generally, knowledge about how the patches worked was poor, although interest was high.

Oh, I've just seen it on TV. I don't know how it works. (3M)

Do you smoke with the patches on or do you take them off? (KN5M)

I heard it tastes funny when it's on and you're smoking, is that true? (KN3W)

The following participant reported that his friend's patch "always falls off." In any case, the participant suggests his friend uses the patch outside of work hours and that this is effective for him.

I just know that it helps you stop smoking. One of my mates, he said, because he works in a factory, he said that it always falls off. He says he uses it at night time, before he goes to sleep. That works for him. (3M)

One participant reported how her grandfather had been given patches by the doctor but her grandfather was clearly unaware of their correct use.

The doctor gave [my granddad] the patches. Yeah, we were all like 'Grandpa what's that for?' ...He's like 'oh, so I can stop smoking'. We're like 'oh yeah'. ...And then he walked outside to all the men where they were doing the pigs and that, and sit there [inhales and motions to smoke] with his patch on. ...I don't think my aunty explained it properly to him, 'cos normally she takes him to the Doctors. She's a bit of a [laughter] – she would have told him in Tongan just to put it on and then it will help him, but he probably just stuck it on and then sparked up. (16W3).

Lozenges

Many of the participants were not aware there were nicotine replacement lozenges, although there was interest in how they worked. Some of the participants thought lozenges were lollies and to be eaten like lollies. There was some concern that lozenges were problematic for feeding the addiction to nicotine.

Never heard it. (KN3W)

Didn't know there were lozenges. Is that like the chewing gum? (KN3W)

I think lolly would work on the motion. Keep your mouth busy, so instead of smoking you put it in your mouth. Yeah, I think that would be an option. (KN4bM)

They were just telling me about it. I had a taste and went through one or two. My sister tried it and she took the rest of mine ... So it wasn't much good. (3M1) Is it just a normal tablet? (3M2)

Can, is it, oh, is it good for your health to be addicted to nicotine? Like they go off smoking, but they then you get addicted to those lozenges. (5M)

Inhaler

There was some interest in the inhaler but most participants were not fully aware of what and how the inhaler was used. Cost was considered a potential barrier to using the inhaler.

It may work with some but I think it won't work for everyone. (KN4bM)

You inhale it? Oh. So it's like, you don't burn it but you still breathe it in? (5M)

Do you light it up? What is it, an inhaler? We've only heard of the cheap stuff. We haven't heard of the expensive stuff. Probably just not available for poor people. (3M)

When told of the price, some participants laughed.

That's why I've never heard of it. (16W) [Laughter]

One participant knew someone who had successfully used the inhaler to stop smoking, and this inspired interest in the inhaler from another participant.

I've heard of someone using it, and she's been smokefree for six years. My child's daycare teacher. She said she used it. She's European. ...She had this other one and ...she got it from Victoria Park Market, and it was sort of like that, too. Like, whenever she felt the urge she'd use that. (16W1) ...I think after hearing that I'd say I would [use it], yes. (16W2)

E- cigarette

Participants had some knowledge of e-cigarettes, acquired mostly through recent media coverage. Some thought this product usefully addressed the behavioural aspect of smoking.

I heard on the radio that they've got this thing. It's like a smoke, and it feels like a smoke and everything, but it's not ...So what if they keep doing that and doing that and they're paying for exactly the same thing as a packet of smoke? Or like even more? (KN3W)

I've heard of that one. (6bM1) My mate's on it. (6bM2) I've seen it on the news. (6bM3)

It's a plastic cigarette. (5M)

But it doesn't make you quit though? Doesn't make you stop smoking? (KN3W)

I think it would be better to do with the habit. ...Yes. I need something to do with my hands, because my hands are so used to smoking and I think it would be good. (17W)

There were some concerns that the likeness of the e-cigarette to real cigarettes would trigger the urge to smoke. Recreating the behaviour of smoking was seen to be contrary to the goal of cessation.

It's the habit of holding it eh. That would probably bring on, yeah, take you back again to number one. You know, because you want one. It doesn't matter that you're not using the real thing. But it's the habit of you holding the cigarette and you're using it. You wanna get rid of it. Yeah, because you're holding it and you're smoking. It doesn't matter that it's not a smoke. (19W)

Nicotine-free prescription medicine

The majority of the Pacific participants were either misinformed about, or had not heard of nicotine-free prescription medicines such as Zyban, Norpress, and Champix. There were concerns about the addictive quality and potential side-effects of such products

Champix. No. What does it do? (17W)

Like what are the side effects for all of these things? Like can people get hooked on those? (KN3W)

You'll probably get addicted to pill popping. Like and if I have to take a pill to quit a habit, then I'll be dependent on the pill and then that's going to be my addiction. And I've moved from drugs in smoking to pills. (5M)

I don't trust those. It affects you when you're older. Like it can affect your bones or – (18W1) It's like any other drugs and tablets, aren't they? They've got other chemicals in them. (18W2) That's why I'd rather not take any of that stuff. Just keep cigarettes. (18W1) [Laughter]

But do you think there's any other side effect? (17bW)

The following participant was dismissive of prescribed medication to assist quitting, and after being told about Champix, expressed disbelief at the number of such cessation products available.

It's like it gets worst and worst. (KN3W)

Despite concerns expressed by many participants, one participant indicated their willingness to use pharmaceutical products for stopping smoking in the absence of any other effective support.

I think I would be if nothing else kind of worked. (16W)

Other methods

Pacific participants had little knowledge of alternative therapies such as hypnotherapy, acupuncture, or of self-help books, pamphlets and internet programmes. There was a great deal of interest in how these therapies/methods would help to quit smoking. The cost of accessing these resources was raised and considered to be a barrier to their use. About hypnotherapy participants said:

Yeah, it cost her \$350. That was over on the Shore. Whangaparaoa. One hypnotherapist was charging that much. (6bM)

All the people I know find it very helpful and it's very useful. It's very successful. It's got a 99% success rate but the problem is it's very, very expensive. I think you have to go three times over a period of three months or something like that, or two months. (19W)

So they pay the guy, you stop smoking for a few days maybe and then you already paid the guy and you go back to smoking. (19M)

One participant in this latter group had used hypnotherapy, and stressed the ease with which she stopped smoking for six months in a previous quit attempt.

It was really good, it was the easiest to quit smoke aye? ...I just went once and it was just, it was no effort, no hard work. Because... when you're quitting you try so hard, you're totally stressed, you've got to sit down and have a smoke anyway. ... But with that, that was the easiest, there was no work required. All I did was turn up with a whole mass in the lecture theatre with about, I don't know, 300 people in there. They ask us to hand our packets of cigarettes over and we just find a place where you can lie down on the floor where you're comfortable and they did all this... And they have tapes as well, and if you, you had to re-energise yourself into, you know, staying strong and so you just, like, listen to that tape or maybe it's

CDs now. So I just lie down and have a listen to it. But it's absolutely no work required. (19W)

This participant 'accidentally' relapsed after six months abstinence, following a self-imposed 'test' of smoking a single cigarette.

It was my biggest regret, picking up the first cigarette after 6 months. I just, I was testing myself actually. ...I was going 'I'll show you, I'll just have one and I'll promise you I'll never touch it'. Wrong. I pick up that first cigarette and I was away smoking again. I was trying to be smart, you know. (19W)

Participants were not aware that acupuncture could be used as a method to quit smoking.

I thought it was just for pain. (3M1) I thought it was just for pain relief for your back. (3M2)

Yeah. I've heard of it but not for smoking. (6bM)

The use of motivational books to stop smoking was used by some participants. One participant thought that such books had some potential for cessation purposes, but relapse was inevitable once you stopped reading the book.

They only work as long as you're reading it. ...You know, it's really motivating while you read it, 'oh yeah, that's really really good', but you close the book and you're back to the cigarettes. (19W)

Some participant's did not think that reading motivational books about quitting smoking would work for them.

Reading's just not in the vocab. (18W)

Accessing cessation support on the internet was only of any interest to some of the younger participants.

The internet? You mean like – (16W1) Websites or groups? (16W2)

Usually that's the internet's the first place I go to if I want to find out anything. (5M1)

One participant in group 16 had accessed the Quitline online.

Quitline

Quitline was the cessation service most known to participants. Many participants indicated their reluctance to talk to 'a stranger' over the phone about stopping smoking, and one participant suggested this method was not culturally suited to Pacific peoples. Some people expressed a preference for talking face-to-face.

Not too comfortable calling up a stranger. Probably just talk to a family member. Easier to hear it from them than a stranger, don't know. Those people on the ads, I don't know them eh. So like, maybe if it was someone you knew, you know, who you can relate to. (3M)

The majority of us, Pacific Islanders will not ring. It is just not our thing to pick up the phone and talk to someone. This is our thing, people coming and talking to us. (17W)

For me, I just shy away from the professionalism of the whole thing. It's just I like the personal face-to-face type of thing. Not on the phone. (6bM)

The people who work at Quitline, are they people who used to smoke? Having to talk to someone about it, like it's your business you started, so you should be the one to quit, you know. (17bW)

One participant perceived Quitline to only be relevant to “*those major heavy smokers on the brink of the death type people.*” (5M)

A couple of participants had attempted to contact Quitline, but were dismissive of the service for not answering calls.

They didn't answer. Yeah, I rang them but they never answered. They useless man and they never answered my call. (19W1) ...Yeah, I think I quite agree with that Quitline. You know, it rings and rings and rings, so you gave up and you hang up. You know, so you totally give up. You know, we're busy working people. I don't believe it works for working people. (19W2)

They just don't answer, nothing answering, I'm sure it's like engaged. Is it like 24 hours? (KN3W)

One participant who had received calls back from Quitline, had avoided them because they came at inconvenient times. There was some perception that follow-up calls were unwelcome ‘check-ups’.

When they tried to ring me again I kind of like, avoided the phone call. Because they'd ring at out of it times. (16W1) To check up on you? (16W2) Yeah. (16W1)

This participant opted to use the online service offered by Quitline, preferring the anonymity this afforded.

You just order it [online]. Like, you don't have to talk to them or anything. You just answer questions on how many smokes you smoke, whatever, and then they give you the option of gum, patches or lozenges. (16W1)

Confectionary

The use of confectionary such as lollies and chewing gum were mentioned and used by a number of participants. Participants would refer to gum as a lolly.

Yeah, but the gum make me cough all the time, so I just chewed the, you know, the ordinary PK gum, Juicy Fruit, whatever. I eat a lot of lollies. (19W)

For me Extra does the job. If you eat Extra that will make me not want to smoke because I want to keep that taste and the smell away. (5M)

Chew a lot of chewing gum. Keep your mouth busy. (19M)

Like I use to just eat sweets hard out to try and, whenever I wanted to have a smoke? (3M)

Pacific smoking cessation services

There were different views about accessing Pacific cessation services. While many participants were unaware of any such services which currently operated, participants from two groups had been recruited with the help of a central Auckland Pacific quit provider. Of these, most assessed the service favourably. One participant appreciated the funded Pacific service and the advice they offered.

The thing that, you know, what the Government, through these guys here are giving out and that really helped, well that's one advice to stop. (17bW)

This participant suggested one of the strengths of such a localised, and personalised service was the potential knock-on effect and mutual support of people quitting together.

That type of service, yeah, it's sort of like a little, you know, because someone will stop and then they'll tell somebody else, and then they get somebody else involved. And then you form a little group sort of thing. And then, you know so,

you know what I mean if you have a bit of a support group there. Because we're like alcoholics aye? It's like ...it is a struggle, yeah, yeah. (17bW)

The appeal of group support, along with practical assistance was echoed by others.

Yeah, a smokefree programme where you get more practical help. Get like a group of smokers together and do a team thing. ...Yeah. Like an AA thing but for smoking. (6M)

A group of younger participants had previously stopped smoking together as part of a more comprehensive detox programme in preparation for a dance competition. They talked about the benefits of such an approach.

[It helped before] doing it as a group. (5W) Yeah. Yeah, when you do it as a group it's more easier than doing it by yourself. (5M) ...Like for us, well it wasn't [so much] smoking, it was alcohol, we went on a 1 month detox and it was good. We didn't feel like we had to drink because all of us were on it together. (5W)

One participant mentioned a similar model, a church-based group fitness programme, which was currently in use in his community.

Basically yeah. It's open to the community, to promote community health. (6bM)

Compared to media advertising about not smoking, another perceived benefit of the Pacific service was the detailed explanations provided by the cessation worker.

It's so different to when [name of Pacific cessation worker] came over. He can sort of explain the whole thing, you know, with every single thing to really understand what are the things happening, which is really good. (17bW)

Another participant was in favour of the home deliveries of NRT and support this service provided.

The service is good, he does little home deliveries. I don't have to go anywhere. (19W)

Getting to such services was perceived to be a barrier to access. When told about the Pacific service, one participant said:

It's too far away. Looks like it's too far from home. Where are they based? (3M)

Using a Pacific service was of interest to some who perceived such a service would be less judgemental and intimidating than a non-Pacific service.

We'd want to speak to someone that we relate to. She's not going to judge us. And she's also not someone we're scared of. (3M)

Another participant expressed interest in dealing with a range of different people, rather than the same person from a different Pacific ethnicity than themselves.

No, I'd rather have the Palagi than have the Samoan all the time, aye? Because we're not all Samoans. (19W)

Some participants were sceptical that any cessation service, let alone a Pacific-specific service would be effective, while others expressed discomfort generally at seeking cessation support.

I wouldn't go to see them. I wouldn't bother using all those services. Never work. (KN4bM)

You still wouldn't use a Pacific Service? *I just wouldn't use any of them in general. (16W1) ...I mean, Māori or Pacific – it doesn't matter. Like, they're all the same. (16W2) I think it's just the whole talking to someone thing. (16W3) Yeah. When you stand up in the group and say 'Hi, my Name's Bob - I have a drinking problem'. (16M)*

Māori smoking cessation services

The majority of participants were not keen to access and use a Māori smoking cessation service. Some participants stated that a Māori cessation service would not be suitable for Pacific people. Many Pacific people did not feel comfortable that their needs and issues surrounding smoking would be addressed when using a Māori smoking cessation service.

It's Māori. You know, because it's not Pacific but they probably all have a different approach that, like a Māori might understand it but we won't, so it's still based on that cultural understanding. (5M1)

Like it wouldn't matter to me if it was Māori or Pacific Island. Either way I wouldn't go. They could be held by white people, and I still wouldn't want to go. No. It's regardless of that. I mean if you can help me quit, well then good. I'm not going to say 'you're Pacific Islander, you'll help me'. No. (5M2)

Stopping unaided

'Stopping unaided' includes reference to stopping smoking 'cold turkey,' or by using 'willpower' or 'mental strength,' and was the 'method' considered to be *'the best thing'* (19M) by most participants.

Cold turkey that's what I used to stop smoking. (3M)

That's by far the best. (16W)

With cold turkey you just stop yourself. (19M)

One participant reported that as "a casual smoker" he was not "so buzzed into smoking that [he] need[ed] outside help." (5M) He continued:

I think we actually have the willpower to quit on our own. ...It's like mental strength. (5M)

A couple of participants thought that as stopping smoking was "all in [the] head" (17bW), "in your mind" (16W), the use of cessation products was unnecessary.

I wouldn't try anything to stop myself from smoking. I can stop myself. (17bW)

Yeah, my Dad thinks that you don't need anything else, you can just stop. Because when I try and give him an excuse, he says 'no, you can just stop.' (16W)

Despite its popularity, many comments suggested that the experience of stopping smoking 'cold turkey' was "not good" (6W). Quitting without any formal support was unpleasant, not just for the person stopping but for those around them.

Kind of get withdrawals for the first couple of days. Get all tired and weak. Dizzy. (19M) ...Yeah, you're mahi all the time. Tired, sleepy. (19W1) Yeah, that's for the first, like, 48 hours. (19M) ...Hungry and eating. (19W1) ...And I get angry very easily. (19W2)

You can't sit still. You get agitated and fidgety. (6W1) And frustrated. (6W2) ...And pissed off. (6W1) Yeah, all that. You take it out on the next person that's next to you for no reason. (6W2) And you start taking it out on kids. And you start smashing things. (6W3) Getting all angry. (6M)

One participant considered these effects to be an anticipated consequence of quitting.

...you know, I know I get bad temper [and] I'll just eat and I have to yell at my son for no good reason. But I'm just going through that. (19W)

Pacific Discussion

Smoking status

There was a discrepancy in how some participants classified their smoking status. A small number of participants indicated that they were not smokers. Of these, two went on to indicate light smoking (i.e. 1-5 cigarettes per day), another revealed he only smoked in context-specific circumstances (e.g. when he drank alcohol); while another was known personally to a facilitator/team member, and was understood to still smoke, albeit 'intermittently' (*"I'm a non-smoker ...I never buy a pack of smokes. I smoke when the guys in the pub [are] smoking ...But yeah, I do like smoking."* (19M3))

If people do not consider themselves to be smokers, they will not consider they need to stop smoking or be open to discussing cessation support. Smoking prevalence among Pacific people may also be underestimated.

Data collection tools (such as the census) should be honed in order to accurately assess smoking prevalence. They should capture light, intermittent and/or non-daily smoking patterns. Any education about the risks of smoking should include the risks of light, intermittent and/or non-daily smoking.

Family

Family played an important role for some participants in providing tensions and triggers to stop smoking. For example, not being permitted to smoke by parents was a significant trigger for some young people to stop smoking. Older participants and those who were parents expressed strong concerns about children and young people smoking. However the effect of modelling smoking behaviour did not seem to be well understood. Whilst family might sometimes prompt quitting, in other cases family and friends triggered smoking and were barriers to quitting.

The family underpins Pacific communities. The negative impact and effects of smoking on the family needs to be promoted widely within Pacific communities. Programmes and strategies must not only target the individual but also extended families. There needs to be strategies that can be inclusive for extended family members on how to help reduce smoking amongst Pacific communities. For instance, educating people about the role model effect and the important role that parents and community elders play in discouraging younger family members from smoking and keeping their young people smokefree could invoke altruistic quitting in some.

Health

Across the Pacific groups, participants identified physical health as an important reason to stop smoking. This was most often a temporary solution in response to poor health. Quitting for fitness and/or lack of energy was perhaps another aspect of this, in that stopping smoking for these reasons was often an impermanent response to an immediate physical concern.

There was a prevailing sense that smoking was not as hazardous to health as was promoted. Some participants were conflicted about this issue. People who had smoked for many years were 'evidence' that smoking did not cause premature death. In some cases, the health risks of smoking were openly disputed and *stopping* smoking was imbued with risk for some.

For some of the mostly older Pacific Island participants, smoking was a stimulus, and perceived to provide them with an 'energy boost' to continue with day to day routines.

Our findings suggest that the health risks of smoking are not well understood by Pacific peoples. Health campaigns and education programmes specifically targeting Pacific communities, with clear messages are required.

Pregnancy

Participants had mixed views about quitting when pregnant. Some demonstrated a good understanding of stopping for the health of their unborn child, while for others, quitting was associated with morning sickness and being too sick to smoke. If pregnant women did stop smoking, resuming smoking post pregnancy was common. Irrespective of the motive for quitting while pregnant, sustained quitting for the health of the baby once born was not common.

- ***It is recommended that antenatal and post natal programmes target Pacific communities (i.e., pregnant women, their families and partners), to inform about the health impact of smoking while pregnant, and the risks of SHS.***
- ***Support must be offered to women who stop smoking during their pregnancy to remain smokefree for their own health and the health of their baby and families.***

Environmental

Some of the parents said they made efforts to keep their homes smokefree; this consciousness is likely to have been influenced by smokefree awareness programmes and legislation aimed to address the risks of SHS. Smokefree policies restricting smoking in public areas was a tension for many participants, and made smoking less easy. TV ads and social marketing campaigns caused some participants to think about the health risks of smoking. Some participants employed strategies to resolve the cognitive dissonance induced by their continued smoking in light of these messages. Several participants, particularly younger ones, thought some of the TV and graphic warning messages were so extreme that the messages did not apply to them. Smokefree TVCs and more generally, smoking on TV, triggered the urge to smoke in some participants. A number of participants were supported to smoke by the access and availability of cigarettes and the promotion at point-of-sale. Easy access to and availability of cigarettes was a motivational force to smoke, and a barrier to quitting.

Overall, cost was ranked the number one reason for stopping smoking by Pacific participants. It was also one of the main triggers for past quit attempts. However, participants' discussions revealed that past quit attempts that were motivated by cost, were mostly temporary, lasting until the cost of smoking could again be met. In the absence of other motivational tensions, triggers and/or treatments for stopping, it is possible that cost will only be a trigger for reducing tobacco intake or stopping temporarily. Price increases are likely to be more effective accompanied by other motivational forces to stop. For example, effective and accessible cessation support and major awareness campaigns about the risk of smoking to the Pacific family could be provided to promote sustained quitting in people motivated by price increases to stop smoking.

HPs were mentioned as a source of smoking cessation advice. Some participants listened to the advice of HPs, whilst others did not. There was criticism that HPs who smoke and who advise their patients to quit smoking are hypocritical. HPs who smoke should consider stopping to improve their credibility in providing cessation advice to others.

Culture

The place of smoking in Pacific culture was not fully explored but some views about this were expressed. There was a suggestion that parental support for smoking initiation was associated with cultural practices celebrating a rite of passage into adulthood. In another group, a discussion arose about culture which suggested that smoking initiation for young women was much easier in New Zealand culture. Some participants became entangled in New Zealand smoking environments and therefore smoking became part of their current culture.

Kava clubs and parties were environments where heavy smoking was reported, and many of the Tongan participants spoke about how smoking was an associated behaviour during kava sessions. As a common venue where smoking occurs, kava ceremonies are an ideal place to promote smoking cessation and services targeting Pacific men.

The church was also identified as a place where smoking occurred frequently. As many Pacific families attend church, this setting is an ideal environment for cessation activity and education. As smokefree legislation and policies had the potential to influence participants' smoking behaviour, Pacific churches are venues where smokefree policies need to be more proactively promoted.

Spiritual

Spirituality is important to many Pacific people. For some participants, being religious was part of the church philosophy and this was an important trigger for some participants to give up smoking. Contradicting this, the church venue was also an environment where smoking was a popular activity.

Mental

Negative affect, that is negative emotions such as stress, worry, loneliness and boredom were identified as triggers to smoke and/or relapse.

For many, smoking was closely linked with other behaviours such as drinking coffee. Smoking was also closely linked with drinking alcohol. This occurred across Pacific groups regardless of age or gender. For some participants who did not smoke on a regular basis, alcohol consumption would trigger smoking to occur. Alcohol campaigns about moderate and responsible drinking could include messages about accessing smoking cessation products and services.

Participants expressed beliefs in the necessity of will-power to quit smoking. Quitting was dependent on the individual's will power to overcome stopping to smoke. Other myths surrounding smoking and stopping smoking also acted as barriers to quitting. These included the notion that smoking was an individual's personal choice.

A number of mostly older participants held a fatalistic view about not giving up smoking. Of these, many felt that as death was imminent (due to their age) and/or inevitable, quitting was pointless. Quality versus quantity of life was not discussed. Fatalistic attitudes undermine motivation to quit smoking, and should be addressed. Drawing on the centrality of family to Pacific peoples, strategies promoting stopping smoking for the sake of living longer, healthier lives and being around for families, children and grandchildren could be utilised to counter fatalism. Stressing the importance of the role model effect could, again, help encourage smokers to 'quit for others' if not for themselves.

Relative ranking of reasons to stop smoking

Overall, participants ranked staying healthy as the number one reason for quitting smoking, followed by cost, to live longer, for children's health and to be a positive role model. There was some disparity between the ranking of 'to be a positive role model for my children' and what participants were saying. Despite this reason ranking highly, many participants considered that their smoking did not influence their children's uptake.

Smoking cessation methods

The most common quit method used across all Pacific groups was cold turkey. Many participants had little or no knowledge of smoking cessation services and NRT products, other than Quitline, and nicotine gum and patches. Few participants had good knowledge of how to use these NRT products. Poor and/or incorrect information about NRT products was a significant barrier for many participants. Many participants were not fully aware of the range of smoking cessation products and cessation services that was available. There needs to be more information and community awareness about access and use of the full range of effective, subsidised cessation products.

Few participants knew about the e-cigarette and inhaler. Pacific participants had no knowledge or very limited knowledge about nicotine free prescription medicines such Zyban, Norpress, and

Champix. The cost of alternative therapy such as hypnotherapy, acupuncture, books, pamphlets and internet was a barrier to accessing these resources.

Smoking cessation services

Quitline

Pacific participants had some understanding of the service Quitline provides. There were some reservations about using Quitline as Pacific participants were not inclined to talk to a stranger over the phone. Pacific participants felt more comfortable with face-to-face interaction with an individual and for many of the participants this was the preferred method of receiving smoking cessation advice. Some participants who had used the Quitline indicated that their phone calls were often not answered. Participants indicated this was frustrating and it discouraged them from using Quitline.

Pacific smoking cessation services

There were a range of views regarding accessing Pacific cessation services. Many participants were in favour of using such a service while a few others were happy to see a Palagi. Smoking cessation services specifically targeting Pacific people in Auckland are few and relatively new, and many participants were not aware of any such services. Feedback from participants who were using Pacific cessation services was largely positive. Group approaches to health services (including smoking cessation) were acceptable to Pacific participants.

Māori smoking services

The majority of the Pacific participants were not in favour of accessing a Māori smoking cessation service as they felt that this service would only cater for Māori. Participants stated a Māori service would not be culturally appropriate for a Pacific person.

In conclusion, regarding cessation services, these need to be more at a “face-to-face level” so Pacific smokers who want to quit can meet a quit service counsellor. Group approaches are acceptable, offer mutual support and should be utilised more broadly. Pacific smoking cessation services need to be promoted widely in the Pacific community. A wider range of education awareness programmes and resources which are culturally appropriate for different Pacific groups need to be developed. Cessation support needs to be affordable, and education and advice on how to use treatments properly should be readily accessible.

Chapter Three: Ex-smokers data

Donna Watson & Dr Janine Paynter

You want to stop but you just need a reason. (9W)

Participants

Demographics and smoking history

Seventy-five percent of participants were female, and most participants (78%) identified as Māori. More than half the participants (55%) were aged between 26-45 years old. While 56% of participants were in paid employment, 66% were eligible for a Community Services Card (a proxy indicator of lower SES). Participant demographic and smoking history is summarised in Table 20.

Participants were most commonly aged between 11–15 years when they smoked their first cigarette. Just under half (49%) the participants smoked regularly by the age of 16, with an additional 38% becoming regular smokers by the time they reached 21 years of age.

Table 20: Socio-demographic characteristics and smoking history of ex-smokers (N = 32)

		N	%
Gender	Female	24	75.0
	Male	8	25.0
Ethnicity*	Māori	25	78.1
	Cook Island	1	3.1
	NZ European/Pākehā	11	34.4
	other	2	6.3
Age (years)	16-20	1	3.1
	21-25	1	3.1
	26-30	4	12.5
	31-35	4	12.5
	36-40	5	15.6
	41-45	4	12.5
	46-50	2	6.3
	51-55	5	15.6
	56-60	3	9.4
	61+	3	9.4
NZ born	Yes	32	100.0
Employed outside the home	Yes	21	65.7
	No	9	28.1
	Missing	2	6.3
In paid employment [†]	Yes	18	56.3
	On a course	4	12.5
Terms of employment	Full time	11	34.4
	Part time	6	18.8
	Missing	1	3.1
Eligible for a Community Services Card?	Yes	21	65.7
	No	11	34.4
Age (years) at first cigarette	≤10	2	6.3
	11-15	24	75.0
	16-20	4	12.5
	>20	1	3.1
	Missing	1	3.1
Age (yrs) when started regular smoking	11-15	15	46.9
	16-20	12	37.5
	>20	2	6.3
	Missing	3	9.4

*Ethnicity is reported here as multiple response, therefore percentages total more than 100%.

[†]One participant was in paid employment and on a course.

Reasons for stopping smoking

Participants were asked to record their cessation history, including the age at each past quit attempt, their reason for stopping, and the method they used to stop.

On average participants had made three attempts to stop smoking. The number of attempts per participant ranged from one attempt to eight.

The reasons for stopping smoking in previous quit attempts are summarised in Table 21. Health-related reasons were cited most frequently. Reasons cohering around whānau and pregnancy were the next most cited for stopping smoking. Not liking smoking, wanting to quit and cost represented the next most oft mentioned reasons.

Variation by age

Pregnancy-related reasons for quitting were most relevant when participants were between 16-25 years old. While health and whānau related reasons occurred across the age groups, health reasons spiked for participants at 16-25 years old and at 41-45 years old.

Reasons for relapsing

Participants were asked to record their cessation history, including the age at and reason for each relapse. The reasons for relapsing are summarised in Table 22. Negative affect reasons were cited most frequently; these were primarily related to stress. Reasons relating to social inclusion and identity were the next most cited for resuming smoking. Whānau-related and behavioural and physical associated reasons were identified the next most often, although these were nominated less frequently.

Variation by age

Resuming smoking because of negative affect was most relevant when participants were between 21-25 years old. Social inclusion or identity was cited most by participants as a reason for relapsing between 10-20 years of age.

Table 21: Ex-smokers reasons for stopping smoking by age quit attempted

Reason for stopping smoking	Age Group									Total
	11-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	
Health	2	8	10	1	6	6	15	6	4	58
Whānau	4	5	5	2	4	6	2	2	6	36
Pregnancy	1	7	9	3	0	0	0	0	0	20
Don't like it/want to quit	1	3	6	0	3	1	2	0	0	16
Cost	0	2	2	1	2	2	2	0	0	11
Social inclusion or identity	1	0	0	1	2	1	2	0	0	7
It's time	0	0	2	1	1	0	0	0	2	6
No reason/Just trying	0	3	0	1	1	0	0	0	0	5
Church	0	0	0	0	1	0	0	0	2	3
Career	0	0	0	0	0	0	0	2	0	2
Making one's own choices	0	1	0	0	0	0	0	0	0	1
Smokefree policies	0	1	0	0	0	0	0	0	0	1
	9	30	34	10	20	16	23	10	14	166

See Appendix F for full details

Table 22: Ex-smokers reasons for relapsing by age at relapse

Reason for relapsing	Age Group									Total
	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	
Negative affect	0	6	14	5	1	3	0	0	0	30
Social inclusion or identity	6	7	3	1	3	2	0	1	0	23
Whānau	6	2	0	2	0	2	0	0	0	12
Behavioural and physical association	0	3	5	0	1	0	1	0	0	10
Reason for stopping no longer relevant	3	2	2	0	0	1	0	0	0	8
Alcohol	0	4	1	0	2	0	0	0	0	7
Wanted to smoke	3	1	0	1	0	1	1	0	0	7
Appearance	0	0	1	1	1	1	0	0	0	4
No reason	0	0	1	1	0	1	0	0	0	3
Location	0	2	0	0	0	0	1	0	0	3
Employment	0	1	0	0	0	0	0	0	0	1
	18	28	27	11	8	11	3	2	0	108

See Appendix G for full details

Reasons to stop smoking or to relapse

This section presents the key points discussed by participants related to the motivational forces to stop or to resume smoking.

The Physical Realm/Te Taha Tinana

The findings reported here relate to motivational forces to stop smoking or to relapse or continue smoking within the physical realm. Motivation to stop smoking categorised within the physical realm referred in most part to the effects of smoking (and of not smoking) on the body and largely involved health concerns. Within this realm, participants discussed the role of the addiction to nicotine and smoking. The aesthetics of smoking, such as the repellent smell, was frequently mentioned in relation to stopping smoking and/or remaining smokefree, while weight gain was discussed as a trigger to relapse.

Health

Health was an important motivation for stopping smoking. Health-related tensions to stop smoking included concerns about fitness, sports performance, and maintaining good health. Some concerns such as stopping smoking to have more energy, to not grow old early and to live longer, were not considered relevant for younger smokers. For example, as one participant commented:

To have more energy? No, I was young with energy anyway. (26W)

Some older participants indicated that their smoking-influenced health-related concerns changed with time. One participant noted for example,

When you're younger you want fitness for sport or something but now it's just to live longer. (12W)

For some older participants the desire for longevity and good health was related to whānau.

Living for your kids is the reason we all want to live longer. (9W)

To stay healthy is number one, for the mere fact you've got everybody else around you, your family, kids, and grandkids on the way. When it's your health you're not going to enjoy them. (12M)

Health-related triggers to stop smoking were often linked to being ill at the time of stopping. Such illnesses ranged from coughing and fatigue to more severe illnesses requiring hospitalisation:

I started to cough a lot and feeling tired and that. So I thought no, I knew I had to give up smoking. (21W)

The day before I had my heart operation I just chucked it away. (9W)

Seeing how smoking affected the health of someone close was sometimes not a sufficient motivation to stop for some participants. However it was a temporary trigger to stop smoking for one participant, and made some participants worry about the effects of smoking on their whānau.

I knew a man who died of emphysema, but it didn't make me stop. (21W)

No, I didn't see that till later on, after I'd stopped and it started happening to people I knew. So that wasn't a reason. (26W)

I've had that in my family quite a lot. Quite often and it still didn't register. It still wasn't enough. Even though that was one of the times where I had attempted to stop. I still went back to smoking. (9W)

Especially when you've got emphysema in the whānau aye? (12W1). Because that makes me think a lot about my whānau and their smoking. (12W2)

Improvements to health which occurred after quitting were frequently cited by participants, and provided tension to stay smokefree.

You can tell the difference in yourself when you stop smoking. (15W)

The smoker's cough going. (12M)

I don't have to use my inhalers any more very much and that's a good thing. (20W)

In contrast to concerns about the health risks of smoking some participants thought there were health risks associated with *stopping* smoking.

Yeah, sometimes it can go the other way aye. (9M) It can kill you faster if you give up. Your body's not used to it. (9W1) I seen my father-in-law was told to stop. Within six months he was dead he was better off to keep the nicotine in him than to take it out. He just shut down. (9W2)

Similarly another participant suggested that a lifetime of smoking had failed to affect his grandmother.

Yeah my grandmother, she was 100 when she died, she smoked. And at that stage she never stopped smoking, until she died and it wasn't the smoke that killed her. She fell over and broke her hip. (15M)

The same participant had "another grandmother...that one never smoked." His non-smoking grandmother died at age "112, 113", 12-13 years longer than his grandmother who smoked, although this increased longevity was not commented on.

In discussing government revenue from cigarettes versus health expenditure, two participants indicated that smoking-related health effects were not an immediate concern.

Yeah, [the government, will be paying] out the health things that go on in later life. (9W1) But it takes twenty years for the health – so for those first twenty years they are. (9W2)

Physical discomfort experienced when quitting provided a trigger for some participants to relapse.

I got chronic fatigue, I was so crook. And when I started smoking again it went away. (12W)

Just one participant discussed the critical role of cessation treatments to manage his nicotine cravings. He referenced his use of nicotine replacement therapy (NRT), saying:

But the treatments definitely helped. In those first few months it's like training wheels. (21M)

The addiction to nicotine and the ease with which this occurred was referenced by several participants. While illness triggered some participants to stop smoking (as cited earlier), others continued smoking while sick, despite the extreme discomfort it caused.

When you restart you get a headache and wheezy. (26W1) By the second smoke you're fine. (26W2) Yeah, the first one I was 'oh yuck', and then when I've had another kick at it I was fine. (26W1) I know, we smoke for the dumbest reasons. I developed bronchitis one winter and I had a disc inhaler, and every time I inhaled my smoke it was sore, but do you think I put my smoke out? No, I just continued

to smoke. (26W3) But it's like people when they get the flu and they're coughing and spluttering, I mean, we're our own worst enemy. (26W2)

The following excerpts further highlight the addictiveness of cigarettes and the absence of choice in the presence of such an addiction.

Oh, no. You get that craving and you've just got to have it. (21W1) Once I had one, I was away again. (21W2) You're hooked. You're right back in it. (21W1) Yeah, with me it just took one cigarette. So then I realised it was addictive. It wasn't a choice. It was an addiction. (21W2) Oh dear. It's like talking to alcoholics isn't it? (21W1) It is really. (21W3) When you're smoking, you're kind of controlled by it to an extent. (21M)

I'd have my fix that would last me until the morning, you know. I say it was a fix because that's what it was. (21W3) I remember my mum used to actually get really anxious if she didn't have a packet of cigarettes, cos she was worried about waking up at 3 in the morning and not having any cigarettes and having to drive up to the service station. My mother would get really anxious if she knew that she might not have a cigarette. (21M) You're not attuned to stopping. You're attuned to smoking. So if you haven't got any, it is difficult isn't it. Really. (21W2)

To avoid running out another participant commented with disbelief *"I used to buy them by the carton. By the carton!" (21W)*

Nicotine addiction heightened participant's susceptibility to triggers to smoke.

Because even on the phone, you know - (12W1) Yeah, yeah, you roll your cigarette, you get your phone to go and sit on the doorstep. (12W2) Yeah, all those little things. (12W1)

Yeah, coffee and a cigarette. (12W1) And actually having to give up some things that you really enjoy. Like starting the day with a hot drink and that cigarette in the sunshine on the doorstep, you know, I miss that. But I'm not stupid enough to think that I can do it without the cigarette too often, so. (12W2)

I'd have a cup of tea and have a smoke. (9W)

Aesthetics

At least one participant from every group mentioned the repellent smell of cigarettes. For one participant, this was a trigger to stop smoking.

I was getting sick of smelling my clothes and my hair. Although I sprayed and I was conscious of eating peppermints and chewing gum a lot, I still felt conscious around people who didn't smoke. That made me not want to continue. (26W1)

Mostly, participants did not have an awareness of the smell of smoking until they stopped.

I didn't know that 'till after I stopped and started smelling people. I went 'hmm, do they smell like me'? I didn't know I did. No-one told me. (26W2) That's because they all smoked. (26W3) [Laughter]

Awareness of the smell of cigarette smoke was a real deterrent to relapse for most participants, providing a tension to stay smokefree.

I'll never go back because of the stink, and you can't breathe aye? (12W1) I feel sick when I smell it. (12W2) Me too. (12W1) I get outside or I get my spray out. (12W3) I get really crabby, I get really shitty if I smell it. (12W1) It makes me really vomit. (12W3)

I couldn't go back to smoking, I can't stand the smell. (26W)

In addition to finding the smell offensive, some participants spoke about their general distaste for smoking.

If we see a young girl walking down the street and she's smoking I say [to my daughter] 'see I used to do that', I'd say 'see that looks disgusting'. (15W)

For one man, this distaste extended to disliking smokers being around child family members.

To be honest I don't even like some of my cousins picking up my moko. (9M)

A few participants indicated how stopping smoking had also enhanced their sense of taste.

Well even the food tastes better too, when you're eating your food and it's quite nice. (12M) Food tastes wonderful. Yeah, that was a result, afterwards. Food just really tasted awesome. (21W)

Weight gain

Several participants discussed weight gain following stopping smoking. For some this was a reason to relapse.

One of the reasons you go back to smoking is you put on a lot of weight. (9W)

Others mentioned their commitment to remain smokefree despite weight gain.

I made a decision, okay, I'm going to put on weight but at least I'm not going to die of lung cancer or have emphysema or anything like that. (12W)

I've put on 16kgs which is very hard to get off. So that's my only worry at the moment, but I know I won't smoke again. (12M)

This latter participant indicated how he had used NRT to avoid unnecessary eating. He stated:

I did a bit of (NRT) gum which is pretty revolting, but that was in my mouth all the time for the next month or so. (12M)

One participant suggested cessation support should include educating people about the mechanics of smoking in managing weight gain, and how to address this post quitting.

Probably need some sort of help after giving up smoking as far as weight. Knowing more about what the nicotine does to your body in those areas. How the nicotine stops you from putting that weight on. If you could have more information about what nicotine actually does to your body and once it's gone. (9W)

Pregnancy

Pregnancy overlaps and intersects the physical (te taha tinana) and family (te taha whānau) realms. It is considered here as a separate section.

For some participants, being pregnant was a trigger to stop smoking, while for others it was not. For one woman, finding out she was pregnant provided a clear prompt to quit.

The doctor said I was pregnant, so I just stopped. It was very easy to just stop, because I had a reason, another person besides myself to think about. (26W)

A variation on this theme was to stop smoking for a specific pregnancy, as in the case of one respondent who stopped smoking when she was pregnant with her son.

You just quit when you found out it was a son. Were your other children daughters? They're all girls, yeah. (21W)

The effects of smoking during pregnancy were acknowledged by some of the women.

My oldest was born with nicotine withdrawal symptoms because I was addicted serious, I just had to have cigarettes. It's disgusting. (12W)

I had one daughter who smoked and another one who was very good. As soon as she realises she's pregnant, she just dropped her packet of smokes. There is a weight difference in the babies. (9W)

For some of the participants, smoking while pregnant was common and represented a tension for not prioritising pregnancy as a reason to stop smoking.

I know somebody who's pregnant now and she's still smoking so that's. (20W1) I know a few chicks like that too. (20W2) Yeah, it's so common it's not funny. So it's like last [in terms of importance for stopping smoking] to me. (20W1)

Pregnancy weight gain was a trigger to relapse following smoking abstinence during pregnancy.

Because [my daughter] puts the weight on, she starts up again. (9W1) ...That's what I did after my last one. I was smokefree for a good nine months after I had him and I still couldn't shake the weight off so I started smoking again. It just fell off like that. (9W2)

The Familial/Social Realm/Te Taha Whānau

Family and friends play important roles in the motivation to stop smoking or to relapse or continue to smoke. Stopping smoking for children was a salient theme. This mainly included: for children's health and the desire not to model smoking behaviour to children. Support from family and friends acted as a treatment to sustain quitting for some.

Family/friends and social environment were themes in participants' comments in relation to experimenting with smoking and, more commonly, the difficulties associated with stopping smoking. Some older participants referred frequently to their grandchildren/mokopuna. One participant spoke about finding out she "was going to be Nanny and [having] these wicked ugly visions of [her]self with a rollie hanging out of [her] mouth, hanging onto this moko" (9W), while another simply stated "Yeah, that's why I gave up smoking. For the mokos." (9M)

Children's health triggered many participants to stop smoking and/or provide a smokefree environment.

For me it was my children's health. (26W)

You need to make your home smokefree because the children as they grow up seem to develop diseases like asthma. (12W)

For one participant, it was his son's health combined with his son's direct prompting that provided the final impetus to quit.

My son had asthma from the start. I was reading him a book, and all the windows were closed and he opened up all the windows, and it was cold because it was winter time. I had the TV on at the same time, and yeah, he just got angry. He let the smoke out, and he walked out of the room and I went back and closed the windows again. He walked back and he said Jesus, dad, the smoke. And I sat there and I thought to myself, 'you selfish bastard'. So I stopped smoking. And I had two cigarettes in my packet. I had tea that night, and had two cigarettes and I've never smoked again. (15M)

One woman admitted she hadn't been able to give up for herself, but was motivated by "the health of [her] children" and the desire to provide them with "a [smokefree] role model." (26W)

Role modelling smokefree behaviour, or rather the desire to *not* model smoking behaviour, was tied to relatively recent smokefree consciousness and education for several participants. A conversation between four participants, including three older women illustrates this.

Well, I certainly wasn't a role model for my children. At the time, it [smoking] was the thing to do. I think just about everybody either tried or did smoke. Then, it's the education that goes with it. And that started, what, 20, 30 years ago. (21W1) Yeah, it was socially acceptable to smoke in people's houses, wasn't it. (21M) Absolutely, yeah. So [quitting for the children] wouldn't have been a priority for me, for my age group. Did you smoke in front of your children? (21W1) Yeah. (21W2) Did you? (21W1) Yeah. (21W3) So it [stopping] just wasn't done for the children. (21W1) Now I think it really is a huge priority. Back then, no. There wasn't really that awareness about it. (21W2)

A few participants identified the positive role of their whānau/friends active support during their quit attempts.

Children, children, their encouragement. (12W1) Yeah, my boy goes, 'you're not bloody smoking again, are you mum?' 'I say 'no'. He'll say 'Well I'm really proud of you'. (12W2)

That's the good thing about your friends though, when they know that you're stopping, they'll support you with that ...you grab that cigarette and they're like, 'no, no, no'. (12W3)

One participant said he stopped smoking at a young age because his parents did not allow him to smoke.

Whānau and friends also created tensions and triggers to *start* or *resume* smoking and barriers to stopping. Permissive family attitudes towards smoking enabled early experimentation with cigarettes for at least one participant. This participant recollected how she first tried smoking around age 11 *"just mucking about with cousins"* at a family party, *"when aunties and uncles were drinking, drunk, and they weren't aware of us."* (15W)

In addition to their role in early experimentation with cigarettes, family and friends were frequently cited as barriers to stopping smoking. *"Home pressures"* (9W) and *"relationship issues"* (20M) for example, were cited as barriers to quitting. Elsewhere, whānau were implicated in actively inducing participants to relapse. One participant recalled how she *"gave up smoking cigarettes, totally, and then [her] brother came back from Aussie, and he had lots of different types of cigars."* She said *"he convinced me that smoking cigars wasn't as bad as cigarettes."* Although she conceded *"smoking's smoking at the end of the day."* (15W)

Stopping smoking was made especially difficult when smoking was prevalent in participants' family environments.

When I stopped the first time [my partner] was still smoking which was probably another factor in why I started again. (26W)

One young Māori participant indicated that whānau on the marae:

...discouraged me [from stopping] smoking just because absolutely everyone there smokes. So mum, dad, aunties, uncles, nan's, koru's, cousins, little cousins, everyone smokes there. (20M)

Smoking as normalised social behaviour, and the difficulties of quitting when *"everyone else was [smoking]"* (15W) were recurrent themes.

It hard when I go with my mates and play sports, rugby and all that. They have smokes and all that. (9M)

Socialising went hand-in-hand with alcohol which in turn, lowered participant resistance to stay smokefree.

In the early stages it is really hard. I remember going and having a drink, you know, with friends and that, and they were just, my attempts were dismal really to begin with. Because I just blew it every time. (21W)

Similarly, *"sneaky puffs, Friday afternoons at the pub"* (21M) resulted in a return to smoking for another participant, while another commented:

Every time I'd have a drink I still had a smoke. So I got to a point where I stopped during the day, but then if I went out somewhere I would smoke a pack that night when I was having a drink. (26W)

In this context, one participant acknowledged how stopping smoking was an ongoing *"process, especially when you're out drinking and you see other people really enjoying them."* (12W)

"Holiday season" (20M), *"Christmas and tangi"* (12W) were social events participants identified where family/whānau, socialising, alcohol and smoking came together.

The Mental/Emotional Realm/Te Taha Hinengaro

In this section, we report the results related to motivational forces situated within the mental or emotional realm. These included beliefs participants held about their readiness to stop smoking. Also captured are the cognitive/behavioural cessation strategies, both novel and evidence-based, including avoidance, affirmations, positive reinforcement, aversion techniques, mind over matter, and stress reduction, variously proposed by participants to deal with aspects of stopping smoking. Conversely, smoking was spoken about as a way to cope with negative emotions and stress.

“It’s time”

Many participants held beliefs about their readiness to stop smoking that they had reached a critical ‘time’ point to stop..

I always kept thinking in my mind ‘it’s time to do it, it’s time to do it’. (26W)

I just can’t be bothered with smoking. (15M)

For some this occurred as a response to an epiphany, for example, the realisation of increased cigarette consumption, or that smoking was no longer enjoyed.

And when I realised I was smoking a packet and a half of 25s a day, I knew that was it, I had to stop. (26W)

It was time for me because it just tasted yuck. (9W)

I used to love smoking. And then it was like ‘ugh, I don’t like it anymore, I’m getting sick from it’, you know? (12W)

For others, the time to act corresponded with life circumstances conducive to stopping smoking.

One participant, who successfully stopped smoking at aged 68, had only tried to stop smoking once previously when she was 23 years old. She described how at aged 68 “years of public education [about the risks of smoking], understood but never actioned” culminated in the belief that “the time was right for me” to stop smoking. This time coincided with her retirement, (leaving “a very responsible job”), and an overseas trip with non-smokers. She said:

I suddenly decided I was going to stop and I used that opportunity – I left a cigarette sitting on my windowsill and I was away for nearly 6 weeks and didn’t smoke. When I came back they were still sitting there, so I fired them in the rubbish tin very quickly. (21W)

This theme was echoed by a fellow participant who talked about his employment in health research and the opportunity to stop smoking in such an environment. He noted:

Yeah, I think it was definitely a case of the time being right and there being an opportunity and needing to take it. (21M)

For one participant, quitting when it “was time” was qualitatively different from other quit attempts.

Yeah, you just know when it’s time. There’s something different about it, no matter how many times you’re trying to give up. (12W)

The following conversation suggests that the absence of withdrawal symptoms is evidence that the time is right. Conversely, when the time *isn’t right*, withdrawal symptoms will be significant. The inference is that when the time is right, quitting will be easy.

Some people have different reactions when they’ve given up smoking; the withdrawal symptoms. Oh, some of them are bloody shitty, you know? (12W1)

*And I think that's when you know it's time because if it ain't time, horns and 'aaah'.
(12W2)*

The reliance on it being the 'optimal time' to stop meant smokers couldn't be coerced into quitting.

I don't think anyone can force you to give up. (21W).

As one woman said, "You yourself know when it's time to quit." (12W)

Strategies for stopping smoking

For many participants, successfully stopping smoking meant avoiding environments where other people smoked or which participants associated with smoking, avoiding particular friends who smoked or changing their social group, maintaining a smokefree environment and/or not drinking alcohol.

*So yeah, I didn't go out as much, so I had to become a little bit socially reclusive.
(21W1) Keep away from temptation. (21W2) Just to keep myself safe. Because I
knew I just can't do it if they're smoking. And then it was a lot easier. (21W1)*

I couldn't see my friends for about four or five months. (9W)

It's been over two years and I still haven't had a heck of a lot to drink. (9W)

Every time my kids come around, [I tell them] 'get outside and smoke'. (12M)

*Staying away from the environment you normally smoke around. Like for me, we
have an outside deck kind of thing where we smoke. I've got to stay away from
that area. Also like stay away from environments I know will be hard for me like
the marae and stuff like that. (20M)*

Change the mates. (26W)

In contrast to these avoidance strategies, several participants described how they deliberately exposed themselves to particularly unpleasant aspects of smoking or to others who smoked as a part of their strategy for quitting.

*And when things are getting really rough, I fill up a little jar or a tin and put some
cigarettes in there with some water. It stinks. It just puts you off. Oh, the smell and
the look of it and you're thinking 'oh I'm putting that in my lungs'. (12W)*

*I think for the last quit attempt, [being around other smokers] was just an extra
part of the challenge. And yeah, I was quite determined from the beginning. So
my resolve was quite strong. So I just gritted my teeth and got through it. (21M)*

The latter participant had stopped smoking while employed in a tobacco control setting, so his smokefree status was validated in his daily work environment.

Like the participant who left a cigarette on her windowsill before leaving for an overseas trip, several other participants deliberately kept some cigarettes around them while they were stopping smoking.

*So I decided I'd go home, put 5 cigarettes in my packet and allow myself 5
cigarettes for the day and that's all, but I never ever went into it. I kept my packet
with the 5 cigarettes in it for 3 years, and I would take it out every now and then
and look at it and go 'yeah'. (26W1) I've still got my cigarettes in my drawer in my
office that I haven't touched. I've got the lighter and it all in there. (26W2)*

*I left the packet of smokes on the table for three days. I just walked past it. You
know? It was still playing on my mind. But I never touched it. And on the third
day I just squashed it up and threw it away. (21W)*

For one participant, her smokefree status was tenuous, and self-affirming this status was, at times, "a daily thing" (12W). She said:

Really clear, if I have that first puff then I'm a smoker, you know? So some days you'll wake up and say 'I choose to be a non-smoker today. (12W)

This affirmation reinforced the tension to remain smokefree.

Many participants referred to the role of the power of the mind in stopping smoking. One participant for example, knew someone who had:

... paid, like five hundred bucks [to attend] this seminar and when she left she just never smoked again. They didn't talk anything about the health benefits or anything. It was like a power mind thing. (26W)

Another participant simply stated:

I just gave it up. It's just mind over matter for me. (9M)

Determination was discussed by several participants as an important aspect of a successful quit attempt. One participant for example who used NRT as a primary cessation method, indicated how drawing on the "determination to get through, helped [him] stay smokefree." (21M)

A sense of pride in having stopped smoking and staying stopped was evident in that participants' could cite the day and year they had quit.

I was proud of my ability to remain smokefree and I always remember the date and celebrate it. I jump up and down, yay!! (26W)

Positive feedback from other people created a motivational tension to remain smokefree.

I get a real buzz when I tell people that I'm smokefree. People go "Gee that's really awesome." (9W)

Smoking as a coping mechanism, a relaxant and an excuse to take some "time-out."

Whereas a host of strategies were used to help with stopping smoking, at other times smoking was discussed as a strategy for dealing with negative emotions.

One participant discussed how negative emotions increased the motivational tension to relapse by making one more vulnerable to triggers to resume smoking.

Yeah, I think depression, where you actually become a bit self destructive and you don't realise it at the time but you're doing stuff that you would normally have the willpower to counter. Triggers will actually have an effect. (12W)

Negative emotions were also mentioned as triggers for relapsing. General as well as specific stresses were recurrent themes in this context.

My sister started again because our uncle and our granddad died like and she just started smoking out of grief. (20W)

A lot of people smoke because of financial stress. (9W)

I found whenever I was in a stressful situation I'd want to light up. (26W)

Life stressors, like could be someone else is sick or there's a death, you know? (12W)

Smoking was perceived to be "a form of relaxation" (12W1), "an excuse for time out" (12W2), particularly in times in stress.

It has a calming affect on me, when I had all of those problems and that. (21W1)

As another participant said:

When you've been a smoker, you've experienced the comfort of smoking. It is a soother isn't it. It's a drug. Yeah, sort of that instant gratification. I'd have a ciggy

thinking I just need a ciggy. And I'd smoke away. And temporarily my fears would be quelled and I'd feel a little more at ease. But then I'd become even more agitated afterwards. (21W2)

The Environmental Realm/Te Ao Turoa

This realm includes government strategies to reduce tobacco use such as increased taxation on tobacco and enhanced smokefree legislation. These were discussed as motivational tensions that created the space to be smokefree, rather than triggers to stop smoking. There were mixed reactions about how the price of cigarettes impacts on peoples' smoking.

Motivational forces within the environmental realm also included shifts in how smoking was perceived socially. For example, legislative restrictions on where to smoke made smoking less acceptable, and for some ex-smokers supported their smokefree status. In contrast, some ex-smokers felt excluded from their friends who still smoke. Older participants recalled a pre-legislation era when smoking was normalised. Others recalled how they adapted their smoking behaviour to counter legislative changes. In some cases smoking was perceived to be privileged, for example, workers who smoked took additional breaks in order to smoke.

Cost

Some participants indicated a high awareness of the financial implications of smoking.

The only reason I gave up was for my savings. The thought of the money that you had spent! (9W)

Smoking cost money that could be better spent elsewhere.

I've got about nine grandchildren, and I've got to think about them as well. I mean why not put the money towards their education? (12W)

Yeah, I think ten dollars a week was getting a bit much, we could be spending it on something like lunch. (26W)

Conversely, many other participants did not consider cost a reason to stop smoking. A recurrent theme was that addicted smokers "can always find money for cigarettes." (12W)

You don't really care about cost at the time. (15W1). Yeah, after you realise you've got no money. (15W2) You've got no money but it doesn't matter. (15M) Yeah, you're not thinking about the money. (15W1)

If you want a cigarette you'll find a way. (9W1) Those that can't stop smoking, they'll cut out the bread and the milk [rather] than the cigarettes. (9W2) They'll still pay for it, if they want it. (9M)

And with putting the prices up - you know, If you're a smoker, you're going to smoke. (21W)

A few participants suggested that price increases, particularly relatively small ones, would be absorbed.

They put three more dollars on a packet of smokes, that's not going to stop a smoker. (9W)

People think about [cost] last though because no matter what they will find that dollar coin in that car. (20W1) Yeah (20W2) [Laughter] If they need ten bucks and they've only got nine. (20W1) On the back of a seat, you'll lift up those car mats. (20W2)

One participant inferred that even in extreme circumstances, the cost of smoking would be met. She commented:

My only advice to my children is, 'right, when a thirty gram becomes fifty dollars, that's the time to bloody well give up'. 'Oh, true, true, mum'? I said 'yeah, we'll see if we put it into practice'. (12W)

Some participants were willing to change to cheaper sources of tobacco..

And as smoke prices went up, because I used to smoke a pack a day, we changed to the rollies because it was cheaper. (26W1) When you've only got rollies and you want a smoke, you'll learn how to roll. (26W2)

Distrust of the government's motives in raising the price of cigarettes was evident amongst one group.

The government will keep doing it. (9W) Smoke factories will take off overseas and the government will say "where's that extra money?". They're not going to have it anymore so us guys are going to be lumbered with it. Of course when they are taxing the factories they are making heaps the government. They're making millions. (9M)

Smokefree legislation

Participants talked favourably about other government interventions. For example, restrictions on where people can smoke were perceived to have usefully helped encouraged people to stop.

If they want people to stop, what they've put in place has been effective. You don't smoke at work. You don't smoke in social environments. You have to go outside to smoke. So immediately you realise that you're on the outside looking in. Missing out on all the fun because you've gone out to have a cigarette. (21W)

Such restrictions could operate as a motivational tension, making smoking a less easily practiced behaviour. It resulted in reduced smoking for some, and had the potential to be a trigger to stop for others.

I've known people who have actually cut down on their smoking because of having an environment in the office and that where they can't smoke. They haven't stopped, but they have cut down the quantity. (21W1) It didn't reduce my quantity. (21W2) It reduced mine. (21W1)

I suppose, legislation makes us quit. (15W) Leaving you out in the cold. Yeah. (15W)

Participants acknowledged the benefits of smokefree environments.

I do enjoy going out more because I know I'm not going to be stuck in a room of smokers. (26W1) And I love that nobody smokes at work anymore. That is so cool. You know, in the office, just that big haze of cigarette smoke, it's just awful. (26W2)

As ex-smokers, a couple of participants indicated that they missed the social interaction with smokers, and reminisced about past experiences of this.

It's the socialisation that I miss too. Quite often I'll go and stand outside with the smokers because, yeah. (12W1) Well, everyone ends up outside. (12M) Yeah. (12W1) I've heard the best conversations happen out there. Oh you have some funny conversations. (12W2) Absolutely. (12W1)

Moreover, legislation was seen by one participant to privilege smokers by granting them "time out" in order to smoke.

I work on a lot of building sites and now, working in the workplace, you're not allowed to smoke but you're allowed in a certain area. What we can't understand as non-smokers, the smokers can go over there anytime and have a smoke but we've got to carry on working. They've got more rights than what we have. (12M)

This participant continued:

Yeah, I think that's the reason why you could go back [to smoking], is that you're not giving yourself time out. (12M)

Several participants discussed how they extended the smokefree environments to their own homes and vehicles.

[name of Aukati Kai Paipa coach] helped me make my whare smokefree and that stayed even though I went back to fagging. So I wasn't willing to get out of bed when I was sick and go outside to have that cigarette. (12W1) Well for myself, if friends who smoke come around home I just say to them straight out, 'right, if any of you are smokers, sorry, but you have to go outside and smoke because my house is smokefree'. (12W2) Yeah, that certainly helps. (12W1) Yeah, there's the smokefree stickers, it means you don't have to ask people to not smoke. So they're always really good. Putting labels up, like even putting one in the car was real cool for the kids, auahi kore. (12W3)

The perception of smoking as not the norm was fuelled by smokefree legislation, and effected people's smoking behaviour. When asked if smokefree legislation impacted the decision to stop smoking, participants responded:

Yeah, it was socially unacceptable. (21W)

Legislation, yeah, definitely legislation. How do we know that smoking is bad for you? How do we know that? (15W)

Thus legislation strengthened beliefs about smoking as unhealthy. Smokefree education was seen to be an important aspect to informing people about the risks of smoking.

The reason why we know what we know now is because of the education of the smoking is working. Because, for the ideas to go through that wouldn't be there, because we wouldn't know any better. (15W)

You're wiser as you get older. (21W1) Well, it's the education that goes with it. And that started, what, 20, 30 years ago, when they went around the intermediate schools with horrible looking jars, with what looked like somebody's smoker's lung. Things like that. (21W2)

The latter participant acknowledged that "all the health education that goes on, we know it all, but for some reason or another you just ignore it." Years of smokefree education however laid the foundation, and created the tension for this participant to successfully become smokefree in the presence of the right trigger some years later.

On the morning we left [on an overseas trip] I thought 'I'm going to leave my cigarettes here and see if I can stop.' So I guess all the social conditioning finally gets to you, sooner or later. (21W)

There was a mixed response to the effectiveness of TV ads and graphic warning labels on cigarette packets. Some participants thought they were ineffective.

You change the channel don't you? (12M)

There's heaps of TV ads about that. But people still smoke, so. (15M) Yeah, they don't give up. (15W)

Yeah I don't really take much notice of [TV ads about stopping smoking]. (26W1) Yeah, I agree. (26W2)

The way they have on your tobacco packets and that now, and they have warnings and the pictures. And you used to get the warnings, right around them and you used to get them and think stuff that, but now with the pictures, nah they don't do stuff all. (15W)

On the other hand, TV ads and graphic warnings were considered to provide necessary motivational tension for some participants, educating people on “the hard truths” of smoking and acknowledging the health risks of smoking.

Like with the cigarette packets we see the gums, we see the eyes, we see all of that and we know what smoking actually does to you, it does cause cancer, so that's what I'm saying I don't know how to express it, in a way that the hard truth...umm, fear. (15W1) Scare tactics. (15W2) Yeah, scare tactics, it helps. (15W1)

I think TV ads about smoking are important. Otherwise it's not seen as having any significance in the health. (21W) I think, maybe in the background, having those messages there is helpful. (21M)

That's kicking in now. Especially when you see them dying. That guy died. (9W) That's good that, those TV ads. (9M)

The capacity of TV ads to trigger a quit attempt was negated then acknowledged by one participant.

But there's got to be something else creating that moment. (21M1) To make you stop. (21W1) Yeah, to take action. (21M1) I think they do condition you over time. But whether it causes you to take action or not, that's a different story. (21W2) But if like, say, I'd been contemplating quitting for any number of other reasons and then you're sitting at home thinking about it, and you look up and see one of those ads, and if it's got the number for the Quitline then you might just call it. (21M1)

Thus the offer of treatment could also act as a trigger.

Several participants noted the function of TV ads in educating children about the risks of smoking. The value of this was twofold: firstly children thus educated, played a role in prompting their parents to stop smoking; and secondly, TV ads were thought to reduce uptake by children.

I think kids see these and they're usually the biggest advocates, I've noticed. Like even people I see that are stopping smoking. It's been because of the children seeing the ads. I saw someone today, and he wanted to stop smoking because his little son, he's got two little kids, and they come up and they go “that's not good for you daddy”. And they're like, “don't smoke, daddy”. And they can see everything, they say it like that. (15W) [Laughter]

Yeah, when your kids are saying – (12W1) “Quit, your eyes are going to fall out.” (12W2) From that ad. (12W1) My son's favourite was ‘do you know that every time you have a cigarette you're taking 10 minutes off your life? Do you know how that is for me? (12W3) I know, my kids can't stand it. I don't think they'll ever smoke. (12W1) Social pressure. (12W2) They're a lot more informed now aren't they? (12W3)

[TV ads] keep it real for our youth, I reckon. (12W1) Yes, yes. It's not for the person who's trying to quit. (12W2) True, really true, yeah, before they start. (12M) Yeah, I think they need to be out there, those ads. (12W1) So that's preventative – (12W2) Preventative, yeah. (12W1)

An additional function of TV ads was to affirm the decision to be smokefree. One participant said:

What helps now is those ads on TV I must admit. You're like ‘yep, that's not going to be me’. Whereas before you'd think, you know, ‘people shoving information down my throat’, you know? (12W)

Tobacco control initiatives were related to a heightened smokefree consciousness. For some, this in turn was part of a more holistic healthy lifestyle paradigm.

And I think too, that there's a big push for umm, you know, health and wellbeing, with umm, food, and drinking, and you know, to [not] smoke, it's just all part and parcel of it I think. (15W)

It's not just staying smokefree; it's a whole lifestyle change. (9W)

In response to the discussion about the role of smokefree initiatives, older participants recalled a pre-legislation time when smoking was normal and cigarettes more readily accessible.

We always had cigarettes in our lives as kids. It was part of the norm, that was part of our growing up with our parents. (9W1) They encouraged us to smoke. There were no Quitlines back then or help. (9W2) There was easy access actually. (9W1) Less than \$2 (9W3) Easy access to the cigarettes and tobacco. (9W1) Mild 10 back then. (9W2) Fifteen cents for ten smokes. (9M) Now they don't hand them out. (9W1)

Every household had ashtrays everywhere you went in the kitchen, in the tins, ashtrays everywhere, sitting in the toilet, washhouse, outside. It was just a normal thing to have ashtrays everywhere. (15W)

Back when I was in high school, the Duke Street dairy used to sell you 5 cents a smoke. We bought them individually so it was easy for us high school kids to pop just up the road and get a couple of smokes and go back behind the library. And it was very easy back then. There were no laws back then on what age you could be. (26W1) Yeah, teachers were smoking in the classrooms when I was in primary. People smoked everywhere. (26W2) And smoking in Marae too, you know, in the wharenui, which was really really horrible when you had your baby there. And we'd be saying to the nannies, you know, 'don't smoke in the wharenui', and they'd mumble away 'we'll do what we like'. Now they don't. And because, like, you know, you're all sleeping in together and we were terrified that the wharenui would burn down so I always made sure that whenever I went onto marae I slept by the door with my children. That was scary stuff. (26W3)

One participant had formally worked in a cigarette factory.

We got free cigarettes. They were just all in a box and you just helped yourself. But I used to give them away to cousins and all that. It was just a normal thing, everybody smoked. So that's how I got really back into it. (15W)

Her daughter noted:

[My mother] used to keep cigarettes in this jar [at home], and we would literally just go [and take handfuls]. And it was really funny too because, I wasn't really a smoker, I'd have an occasional, puff, but it would be my friends that would come around that would nick all of mum's cigarettes. So I became the new supplier. I was popular really quickly at school 'cos of that. (15W)

Older participants observed how the shift from this pre-legislation time, to a more smokefree-conscious New Zealand had affected smoking uptake and access.

I noticed, just looking at our family, [older relatives] did start really young, whereas, you look at myself and [younger relatives], it's got a bit more later in starting. Is that because, by that time the messages of smoking health warnings were coming in? At that time? Because we would have been through the 80s. Late 80s for you maybe? (15W1) Yeah and what about like the age restrictions, like I remember buying smokes at the shops? And then one day I wasn't allowed to buy them anymore. (15W2)

Some considered legislation and/or attitudes to smoking to make it easier to be smokefree.

So a smoke free environment, that would help because, you know, it's been put in place. (26W1) Oh it would help, yeah, but it didn't exist when we were smoking. (26W2)

I think because it's socially less acceptable [now], it's easier. (12W)

Many participants conveyed their pride in being smokefree, and smoking was perceived to be socially undesirable.

It's cool to be smokefree now. (9W1) It is. I get a huge buzz when I tell people I'm not smoking now. (9W2)

And it looks good [referring to displaying having smokefree stickers up]. It looks good being smokefree. (12W)

The stigma of it helps to stay smokefree, I suppose. I mean it is anti-social. (15W)

And for me too, you know, the health field. It's a lot less acceptable to be smoking if you're working in the health field or the mental health field now. (12W)

Smoking's not as socially acceptable as it used to be. (9W)

Less frequently, the social unacceptability of smoking was disputed, considered to pertain more to older people, or to refer more to uptake than cessation.

It's still cool amongst our pregnant young women. (9W)

I think when you're a teenager you smoke for different reasons, but when you get to our age it's just not cool to see a 50 year old fagging away, you know, losing the teeth. (12W)

It's not cool anymore?(26W1) Well is it, is it not? I don't know. A lot less people smoke in our friends, a lot of them have given up now. (26W2) I don't think I smoked because it was cool I just did. (26W1) I did when I was 13, obviously. (26W2) I did. (26W1) That was the reason to start, not the reason to stop. (26W2) You're 13 and we thought that would be so cool if we smoked her father's smokes, you know, as you do at that age. (26W3)

One participant noted how smoking behaviour on the marae contradicted the view that smoking was unacceptable.

I look at the marae, and see how acceptable it still is to smoke there. So it's out there that smoking's not good but people are still doing it in big groups socially. (12W)

This participant had smoked intermittently for some years and finally stopped when she realised her "social smoking fed that myth that you can get off smoking." She continued, noting how the acceptability of smoking did not serve Māori.

I can say I don't need a cigarette for 5 years and have 1 and not have another 1, but why do it? You need some sort of social pressure to not [smoke]. And that's what's different about Māori, it's still not a strong enough social pressure. (12W)

The Spiritual Realm/Te Taha Wairua

Spirituality was seldom mentioned in relation to stopping or restarting smoking. When spirituality was discussed it was considered more as a resource to equip people to stop smoking or to affirm their decision to be smokefree rather than a trigger.

Three women discussed how their spirituality provided a motivational background to sustain a smokefree way of being. Each woman had a different approach to spirituality. Each approach favoured being smokefree.

And we look at the body as being the temple of God, you know. And God doesn't have anything left in himself, so our body is supposed to be clean, kept healthy. The whole thing. (21W1)

I think because I took up yoga and meditation, and that really is conducive to my spirituality, just the essence of who I am, and what life is all about. That has really helped me stay smokefree. Yeah, the whole holistic concept of it. (21W2)

Part of mine too was about mana ahuaaki, and about acknowledging that my body's tapu and what am I doing to it. (12W)

Similarly, another participant referred to the holistic sense of health induced by being smokefree.

You can tell the difference between when you're smoking and when you're not. The way you felt. You're healthy. You're healthy of mind and body, and soul, spiritually. (15W)

Two participants used prayer as a treatment to manage cravings.

And so I prayed and the next day I didn't have the urge to smoke or anything. (21W)

The help of Atua [God] of course. Oh absolutely. That serenity prayer is great isn't it? (12W)

Relative ranking of reasons for stopping smoking

Table 23 presents the ranking order of reasons for stopping smoking averaged across the six groups of ex-smokers. Reasons related to children, pregnancy and to personal health were rated the most important reasons for stopping. Having personal control (tino rangatiratanga: making one's own choices) and "it's time" were also considered to be important. TV ads and following the example of others who had stopped were ranked as the relatively least important reasons.

Table 23: Relative ranking of reasons for stopping smoking (N=32)

Reasons	Rank	Average
To be a positive role model to my children	1	3.3
To stay healthy	1	3.5
For my children's health	2	4.0
To have a healthier pregnancy	3	4.2
Getting pregnant	3	4.2
To get better	4	4.7
Tino rangatiratanga: Making one's own choices	4	4.7
To live longer	5	5.0
It's time	6	5.8
To have more energy to do things	7	6.0
Seeing what smoking does to someone close	8	6.5
Fitness	9	6.7
Smokefree environments	10	7.7
Doctor told me to stop	11	8.3
Cost	12	8.5
It's not cool anymore	13	9.0
To not grow old early	14	9.5
It stinks	15	9.7
If they can, I can	16	10.2
TV ads about smoking	17	10.5

Qualitative comments related to relative ranking of reasons to stop smoking were largely integrated into the overall ex-smokers transcript data. The exception is where specific reference was made to ranking a reason relatively, how a reason is or should be ranked, or to a specific reason which has not been mentioned elsewhere. Such comments are reported here.

"To be a positive role model for my children"

Asked to rank the above reason, two participants recognised that ranking this as an ex-smoker was likely to be very different from how they would have ranked it as a smoker.

That's quite hard with, like, now we've given up we know how we'd rate it. But when we were smoking we'd rate it quite differently. (21W1) Yeah, it's easier said than done. (21W2)

Tino rangatiratanga: Making one's own choices

One participant who thought having personal control over oneself was an important reason to stop smoking, acknowledged the difficulty in being politically inclined in this way in the presence of the addiction to smoking.

Oh, the tino rangatiratanga, that goes up, up here.... But when your addiction's got you by the throat hold, you know, you don't have that much choice. (12W)

Another considered reducing Māori smoking statistics to be a positive repercussion of stopping smoking but not sufficiently motivating in itself.

I think that's a side benefit, I don't think it's a major reason to quit (9W)

Several participants identified the control smoking had over them.

It's kind of like personal sovereignty. Because when you are smoking, you're kind of controlled by it to an extent. Yeah, trying to make that pouch of tobacco last from one pay day to the next, kind of thing. You know, it influences where you're going to go. Who you're going to hang out with. (21M)

You find yourself being ruled by a drug. (9W1)

Recognising the control smoking held over her was a trigger for one participant to stop.

I've seen people go along and pick up butts and break them. (9M) I've caught myself doing that, that's why I finished. (9W2)

"The doctor told me to stop"

Being advised by a GP to stop smoking was considered to be a relatively poor reason to stop smoking for most participants.

Down the bottom. (9W) That's right down the bottom. (9W)

*It doesn't matter who told me to stop, it wasn't going to stop me, so. (12W)
...Yeah, that's what I was like even though I am a health professional, it's got to come from yourself. (12W)*

For some however, GP advice was either implicated in their reason to stop, or otherwise considered to be of some importance.

Well he (Doctor) told [partner's name], that was the reason he stopped, so I joined him. So kind of. (26W1)

Well if the doctor told me I had to for a health reason, I probably would have. (26W2)

"If they can, I can"

Like advice from a GP, following the example of someone else who had stopped smoking was not considered by most to be a relatively important reason for stopping smoking.

Well yeah, that goes down the bottom because I don't care what anybody else is doing. (26W)

One participant however said:

That was one of the reasons I gave up. (9W)

Another participant in this same focus group suggested:

If it's not a big reason it definitely gives you more support to be able to do it. (9W)

Smoking cessation methods

This section gives an account of the cessation methods used by participants in past quit attempts, and their unprompted and prompted awareness of cessation products and services.

Smoking cessation methods used in past quit attempts

Cessation methods which participants reported using in past quit attempts are summarised in Table 24. Most attempts drew on personal resources rather than professional or medical help. The most common formal support was NRT, mainly nicotine patches and gum. Reduced tobacco consumption or purchase of tobacco and family/social environment (mainly parental intervention, avoiding smokers, and spiritual related help) were the next most mentioned methods although these were cited less frequently. No participants reported using prescription medication or GP advice in past attempts.

Table 24: Cessation methods and age used

Quit method	Age Group										Total
	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs		
Unaided	2	17	16	6	4	4	3	1	2	55	
Nicotine replacement therapy	0	3	2	2	2	4	1	3	3	20	
Reduced consumption or purchase of tobacco	0	3	3	1	2	0	0	0	0	9	
Family/ social environment	4	2	0	0	1	0	0	0	1	8	
Substitution	0	0	0	0	3	2	1	0	0	6	
Smoking cessation programmes and services	0	1	1	0	0	0	2	0	0	4	
Stop smoking books or internet	0	0	0	0	1	0	0	0	0	1	
Pregnancy	0	0	1	0	0	0	0	0	0	1	
Lack of access	0	0	1	0	0	0	0	0	0	1	
Nicotine free prescription and GP's advice	0	0	0	0	0	0	0	0	0	0	
Alternative therapies	0	0	0	0	0	0	0	0	0	0	
	6	26	24	9	13	10	7	4	6	105	

Unprompted awareness of cessation products and services

Participants were asked to identify methods for stopping smoking. Across groups, there was greatest awareness of nicotine patches and gum, and Quitline. Awareness of Aukati Kai Paipa (Māori cessation service), hypnotherapy, and the e-cigarette was also high (see Table 25). The two groups who were recruited via a cessation service demonstrated the highest unsolicited awareness of cessation products and services. There was poor unprompted awareness of the nicotine-free prescription medications Champix and Norpress.

Table 25: Unprompted awareness of cessation products and services

Products and services	Focus group no.						Total
	9	15	12	20	21	26	
Gum	√	√	√		√	√	5
Patches	√	√	√		√	√	5
Quitline	√	√	√	√		√	5
AKP	√	√	√	√			4
Hypnotherapy	√		√		√	√	4
Nicotine inhaler	√		√		√		3
E-Cigarette	√		√	√		√	3
Zyban			√	√		√	3
Cold Turkey	√				√	√	3
Doctor	√	√	√				3
Allen Carr	√	√	√				3
Text to quit	√		√				2
"lollies, lollipops"/chocolate				√		√	2
Acupuncture	√		√				2
"Books and videos"		√	√				2
Church/prayer		√			√		2
Lozenges		√	√				2
Champix			√				1
Norpress			√				1
"Transparent nicotine filter"					√		1
Pharmacist/Chemist		√					1
Nasal spray		√					1
Set a date to quit	√						1
Detoxing	√						1
Reduced consumption	√						1
"Herbal cigarettes as a substitute"					√		1
"Auahi Kore, smokefree"			√				1
"Media advertising"			√				1
"\$500 Seminar"						√	1

Discussion of products and services

Participants were asked what, if anything, they knew about the following products and services.

Nicotine Replacement Therapy

Gum

Many participants thought the gum was not an effective cessation treatment, while others reported finding it useful.

I have a friend that, well she's still smoking actually, but she gave up. She tried the gum and the gum didn't work for her. (21W1) ...Yeah, [my daughter's] got heaps of those, but it doesn't work. (21W2)

There's a box of that chewing gum in my bathroom cabinet because my sister's tried to give up. She's chewed it, yeah but she doesn't chew it anymore so it's still there. (20W)

I didn't like the gum but I knew it was useful. (21M)

The gum was really, really good. (9W)

Although the latter participant had successfully stopped smoking with the use of NRT, she indicated she "had got addicted" to them and had taken six months to wean herself off them.

Some participants experimented with other people's gum, and there was an indication that the NRT was used incorrectly.

I chewed it [my sister's gum] just to see what it was like. (20W)

The gum was considered to be unpleasant tasting.

I did a bit of chewing gum which is pretty revolting. (12W)

It's not that nice. (20W) Yeah. It's yuck! (20M)

One participant had developed an approach to combat his distaste of the nicotine gum.

To get around not liking it, I would mix it with other normal chewing gum which had strong flavours to mask the taste of the nicotine gum. (21M)

Patches

Few participants commented on the nicotine patches. An older participant commented that "three of [her] granddaughters got those" (21W1), and there was some thought that patches were handed out "to all the school kids now." (21W2) One person who had used the patches said "they didn't work" (12W), while another participant had a friend who "had luck with the patches." (21W3) For one participant, the patches were an important part of a tailored cessation support programme. He described what occurred when his cessation attempt was interrupted by being prescribed the incorrect dosage of nicotine patch.

I came in the next week to get my next lot of patches, and I was given the wrong ones. They were bigger ones, but I thought, 'oh well, they must be the next ones down even though they're bigger', so I stuck them on. And I just had a rush of nicotine in my body... so I took them off and I never used them again. Then quickly, everyone was really pissing me off, and they were doing nothing, and I had to go outside. So what I mean is, follow the patches, don't take them off. I should have gone back to [my cessation support provider] and said 'can I have the next ones down', but I didn't. But that's what I should have done. Followed the patches and it would have been a lot easier for me I think. (12M)

There was concern that patches were “another cost” (26W), while another participant who had “used patches once” said “I slept with them cause I forgot to take it off and woke up with a red-as arm.” (20M)

Lozenges

Few participants had heard of nicotine lozenges. One participant had heard of them but had not tried them. Of the three participants that had tried the lozenges, one commented “they’ve got a weird taste ...they’re not that nice as well” (20M) while the other said she tried them “because I wanted my son to stop smoking.” (9W) She added “I sent him patches, lozenges and gum, and the bloody hua never tried any of them.” The third participant indicated that “the lozenges were a biggie” (12W) in quitting smoking.

Inhaler

Like the lozenges, little was known about the nicotine inhaler. Someone had “a couple of friends who have used them, with mixed results.” (21M)

This participant recounted how his friends:

...were using patches as well and I think they had the full choice of gum and lozenge as well. They did manage to stay smokefree for a while, but then they started again. (21M)

There were some concerns about the amount of nicotine accessed via the inhaler. One participant incorrectly stated:

I’ve noticed the milligrams is 10 milligrams. (21W)

Other participants indicated they would use the inhaler “if [they] had the cash [to] do it.” (20W)

Microtab

Participants from just one group thought they had heard of the nicotine microtab.

Yeah, I think that’s the one that my daughter was using. (26W1) Do you think that’s the pill that [name] might be on? (26W2) It might be because she had to go through Quitline I think it was, and they did an assessment on her and recommended which one she used, yeah, depending on how much she smoked and all that. (26W3)

E-cigarette

More participants across groups were aware of the e-cigarette, although no participant had used it personally.

Oh yeah I’ve seen those ones. (20M) Oh my friend had one. (20W)

Oh maybe that’s it. Do you think that’s the fake cigarette that [name] had perhaps? (26W)

Media coverage and the use of the e-cigarette by a well-known politician enhanced awareness of this product.

I saw it on the News once. (21M)

Tau Henare stopped smoking with it. (9W)

It was on the news. (15W1) That pen thing, aye? (15W2)

Knowledge about the mechanics of the e-cigarette was high.

Nicotine cartridge, and its electric smoke. Battery at one end and nicotine cartridge at the other. You blow out the smoke and whatever. (9W1) They’re trying to stop from banning it. (9W2)

They have a light on the end of it and every time you suck it, it goes brighter, and it blows smoke. You can change the filter or something. (20W)

Well I never saw it, but she said, yeah, apparently you just smoke it like a normal cigarette. (26W)

It had a battery in it, and it lights up, you know when you suck on it. (15W)

One participant indicated that the e-cigarette would be too expensive for most people [*"Tau Henare could afford it."* (9W)] while another suggested its *"authentic"* look may make it a desirable cessation product for young people.

It'd slot into their social niche. (21W)

Nicotine-free prescription medicine

Champix

The TV ad for this product was familiar to some, *"Is that the one on TV, where that man gets squashed?"* (15W), although one participant said she *"just took note of the little man not the product."* (21W)

There was some knowledge about this medicine, including the suggestion it was effective in the short term.

Is it a three month course or something? (9W1) I have heard of somebody that has been on it, but they went back to smoking about two months after they finished the course. (9W2) It's great while you're on it, but after... (9W1)

Zyban

Some participants were relatively well informed about this medication.

That's just been subsidised hasn't it. (9W)

It's non-nicotine isn't it? (9W)

Others knew people who had used Zyban. Reports of its efficacy were mixed.

Like the two friends that I know, they're all doing the whole Zyban thing at the moment and it's not really working. One of them it's like he kind of spins out on it, it's quite a bizarre medication. Yeah so it hasn't really worked for him so he stopped taking it for that reason, it makes him feel crazy. (20W)

I know one man who gave up using that, and he's been given up about three or four years now. He said it completely just tasted awful to him smoking after using it. (9W)

One participant described an incident of misuse of this drug.

A friend of mine was using it. I remember it was the night that he had his baby. He was no longer required at the hospital so he came over to our place about 1 in the morning, to see the boys and have a bit of a celebration. And, yeah, he actually had some of that stuff. And I don't know why, but he crushed it up and made lines for all of us. [It didn't stop the urge to smoke], it just really burnt my nasal passages and made me have a runny nose for about 3 hours. (21M)

Norpress

Just one participant reported that she had heard of Norpress in passing.

Distrust of cessation products

Several participants were concerned that various cessation products might be addictive. One referred to how hard it was “*getting off the gum.*” (9W)

Following the facilitator's description of Zyban, one participant said

That's another addiction isn't it? The prescription drugs. They're a huge addiction.
(21W)

Similarly, after hearing about the e-cigarette, some participants challenged the validity of substituting one nicotine delivery system for another.

That's sick! After all this time, smoking is a drug. That's a drug. So why give up one to take up another. It just doesn't make sense to me. (21W)

It's just another habit, don't you reckon? (15W)

Additionally, there were concerns about the safety of the e-cigarette.

But with this thing [the e-cig], is it safer? (21M) *You're still inhaling it into your lungs. I can't see that it has any benefit.* (21W)

In discussing her distrust of cessation products in general, the latter participant described her intolerance to prescription drugs.

You might think this is a bit weird but there's not a pill in my house. I took a Panadol about 5 years ago for a headache. And I vomited it up about half an hour later. So something in my system just won't accept drugs of any sort. And yet I smoked. I smoked 20 cigarettes a day. (21W)

Cessation services

Quitline

For the most part participants were aware of Quitline. Several participants had either contacted Quitline themselves or knew others who had done so. Of these, perceptions of the Quitline's effectiveness were varied. One participant stopped smoking with help from Quitline. She described her experience.

I thought Quitline was pretty good. I had like a book and just went down all the reasons why I should stop. Had a look at them every day just to remind myself. Then cut down and then stopped completely. They were texting me as well every day. I'd text them if I had a craving and they'd text me back. They'd say wait five minutes. (9W)

Another participant was less positive.

I used them and they didn't send me anything. I wouldn't use them again. (20M)

Participants who had not used Quitline did not necessarily know what their service entailed.

Oh, I just thought everything Quitline had was free. I've never used them though.
(26W)

I've never tried them. I wouldn't know what they – it's just support and that is it?
(21W)

Aukati Kai Paipa (AKP)

Focus groups 9 and 12 were recruited and conducted by quit coaches from a provider of AKP-type services on their premises. Feedback from participants from these groups was overwhelmingly positive. They described perceptions of effectiveness, accessibility and on-going unconditional support.

It works. (9M) Very supportive. (9W1) They were awesome. (9W2)

She's [quit coach] just been always there. You know, I can just pick up the phone and that's made the biggest difference for me, kia ora. (12W1) It's non-judgemental, just total support. (12W2) No pressure. (12M) Yeah. No beating me with a wooden spoon. (12W2)

Among the other groups, one other participant had used AKP. He described how he was approached at his workplace and offered support.

They actually come up to me and go 'oh you want to quit smoking' and I thought, well I am actually thinking about quitting smoking. So I joined up with their programme, they've given me gum, lozenges and just health, help books, little help books and pamphlets and stuff like that.. They've been really supportive come and check on me at least once a week and I tell them it's hard, they'd give me more lozenges or gum. (20M)

One other participant had heard of AKP.

Is that through Raukawa? They have a stop smoking programme don't they? (26W)

Alternative cessation therapies

Hypnotherapy

None of the participants had personal experience with hypnotherapy, however a couple of people knew someone who had used hypnotherapy to stop smoking, albeit unsuccessfully.

My Dad tried that. (9W1) My sister-in-law did it and she still smoked. (9W2) My aunty tried it but she was deaf and she can't hear them when they go close your eyes and she can't lip read. She didn't give up. [laughter] (9W3)

There was some perception that hypnosis would be an effective quit smoking method.

There's hypnosis. I've heard that's quite effective. (21W)

I remember a guy at the pub saying he'd probably get hypnotised if he wanted to give up smoking. He seemed to think it was a good way. (21M)

One woman whose father had failed to stop smoking after using hypnotherapy, suggested the failure was because her father was not ready to stop at that time, rather than a fault of the method.

You have to want to do it and he was still getting to that stage. (9W)

One participant with a strong allegiance to a fundamentalist Christian church associated hypnotherapy with mind control.

I don't agree with hypnotherapy, having control of someone else's mind. (21W)

Acupuncture

Two participants had tried acupuncture previously. Of these, one reported positively on her experience, although this was not for stopping smoking.

I've been to get some acupuncture done for nerves in my arm. It was great. (9W)

The other participant had used acupuncture to stop smoking, but it was not effective.

I tried acupuncture. That was an expensive smoke. (26W) [Laughter]

Other than these participants, there was little awareness of acupuncture.

Internet and books

The internet

Just one participant referred to using the internet to access stop smoking information.

Oh yeah, I've looked at stories [about quitting]. They have good stories on the internet about quitting smoking. I just Googled quit smoking kind of thing and had a look at the stories. (20M)

A few participants were unclear how the internet could be used to stop smoking.

Why? Would you buy products off there or something? (26W)

Some were open to using the internet although it had not occurred to them at the time of quitting.

Yeah I'd use it now if I had to give up. No, back then I didn't think about. (20W)

Self-help books

Several participants were familiar with Allen Carr's stop smoking books. Although none had read the books themselves, others they knew had. Effectiveness of Allen Carr's method was perceived to be high.

I didn't read it but I gave it to a woman I worked with who had been smoking for 30 years. She read that book and bang she was done. Finished. She was a real good role model. She talked about that book. She just read that and after she read it she was like, oh my god, this is so right, oh yuck. (9W1) I'm pretty sure [name] and [name] used that too. (9W2) My sister's used it. (9W3)

Our daughter read that and she just gave up and she's never smoked since. And she was a heavy smoker. (12M)

A friend of a friend of a friend read it and applied it and stopped smoking. She found it very effective, she gave up, and she was young. (21W)

One participant reported that the book had not been successful.

My mum's got that book. She still smokes. She's probably given up 20 or 30 times. (21M)

Stopping unaided

Stopping unaided captures all references to 'just stopping', stopping smoking 'cold turkey', smoking as 'mind over matter', or stopping using 'willpower'.

Stopping smoking unaided was considered by some to be the only way to stop.

Yeah, I believe that that [cold turkey] is the best thing. You just have to stop. (20W)

This was often associated with the idea that smoking was a psychological or behavioural addiction.

It's just mind over matter. (9W)

Like, it's all in your mind really. (20M) Yeah it's psychological. (20W)

I've been told that it's the (hand-mouth) action that smokers are addicted to, it's not like alcoholics, it's not actually a cigarette itself. I've been told, like ages ago before I tried to quit, just to put the cigarette in my mouth but don't light it, yeah. (20W)

For some participants, stopping unaided was easy.

Yeah, I found it easy to stop because like for a packet of smokes it would take me 3 weeks to go through. I was just a social smoker. (26W)

My first time just going cold turkey because I was pregnant, and I didn't even feel like a smoke and I think that was probably because there was a whole other person to think about, the reason behind that. (26W)

In one such case, stopping occurred almost accidentally once the decision had been made to stop.

Yeah, for me I'd been trying to stop for quite a long time. I'd been rushing around and had got to church with my mother-in-law. I had sat in church trying to catch up to myself, at half past 10 in the morning, and I just realised that I hadn't had a smoke all morning and I thought 'oh, I've come this far into the day without having a smoke, I might as well try and give up smoking'. (26W)

In the absence of subsidised cessation products, stopping unaided was the only option for one older participant.

Nothing was subsidised, you didn't have any of that back then. You didn't have patches or nicorette or anything like that. I couldn't get anything if I wanted it, unless I had to pay through the nose. (9W)

"Willpower" (12W1), which was associated with stopping smoking unaided, was considered "a tough one" (12W2) to access. There was a suggestion that willpower was more available when a person was ready to stop.

Sometimes because it's time, I think. (12W)

While many ex-smokers indicated they stopped smoking unaided at some point in their smoking history, as indicated below, for some these were short periods of abstinence followed by relapse shortly after.

I just decided to stop. Yeah, I've been wanting to stop for ages. Yeah that didn't last for very long. I think I just had the thought of oh well keep smoking....and then cold turkey again, worked for two months. (20W)

Ex-smokers' Discussion

While immediate health problems commonly triggered people to stop smoking, the far-reaching ramifications of smoking on health were often underestimated. The risks of smoking during pregnancy were still not understood by many. Some people believed that stopping smoking carries risks. To counter this, consistent messages and education about the health risks of smoking to people who smoke, to people around them, and to unborn babies should be maintained in schools and across media. The benefits of stopping smoking should be re-iterated and myths about the risks of stopping smoking need to be debunked.

Whānau/social groups play a powerful role as both facilitators for and barriers to quitting. Although smokefree consciousness has been heightened by tobacco control initiatives, there are communities where smoking is still common. In environments where smoking is common, stopping smoking is especially difficult. Wiltshire et al. (2003) discuss the extraordinary difficulties faced by people trying to stop smoking when they reside in a 'smoking world' (p.301). In order to provide a supportive environment, where smoking is common within groups, group quitting should be encouraged.

Some parents in our study were triggered to quit smoking by prompts from their children. TV advertising and school education programmes ensure young (pre-teen) children are aware of the risks of smoking, and incitement from children may be a function of this awareness. Such prompting from children was also found in Wiltshire et al. (2003). While quite a lot is known about parental influence on children's uptake, less is understood about the potential of children to provoke their parents who smoke to stop. This is an area for further research and a possible resource which could be utilised to a greater extent. Concern by parents/grandparents to model smokefree behaviour, and to safeguard their children's/moko's health was evident in our study. Capitalising on this by encouraging responsibility in those who smoke to provide a smokefree environment and model smokefree behaviour to younger whānau, could invoke altruistic quitting triggers for some (Repace 1993).

Mainstream social and cultural norms which stigmatise smoking contributed to a tension to stop smoking for some of our participants. Stuber and Galea (2009) have found that a consequence of experiencing stigmatisation is that smokers are inclined to conceal their smoking status from their doctor.

Relapse due to negative emotions was common among participants. It is unclear to what extent this emotion was a repercussion of poorly managed withdrawal symptoms. The experience of negative emotions may also be linked with being of low SES, of which the majority of our participants were. The personal and material circumstances of smokers' lives influence and impede quit attempts. For some of our participants, smoking was an "emotional management tool" (Wiltshire, Bancroft et al. 2003) within the daily context of their lives.

In order to avoid relapse, identifying withdrawal symptoms should be encouraged through education. Abundant triggers should be coupled with extensive and accessible cessation treatments to alleviate withdrawal symptoms and to improve the likelihood of successful quit attempts.

Beliefs about the importance of stopping smoking when 'it's time' (i.e. the time is right) were a theme that has been reported in other studies (e.g. Wiltshire, Bancroft et al. 2003). Believing that a certain state of readiness is a necessary prerequisite to quitting was found in a study by Balmford and Borland (2008), where smokers stressed the importance of 'wanting to quit.' Waiting until the time is 'right' or until one is in some way 'ready,' is potentially problematic. Aside from deferring spontaneous impulses and delaying quitting, people who do try to stop smoking and who relapse, can tell themselves that the time wasn't really right, or that they didn't really want to stop. A further

concern is that where such beliefs are seen as a sufficient condition to successfully stop smoking, the benefit of using cessation assistance could be overlooked.

Stopping smoking on impulse (unplanned attempts) was common in our study (as in West and Sohal 2006). Thus triggers should be plentiful and varied. Impromptu quitting highlights the necessity of arming people with information about and ready access to effective cessation support.

Ex-smokers demonstrated a good appreciation of the addictiveness of smoking. Discourse about smoking as a 'personal choice' was notably absent and as ex-smokers, many appeared to understand the risk of relapse.

Cessation Methods

Nicotine gum and patches had been tried by many participants in the ex-smokers groups, and unprompted awareness of these NRT products was high. Two groups of participants were drawn from cessation services which provide NRT, and this is likely to have influenced this awareness. In some cases, there was a perception that the gum and/or patches were ineffective. Fewer participants had heard of the nicotine lozenges, inhaler or microtab. Like the nicotine gum and patches, participants were well-informed about the e-cigarette, although no-one had used it personally or had family/friends who had used it. The e-cigarette had received recent media coverage, and had been seen by participants on the news. Others knew that a well-known Māori politician had used the e-cigarette.

Some participants were moderately informed about nicotine-free prescription medication. Its use was not widely reported however, and there was mixed views of its effectiveness.

Poor understanding of cessation products included apprehension by some about their addictive potential and safety. Misperceptions about nicotine as a carcinogen have been found to be high amongst Māori, Pacific and low socio-economic peoples (Edwards, Wilson et al. 2010). Such concerns and perceptions are a barrier to accessing and using pharmacological cessation support.

Awareness of and knowledge about Quitline and Aukati Kai Paipa (AKP) was relatively high and some participants had personal experience with these services. Two groups were recruited through AKP services, and participants from these groups provided positive feedback about the wide range of cessation support offered by AKP.

Wiltshire, Bancroft et al. (2003) suggest using media campaigns to heighten awareness of people who have successfully used cessation products to stop smoking, to contest attitudes about ineffectiveness. Edwards et al. (2010) recommend mass media education campaigns targeting Māori, Pacific and low-income groups about NRT to dispel safety concerns. Campaigns should also address consumer concerns about becoming addicted to NRT. We suggest extending these recommendations to include employing the 'Weight-Watchers' or 'Jenny Craig' strategy of enlisting well-known people who smoke to use and advertise cessation treatments. Enlisting people who are well-thought of by respectively Māori, Pacific, and low socio-economic peoples is likely to increase involvement with the message (Aldoory 2001; Vaughan and Hogg 2008).

Participants drew variously on a number of cognitive and behavioural strategies on their journey towards successful quitting. Some of the participants used these strategies in combination with pharmacotherapies, while others did not. The latter participants mostly described their method of quitting as going 'cold turkey.' The strategies which participants described indicate the resourcefulness of some smokers to draw on other forms of support. For example:

- Some participants, particularly those motivated to quit on an impulse, kept some cigarettes 'just in case' they decided to resume smoking. These 'safety net' cigarettes seemed to support quitting amongst our participants rather than impede it as has

been hypothesised by Dessaix, Murphy et al. (2009). The downside of retaining 'safety net' cigarettes however, is that this may prevent those who are trying to stop smoking from sufficiently preparing themselves (e.g. arming themselves with adequate cessation support) for stopping.

- For some participants, avoiding environments and behaviours associated with smoking and avoiding people who smoked was critical to remaining smokefree.
- Celebrating quit dates and feeding off positive feedback from others were another two examples of strategies that helped participants remain smokefree.

Consistent with other studies, many participants stopped smoking without formal (NRT) or professional support. As indicated above, stopping unaided may incorporate a raft of seldom acknowledged creative strategies. However, the sole reliance on cognitive and/or behavioural strategies (where these are used) leaves people vulnerable to the long range effects of addiction to nicotine. Our findings (and others, i.e. Dessaix, Murphy et al. 2009, Balmford and Borland 2008) indicate that although stopping unaided may be successful in the short term for some people, the risk of relapse was high.

Various perceptions contributed to the practice and endorsement of stopping smoking unaided. These included the perception that:

- Smoking was strictly a psychological or behavioural addiction therefore NRT was not considered necessary;
- 'Social smoking' or smoking few cigarettes per day did not constitute a real addiction;
- In the presence of a strong motivation to quit (e.g. an indisputable 'trigger' such as being pregnant), stopping smoking was easy;
- Stopping smoking when 'the time was right' was a sufficient condition to stop.

In an Australian study investigating the use of cessation aids among low socio-economic smokers trying to quit, Dessaix, Murphy et al. (2009) discuss the merit of acknowledging the role of 'willpower.' Our participants used this and related terms (e.g. 'mind over matter'). These terms mostly described quitting in the absence of cessation support. Dessaix, Murphy et al. argue that to dismiss the role of willpower is to risk alienating smokers. Elaborating upon their recommendations, we suggest reframing the notion of 'willpower' with its emphasis on self-control, as 'determination' to stayed stopped. Acknowledging the important role that determination plays in staying smokefree, alongside messages that multiple and varied cessation products and services are an available and equally important component of a comprehensive long range approach to stopping smoking, could increase the likelihood of long term success.

Chapter Four: Stakeholders' Workshops

Two workshops with key stakeholders were held (one in Auckland and one in Wellington) to discuss the preliminary results. Stakeholders were given an overview of the study, the key themes arising from the Māori and Pacific groups and they were presented with the Snakes and Ladders model.

The Snakes and Ladders model

The reasons for quitting and for relapse occur across multiple areas of influence, such as the family, social, and environmental realms. This highlights the need for a broad-based, wide-reaching approach to tobacco control and the recognition that many people make spontaneous quit attempts following a particular prompt that resonates with them. WhyKwit's findings culminated in the development of a new way of thinking about the process of stopping smoking. We distilled this knowledge, together with cutting-edge addiction, systems-change, social marketing and behaviour change theory and empirical evidence (West 2001, 2006; West and Sohal 2006) into a simple integrated framework and communication tool that uses the metaphor of the board game Snakes and Ladders. Like the board game, a smoker's motivation to smoke is affected by environmental factors, socio-economic determinants, social contexts, tobacco industry marketing, and personal events that with the roll of the dice move them towards the end goal ('tensions to quit' (West and Sohal 2006)) or leave them scarcely progressing (opposing pressure to smoke) in the game. Life's chances (represented by the dice) occasionally provide opportunities (ladders) to leap ahead (make a quit attempt), but equally, snakes (triggers to relapse) can undermine progress towards the end goal (abstinence from smoking).

Stakeholders' feedback

The suggestions and comments arising out of the stakeholders' workshops are summarised below for the Māori, Pacific and ex-smokers results.

Māori

The results confirmed for stakeholders that the 'It's About Whānau' theme was still highly relevant to motivating quitting among Māori. However, stakeholders were concerned about the knowledge gap on the harms and risks associated with smoking during pregnancy. The need to design effective intervention to work with marae leaders was identified as necessary to reduce Māori smoking.

Other environments that needed to be targeted, included workplaces. Some professional groups were singled out as critical for reducing Māori smoking prevalence. Māori nurses, for example, were reported to have a disproportionately high smoking prevalence compared to non-Māori and were promoted as a group needing targeted assistance.

Also considered to be important, was addressing smoker's perceptions of themselves because if they do not consider themselves a smoker, they won't see the offer to help as relevant to them.

Both Auckland and Wellington stakeholders discussed the need to try and clarify for people that smoking is not consistent with many tikanga, or to have tikanga reiterated or established to reduce smoking in Māori environments, like marae. More of an emphasis on impacting people i te taha wairua rather than i te taha hinengaro (through didactic educational approaches) was suggested.

More policies restricting smoking being used as a time-out or reward was suggested. For example, removing the unfair access to extra breaks at work that smokers enjoy.

Stakeholders got a clear message from the results that cessation information and support needs to be taken out to smokers. They expressed concern that there were geographic areas of high smoking prevalence that had no local access to cessation support.

Finally, stakeholders thought more needed to be done to generate a group commitment to smokefree – recruiting hapū and iwi across the nation to tautoko the kaupapa.

Pacific

Stakeholders were pleased to see smokefree pregnancy ranked so high as a reason to quit. They suggested however, that to address the poor knowledge of the broader range of health risks from smoking, Pacific workers needed to combine health promotion and cessation. They also might need to cover a broader range of health topics to attract Pacific peoples' interest and get them to listen/attend.

There was a desire to have the Pacific health workforce trained in the Snakes and Ladders model, the theories behind it and the WhyKwit results for Pacific. There was concern expressed however, about the great need to build Pacific capacity to address the needs identified by the research.

That church ministers smoked was added as a factor undermining quitting in Pacific communities. Improving awareness of health risks, stakeholders thought, could usefully be done early through secondary schools.

Stakeholders identified the need to build the capacity of mentors beyond celebrities and sports people. There are people within Pacific communities who could mentor smokers but whom are not being fully utilised.

It was suggested that social marketing campaigns specifically targeted at Pacific were especially needed given lack of capacity to cope with the level of identified need for cessation support.

The stakeholders supported the finding that some Pacific people do not consider that they are a smoker because they smoke so little or intermittently. They suspected that this could mean that surveys which establish prevalence could be underestimating the numbers of Pacific people who smoke. Future studies and surveys and interventions need to clarify that "a smoker is a smoker is a smoker". That is, Pacific people need to be asked if they smoke at all, even if only occasionally.

Pacific stakeholders pointed out that the power of children to prompt quitting is time-limited to younger children only. When the children of smokers get to college age and start smoking themselves they will cease nagging their parents to quit. Therefore, interventions targeting families need to reach parents of younger children.

Interventions need to raise Pacific awareness of treatments, but it was thought that the costs involved in accessing cessation aids/support would be an ongoing barrier to Pacific people's use of them. Further attempts to reduce Pacific smoking rates in New Zealand are hampered by the lax tobacco control measures in Pacific Island nations. Travelling between New Zealand with relatively comprehensive smokefree legislations to a country with little smokefree legislation makes quitting more difficult. Stakeholders identified the need to raise awareness of smoking related harms among Pacific people in the Islands and reduce the number of cigarettes brought into the country via duty-free.

Smoking myths need to be addressed in a culturally appropriate way, for example oral and face-to-face communication, to maximise Pacific engagement.

Stakeholders wondered about how different the findings would be if the same research was done with Māori and Pacific health professionals.

Ex-smokers

Stakeholders noticed that advertising was ranked last by WhyKwit participants but was frequently talked about during discussions. Stakeholders thought the adverts kept the health effects fresh in smoker's minds which might suggest that tensions and triggers are very fluid. It was suggested that cessation products and services continue to be endorsed as the promotion can trigger a quit attempt.

The SmokeFree Environments Act (SFEA) was recognised as being instrumental in de-normalising smoking.

It was felt that future intervention models could better utilise family and friends of smokers who often refer smokers to cessation services, including coaching family and friends on how they can best support the person attempting to stop smoking.

Chapter Five: Whole study discussion

Discussion

This section presents some concluding comments about the study results as a whole (across Māori, Pacific and the ex-smokers' groups). In some cases, themes which did not necessarily warrant discussion *within* groups, emerged as commonalities *across* groups, and are therefore discussed in detail here.

Participant demographics

Our aim to focus on Māori, Pacific and low socio-economic people who smoke was met. Over half of the participants identified as Māori (53%) and/or of Pacific ethnicity (45%). Over half of the participants were eligible for a community services card – a proxy indicator of lower SES. Men were under-represented in the study. However, this was mainly due to over-representation of women among the Māori and ex-smoker groups. Among the Pacific groups, over half the participants were men. This was achieved by running gender-specific groups.

Age of initiation

The Māori and ex-smokers participants had a similar age of initiation with most of them trying their first cigarette by the age of 15. Most Māori (52%) and 84% of ex-smokers had progressed to regular smoking by the age of 16. Pacific participants reported later initiation and tended to become regular smokers at an older age; 20% reported being regular smokers by the age of 16, and an additional 43% being regular smokers by the age of 21.

Desire to quit

Most of the participants who were still smoking, wanted to stop. Intent to stop smoking sometime in the future was higher among Māori participants (91%) than Pacific (79%). The percentage wanting to stop within the next 3 months was however similar for Māori and Pacific. Addiction levels indicated by time to first cigarette were similar for Pacific and Māori participants.

Number of previous quit attempts

The number of previous quit attempts ranged from 0-8 across the whole sample. On average younger participants reported 2.9 previous quit attempts, slightly more than the older participants (2.2). As a group, ex-smokers had made on average, the most attempts (i.e., three).

As discussed in the limitations, asking participants to recall quit attempts is scientifically weak. Our experience suggests that measures of number of previous quit attempts that rely on recall, especially where a data collection method restricts time for responses or prompts, as surveys might do, should be read with caution. Even with our qualitative method with interviewer prompting, many participants struggled to recall their previous quit attempts. Some participants discounted periods of not smoking as not relevant to count as a quit attempt and/or they became disenchanted with the exercise and stopped after providing a few quit attempts.

Motivation to Stop Smoking

Motives for previous quit attempts, across the Māori, Pacific and ex-smokers groups were roughly the same, with health reasons and quitting for children or pregnancy being the most commonly cited triggers to quit. The ranking exercise revealed the reasons participants thought they, as a group, *should* quit. These represented more of a collective, value-based set of reasons. Pacific participants were more likely than Māori, to align these reasons with their actual reasons for previous quit attempts (see Tables 26 and 27 respectively).

Table 26: Pacific ranked versus actual reasons for stopping smoking

Why Pacific peoples should quit (ranked reasons)	What triggers Pacific peoples to quit (reasons for past attempts)
1. To stay healthy	Health
2. Cost	Family
3. To live longer	Cost
4. Children's health	Don't like it/want to quit
5. Role model to my children	Pregnancy
6. To not grow old early	Social inclusion or identity
7. To have a healthier pregnancy	It's time
8. Fitness	No reason/just trying
9. To have more energy to do things	Smokefree environments
10. To get better	TV ads about smoking
11. Seeing effects of smoking on s'one close	Church
12. Getting pregnant/protect fertility	Career aspirations
13. Doctor told me to stop	
14. If they can, I can	
15. Smokefree environments	
16. It's time	
17. Making one's own choices	
18. It's not cool anymore	
19. It stinks	
20. TV ads about smoking	

Table 27: Māori ranked versus actual reasons for stopping smoking

Why Māori should quit (ranked reasons)	What triggers Māori to quit (reasons for past attempts)
1. Children's health	Health
2. Role model to my children	Don't like it/want to quit
3. To have a healthier pregnancy	Pregnancy
4. To stay healthy	Whānau
5. Getting pregnant/protect fertility	Cost
6. To have more energy to do things	Social inclusion or identity
7. Seeing effects of smoking on s'one close	No reason/just trying
8. Fitness	Making own choices
9. To get better	New environment or context
10. To live longer	It's time
11. Doctor told me to stop	Career aspirations
12. Tino rangatiratanga: Making own choices	TV ads about smoking
13. To not grow old early	Sokefree environments
14. Cost	
15. It stinks	
16. Tino rangatiratanga: Māori control over Māori matters	
17. It's time	
18. Smokefree environments	
19. If they can, I can	
20. It's not cool anymore	
21. TV ads about smoking	

Health was the main reason for quitting. Health encompasses a range of physical-related reasons, such as, wanting to stay healthy, wanting to live a long life, wanting to lessen ill-effects of a chronic condition, wanting to maintain or improve fitness or sporting performance and wanting to avoid ill-health. Most common of all the health reasons was quitting because of an acute bout of illness – the flu, being badly hung-over from excess drinking and smoking or being hospitalised. In these cases, stopping smoking was usually reluctant and often temporary, lasting for the duration of the illness.

In spite of health figuring strongly as a reason for stopping smoking, the risks of smoking were often underestimated and perceived to be a long way off. To counter this, consistent messages and education about the health risks of smoking to people who smoke, of smoking while pregnant, and the risks of SHS for children and bystanders should be maintained in schools and across media.

The benefits of *not* smoking or having stopped smoking were frequently discussed, mainly by ex-smokers, but also by participants in the Māori smokers groups. An enhanced sense of smell and taste, greater productivity, improved health, and a heightened sense of self-efficacy are just a few of the rewards that should be promoted to people wanting to stop smoking. Aesthetics, particularly not liking smoking because of the smell of smoke, was more prominent in the ex-smokers talk than among participants who still smoked. One of the reasons why current smokers don't mention smell as frequently could be that they can't smell it themselves. The offensive smell of smoke could be used creatively in campaigns to trigger quitting across all smokers.

Cost was a more salient reason to not smoke among Pacific participants than others. This could be further explored as a trigger for prompting quit attempts among Pacific people, especially increased tobacco tax excise. There was evidence that stopping for financial reasons was a temporary measure however, which suggests that in the absence of other tensions or triggers to stop, and effective accessible cessation support to stay smokefree, cost may only act as a transitory motive.

Smoking while pregnant

Pregnancy was mostly a trigger and that was mainly due to morning sickness and being put off smoking while pregnant. Stopping for pregnancy was not planned but it was an acceptable outcome if it occurred because it was seen as a temporary quit. More needs to be done to reduce smoking prevalence among Māori/Pacific women of child-bearing age. Cessation support needs to be offered upon confirmation of pregnancy or as soon after as possible. Thirdly, having stopped smoking for pregnancy, women need to be supported to maintain their smokefree status so as not to undermine breastfeeding and to reduce respiratory, and other, health risks for infants. Pregnancy and parenting should be key criteria for prioritised tobacco control intervention.

- ***Future research needs to evaluate the effectiveness of current strategies delivering effective cessation support to women upon confirmation of pregnancy, during pregnancy, and to the parents of infants and young children.***

Some of the discussion of smoking and pregnancy suggested poor levels of knowledge about the effects of smoking while pregnant and/or outright rejection of resultant ill-effects. Among Māori participants, this was because so many Māori women have smoked and were perceived to currently smoke during pregnancy, and participants did not in their experience see the damage smoking does. There was poor understanding of, and some fear of quitting in pregnancy. Amongst Pacific participants the need to stay smokefree for the health of the baby was not well understood.

- ***Future research needs to identify effective ways to rapidly and effectively improve Māori, Pacific and lower SES smokers' knowledge of the negative consequences of smoking during pregnancy.***

Te Taha Whānau – Some past and current initiatives

Quitting for whānau/family-related reasons was common across groups. This included stopping for the health of children and to be smokefree role models to children. Quitting for kids, especially if they have a smoking-related or smoking exacerbated illness should be strong enough to trigger quitting among Māori. Pacific people would similarly respond to tobacco initiatives that recognise the importance of family, particularly children and living longer to see grandchildren.

Quit For Our Kids was a programme that offered cessation to parents of children requiring hospital care due to smoking-related illnesses. The pilot programme was never extended, presumably because it did not work. It could be timely to retriail an updated version of that programme given the results of this study.

Te Piripohotanga is a similar sort of intervention currently being trialled by the Clinical Trials Research Unit in conjunction with CMDHB. Māori whānau of a baby potentially going to be exposed to smoking in the home are target participants in that study. The intervention aims to reduce the incidence of respiratory illness in the first year of life. The principles are quite similar to *Quit For Our Kids* in that an intervention worker assists the family to reduce baby's exposure to SHS. Quitting among the parents is however a secondary outcome. *Keeping Kids Smokefree* is another trial relying upon parents' desire to prevent smoking initiation among their intermediate school age children. The results of both of these trials are awaited. Nevertheless, parents from the time they conceive a child up until the child finishes school (by which time most current smokers have progressed to regular smoking) remain an important target group for intervention.

- ***It is recommended that the Ministry of Health establish parents (especially Māori and Pacific parents) of children aged 0-12 years as a priority group for smokefree promotion and cessation support.***
- ***Future research should identify ways to incentivise parents to quit and ways to make effective cessation more accessible to them.***

Future research needs to investigate the role of children in prompting quitting and children's fears for their parents. There is some marketing literature on pester-power, that is, the power of kids to influence adult consumer spending, but little has been said about using children to pester their parents to stop smoking. Research needs to consider also if there are possible negative consequences for children who pester their parents to give up smoking. Ethical considerations have not been explored. For example, it would not be ethical to encourage children to carry this message home if it put them at risk of angry backlash from a parent.

One benefit of creating opportunities for youngsters to do anti-smoking promotion work is that it can lay a foundation for later disquiet (tension to quit) if they should take up smoking.

Non-daily smoking

Some participants in the smokers' groups claimed that they did not smoke daily, or that their smoking was dependant on context and they thought this was a common smoking pattern in New Zealand. Some Pacific participants who were 'light' or intermittent smokers did not classify themselves as 'smokers.' The prevalence of non-daily and/or intermittent smoking has been identified in other studies (e.g. Shiffman, Kirchner et al. 2009; Glover, Watson et al. 2010), and associated with smokefree restrictions. Feedback from our stakeholders included concern that smoking prevalence is being underestimated, particularly among Pacific peoples. In order to accurately track people's smoking behaviour, our findings highlight the importance of being able to measure non-daily smoking. Better information is needed on the prevalence of intermittent smoking, 'social smoking' and 'closet smoking' in New Zealand.

Participants with a non-daily or context-driven smoking pattern tended not to perceive their smoking as serious enough to necessitate stopping or justify seeking support for stopping. This inability to acknowledge the health risks of infrequent smoking is consistent with research showing that intermittent smokers were more likely than never smokers to believe that genes and “nearly everything” causes cancer (Ackerson and Viswanath 2009). Research shows that occasional smoking carries a higher risk of cancer than never smoking (Bjerregaard, Raaschou-Nielsen et al. 2006), and an increased risk of premature death in men (Luoto, Uutela et al. 2000).

The Problem of Unintended Quitting

Across Māori, Pacific and the ex-smokers’ groups’, many of the cited quit attempts were ‘unintended’ – that is, participants stopped because they were too ill to smoke; morning sickness put them off smoking; they had no money to buy smokes. That the ex-smokers reported roughly the same list of reasons that had triggered them to quit in the past, suggests that the difference lies in their being able to stay quit, rather than their having a different reason or trigger to quit.

- ***Future research is needed to determine how these temporary unintended quits can be turned in to more permanent quit attempts.***

Quitting ‘unaided’

Cold turkey, that is quitting unaided was the most commonly cited cessation ‘method’ used in previous quit attempts. It was not however, necessarily a chosen method. That is, many participants ‘just stopped’, they didn’t quit intentionally; they didn’t therefore choose a quit method. Discussion in the focus groups revealed that this was most likely due to an abysmally low level of awareness of the full range of cessation treatments now available, low knowledge of them or where to get them. Māori and Pacific participants had similar questions and concerns about unknown NRT products. Choosing a quit method to help with quitting was not a well-known strategy.

- ***Tobacco control initiatives need to more successfully inform smokers of effective cessation methods and the existence of cessation aids, services and support.***

What would be most useful, given the glaring lack of knowledge among participants of cessation products and services (except for Quitline, the nicotine patch and gum) would be to take the information and support to the smokers wherever they are – in their workplace (to get around the barriers of work hours); at the shops and malls and markets, festivals and events where they are being ‘too busy’ so that they are not inconvenienced by having to go to the doctor or pharmacy, or spend precious hours and dollars they don’t have, and, make the assessment process less intrusive and less time-consuming i.e. don’t ask so many questions. Just get out and patch people up with whichever effective product and type of support they’re open to trying.

- ***Future research could assist with identifying effective strategies for extending opportunities to quit (triggers) in to Māori, Pacific and low SES communities.***

For Pacific peoples, our findings suggest the need for face-to-face culturally acceptable services. Group approaches are acceptable, offer mutual support and could be utilised more broadly.

Glover & Cowie (2010) suggest a range of strategies that could be trialled including Quit and Win type contests, use of a retail approach to ‘sell’ quitting and direct marketing via telephone. Direct marketing via mail using GP databases of clients who smoke (Watson, Bullen et al. 2010) has already been successfully tried. This method could be extended to other databases containing smoking status information. A range of targeted mass marketing methods could be adapted to successfully deliver information about cessation opportunities and methods out to the large

population of Māori and Pacific peoples who have not been reached by previous campaigns as evidenced by higher level of interest in and discussion of electric cigarettes.

The Need to Debunk Smokers' Myths

Something must be done about the 'smokers' myths' to remove the ongoing tension these stories exert that undermines motivation to quit, self-efficacy to quit, and willingness to use effective cessation aids and services.

Quitline, the patch and gum are all suffering from a bagging on the kumara vine – there are too many negative tales circulating about how Quitline were too busy, too boring, only for people ready to quit. The patch causes bad dreams, rashes and welts. The gum sticks to false teeth and tastes like an ashtray. Not good PR. They need a make-over. They need to be resold, repackaged as new, better, improved – different from the service/product of old – to which the stories can no longer be applied.

- ***It is recommended that the Ministry of Health, Pharmac and The Quit Group investigate strategies for re-branding Quitline, the nicotine patch and gum to re-present these three key cessation strategies as somehow new and improved.***

The myth of a person's 'personal choice' to smoke or not smoke was present among participants who smoked, and notably absent from the ex-smokers' talk. Ex-smokers seemed more able to acknowledge that 'choice', in the presence of addiction, was a redundant concept. The poor understanding of 'addiction' and nicotine dependency raises the question of whether something needs to be done to raise health literacy skills on these topics. Or, can an opportune trigger (incentive to quit) combined with ready and convenient provision of cessation treatment result in successful quitting. This is an important question for New Zealand tobacco control, with its desire for a rapid reduction in smoking prevalence across all groups including Māori and Pacific. Health literacy around smoking addiction and cessation was even lower among the Pacific participants in this study. Significant investment of time and money would be needed to raise health literacy to levels presumably required to support the rates of quitting desired.

- ***Future research needs to identify minimum levels of intervention required to: 1) trigger quit attempts among Māori and Pacific and lower SES people and; 2) enable those quit attempts to result in sustained abstinence.***

West's (2006) theory provides for people to jump from the start position (first time quitter) to smokefree forever, without the progressive accumulation of knowledge and skills that previous behaviour change models assumed was necessary. The ex-smokers displayed a greater understanding of how addictive and controlling nicotine dependency was. Whether this explains why they managed to stay smokefree cannot be concluded from this study.

Maybe for some people it's not until they've stopped that they become aware of the full range of benefits of not smoking – and they can look back and realise how controlled they were, how much a hold the addiction had on them. One advantage of assisting people to quit, even if temporarily is that they may stop long enough to experience this and learn from it. This new knowledge should then add to the background tension to quit again should they relapse.

- ***Future research is needed to test West's theory particularly: that quitting success is NOT dependent on improved knowledge about smoking, nicotine dependency/addiction and quitting.***

Fatalism, which undermined motivation to quit, was more prominent in Pacific discussions. Older Pacific participants especially, who expressed fatalistic attitudes, were reluctant to stop smoking. Drawing on the centrality of family to Pacific peoples, strategies promoting stopping smoking for the sake of living longer healthier lives and being around for families, children and grandchildren could be utilised to address this. Stressing the importance of the role model effect could, again, help encourage smokers to quit for others if not for themselves.

Preventing Relapse

Environmental factors, such as smokefree environments legislation, provide important background tension-builders towards becoming smokefree for some people, making smoking less normative and acceptable. For some ex-smokers and people trying to stop, this endorsed and aided their goal to be smokefree. Smokefree environments legislation was acceptable, considered normative, and prompted favourable feedback even from smokers. There are however, still environments, such as some marae, wānanga, Pacific churches, and kava ceremonies which need to be assisted to reduce the smoking-permissive culture reportedly still engrained there.

Negative affect and other people smoking were primary triggers to relapse across Māori, Pacific and ex-smokers. Alcohol was, however a more prominent reason for relapsing for Pacific than for Māori.

Addressing some of the background social determinants of smoking would help people to remain smokefree once they have quit. However, revolutionising society to remove discriminatory division of labour; social stratification by gender, ethnicity, and sexuality; institutional racism in the education, political, legal and health systems etc, takes time – time within which disproportionately high smoking-related morbidity and mortality among Māori and Pacific people will continue. Strategies that can help low SES, marginalised, depressed people who smoke to quit despite their stressful and upsetting life circumstances must be found. It can be done. Smoking prevalence among those groups is going down. Innovative interventions are being trialled, for example, a pilot programme in Scotland rewarded pregnant women with grocery vouchers for every week that they managed to not smoke while pregnant. The programme was so successful it was extended borough-wide to all smokers.

Conclusion

Smokers in this study frequently demonstrated an interest and readiness to quit smoking. Despite broadly similar reasons for stopping smoking (e.g. health, family), these were variously experienced as motivational tensions/triggers for different people in different contexts and at different points in their lives. There is therefore no one-size-fits-all approach. Rather, it is critical to maintain a diverse range of tensions and triggers in order to maximise the potential to motivate smokers to quit. Moreover, there is an equally important and clear need for effective and accessible cessation treatments to be marketed (and in some cases, re-packaged) to smokers. In the absence of such support, however salient and effective tensions and/or triggers are to stop smoking, many quit attempts are likely to be short-lived.

Innovation and novelty in messages and products is likely to be important in order to capture attention or appeal to people who haven't been influenced or captivated by existing cessation support.

Study strengths and limitations

Strengths

This study is the first detailed qualitative study in New Zealand to examine what motivates Pacific and low socio-economic peoples to stop smoking. It adds to existing knowledge on Māori smoking. It was a large study with mainly Māori and Pacific people interviewed in a range of urban, metropolitan and smaller town centres across New Zealand.

Ethnic specific groups enabled us to respect the tikanga and traditions of respective groups. Separate focus groups by age served to make it as comfortable as possible for younger and older participants to discuss their smoking-related views and experience amongst their peers. The study provided for the use of Pacific languages within the focus groups which creates a sense of being comfortable to converse in their own ethnic languages. Where possible, researchers were ethnically matched with focus group participants.

The use of Māori and Pacific researchers, facilitators and note takers built capacity and provided training opportunities. Two Pacific students, for example, completed their Bachelor of Health (Hons) postgraduate qualifications. A number of other Pacific researchers were able to gain new research skills.

When focus groups were facilitated in Pacific languages, translation and transcribing was undertaken by fluent and competent speakers of that particular ethnic language. The transcripts were then translated into English. This was cross checked and double checked by the Pacific co-principal investigator for consistency.

The focus group transcripts of all groups underwent a rigorous checking process, checked initially by the facilitator and checked again by another research team member for consistency and meaning.

Limitations

Community workers and students were amongst the focus group facilitators. One of the repercussions of utilising non-professional facilitators was that in some cases they led the participants' responses. For example, regarding feedback of cessation products, one facilitator led the discussion by saying "*some [products] don't work for brown people.*" To avoid bias, sections of data related to such leading have been removed from the analysis.

A related limitation is that in some cases, participants could have been prompted for further comment. It was also evident in some cases that facilitators were providing inaccurate information about cessation products.

For three of the Pacific groups, a lack of information was provided to participants by their community group and as result of this, these participants did not fully understand the nature of the research. As a result of this, facilitators of the two groups of older participants made the decision not to follow the focus group schedule and a more informal discussion about smoking was held. Some of the older Pacific participants spoke English as a second language, and in some cases, this may have restricted people's comments.

The study does not consider the findings by Pacific ethnic group, but rather groups all Pacific results together. Moreover, as the Pacific focus groups were recruited and conducted in Auckland only, the findings are not representative of Pacific peoples across New Zealand.

Across all groups, there was a number of “no-shows.” That is, some people who were recruited did not attend the focus groups as scheduled. Therefore the numbers in some focus groups were small. Where feasible, we countered this by running additional groups. On two occasions, groups were re-scheduled. At other times, focus group participants arrived late. This cut into the room booking time for one group and as a consequence, the schedule of this group was condensed.

There were some possible issues with some of the focus group exercises which may affect the validity of the data. Recalling multiple past quit attempts was difficult for some participants who may have tried stopping one-two times a week. Moreover, assuming quit attempts were recalled in a standard way is potentially problematic. Some participants seemed to recall only those attempts which were successful for a month or so, whereas others, who perhaps had attempted quitting less often, noted attempts which lasted just a day or so.

A number of participants reflected on the process of ranking reasons for stopping smoking. Many comments concerned the complexity of teasing apart and prioritising reasons, “*That was hard*” (22W), while others discussed how to interpret the cards.

Well, if a doctor said to stop smoking...(7W) Might be a medical condition or reason behind it. (7W) It depends what the circumstances – (7W)

There was some dissent amongst one group on how the ranking should be achieved.

I'm just wondering why you have to spread it out, because you want things to be good or because you can't prioritise? (12W) Well for me, I've prioritised by saying that those four cards there have equal importance for me at the time. (12W) But it's a group thing. (12W) Yeah, but I'm putting forth my reasons so that anyone else that wants to put forth their reasons can swap things around. (12W) I just think that when people don't necessarily say, doesn't mean they agree. You know what I mean? It's just that some of us are stronger talkers, you know what I mean? (12W) Yeah...I mean we could take over it, it's easy to do that. (12W)

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Appendices

Appendix A: List of abbreviations

Appendix B: Māori reasons for stopping smoking by age quit attempted (full detail)

Appendix C: Māori reasons for relapsing by age at relapse (full detail)

Appendix D: Pacific reasons for stopping smoking by age quit attempted (full detail)

Appendix E: Pacific reasons for relapsing by age at relapse (full detail)

Appendix F: Ex-smokers reasons for stopping smoking by age quit attempted (full detail)

Appendix G: Ex-smokers reasons for stopping smoking by age quit attempted (full detail)

Appendix A: List of abbreviations

AKP	Aukati Kai Paipa
e-cigarette	electric cigarette
GP	general practitioner
HP	health professional
NRT	nicotine replacement therapy
SES	socio-economic status
SFEA	Smokefree Environments Act
SHS	second-hand smoke
TVCs	television commercials

Appendix B: Māori reasons for stopping smoking by age quit attempted (full detail)

Appendix B: Māori reasons for stopping smoking by age quit attempted (full detail)											
	Age group									Row	Total
Māori reasons for stopping smoking	11-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	total	
<i>Health</i>											
Health unspecified	1	2	3	4	6	1	1	3	1	22	
Maintaining good health	0	2	0	0	1	0	0	0	0	3	
To stay healthy	2	4	1	0	0	0	0	0	0	7	
To avoid ill health	0	0	1	0	1	1	0	0	0	3	
Longevity	0	0	1	0	0	1	0	1	0	3	
Due to ill health, to get better	4	10	3	5	3	1	0	1	1	28	
Fitness	4	5	2	1	0	0	0	0	0	12	
Sports performance	2	3	1	1	1	0	0	0	0	8	86
<i>Don't like it, want to quit</i>											
Want to quit, don't like smoking	1	9	1	4	3	1	0	1	0	20	
Smell	0	1	0	2	0	0	1	0	0	4	
Taste	0	1	1	1	0	0	0	0	0	3	
Bad or dirty habit, disgusting, unclean	0	7	0	0	0	0	1	0	0	8	
Oral health	0	1	0	0	0	0	0	0	0	1	36
<i>Pregnancy</i>											
Pregnancy unspecified	0	2	1	0	0	0	0	0	0	3	
Pregnant and felt sick, couldn't smoke	1	11	9	2	0	0	0	0	0	23	
To have a healthier pregnancy	1	2	0	0	0	0	0	0	0	3	29
<i>Whānau</i>											
Whānau unspecified	0	0	1	0	0	0	0	1	0	2	
For children	0	0	1	0	3	0	1	0	0	5	
Health	0	0	0	1	1	0	0	0	0	2	
For partner, spouse, boy/girlfriend	0	0	1	0	1	0	0	0	0	2	
Not permitted to smoke by parents	5	3	0	0	0	0	0	0	0	8	
Seeing what smoking does to someone close	0	0	0	0	1	1	0	0	0	2	
Whānau support, making a pact or bet	0	2	0	0	0	0	0	0	0	2	23

Māori reasons for stopping smoking	11- 15Yrs	16- 20Yrs	21- 25Yrs	26- 30Yrs	31- 35Yrs	36- 40Yrs	41- 45Yrs	46- 50Yrs	51+ Yrs	Row total	Total
<i>Cost</i>											
Cost unspecified	0	1	0	1	1	0	3	0	0	6	
Unable to afford to smoke	1	5	1	0	0	0	0	0	0	7	
Aware of financial implications of smoking	0	2	1	1	2	1	0	0	0	7	20
<i>Social inclusion or identity</i>											
It isn't for me, not a good image	0	4	0	0	0	0	0	0	0	4	
Social support, made a pact, bet with friends	1	0	0	0	0	0	0	0	0	1	
Smokefree peers	0	1	0	0	0	0	0	0	0	1	
It's not cool, socially acceptable anymore	1	2	0	0	0	0	0	0	0	3	9
<i>No reason/just trying</i>	1	2	1	0	0	2	0	0	2	8	8
<i>New environment, context, location</i>	0	2	0	0	2	0	0	0	0	4	4
<i>Tino Rangatiratanga</i>											
Making one's own choices	0	4	0	0	0	0	0	0	0	4	4
<i>It's time</i>											
It's time unspecified	0	0	0	1	0	0	0	0	0	1	
New years or birthday resolution	0	1	0	0	0	0	0	1	0	2	3
<i>Career aspirations</i>	0	1	0	0	0	1	0	0	0	2	2
<i>No ID and under legal age to buy tobacco</i>	1	0	0	0	0	0	0	0	0	1	1
<i>TV ads about smoking</i>	0	0	0	1	0	0	0	0	0	1	1
Total	26	90	30	25	26	10	7	8	4	226	

Appendix C: Māori reasons for relapsing by age at relapse (full detail)

	Age group										
	≥15Yr	16-	21-	26-	31-	36-	41-	46-	51	Row	
Māori reasons for relapse	s	20Yrs	25Yrs	30Yrs	35Yrs	40Yrs	45Yrs	50Yrs	+Yrs	total	Total
Negative affect											
Stress	1	7	4	1	1	2	0	2	0	18	
Life events, bereavements	0	1	1	0	0	0	0	0	0	2	
Relationship and family stress	0	4	2	0	0	0	0	0	1	7	
Moving to another area	1	1	0	1	0	0	0	0	0	3	
Work stress	0	0	1	0	1	0	0	0	0	2	
Relief of negative affect experienced as withdrawal symptoms	0	0	0	1	0	0	0	0	0	1	
Boredom	1	3	0	0	1	1	0	0	0	6	
Sadness, depression	2	0	0	0	0	0	0	0	0	2	41
Social Inclusion or Identity											
Smoking as an aide, while socialising	0	1	0	1	0	0	0	0	0	2	
Peer group smoking	1	4	1	0	0	0	0	0	0	6	
Everybody	4	4	1	0	1	0	0	0	0	10	
Friends	3	4	0	0	2	0	0	0	0	9	
To be accepted in the cool crowd, to fit in	6	1	0	0	0	0	0	0	0	7	
Peer pressure	4	1	0	0	0	0	0	0	0	5	
Following friends/siblings	1	0	0	0	0	0	0	0	0	1	40
Behavioural and Physical Associations											
Temptation, craving, addiction	2	2	1	2	0	0	0	2	0	9	
‘Just one puff...’	0	0	1	0	1	1	0	1	0	4	
Habit, ritual	0	2	0	0	1	0	1	1	0	5	
Paired associates e.g. coffee, kava, food, drugs	0	0	0	1	0	0	0	0	0	1	
Withdrawal symptoms	0	0	0	0	1	0	0	0	0	1	
Triggers	0	0	0	0	1	0	0	0	0	1	21
Reason for stopping no longer relevant											
Sports or training programme finished	0	0	0	1	0	0	0	0	0	1	
No longer sick	0	4	0	2	0	0	0	0	1	7	
No longer pregnant/ or breast feeding	0	2	5	1	0	0	0	0	0	8	
Able to get cigarettes	4	0	0	0	0	0	0	0	0	4	20

Māori reasons for relapse	11- 15Yrs	16- 20Yrs	21- 25Yrs	26- 30Yrs	31- 35Yrs	36- 40Yrs	41- 45Yrs	46- 50Yrs	51 +Yrs	Row total	Total
<i>Wanted to smoke</i>											
Wanted to smoke	2	0	1	1	0	1	0	0	0	5	
Enjoyed it, missed it	0	0	0	0	0	1	0	0	0	1	
Felt good about myself	0	2	0	0	0	0	0	0	0	2	
Reward smoke	0	0	0	1	0	0	0	0	0	1	
Looked cool	2	0	0	0	0	0	0	0	0	2	
Needed stimulus (e.g. after training)	0	2	0	0	0	0	0	0	0	2	13
<i>Alcohol</i>	2	4	2	2	1	0	0	0	0	11	11
<i>Whānau</i>											
Whānau permissive of smoking	2	0	0	0	0	0	0	0	0	2	
Whānau providing cigarettes	1	0	0	0	0	0	0	0	0	1	
Lack of whānau support	0	1	0	0	1	0	0	0	0	2	5
<i>Employment</i>	0	0	0	2	2	0	0	0	0	4	4
<i>No reason</i>	1	2	0	1	0	0	0	0	0	4	4
<i>Financially able to smoke</i>	1	2	0	0	0	0	0	0	0	3	3
<i>New environment, context, location</i>	0	2	0	0	0	1	0	0	0	3	3
<i>Weight gain</i>	0	0	0	0	0	1	0	0	0	1	1
Total	41	56	20	18	14	8	1	6	2	166	

Appendix D: Pacific reasons for stopping smoking by age quit attempted (full detail)

Pacific reasons for stopping smoking											Row total	Total
Age												
	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs			
Health												
Health unspecified	2	4	2	3	0	1	1	1	0	14		
To stay healthy	0	2	3	0	0	0	0	0	0	5		
To avoid ill health	1	0	1	0	0	1	0	0	0	3		
Longevity	1	3	1	0	0	0	0	0	0	5		
Preventing worsening health	0	1	0	0	0	0	0	0	0	1		
Due to ill health, to get better	3	11	0	2	1	2	1	2	3	25		
Doctors or health professional's advice	0	1	0	0	0	1	2	0	0	4		
Fitness	1	2	4	1	0	0	0	0	0	8		
Sports performance	0	5	3	0	0	0	0	0	0	8		
To have more energy to do things	0	0	1	0	0	0	1	0	0	2		
Lifestyle change	0	0	0	0	0	0	0	0	1	1		
To not grow old early	0	2	0	0	0	0	0	0	0	2	78	
Family												
Family unspecified	0	1	1	0	1	0	0	0	0	3		
For children	0	1	1	1	0	0	1	1	1	6		
Health	0	0	2	0	1	0	2	0	0	5		
To be a positive role model	0	3	0	0	0	0	0	0	0	3		
Based on their wishes	0	0	0	0	0	0	1	0	0	1		
For partner, spouse, boy/girlfriend	0	0	3	1	2	0	0	1	0	7		
Not permitted to smoke by parents	6	6	2	0	0	0	0	0	0	14		
Seeing what smoking does to someone close	0	4	0	0	0	0	0	0	1	5	44	
Cost												
Cost unspecified	0	1	2	0	0	1	2	2	0	8		
Unable to afford to smoke	1	5	3	1	1	1	1	1	1	15		
Awareness of financial implications of smoking	2	7	2	1	0	1	2	0	0	15		
Parents not funding it	0	1	0	0	0	0	0	0	0	1	39	

Pacific reasons for stopping smoking	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	Row total	Total
<i>Don't like it/want to quit</i>											
Smell	1	1	0	0	1	0	0	0	0	3	
Taste	1	0	0	0	0	0	0	0	0	1	
Bad or dirty habit, disgusting, unclean	0	1	0	0	0	0	0	0	0	1	
Oral health	0	1	0	0	0	1	0	0	0	2	
Want to quit, don't like smoking	0	3	2	1	1	1	0	0	0	8	15
<i>Pregnancy</i>											
Pregnancy unspecified	0	4	2	2	2	0	0	0	0	10	
Pregnant and felt sick, couldn't smoke	0	1	2	0	0	0	0	0	0	3	
Awareness of another's pregnancy	0	1	0	0	0	0	0	0	0	1	14
<i>Social inclusion or identity</i>											
It isn't for me, not a good image, not a 'smoker'	1	1	0	0	0	0	0	0	0	2	
To be accepted in the cool crowd	1	0	0	0	0	0	1	0	0	2	
If they can, I can	0	0	1	0	0	0	0	0	0	1	
Social support, making a pact/bet with friends	0	1	0	1	0	0	0	0	1	3	8
<i>It's time</i>											
New years or birthday resolution	0	2	4	0	0	0	0	0	0	6	
Epiphany	0	0	0	1	0	0	0	0	0	1	7
<i>No reason/just trying</i>	1	4	2	0	0	0	0	0	0	7	7
<i>Smokefree policies</i>											
No ID and under legal age to buy tobacco	0	2	0	0	0	0	0	0	0	2	
Smokefree environments	0	2	1	0	0	0	0	0	0	3	5
<i>TV ads about smoking</i>	0	1	3	0	0	0	0	0	0	4	4
<i>Church</i>	1	0	1	1	0	0	0	0	0	3	3
<i>Career aspirations</i>	0	0	0	0	0	0	0	0	1	1	1
Total	23	85	49	16	10	10	15	8	9	225	

Appendix E: Pacific reasons for relapsing by age at relapse (full detail)

Appendix E: Pacific reasons for relapsing by age at relapse (full detail)											
Pacific reasons for relapse	Age Group									Row total	Total
	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs		
<i>Negative affect</i>											
Stress	0	1	6	3	1	1	3	0	0	15	
Boredom	0	3	2	1	0	1	0	0	1	8	
Anger	1	0	0	0	0	1	0	0	1	3	
Fatigue	0	0	0	1	0	0	0	0	0	1	
Life events, bereavements	0	1	2	1	0	0	0	0	0	4	
Relationship and family stress	0	0	2	1	0	0	0	0	1	4	
Work stress	0	0	1	0	0	0	0	0	1	2	
University stress	0	0	4	0	0	0	0	0	0	4	
Stress relief	0	2	3	1	0	0	0	0	0	6	
Coping strategy	0	2	0	0	0	0	1	0	0	3	
Having time out for oneself	0	0	1	0	0	0	1	0	0	2	
Relief of negative affect experienced as withdrawal symptoms	0	1	0	0	0	0	0	0	0	1	53
<i>Social inclusion or identity</i>											
Smoking as an aide, while socialising	1	2	3	0	0	0	0	0	0	6	
Peer group smoking	1	1	0	0	0	0	0	0	0	2	
Everybody smoking	0	3	0	1	0	0	1	0	0	5	
Friends	3	9	3	0	0	0	2	0	0	17	
To be accepted in the cool crowd, to fit in	2	0	0	0	0	0	0	0	0	2	
Peer pressure	1	2	2	0	0	0	0	0	1	6	
Following friends/siblings	1	1	0	0	0	0	0	0	0	2	
Lack of support from friends	0	1	0	0	0	0	0	0	0	1	41
<i>Behavioural and physical association</i>											
Temptation, craving, addiction	0	4	6	2	2	0	2	1	2	19	
“Just one puff...”	0	1	0	0	0	0	0	0	0	1	
Habit, ritual	0	1	1	0	0	1	0	0	0	3	
Paired associates e.g. coffee, kava, food, drugs	0	1	0	0	0	0	0	1	0	2	25

Pacific reasons for relapse	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	Row total	Total
<i>Reason for stopping no longer relevant</i>											
Sports or training programme finished	0	0	2	0	0	0	0	0	0	2	
Bet with friend ended	0	1	0	0	0	0	0	0	1	2	
No longer living with parents	0	0	0	0	0	0	0	0	0	0	
No longer sick	0	2	2	0	0	0	0	1	2	7	
No longer pregnant/ or breast feeding	0	1	2	1	0	0	0	0	0	4	
Baby no longer sick	0	0	0	0	0	1	0	0	0	1	
Legally able to buy cigarettes	1	1	0	0	0	0	0	0	0	2	
Able to get cigarettes	0	3	0	0	0	0	0	0	0	3	
Able to get fit and smoke	0	1	1	0	0	0	0	0	0	2	
Left the church	0	0	0	1	0	0	0	0	0	1	24
<i>Alcohol</i>	0	5	4	2	2	0	1	0	0	14	14
<i>Family</i>											
Family members smoking	0	6	0	0	1	0	0	0	0	7	
Family permissive of smoking	0	2	0	0	0	1	0	0	0	3	
Family providing cigarettes	0	2	0	0	0	0	0	0	0	2	
Lack of family support	0	1	0	0	0	0	0	0	0	1	13
<i>Wanted to smoke</i>											
Wanted to smoke	2	1	0	1	0	0	0	0	1	5	
Enjoyed it, missed it	0	0	1	0	0	0	0	0	0	1	
Looked cool	1	0	0	0	0	0	0	0	0	1	7
<i>Financially able to smoke</i>	1	3	1	0	0	0	0	0	0	5	5
<i>Strategy for weight loss</i>	0	1	1	0	0	1	0	0	0	3	3
<i>Employment</i>	0	0	0	0	0	0	1	0	0	1	1
<i>New environment, context, location</i>	0	0	1	0	0	0	0	0	0	1	1
Total	15	66	51	16	6	7	12	3	11	187	

Appendix F: Ex-smokers reasons for stopping smoking by age quit attempted (full detail)

Ex-smokers reasons for stopping smoking	Age group									Row total	Total
	11-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+ Yrs		
Health											
Health unspecified	0	3	6	1	4	3	7	4	2	30	58
To avoid ill health	0	0	0	0	0	1	0	0	0	1	
Due to ill health, to get better	1	3	3	0	1	2	4	0	0	14	
Fitness	0	1	1	0	0	0	0	0	2	4	
Sports performance	1	1	0	0	0	0	2	0	0	4	
Lifestyle change	0	0	0	0	1	0	0	0	0	1	
To not grow old early	0	0	0	0	0	0	2	2	0	4	
Whānau											
Whānau unspecified	0	0	0	0	1	1	0	0	2	4	36
For children	0	2	2	1	0	2	0	0	4	11	
Health/wellbeing	0	0	0	0	2	2	0	2	0	6	
To be a positive role model	0	0	1	0	1	1	2	0	0	5	
For partner, spouse, boy/friend	0	1	2	1	0	0	0	0	0	4	
Not permitted to smoke by parents	4	1	0	0	0	0	0	0	0	5	
Whānau support, making a pact or bet	0	1	0	0	0	0	0	0	0	1	
Pregnancy											
Pregnancy unspecified	1	4	5	3	0	0	0	0	0	13	20
Pregnant and felt sick, couldn't smoke	0	2	3	0	0	0	0	0	0	5	
To have a healthier pregnancy	0	1	1	0	0	0	0	0	0	2	
Don't like it/want to quit											
Smell	0	0	4	0	1	1	2	0	0	8	16
Bad or dirty habit, disgusting, unclean	1	1	0	0	1	0	0	0	0	3	
Want to quit, don't like smoking	0	2	2	0	1	0	0	0	0	5	
Cost											
Cost unspecified	0	2	2	1	2	1	2	0	0	10	11
Unable to afford to smoke	0	0	0	0	0	1	0	0	0	1	

Ex-smokers reasons for stopping smoking	11-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	Row total	Total
<i>Social inclusion or identity</i>											
It isn't for me, not a good image, not a 'smoker'	1	0	0	1	0	0	0	0	0	2	
Social support, making a pact, bet with friends	0	0	0	0	2	1	0	0	0	3	
It's not cool, socially acceptable anymore	0	0	0	0	0	0	2	0	0	2	7
<i>It's time</i>											
It's time unspecified	0	0	0	0	1	0	0	0	2	3	
New years or birthday resolution	0	0	2	0	0	0	0	0	0	2	
Epiphany	0	0	0	1	0	0	0	0	0	1	6
<i>No reason/Just trying</i>	0	3	0	1	1	0	0	0	0	5	5
<i>Church</i>	0	0	0	0	1	0	0	0	2	3	3
<i>Career aspirations</i>	0	0	0	0	0	0	0	2	0	2	2
<i>Making one's own choices</i>	0	1	0	0	0	0	0	0	0	1	1
<i>Smokefree policies</i>	0	1	0	0	0	0	0	0	0	1	1
Total	9	30	34	10	20	16	23	10	14	166	

Appendix G: Ex-smokers reasons for relapsing by age at relapse (full detail)

Ex-smokers reasons for relapse	Age									Row total	Total
	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+ Yrs		
<i>Negative affect</i>											
Stress	0	1	4	3	0	1	0	1	0	10	30
Boredom	0	0	1	1	0	0	0	0	0	2	
Stressful circumstances	0	1	0	0	0	0	0	0	0	1	
Life events, bereavements	0	0	1	0	0	0	0	0	0	1	
Relationship and family stress	0	2	5	1	1	1	0	0	0	10	
Moving to another area	0	2	2	0	0	0	0	0	0	4	
Work stress	0	0	1	0	0	1	0	0	0	2	
<i>Social inclusion or identity</i>											
Smoking as an aide, while socialising	0	1	2	0	0	0	0	0	0	3	23
Everybody smoking	1	3	0	0	0	1	0	0	0	5	
Friends	4	1	1	0	2	1	0	1	0	10	
To be accepted in the cool crowd, to fit in	0	2	0	1	1	0	0	0	0	4	
Following friends/siblings	1	0	0	0	0	0	0	0	0	1	
<i>Whānau</i>											
Whānau members smoking	1	0	0	0	0	1	0	0	0	2	12
Partner, spouse, boy/girlfriend	1	1	0	1	0	1	0	0	0	4	
Parents	0	1	0	0	0	0	0	0	0	1	
Siblings, cousins	2	0	0	1	0	0	0	0	0	3	
Whānau permissive of smoking	1	0	0	0	0	0	0	0	0	1	
Whānau providing cigarettes	1	0	0	0	0	0	0	0	0	1	
<i>Behavioural and physical association</i>											
Temptation, craving, addiction	0	2	0	0	0	0	1	0	0	3	10
Withdrawal symptoms	0	1	5	0	1	0	0	0	0	7	

Ex-smokers reasons for relapse	10-15Yrs	16-20Yrs	21-25Yrs	26-30Yrs	31-35Yrs	36-40Yrs	41-45Yrs	46-50Yrs	51+Yrs	Row total	Total
<i>Reason for stopping no longer relevant</i>											
No longer living with parents	1	0	0	0	0	0	0	0	0	1	
No longer sick	0	0	0	0	0	1	0	0	0	1	
No longer pregnant/ or breast feeding	0	1	2	0	0	0	0	0	0	3	
Able to get cigarettes	2	1	0	0	0	0	0	0	0	3	8
<i>Alcohol</i>	0	4	1	0	2	0	0	0	0	7	7
<i>Wanted to smoke</i>											
Enjoyed it, missed it	1	1	0	1	0	1	1	0	0	5	
Looked cool	2	0	0	0	0	0	0	0	0	2	7
<i>Weight gain</i>	0	0	1	1	1	1	0	0	0	4	4
<i>Location</i>											
New environment, context, location	0	1	0	0	0	0	1	0	0	2	
Returned home	0	1	0	0	0	0	0	0	0	1	3
<i>No reason</i>	0	0	1	1	0	1	0	0	0	3	3
<i>Employment</i>	0	1	0	0	0	0	0	0	0	1	1
Total	18	28	27	11	8	11	3	2	0	108	

