



Smoking and Pregnancy
Audience Research
Identifying motivational messages
and communication channels

Volume One

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1 Reporting Structure

The report for this research consists of two separate volumes. The two volumes are listed below with their key areas of content.

Volume One: Executive summary & detailed analysis. This volume contains the following:

- Executive summary
- Research overview
- Smoking attitudes and experience
- Motivational messages
- Message tone and style
- Summary and conclusions
- A profile of the women in the sample.

Volume Two: Appendices. This volume contains the following:

- Appendix A – Interview guides used in interviews
- Appendix B – Profiling questionnaire
- Appendix C – Responses to profiling questionnaire
- Appendix D – Stimulus materials used in interviews.

2 Executive Summary

2.1 Research overview

The overall objective of this project is:

*To establish messages that may motivate **women of child-bearing age who smoke** and **pregnant women who smoke** to make a quit attempt, to explore ways to best communicate these messages.*

A sub-objective of this project is:

To explore and identify the most appropriate communication channels in which to reach these women.

This study is the first part of a three-stage project to meet these objectives.

Thirty face-to-face in-depth interviews were conducted with women who were in the following categories:

- Pregnant women who smoke
- Pregnant women who have become ex-smokers in response to their pregnancy or because they intended to become pregnant
- Non-pregnant smoking women without children
- Non-pregnant women with children who became ex-smokers in response to a previous pregnancy.

Interviews were conducted in different cities and towns throughout New Zealand. The locations were Auckland, Wellington, Whangarei, Palmerston North, New Plymouth, and Oamaru.

Twenty-four women were interviewed at central and neutral locations that could be conveniently reached. Four women felt more comfortable expressing their views in their own home or had commitments that made this a more convenient option for them. Two women were interviewed by telephone. The inclusion of telephone interviews was kept to a minimum, but in these two cases the methodology provided access to women who would not have participated otherwise.

Women were told at the time of recruitment screening that the interview would be conducted in English, and the offer of a translator or an attending support person was made. There were no requests for a translator to be present, and one woman requested the presence of a support person.

Each interview was audio-recorded for analysis purposes only. Written transcripts were not used. The recorded interviews were replayed to aid the analysis process.

Synovate started the recruitment process on 29th June 2009 and interviewing was completed on 11th September 2009.

During the recruitment process women were asked about their current and previous smoking habits, and what role pregnancy played in the current smoking habits, i.e. whether they had stopped due to a pregnancy, whether they had stopped but subsequently lapsed or relapsed.

The final sample was 30 women, split as follows:

- Pregnant women currently smoking (n=8)
- Pregnant women who became ex-smokers in response to their pregnancy or because they intended to become pregnant (n=9)
- Non-pregnant women who smoke and do not have children (n=4)
- Non-pregnant ex-smokers – have children and quit during recent pregnancy (n=5)
- Non-pregnant smokers – have children and quit during recent pregnancy but started again (n=4).

2.2 Smoking attitudes and experiences

Knowing the target audience

The adverse health effects caused by smoking are recognised and understood by almost all of the women who participated in the study. Their knowledge varies from general acknowledgment of health risks through to more detailed understanding of the risks of heart problems and cancer. Smokers and ex-smokers alike describe the practice of smoking as being dirty and are, in some cases, quite disgusted by the smells and staining of teeth and fingers that occurs.

For highly addicted women withdrawal effects can be unpleasant and difficult to deal with, while others can give up with minimal physical and emotional disruption. The addiction can take the form of a well-established habit or social behaviour which, again, brings challenges to those who desire to quit.

The conflict that occurs between the need to smoke and the desire to stop is apparent among these women and places them alongside other smokers and ex-smokers in general in regard to their experiences and attitudes to smoking. However, their role as a mother creates an additional dimension to the situation by introducing their responsibility for the wellbeing of their child into the equation.

The impact of pregnancy on smoking

Pregnancy brings physical and emotional challenges to women that can impact on smoking behaviour in a number of ways.

In some cases women become physically averse to smoking. The effects of morning sickness make smoking less enjoyable and this helps to make stopping a natural event. However, for women who smoke for social reasons or as a stress reliever, the tendency to fall back on old behaviour is high and, in some cases, is actually a planned event for after the birth.

The responsibility towards a new life can be a powerful motivator. It prompts women who have previously considered quitting into taking that step, and it motivates women who have previously ignored the possible effects of smoking on their own health. Women who care little for their own health and wellbeing can be passionately protective of the health of their unborn babies.

The emotional aspects of pregnancy can strengthen the desire to smoke. Women who feel they lose some sense of 'self' may consider smoking to be an expression of themselves as an individual person rather than a mother. In situations where women have had to change a wide range of behaviours including drinking, working, and socialising, their smoking may be considered as something they can easily retain.

During pregnancy women can receive a lot of attention and advice from friends, family, and healthcare professionals. This advice does not always help women to become more motivated to stop smoking. Respected mother figures in the family may be able to present a strong case for continuing to smoke by showing that other children born to smoking women have been happy and healthy. This type of situation is particularly evident among some of the Māori women who participated in the study. This social pressure, or 'auntie-syndrome', can provide women with a degree of justification to continue their smoking behaviour.

For some women pregnancy can bring new levels of stress into their lives, and the need to smoke can be even stronger. If smoking is perceived as a stress reliever, then dealing with the additional stress makes pregnancy a difficult time to break the smoking habit.

Women who participated in the study know that smoking is bad for their unborn child. It is clear that many pregnant women who smoke struggle with feelings of guilt and embarrassment at their inability to stop. The ability to avoid facing the possible consequences of smoking while pregnant allows women to continue their behaviour. The challenge is to make them accept the possible consequences and to translate that into positive action by delivering just the right kind of motivation.

Current and previously pregnant women in the study discuss their strong feelings of protectiveness towards their unborn child. While some women have already managed to translate this instinctive protectiveness into a successful quit attempt, others have struggled and failed to maintain a smoke-free pregnancy. Pregnant women who continue to smoke *want* to stop for the health of their baby, they understand that smoking can damage their child, but they either successfully push it away from their minds or look to others for reassurance that actually everything will turn out well for them.

Motivation for quitting

Women who currently smoke have not acted on personal health warnings or knowledge of the risk of smoking. Even women who have given up smoking due to pregnancy did not act out of a sense of personal self preservation but were prompted to change for their pregnancy. When smokers become pregnant, they do not exhibit heightened awareness or concerns over their own health, but their position changes because of their sense of responsibility to the baby that they carry and as a response to their role as a mother. The health of their baby is paramount in motivating them to stop smoking.

The advice of others can seriously reduce the motivation to quit smoking. Women who have been told that stopping smoking could be bad for their child use their motivation for a healthy child to justify their continuing smoking behaviour. Women in the study give examples of this type of advice which was received from family members or from a healthcare professional.

While the outcome of this advice is negative in relation to smoking behaviour, the role of the motivation of a healthy baby is the same.

Successful quit attempts and identification of barriers

Ex-smokers describe the different ways in which they approached the desire to stop smoking and the different ways their bodies responded to the change in behaviour.

Some women were able to stop immediately and not have another cigarette at all – sometimes described as the ‘cold-turkey’ approach. Women who succeeded in this way were often very close to stopping anyway, before pregnancy, and responded well to the final push created by additional responsibility for the health of their baby. These women are also less likely to have experienced strong physical reactions, or withdrawal symptoms, and this aided their attempts. Women who succeeded in this way sometimes describe their experience as being really easy.

Having a high level of physical addiction or a pattern of habitual smoking behaviour that has been established over a long period of time can be important barriers to stopping smoking. While support from family or friends can play a role in overcoming these barriers, most women are adamant that smoking is a personal decision that they need to deal with themselves. At a time when women may be feeling somewhat less in control of their lives, being pushed by others to change behaviour can be interpreted as interference.

Key barriers to quitting

There are a wide range of barriers to attempting to quit or to successfully completing a quit attempt. Women describe these barriers as:

- **Social** – when people are smoking around the woman. Smoking is about friends, family, and companionship – and maintaining a position in the social circle.
- **Habit** – some women describe having a cigarette in their mouth with no recollection of making an active decision to have it.
- **Deferment** – women feel that smoking is a problem that could be addressed at any time and put it off in the hope that it would get easier.
- **Enjoyment** – some women just want to keep smoking because they enjoy the experience.
- **Stress release** – women who use smoking as a stress reliever.
- **Confidence** – when confidence is low, smoking gives them something to do with their hands.
- **Weight control** – women who believe that they will gain weight if they stop smoking.
- **Drive** – when the desire to quit is not strong enough to create sufficient discipline to follow through on the intention.
- **Emotional factors** – women who describe increased level of irrational emotional responses when they try to stop smoking.
- **Addiction** – the physical and emotional response effects of withdrawal are too strong for some women.
- **Denial** – some women reassure themselves by thinking that stopping smoking is effective only if done early, while others refuse to completely acknowledge the harm that they are doing.
- **Comfort** – when so many things around them are changing, including their own bodies, it is difficult to manage without the continuity and comfort provided by smoking.
- **Personal space** – smoking behaviour gives some women an excuse to step aside and take some time out for themselves.

Reasons for lapsing and relapsing

Women who continue to smoke but who have attempted to stop describe the factors that contribute to their lack of success. They include:

- **Stress** – situations where stress levels increase, including a death in the family or relationship break-up, kids becoming too much to deal with.
- **Emotional pressure** – situations where the emotional side effects caused by not smoking become too difficult for women to cope with.
- **Boredom** – when women find themselves with little to do, the lack of distraction and additional time on their hands draw them back into smoking.
- **Weight gain** – weight gain is difficult for some women to deal with and they feel that returning to smoking will help with this.
- **Denial** – believing that the pregnancy is far along enough to safely return to smoking, or that after the birth there is no further need to abstain.
- **Social** – when women feel on the outside of the family circle or in social situations; women who feel that it was time to reclaim their lives as an individual.

Reviewing results from women in subgroups

Māori women are more likely to discuss smoking as part of their social norm, often in conjunction with drinking behaviour. They feel that this makes it more difficult for them to stop. Women in this group also present a more fatalistic approach to their health, acknowledging that lower life expectancy is an accepted fact and that attempting to make changes is futile.

Results from Pacific women who participated in the study show that the family group is important in advising women on their smoking behaviour, but that it can be both positive and negative, either supporting a non-smoking stance or encouraging smoking.

Women who have smoked for a long time are often older. For these women the behaviour is well established, and physical dependency plays a big part of their smoking experiences. Older women are also more likely to have had other children and use these healthy children as examples of why it is not really necessary to stop smoking for the current pregnancy or subsequent pregnancies.

2.3 Motivational messages

This section examines responses of the women to types of messages that will and will not work to encourage women to think about a quit attempt or to try to quit smoking.

Spontaneous generation of quit messages (ex-smokers)

Women who had stopped smoking during pregnancy themselves were asked to spontaneously discuss possible messages that would encourage other women towards a quit attempt.

Without any specific stimulus or direction women found it difficult to generate their own messages. However, just under half of the ex-smokers did contribute their thoughts. Two key themes arose from the discussions:

1. The lack of choice the baby has
2. A single specific graphic effect or image on the baby showing the harm from smoking.

Women believe that the key to a successful message is ensuring that it is clearly aimed directly at the target group – pregnant women. They believe that a general quit smoking campaign will not be as effective as a specifically targeted approach. The women acknowledge that they have stopped smoking in response to pregnancy or pending pregnancy, and that they have not previously responded to quit campaigns. The women describe the need to clearly link the smoking behaviour with potential harm caused to the unborn child in order to prompt a quit attempt.

The process to identify message communications

A range of messages were presented to the women and they were asked to consider the motivational strength of each one in relation to encouraging women to stop smoking. Thirty-three messages were shown to each of the 30 women who participated in the study. The aim of this exercise was to tease out individual dynamics and key themes from the different types of messages.

Powerful themes for motivational messages

The most powerful themes for messages are:

1. Messages that focus on the **health and the wellbeing of the baby** rather than the mother

Messages that are focused on the health of the mother have less impact than those that bring the welfare of the unborn child to the fore. Many women have already rejected, or failed to act on, personal health messages designed to encourage quit attempts, and are adept at pushing these warnings or encouragements aside. Tapping into the emotional connection that a pregnant woman has with her child gives power to the message.

The women describe the most motivational messages as those that force the mother to confront the consequences of her actions and acknowledge that while the mother may choose to smoke, the baby has no choice at all. Messages that focus on the baby introduce a powerful leverage point that can translate love for the baby into the desire to make the right choices for him or her.

Examples: ***‘when you are smoking your baby smokes too’ OR
‘toxins from smoking are passed through the placenta to your baby / fetus’***

2. Messages that focus on showing **specific and biological harm to the baby**

Women in the study describe the strong motivational power of messages that clearly indicate what smoking is doing to the baby. Messages that focus on specific and biological harm to the baby have motivational power because they can combine single images or concerns with a direct and explicit outcome. This type of message creates a direct link from the smoking behaviour of the mother to the harm inflicted on the child. When the adverse outcome is both tangible and believable, the women cannot so easily resort to denial as a barrier to changing their behaviour.

Messages that focus the women on specific harm and also succeed in making the link to smoking are considered to have strong motivational impact. Using specific references to lungs and breathing works well because women who are smoking or who have quit are familiar with some of the side effects themselves, such as breathlessness and coughing.

Linking smoking during pregnancy with understandable and believable harm to the unborn child is particularly potent for pregnant women and those who have already had children. Pregnant women describe the vulnerability of the unborn child, and those who have already brought babies into the world understand how precious they are to them.

Example: ***‘smoking can harm the development of a baby’s / fetus’s lungs
and make it hard for them to breathe’***

3. Messages that are **immediate and show direct impact on the baby**

Messages that focus on the immediate and direct impact on the baby are considered to be highly motivational. Women do respond to future-oriented messages (such as *'if you quit, imagine your baby growing up as a healthy happy child'*), but the motivational power of messages that focus on what could be happening to the unborn child right now is much stronger. The presentation of undisputable facts that link their behaviour to harm to the child encourages women to confront the consequences of their actions and make the best decisions.

Example: ***'smoking restricts the amount of oxygen your baby / fetus is getting'***

4. Messages that **resist argument and contradiction**

Highly motivational messages are successful because they clearly communicate the adverse consequences of smoking while pregnant in a definite and irrevocable manner. They do not suggest or intimate that a problem **might** occur but state clearly that this **will** or **does happen**. This suggests that when a message creates an opportunity to infer that smoking harms only some babies or only creates problems under circumstances, then women can grasp this as a reason why it is acceptable to continue to smoke. In order to successfully motivate intent to change smoking behaviour, a message needs to be strong enough to stand up to any contradiction offered by family and friends. It can then work against any 'myths' that the mother may be subjected to.

When a message succeeds in communicating an irrefutable fact in a way that suggests an immediate impact on the baby, then it is motivational on more than one level.

Example: ***'toxins from smoking are passed through the placenta to your baby / fetus'***

Weaker themes for motivational messages

Less powerful themes for messages are:

1. Messages that offer an alternative to action

Women in the study feel that messages that talk about the timing of a quit attempt in pregnancy might be construed as an opportunity to postpone the change in behaviour. This suggests that on their own these types of messages may mislead women into thinking that they can afford to delay their quit attempt. Messages with these types of theme will need additional information to counteract this conclusion. The messages will need to include clear explanation of what is happening to the baby as a result of the mother smoking at each stage of pregnancy to avoid any misinterpretation.

Women in the study feel that women who are smoking while pregnant may think about stopping at a more advanced stage of their pregnancy, but that they will be less likely to take that action right now. This indicates that messages of this type may work well at drawing attention to the need for a change in behaviour without creating a strong motivational desire to make the change.

Example: ***'it is better for your baby's / fetus's health to quit part way through your pregnancy than not at all'***

2. Messages that are judgmental

Women who are pregnant and smoking often describe very strong feelings of guilt because they were aware that their actions are bad for the health and development of their unborn child. Women who feel this way also display a high level of sensitivity to being judged by others. Even among women who have successfully stopped smoking the feeling is that their actions are not anyone else's business.

Women also voice their opinion that other people should not judge them because they do not know all the circumstances or how hard a woman may have tried to stop, and the difficulties she may have encountered in the process.

The sensitivity to this type of message is particularly apparent among women who may already be feeling marginalised due to ethnicity or economic disadvantage.

Overall the women feel that smoking is a personal decision that they have to come to themselves, and using a judgmental type of message does not motivate them at all. The guilt that women feel has the power to motivate change, but has to be translated into action as an expression of their own personal choice.

Example: ***'family members / friends / people important to you disapprove of your smoking during pregnancy'***

3. Messages that lack credibility

Women in the study describe much stronger feelings of motivation to quit smoking when the information provided by the message is credible.

During pregnancy women receive a lot of different types of advice from healthcare professionals, friends, and family. Some of the information may be contradictory or confusing, so women have to try to decide for themselves which sources are reliable and what information is true. Thus motivational quit smoking messages have to be sufficiently credible to convince the women and, in some cases, to counteract contradictory advice that they may be receiving from others.

When women read messages that fail to attain credibility, they talk about examples or situations that could refute the claims made. For example, a woman who smoked during previous pregnancies and had strong healthy babies may argue that smoking during pregnancy does not result in low birth-weight infants.

Similarly, women will just not believe some of the information presented in the messages and do not consider them to be motivational.

Example: ***'you are far more likely to have a premature or low birth weight baby if you smoke'***

4. Messages that lack relevance

For a message to create a motivational response, it has to exhibit some kind of relevance to the woman or her situation. Women in the study sometimes feel that the content of a message has failed to resonate with them, missing the point by focusing on aspects that do not matter to them. When the message presents facts that are just not important to them, it fails to create any sense of motivation to stop smoking. For example, messages that suggest that other people will look favourably on the mother if they stop smoking fail to connect. Women insist that the decision to stop comes from within and is something they do, or might do, for the health and wellbeing of their baby and not as a way of pleasing others.

Most women in the study do not feel that saving money is a strong motivator to stop smoking. For most of the women the other factors that drive them to smoke outweigh the financial considerations. Women do not describe messages that include a reference to saving money by quitting as motivating them to stop smoking. Women who have successfully quit smoking refer to the money they saved as a benefit rather than an initial motivator.

Example: ***'if you quit smoking you are showing everyone what a great mother you are'***

5. Indirect or less specific messages

Women react quite favourably to messages that take a more lightweight approach, but they are less likely to consider them as strong enough to motivate a quit attempt. Messages that are considered in this way have the theme of the baby's start to life, which women sometimes describe as being more appropriate in motivating a woman to stop smoking in preparation for a planned pregnancy.

Messages that suggest that even low levels of smoking are harmful are found to be slightly confusing, with women wondering why the message is not simply that all smoking is harmful.

Reactions from the women in the study show that messages which do not include clear and specific information about the harm that smoking inflicts on the unborn child fail to create a strong motivation to stop.

When messages take a less direct route in reaching the motivational power that comes from the mother's desire to have a healthy baby, they are weaker and less successful. While lacking the strength to motivate, the messages are quite well received by the women in the study and could have some merit if applied in a support role to other more direct communications.

Example: ***'give your baby a smoke-free start to life'***

Subgroup analysis

There are generally small differences in subgroups in terms of the key messages and themes they relate to. Message themes that are considered to be highly motivational perform across a wide range of women. The differences in the reactions of women in different subgroups tend to take the form of a stronger or weaker strength of feeling.

Ethnicity

Māori and Pacific women are particularly motivated by messages that linked smoking to cot death and those that suggest that their baby will have breathing problems if the pregnant woman smokes. Māori women did not react well to message themes that suggested smoking during pregnancy is not normal or that people who did not support their quit attempts were not true friends. This reaction reflects the way that smoking has become an accepted part of life for some Māori women.

Pregnancy status

Pregnant women are similar to other women in study in their response to the message themes. However, they are particularly motivated by messages that focus on lung development and breathing problems caused by smoking during pregnancy. Women who are not pregnant but who have already have children respond well to the motivational aspects of messages that suggest that smoking during pregnancy increases the risk of cot death.

Women who smoke but are not pregnant and have not started their family yet are less likely to respond to the same types of message themes. The strength of messages that focus on the baby and the specific harm that smoking does to the unborn child is weakened as the women cannot envisage the unborn child in the same way. However, there is some suggestion the messages that refer to the womb as the start to the baby's life have some motivational value to this group of women.

Smoking status

Women who smoke respond to the motivational aspects of message themes that focus on the specific harm that smoking during pregnancy does to the baby. They are also motivated by messages that highlight the harm as being related to breathing either due to impaired lung development or restriction of oxygen. Women who smoke also react to the suggestion that they are passing toxins on to their unborn child and that smoking during pregnancy increases the incidence of cot death.

2.4 Message tone and style

Women in the study were asked not only to consider the content of the different messages, but also to identify the most successful tone and style to motivate pregnant women to attempt to quit smoking. They were asked to think about the type of delivery that would really bring out the motivational aspects of the message themes. This included use of particular words, people, and images, as well as the best delivery channel.

Initially the discussion explored the women's unprompted views. These were then explored further by introducing pictures from different social marketing campaigns (including quit smoking) for additional discussion.

The women's views show that they consider the act of smoking to be a very serious issue. Among pregnant women still smoking, and among those who have successfully managed to stop, the potential to cause damage to the child through smoking is considered grave. They believe that the tone and style of messages need to reflect this if they are going to succeed in motivating a change in smoking behaviour. This belief is consistently held across the subgroups of women who participated in the study.

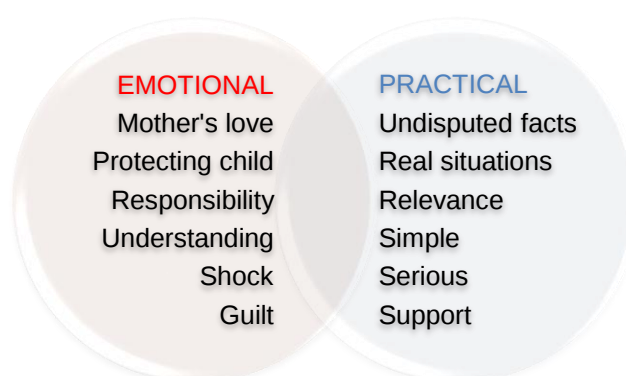
The tone and style for messages that women feel could most successfully motivate an attempt to quit smoking are described as:

- **Serious and factual**, blunt and to the point, delivering hard, undisputable facts
- **Personal responsibility**, clearly showing the responsibility of the woman regarding the health of her baby and that the woman is making her own personal decision
- **Graphic**, sufficiently shocking and attention-grabbing to make women take notice and prevent them from denial
- **Simple**, can be taken in at a glance, simple and straightforward
- **Authentic**, able to be associated with real life, using situations that women can imagine themselves into, things that could happen to them presented in words that they might use themselves

- **Relevant**, sufficiently differentiated from general 'quit smoking' campaigns by showing clear links to pregnancy. Including a baby in the visual stimulus is key in keeping the message tightly associated with the pregnant woman and clearly highlighting the reality of the situation – that the baby is the one to suffer.

Linking emotional and rational factors

For a campaign to succeed in successfully motivating pregnant women to stop smoking, it must connect at an emotional level and a rational level.



Linking the strength of maternal instincts to the undisputable facts can create an emotional response strong enough to motivate action and overcome barriers to stopping smoking.

The more closely the campaign links into the mothering instincts of the mother through showing harm and damage, the stronger the emotional response from the mother will be.

The women in the study are clear about their beliefs that graphic imagery is needed to shock smoking pregnant women of the denial. However, the line between being graphic enough to attract attention and being so shocking as to cause women to shy away, is fine. An example of this is the use of very graphic images on cigarette packs. Some women say they will buy a different pack or turn the pack into a position where they cannot see it. In the case of smoking in pregnancy, there is an opportunity to link the protective instincts of the mother with the harm caused to the child by using images that have emotional content too.

When asked to consider the best type of person to deliver a strong motivational message to pregnant women who smoke, women feel that a female figure will be more acceptable than a male. If the message is to be delivered by someone, that person has to demonstrate high levels of understanding, and women often feel that this can be done only by someone who is, or may have been, in similar situations to themselves.

Women describe the benefits of using an everyday woman, someone who could actually be just like them. Extending this relevance into real life situations or documentary style representations is also described as a way of creating a good environment to deliver a motivational message. Messages delivery works best when the person generates a sense that *'that could be me'* and when the situation says, *'that could happen to me'*.

Situations or settings that bring the message right into the women's lives could be used as an alternative to employing a very graphic or shocking approach. In this situation the portrayal of serious and negative health outcomes in ways that leave little room for doubt that this could happen to their babies would have its very own sharp impact.

The women in the study briefly consider what may be the best delivery channel for motivational messages. They mention that messages can be delivered using posters in areas where women are often visiting or waiting, like bus shelters, healthcare waiting rooms, and other public places like backs of buses, Plunket rooms, and shopping malls. Women feel that posters in healthcare waiting rooms should be supported by pamphlets providing more information.

The use of social networking sites such as Facebook and Bebo is also mentioned as a very good means of delivering the motivational messages. Magazines are also suggested as a good way of communicating with pregnant women who smoke.

2.5 Conclusions

Pregnancy brings a range of physical and emotional challenges to women, and when the pregnant woman is a smoker, she faces additional challenges. At a time of high emotional, physical, and practical changes in her life, a pregnant woman who smokes has to balance her own needs and preferences against those of her unborn child.

While women may experience a range of different reactions and outcomes to their quit attempt, they are bound by a common desire to do what is right for the health of the child. For those who fail in their attempts to quit smoking, or who feel insufficiently driven to attempt to quit, the sense of guilt is very strong. Women who are adept at putting thoughts of the damage that smoking does to their baby to the back of their minds continue to smoke but carry the guilt.

Women who continue to smoke while pregnant may also feel a degree of embarrassment at continuing a behaviour that is frowned upon by others, but this in itself does not provide sufficient motivation to stop. Among pregnant women who smoke, and those who have successfully stopped, there are strong feelings that this is an individual problem – something that the woman has to deal with herself. Often women are judging themselves very harshly and do not respond well to feeling judged by others.

With strong evidence that women in the study know that smoking is bad for the health of the unborn child, the focus for a campaign to encourage women to quit smoking is on making women face the consequences of their actions. Pregnant women recognise that they do hide from the facts, and that strong messages are needed to break through that barrier.

Successful motivational messages have to be unequivocal – simple, realistic, and clearly telling the mother exactly what she is doing to her child. They need to be communicated in ways that demonstrate relevance to women, by being delivered by a woman who is considered to be either '*a woman just like me*' or in a situation or setting that women identify with – '*that could happen to me too*'.

For pregnant smokers messages are most motivational when they specifically state the actual harm that is being done to the child by smoking, when they are delivered in serious and factual tones, and when they are strong enough to overcome the women's resistance. Messages that focus on the women's desire to be a good mother and to give her baby the best possible start are also motivational. These messages bring together the emotional impact of strong maternal instincts and the practical impact of facts that cannot be refuted.

Messages that successfully bring these two elements together have universal strength across all types of women who are pregnant or already have babies, regardless of ethnicity, age, socio-economic levels, or smoking status.

Motivating women who smoke to make a quit attempt while they are in the pre-pregnancy stage is more difficult. Creating a sense of relevance through the prospect of a future pregnancy is likely to be extremely hard. None of the message themes covered in this study are considered to be strong enough to motivate women in this category.

In terms of motivation to make a quit attempt, most of the social environment messages do not perform particularly well. However, while they are identified as less motivational, there is a sense that they do have a role to play in helping the smoker take the step, or in making the attempt successful. The decision to make the attempt is definitely a personal one, but having support from family and friends can help to translate the intent into action. An example of this type of message is ***'friends / family can help you quit by keeping smoking away from you'***.

2.6 Recommendations

The recommended style for a campaign aimed at motivating pregnant women to make a quit attempt is one that communicates a clear and undeniable message that smoking while pregnant causes immediate physical harm to the baby.

Examples of this drawn from the stimulus used in the study are as follows:

When you smoke, your baby / foetus is smoking too.

- This message works well because it provides a link between what the mother is doing (when you smoke) and what happens to the baby (your baby smokes too). With good levels of understanding about the bad effects of smoking on the woman and the baby, this message clearly tells the mother that this is something she is doing – creating a sense of personal responsibility for the health of her baby. It also communicates the lack of choice that the baby has. It is factual and not delivered in a judgemental way. It can draw on the underlying feelings of guilt that the mother feels regarding her smoking behaviour and her strong desire to protect her child. The impact is immediate, it is happening right now, thus cannot be disputed. It demands immediate action.

Smoking can harm the development of a baby's / foetus's lungs and make it hard for them to breathe.

- This message uses the well-known effects of smoking on the lungs to create a scenario that pregnant women who smoke will be able to believe. It has a ring of truth to it because they already have an understanding of the effects of smoking on breathing, either from first-hand experience or through the communication of general quit smoking campaigns. Women with this experience can identify with this type of harm, and their maternal instincts tell them that this is not something they want to inflict on their baby. It is hard to refute when they are already likely to have knowledge around the impacts of smoking on breathing. This message is described as motivational by women who are smoking while pregnant and by those who have already had their babies.

The message theme that has the greatest impact for women post-pregnancy ties smoking with cot death. For women who have already brought babies into the world, especially if they currently have newborn babies, the prospect of cot death is chilling. To suggest that smoking while pregnant can increase the risk is very powerful indeed. This theme is represented in the study by the message ***'smoking increases the chance of cot death'***.

Other motivational messages in the theme of showing physical impact on baby also warrant further consideration. They are:

- *Low birth weight is a leading cause of infant death and complications.*
- *Toxins from smoking are passed through the placenta to your baby / fetus.*
- *Smoking restricts the amount of oxygen your baby / fetus is getting.*

These message themes will be most successful in motivating women when the style and tone of delivery are serious and factual, blunt and to the point; the use of hard, undisputable facts delivered by a woman who is ordinary and has sufficient relevance to the target group of women, or facts presented in situations that the women can easily relate to.

The campaign could benefit from showing real women in real situations talking about their experiences of quitting smoking while pregnant.

The communication needs to focus on the woman as the person who is responsible for her baby, and that her actions have direct and immediate impact on it.

Strong, graphic imagery is needed to illustrate the messages. A degree of shock value is required to reach women who have successfully pushed the consequences of their actions to the back of their minds. The messages and images need to be able to be delivered quickly and simply, to be able to be taken in at a glance.

The use of visual images of the baby works to differentiate this campaign from general quit smoking communications, and is an excellent way of using the power of maternal instinct to drive motivation.

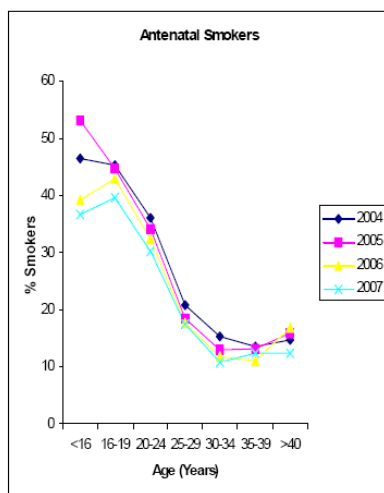
Grounding the campaign in reality is vital. This could be achieved through showing examples of the real effects of smoking on the baby or by presenting real situations and real people where outcomes from smoking or quitting smoking are shown.

3 Research Overview

3.1 Background

In 2008, the smoking rate among people aged 15 years and over was 21%.¹ While this rate reflects a continuing decline over the past 25 years, the Ministry of Health is continuing to work to reduce smoking in New Zealand. Smoking among pregnant women and women in their child-bearing years has been identified by the Ministry of Health as a key area of concern with serious negative health outcomes for women and their babies.

In New Zealand around one-quarter of women of child-bearing age are current smokers.² The New Zealand midwifery database shows that in 2007, just over 19% of pregnant women were smokers when they registered with their midwives. This data also shows that smoking during pregnancy reaches 45.3% among Māori women and 15.7% among Pacific women. The rate for Paheka women was 14.2%. This higher prevalence among Māori and Pacific women identifies them as priority groups for communications relating to smoking during pregnancy.



Smoking during pregnancy among younger women is also shown to be more prevalent. The data shows that in 2007 the highest rates of smoking during pregnancy were among women in aged 19 or less (around 35 – 40%). Levels were lower for the 20 – 24 age group, but at around 30% they were still a cause for serious concern. Prevalence of smoking in pregnancy falls steadily among older women but begins to rise slightly again in those aged 30 years or more.

¹Ministry of Health (2009). *Tobacco Trends 2008: A brief update of tobacco use in New Zealand*. Wellington: New Zealand: Ministry of Health

²Ministry of Health (2008). *ABC strategy for smoking cessation: Framework and work programme* (draft). New Zealand: Ministry of Health.

Other factors have been linked to the prevalence of smoking while pregnant and the likelihood of quitting during pregnancy including:

- Smoking status of partner
- Education
- Low income / unemployment / low socio-economic status / social disadvantage
- Single-parent status
- Unplanned pregnancy
- Number of pregnancies: more likely to quit smoking in first pregnancy.³

The role of the Health Sponsorship Council

The Ministry of Health has commissioned the Health Sponsorship Council (HSC) to develop a social marketing programme aimed at increasing and supporting quit attempts during pregnancy.

This research project is the first stage of a three-stage approach undertaken by HSC. The first stage will use qualitative research to explore the motivations and barriers for quitting among smokers who are pregnant and women smokers of child-bearing age. This research will provide the information required to develop a creative brief for the social marketing programme, with the final stage being the testing of the concepts resulting from that brief.

3.2 Objectives of the research

The social marketing framework that the HSC will use for the overall project is the **locate, communicate, motivate** model. This model proposes that for a particular target group, in this case – female smokers who are pregnant or of child-bearing age, research needs to identify commonalities across this segment in terms of how to locate people within the segment, how to communicate with those people, and how to motivate them. This information will serve the development and execution of a marketing plan in terms of where the advertising / messages will be placed (locate), what creative elements will capture the attention of the target audience (communicate), and what messages will best achieve the desired behaviour change among the target audience (motivate).

The overall objective of this project is:

*To establish messages that may motivate **women of child-bearing age who smoke** and **pregnant women who smoke** to make a quit attempt, to explore ways to best communicate these messages.*

³ Ministry of Health (2008). *ABC strategy for smoking cessation: Framework and work programme* (draft). New Zealand: Ministry of Health.

A sub-objective of this project is:

To explore and identify the most appropriate communication channels in which to reach these women.

Understanding the client group and identifying the research sample

The client groups for the HSC social marketing initiative is **women smokers of child-bearing age** (defined as 15 to 39 years) and **smokers who are pregnant**. Understanding the construction of the client group was critical in the design of the sample for this research project.

The following figures form the basis for the main sample categories in this research:

In 2006, 26 – 29% of women in their child-bearing years were smoking.⁴ This increased to 39 – 61% among Māori women, and 27 – 47% among Pacific women (compared to 22 – 27% among Pakeha women). Similarly, there were higher levels of smoking during pregnancy among Māori women (45%) and Pacific women (16%) compared to 14% among Pakeha women.

3.3 Design

This research project was designed to use a qualitative approach in the form of in-depth interviews with women in the core target groups.

The primary approach was to conduct face-to-face in-depth interviews at a central location. However, in the interests of including the views of a wide range of women, a flexible approach to the actual location was adopted, i.e. in-home, local café, or meeting room, and in two special cases, by telephone. This allowed the research to reach as many women in the client group as possible.

Women were told at the time of recruitment screening that the interview would be conducted in English, and the offer of a translator or an attending support person was made. There were no requests for a translator to be present, and two women requested the presence of a support person.

The objective was to reach a total of 34 in-depth interviews of an average one-hour length for this study. Each interview was audio-recorded for analysis purposes only. Written transcripts were not used, but notes were taken by the researcher during the interview. The recorded interviews were replayed to check that the notes made by the researcher were inclusive and correct.

⁴ Ministry of Health (2007). *New Zealand Smoking Cessation Guidelines*. Wellington: Ministry of Health.

Details of the interview location and use of translators or support people are included in the final sample section of this report.

In conjunction with HSC an analysis framework was created. Information for this framework was collated in the form of a spreadsheet. The information entered into the spreadsheet came from the notes that the researcher made during the interview, and from the replay of the audio recording of the interview. This framework was used as one central file for the key information collected during each interview. The research team used three main methods in their analysis:

- Filtering of the analysis framework to look for trends and patterns across the subgroups
- Verbal discussions of their experiences during the interview based on recollections and notes taken
- Replaying of audio files of the interviews.

Once the detailed analysis had been completed, a report was written by two members of the interviewing team. Each section completed was then reviewed by the other member of the report writing team. On completion the report was proofread by a third member of the wider Synovate team. This person assists the research team but is not directly involved in a research capacity. The draft report was then passed to HSC for review.

A presentation was created in PowerPoint format to highlight key areas of interest and key findings. The presentation was written by the report-writing team and reviewed in the same manner as the report.

Sample design

The sample design was designed to reflect prevalence of smoking during pregnancy cited in the 2007 New Zealand midwifery database as being higher for Māori women (45.3%), for Pacific women (15.7%) and for Pakeha women (14.2%). It also acknowledges the higher rates of smoking during pregnancy among women aged 25 years or less.

The table below outlines the sample frame that was initially recommended.

	Currently Pregnant n=23						Not Currently Pregnant n=11				
	Smokers: Up to 15 Weeks			Smokers: Over 15 Weeks			Smokers: Have no Child		Have Child up to 12 Months Old Aged 15-39		
Age	15- 19	20- 24	25- 39	15- 19	20- 24	25- 39	15-19	20-24	Quit while pregnant & stayed quit	Quit while pregnant but relapsed	TOTALS
Māori	3	2	1	2	1	1	1	1	1	1	14
Pacific	2	1	1	2			1		1	1	9
Pakeha	1	1	1			1	1	1	1	1	8
Asian	1	1	1								3
TOTALS	7	5	4	4	1	2	3	2	3	3	34

The sampling design also took into consideration the following factors:

Quotas

- All have no tertiary qualification (diploma, degree)
- At least 12 to have another smoker in the household
- At least 17 to be low-socio – defined as household income under \$35,000 (based on Nielsen Homescan household income definitions)
- At least five to be single parents
- Currently pregnant – at least 14/23 to be first pregnancy – at least 6/23 to be second or third pregnancy.

Ethnic group prioritisation

When more than one ethnic group was specified, a priority approach was applied, for example:

- Māori and Pacific = Māori
- Māori and Pakeha = Māori
- Pacific and Asian = Pacific
- Pacific and Pakeha = Pacific
- Pakeha and Other = Pakeha.

Geographical spread

The 34 interviews were spread to include a mix of metropolitan and provincial centres.

Initial geographical spread of interviews was as follows:

LOCATION	Greater Auckland	Greater Wellington	Gisborne	Wanganui	Northland
INTERVIEWS	15 Māori 2 Asian 3 Pacific 6 Pakeha 4	7 Pacific 3 Pakeha 4	4 Māori 4	4 Māori 4	4 Māori 4

These areas represented the initial suggested areas of focus, but actual areas were not set until recruitment feedback isolated which areas would provide access to most women in the target groups.

3.4 The recruitment process

This section of the report details the recruitment *process*, describing how the women who participated in the study were located. The *actual* construction of the sample is detailed in the final sample section.

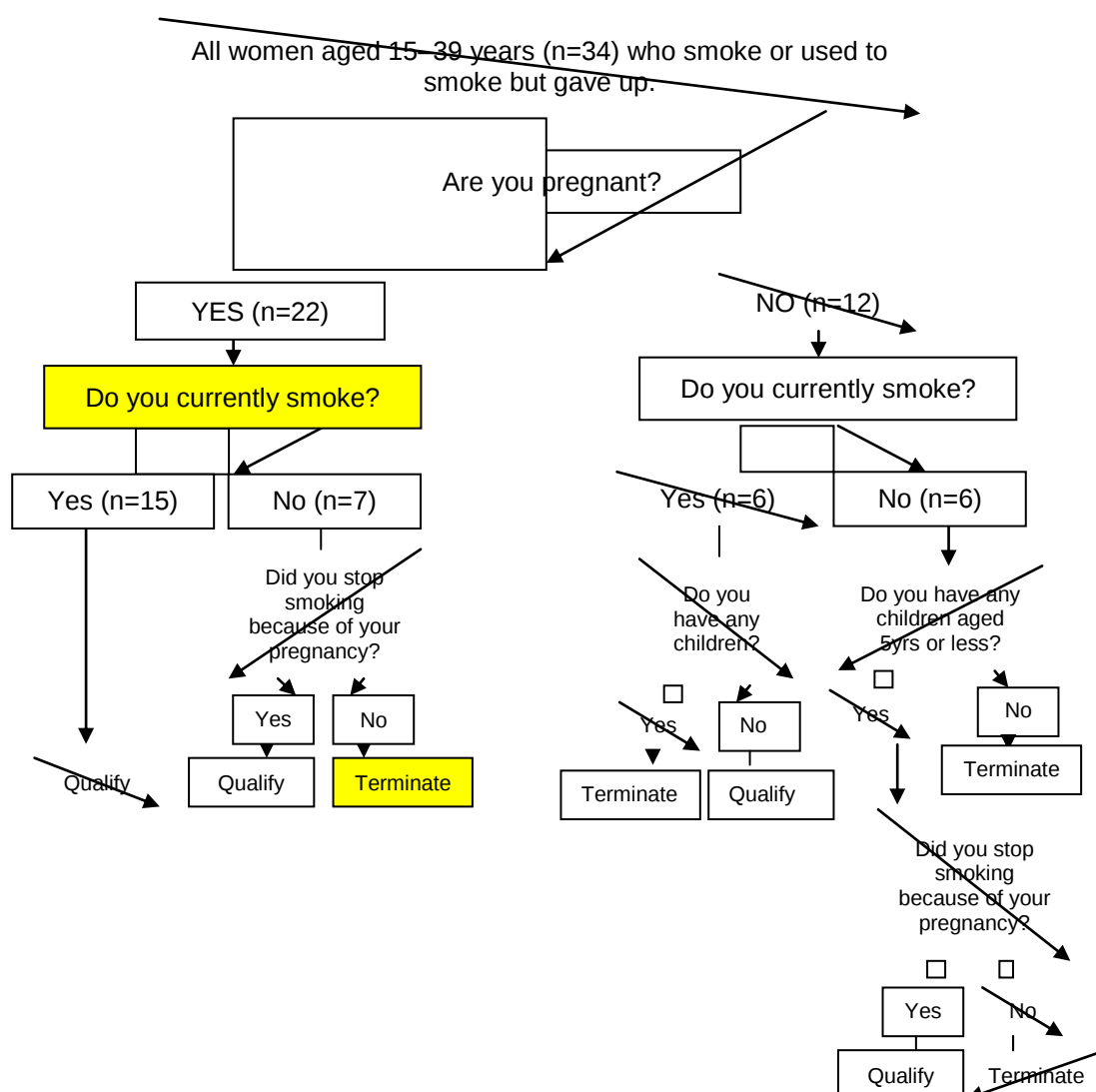
Synovate started the recruitment process on 29th June 2009 and finished on 11th September 2009.

The initial recruitment drive centred on a range of contacts supplied by HSC. HSC placed a notice in the Smokefree Coalition network newsletter with the primary aim of alerting people that this research project had been commissioned and requesting help in locating women in the target market. HSC also provided contact details for the Auckland District Health Board, the Smokefree Coalition website, the Tobacco Free Kore Directory 2009-2010, Auahi Kore, and the New Zealand College of Midwives.

In the first instance, Synovate made contact with each of individuals or organisations supplied. This first stage of recruitment started on Monday 29th June 2009. Overall reaction to the project was positive, with a number of people promising to follow up on leads that could provide access to the required women. After two weeks of pursuing this method, the scope of recruitment was expanded to include the involvement of a professional recruitment agency, Prime Research. On 10th July 2009, any outstanding contacts from the initial recruitment drive were passed to Prime for follow-up, plus the recruitment was expanded into a variety of other leads. These leads included contacting church organisations, pharmacies, medical centres, marae, WINZ, and shops that specialise in baby supplies.

Prime also contacted women on its research panel to see if they qualified for the study. General networking was also undertaken with widespread canvassing of staff at Synovate and Prime to try to access the women. Women who were contacted were also asked to provide details of anyone else they knew who might be willing to participate. As women were contacted and invited to participate in the study, they were also offered the opportunity to bring a support person to the interview with them. All but one woman declined this offer. The one woman who accepted the offer was from Palmerston North and brought a friend as a support person.

The originally proposed sample structure is shown here in flow chart format. To provide a lower socio-economic sample 17 women would have a household income of less than \$35,000, half would have household income under \$60,000, and women with tertiary qualifications would be excluded.



Slow response to the recruitment drive led to a reassessment of the original sample structure. On 20th July 2009, the sample structure was reassessed and is detailed in the following section.

Sample revision (1)

With fewer than anticipated contacts available, the recruitment process could not provide specific individuals to fit the original structure. Discussions between Synovate and HSC led to a revised approach that maintained the most crucial aspects of the sample but allowed the other criteria to fall in a more natural representation of the potential target audience. The main categories relating to pregnancy and smoking were retained, and priority was also given to ensuring sufficient representation of the ethnic groups of interest and the need for an urban / rural / provincial perspective.

In Auckland, it was difficult to find Asian women who were smoking while pregnant or who had smoked during a previous pregnancy. In the 2007 Ministry of Health report, New Zealand Smoking Cessation Guidelines, smoking among Asian women in general was reported as four per cent. Initial reaction from four Asian community organisations that were contacted suggested that smoking during pregnancy was not something that happened in their communities and that if it did occur, they would deal with the problem themselves. For this reason the Asian peoples' quota was removed from the sample at this stage. The revised sample structure is shown here.

		Urban		Rural	Māori	Pacific peoples	Pakeha
	TOTAL	AK / WGTN	Whangarei	Gisborne / New Plymouth / Napier / Hastings	Minimum		
Pregnant & smoking	15	8	1	3 in each of two other areas	3	2	2
Pregnant & non-smoking	7	4	1	1 in each of two other areas	3	2	2
Non-pregnant & smoking (no children)	6	3	1	1 in each of two other areas	3	2	2
Non-pregnant & ex-smoker (quit smoking during a previous pregnancy)	6	3	1	1 in each of two other areas	3	2	2

Other changes to the sample criteria included increasing the household income level from under or over \$35,000 to \$45,000. Specific criteria for other smokers in the household, single parents, and pregnancy stage were removed and allowed to form the natural composition of the sample of women. This revised approach improved the success of the recruitment process, but difficulties still arose.

The pregnant smoking segment proved the hardest to fill particularly for Pacific peoples. Women smoking while pregnant were reluctant to participate in the research, with sensitivity and embarrassment a huge factor in the low response. However, the minimum sample of eight interviews with Pacific women was achieved.

Sample revision (2)

The second revision of the sample was implemented on 4th August 2009. During this revision, the sample criteria were expanded to allow women who were not pregnant but were currently smoking and those who had smoked during previous pregnancies to participate.

The revised sample structure is shown here.

		Urban		Rural	Māori	Pacific peoples	Pakeha
	TOTAL	AK / WGTN	Whangarei	Gisborne / New Plymouth / Napier / Hastings		Minimum	
Pregnant & smoking	15	8	1	3 in each of two other areas	3	2	2
Pregnant & non-smoking	7	4	1	1 in each of two other areas	3	2	2
Non-pregnant & ex-smoker (quit smoking during a previous pregnancy)	6	3	1	1 in each of two other areas	3	2	2

The fourth category was split into two sections:

Preferred criteria

NON-PREGNANT EX- SMOKER SECTION D (i)(Total 6)							
<u>An ex-smoker is someone who is currently NOT smoking.</u>							
<i>All have smoked once a month or more in the past. All have stopped smoking because they were previously pregnant, or planned to become pregnant.</i>							
		Urban	Rural		Māori	Pacific peoples	Pakeha
	TOTAL	AK / WGTN	Whangarei	Gisborne / New Plymouth / Napier / Hastings	Minimum		
Non-pregnant & ex-smoker	6	3	1	1 in each of two other areas	3	2	1

Secondary criteria

NON-PREGNANT SMOKING SECTION D(ii) (Total 6)							
<i>All smoke once a month or more. All have smoked during at least one previous pregnancy.</i>							
		Urban	Rural		Māori	Pacific peoples	Pakeha
	TOTAL	AK / WGTN	Whangarei	Gisborne / New Plymouth / Napier / Hastings	Minimum		
Non-pregnant & smoking	6	3	1	1 in each of two other areas	3	2	1

The education requirement (non-tertiary) was also relaxed only when a woman was considered to be particularly relevant to the study in other ways. Each woman was assessed in conjunction with discussions with HSC.

Final sample assessment

When the number of women successfully recruited reached 27, the content of the sample was reviewed in detail. After discussion with HSC it was decided that the focus for the final interviews should be on reaching a higher number of pregnant women, smokers, and Pacific women.

Two telephone interviews were included in this study. This allowed the research to include the views of women who were not comfortable in a face-to-face setting. The first telephone interview was with a European woman in a farming environment in New Plymouth, and the second was conducted with an Asian woman in Auckland.

The face-to-face interviews were designed to take approximately one hour to complete, and this was considered to be too long for a telephone interview. In conjunction with HSC, it was decided to place slightly less emphasis on general attitudes towards smoking to allow more time to cover the motivational message themes, style, and tone. However, the two women who participated in the telephone interviews were comfortable with the process and the amount of time involved, and were able to cover all the section of the discussion guide.

The interview length was one hour for the first one and 50 minutes for the second one. Both women were emailed a numbered list of messages and a file containing pictures from a range of social marketing campaigns. They were instructed not to open the files until the interviewer instructed them to do so.

The final sample

The final sample was 30 women. Among them eight were pregnant women who were still smoking, and nine were pregnant women who were ex-smokers. In total, 13 non-pregnant women participated in the study. Five were ex-smokers who stopped smoking during a previous pregnancy and had successfully maintained their quit attempt. Four women had stopped smoking during a previous pregnancy but had lapsed or relapsed. The remaining four women were smoking and had not had any children yet.

Thirteen of the 30 women were aged under 25 years, with the youngest being 19 years of age. The views of women aged less than 19 years are not included in this study. Younger women were very sensitive to the issue of smoking while pregnant and were reluctant to participate. Early on in the recruitment process three European women in the 15 – 19 age group were available to participate in the study but did not fit with the desired ethnicity quotas at that stage.

Initial finding from the recruitment process

It was harder to get Pacific women to participate in conversation about smoking in pregnancy. During the recruitment process contacts from Pacific peoples' church and organisations presented a more insular perspective suggesting that issues like smoking in pregnancy are not dealt with or discussed with people outside of their community. At an individual level women are sometimes comfortable talking about the subject in general but shy away from suggestions that they might know someone who was pregnant and smoking, and would be prepared to contribute to the research.

Pregnant women currently smoking (n=8)

A smoker is defined as someone who is currently smoking at least once a month.

They may have tried to stop but are still smoking. This group includes:

- *A lapsed smoker – someone who has tried to stop but is having one or two cigarettes again.*
- *A relapsed smoker – someone who has reverted back to previous smoking behaviour.*
- *A smoker who has cut back on the amount they smoke.*
- *A smoker who plans to quit.*

Ethnicity	Age	Education level	H/hold income	Interview location	Region
Māori	23	NCEA level 2	Under 45K	Central	Urban
Māori	19	School certificate	Under 45K	Central	Urban
European	22	Did not finish school	Under 45K	Central	Urban
Pacific peoples	24	High school	Under 45K	Central	Urban
Māori	26	School certificate	Under 45K	Central	Urban
European	29	Hairdressing certificate	Over 45k	Telephone	Rural / provincial
Pacific peoples	36	Sixth form	Under 45K	Home	Urban
Pacific peoples	44	Te Wananga O Aotearoa	Under 45K	Home	Urban

Two women in this group had previously attempted to stop smoking while pregnant but had not succeeded.

Pregnant women who are ex-smokers (n=9)

A non-smoker is someone who is currently NOT smoking.

All have smoked once a month or more in the past. All have stopped smoking because they are currently pregnant, or planned to become pregnant.

Ethnicity	Age	Education level	H/hold income	Interview location	Region
European	29	School certificate	Under 45K	Home	Urban
Māori	25	School certificate	Over 45k	Central	Urban
European	29	Bursary	Over 45k	Central	Urban
Pacific peoples	25	High school	Over 45k	Central	Urban
Māori	21	School certificate	Under 45K	Central	Urban
European	23	Degree	Under 45K	Central	Urban
European	20	Make-up certificate	Under 45K	Central	Urban
European	23	Business diploma in progress	Over 45K	Home	Urban
Asian	34	Degree	Over 45k	Telephone	Urban

Non-pregnant women who smoke and do not have children (n=4)

A smoker is defined as someone who is currently smoking at least once a month.

They may have tried to stop but are still smoking. This group includes:

- *A lapsed smoker – someone who has tried to stop but is having one or two cigarettes again.*
- *A relapsed smoker – someone who has reverted back to previous smoking behaviour.*
- *A smoker who has cut back on the amount they smoke.*
- *A smoker who plans to quit.*

Ethnicity	Age	Education level	H/hold income	Interview location	Region
Māori	20	University student	Under 45K	Central	Rural / provincial
Māori	26	School certificate	Over 45k	Central	Urban
Pacific peoples	35	Unitech	Under 45K	Central	Urban
Māori	38	Degree	Over 45k	Central	Rural / provincial

Three of the four women in this group had unsuccessfully attempted to quit smoking during a previous pregnancy or had quit during pregnancy and started again.

Non-pregnant ex-smokers – have children and quit during recent pregnancy (n=5)

An ex-smoker is someone who is currently NOT smoking.

All have smoked once a month or more in the past. All have stopped smoking because they were previously pregnant, or planned to become pregnant. This can include women who are not currently lapsed / relapsed, but might have lapsed / relapsed in the past and then quit again.

Ethnicity	Age	Education level	H/hold income	Interview location	Region
Māori	36	High school	Over 45k	Central	Urban
Māori	30	Uni student 1st year	Under 45K	Central	Rural / provincial
European	39	UE	Over 45k	Central	Urban
Māori	29	Bursary	Under 45K	Central	Rural / provincial
Pacific peoples	23	UE	Under 45K	Central	Urban

Non-pregnant smokers – have children and quit during recent pregnancy but started again (n=4)

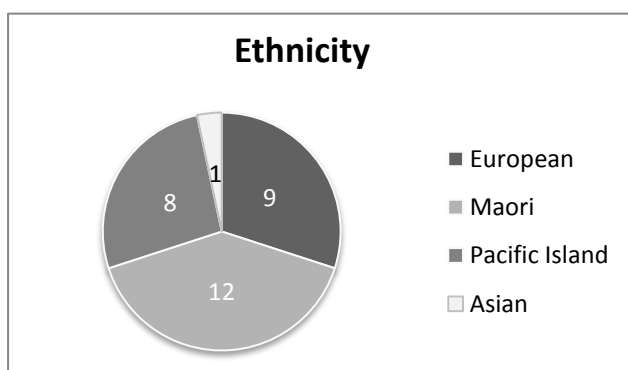
A smoker is defined as someone who is currently smoking at least once a month.

They may have tried to stop but are still smoking. This group includes:

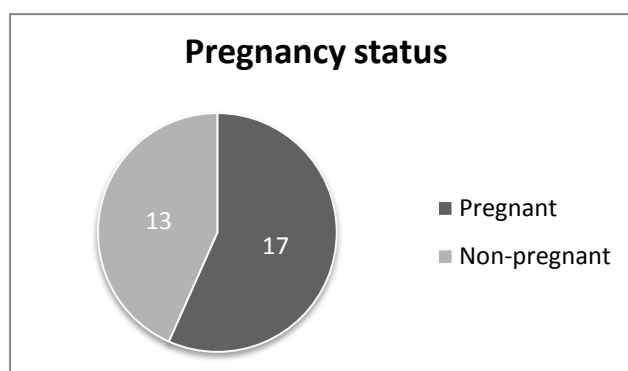
- A *lapsed smoker* – someone who has tried to stop but is having one or two cigarettes again.
- A *relapsed smoker* – someone who has reverted back to previous smoking behaviour.
- A *smoker who has cut back on the amount they smoke*.
- A *smoker who plans to quit*.

Ethnicity	Age	Education level	H/hold income	Interview location	Region
European	28	Polytech Diploma	Over 45k	Prime	Urban
Pacific peoples	21	NCEA level 1	Over 45k	Prime	Urban
Pacific peoples	27	Degree	Under 45K	Prime	Rural / provincial
Māori	37	Did not finish school	Under 45K	Other	Rural / provincial

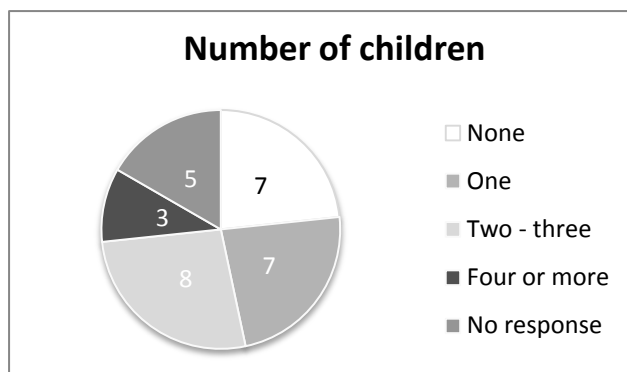
Demographic sample review



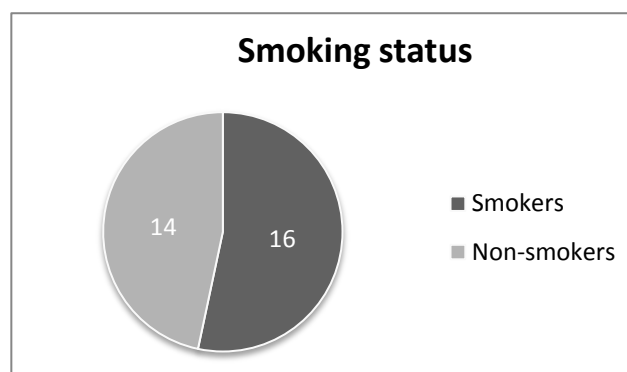
The final sample comprised 12 Māori women, nine European women, eight Pacific women, and one Asian woman.



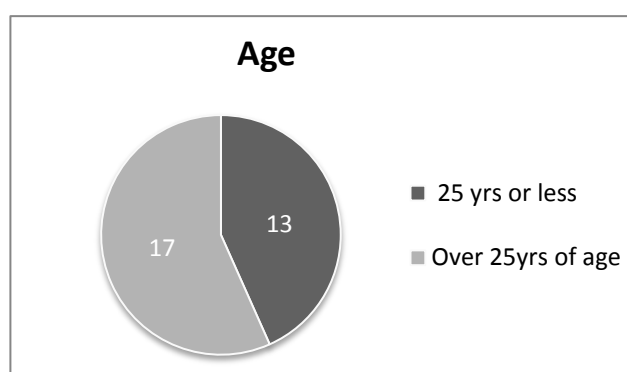
Seventeen of the women who participated in the project were pregnant, the remaining 13 were not.



Seven of the women in the study currently have no children. Eleven have one or two children, with seven having three or more. Five women declined to comment.



Sixteen women are current smokers, 14 are ex-smokers.



Seventeen women are over 25 years of age and 13 are less than 25 years of age. Note that only one woman in the study is under 20 years of age.

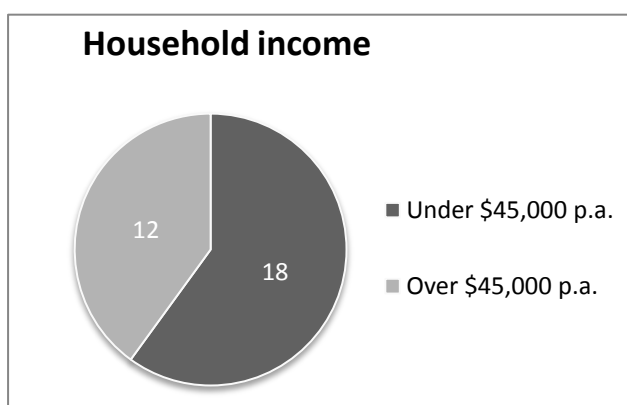
Originally the recruitment focused on recruiting women aged 15 – 19 years, due to the high smoking prevalence in this

subgroup. Despite intensive recruitment efforts only one 19-year-old woman recruited in the 15 – 19 year age group went through to a complete interview. Feedback from recruiters identified this group as especially resistant to participation in this research, a reflection of the sensitivity of the topic.

Also, as mentioned earlier in this report, there were three additional women found in this age group who were willing to participate. These women were European, however, and did not fit with the desired ethnicity quotas at the stage they were recruited in the research.

Age of each participant

25 years or less		Over 25 years of age	
Age	Interviews	Age	Interviews
19	1	26	2
20	2	27	1
21	2	28	1
22	1	29	4
23	4	30	1
24	1	34	1
25	2	35	1
		36	2
		37	1
		38	1
		39	1
		44	1

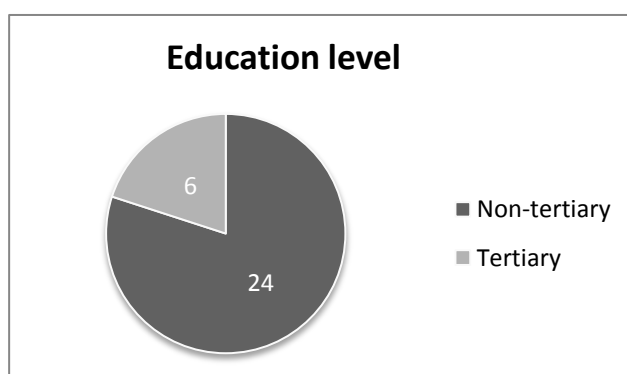


Eighteen women in the study live in households with an income of \$45,000 p.a. or less, with the remaining 12 women living in households with an income above this \$45,000 threshold.

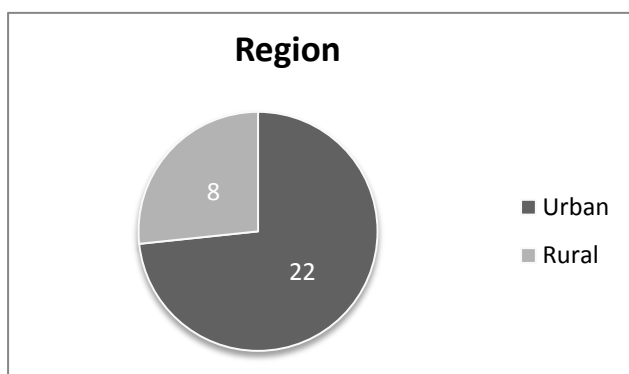
These numbers are in line with the \$60,000 limit set in the

recruitment guide, where at least 17 women had to be earning less than \$60,000. Further details are outlined below.

Four women in the less than \$45,000 p.a. category did not give a specific amount but stated that their income was from a benefit. In the over \$45,000 p.a. category five women stated their household income was \$50,000 p.a., while the remaining seven women gave a figure over \$60,000 p.a.



Just six of the 30 women in the study have a tertiary qualification. This includes women who have completed a University degree or who have a diploma. Women who were in the process of studying at University are not included in the Tertiary qualification category.



Twenty-two women live in urban locations (Auckland and Wellington), with eight coming from rural or provincial locations (Whangarei, Palmerston North, New Plymouth, and Oamaru).

3.5 The interview process and content

Interviews were conducted by three senior researchers with experience in dealing with sensitive topics, health research issues, and different ethnic groups.

The discussion guide was designed in conjunction with HSC. There were four versions each tailored to focus on the specific situation of each group of women. Discussion guides are included in Appendix A in Volume Two of this report.

The guide takes women through their attitudes to smoking and their experiences. The guide is split into four main parts. The first section includes exploration of current smoking habits, previous attempts at quitting, influential events and people in their lives relating to the quitting experience and identifying barriers to quitting among those still smoking.

The second section looks at motivational messages for smoking cessation. The range of prompted message stimuli used is shown in detail in Appendix D in Volume Two of this report. Women who had successfully managed to stop smoking either for a current pregnancy, or during a previous pregnancy, were asked to think of messages which they felt would motivate other women to consider a quit attempt. At this stage the women were not given examples of possible message themes and were encouraged to create their own messages without prompting.

Section three deals with the way in which messages are delivered exploring the optimum tone, style, and mood of messages that motivate quitting smoking. This includes questions around the best person to deliver these messages. Throughout the discussion women were asked to consider whether messages and message delivery would need to be different for pregnant women and for those in the pregnancy-planning stage.

The final section is a profiling questionnaire which shows the range of questions that each participant was asked. These questions help to define the household environment of the woman, including number and ages of people in household and whether anyone else smoked. The questions also help to define the type of media that the women are exposed to and their shopping habits.

3.6 Interpreting this report

Throughout the report, as comments are reported from women, the terminology used is described below:

- Almost all – all the women except 2–3 of them
- The majority – well over half of the women
- A number – about half of the women
- Some – under half of the women but more 6
- A few – 2–5 women.

Throughout this report there are different types of subgroups of women in regard to their smoking behaviour. Through this report women will be referred to as follows:

- Women of child-bearing age who smoke (no children yet)
- Pregnant women who smoke
- Pregnant women ex-smokers (quit while pregnant)
- Ex-smokers not pregnant (quit while pregnant, still quit and have children)
- Smokers with children (not currently pregnant).

Where reference has been made to the age of women, i.e. younger or older women, this relates to women in the study aged up to 30 years (younger) or 30 years and over (older). Researchers decided on this split in analysis as this appeared the point where differences tended to emerge more between older and younger women.

Where there is reference to low-socio households this is in reference to households where household income is under \$35,000. This definition is based on Nielsen Homescan household income definitions.

Through the findings section of this report the authors have attempted to distinguish between opinions and comments made directly by the women and the researchers' interpretations or conclusions drawn from them.

Each section is structured to present the main findings first, followed by a subgroup analysis. The section then finishes with a summary and conclusions.

In terms of subgroup analysis, the sample was constructed to include the views of a variety of women. This was in order to ensure that no subgroups identified to be important were left out of the research. It was also designed to identify, where possible, differences in attitude, and ultimately where adjustments to message, tone, and delivery might be required for an attempt to quit / quit message.

It is important to note this is a qualitative sample, and as such, differences between subgroups are commented on only where there are obvious variations from other subgroups. For true detailed assessment of significant differences between these subgroups a larger scale quantitative research piece would be needed. That method was not appropriate for the key objectives of this research.

4 Smoking Attitudes and Experiences

This section covers the attitudes to smoking during pregnancy and the impact of these attitudes on women's smoking behaviour during pregnancy. This information is designed to set the scene and clarify the environment in which the main findings in later sections are presented.

This section does not look to replicate what has been done in other research or try to be comprehensive as a stand-alone research piece in this area. Its purpose is to create a backdrop against which to present the findings related to key messages for quit and attempt to quit attempts pre- and during pregnancy.

4.1 Attitudes to smoking generally

Women were first asked to describe their current smoking behaviour and their attitudes to smoking.

The majority of the women in this study say they started smoking at school. They talk about it as a behaviour that has become just part of what they do – it is an ingrained behaviour. Generally these women comment that they know the health risks associated with smoking but have continued to do smoke.

Knowledge of health risks

The knowledge of some future negative consequences for themselves as a result of smoking is not a big deterrent for these women. The majority of women say health concerns can be dismissed as something that might happen or something that happens to other people, and are not strong enough to overcome the addiction.

'I know it's not good but I'm not that worried about it – if I want to do something that hurts only myself that's my business'

'I kind of want to give up smoking, I know it's bad, but I really enjoy it'

Some women believe that the health risks associated with smoking are real but do not have a high sense of personal worth or self-preservation. In effect, they do not have a strong sense of concern about their health.

Among some of the Māori women, this resistance to making better choices for their own health comes from a belief that their fate is just inevitable. Their experiences and knowledge of the lower life expectancy among Māori in general create a sense that nothing they do can change what happens to their health. Some then take this a step further and wonder whether the health risks for their baby that are attributed to smoking when pregnant are real and if they are really preventable. In this study, Māori women are more likely than others to view quitting smoking as a potential trigger to adverse side effects for the babies.

'I don't believe smoking affects more than lung-related conditions. After the first couple of years of smoking there is no point giving up as the damage is irreversible anyway'

'I just don't believe there are any health risks to me or my baby'

'I believe going cold turkey is harmful. There's my aunt who was fine until she quit smoking. Six months later she got cancer and a few months after that she was dead. Me and the family believe that if she'd kept smoking, she might not have got the cancer. It was the shock of abrupt quitting that triggered it'

The majority of women can cite a number of negative effects from smoking. Some are able to talk about first-hand experience of the impacts of smoking, with family members and friends experiencing serious negative effects.

'Both my father and now my sister have emphysema'

When asked about the negative effects of smoking, the key ones mentioned by women are:

- Asthma and breathing issues
- Morning cough
- Lack of fitness
- The smell of the smoke (clothes, hands, hair, teeth)
- Wrinkles on the face
- Gum disease / bad breath / ugly teeth
- Lung cancer
- Discolouration of fingers.

Impact of the social setting

The majority of the women in the study who smoke have family and friends who also smoke. Thus a primary reinforcement of smoking is often about fitting in and feeling part of a group in a social setting. Women talk about this being at work, in external social situations or at home. They say it helps make them feel 'cool' or / and part of the crowd, in essence, it creates a sense that they belong. Some women mention it helps them to relax into the moment.

At work, some of the women mention that smoking is part of a way to get down time and socialise. The 'smoko' break gives time out and time to be with other workmates outside the work environment.

When women in the study talk about some of the social aspects of smoking, it is often in conjunction with drinking alcohol. This is especially mentioned among Māori women in the study. It appears women who already feel that their pregnancy and resulting reduction or elimination of drinking have set them apart from their peers may use their smoking behaviour to re-establish their standing as one of the crowd.

'Way to bond with people and meet more people, it strengthens existing social groups'

A few women comment that smokers are simply more sociable and have more interesting conversations.

'The smokers all congregate outside and they seem to have so much fun'

At-home smoking

Smoking at home can be a group or an individual thing, fitting in as part of the crowd or escaping away from the household. For some mothers, going outside to smoke may be one of the few times they have completely to themselves and can be at peace.

Giving relief from stress and taking control back

The majority of the women also talk about using smoking as a reliever for stress. Stressful situations mentioned can range from a simple bad day at work to dealing with conflict or arguments at home.

It is clear talking to the women that smoking gives more control back to the woman, making her feel less pressured and calmer. It doubles as a distraction. The use of smoking as a support during stressful situations presents a big challenge during the quitting process. Women may have few other ways to calm or entertain themselves, or distract themselves from stressful situations.

'The first cigarette of the day is great, feels good, relaxing'

Smoking in the face of disapproval can be a means of taking a stand or exerting control over their lives. Young women (under thirty years of age) especially can see it as being a way of expressing their right to make their own choices, even when they know it is not the best decision for them.

*'No one can tell me to stop smoking – it makes me really angry
when they do'*

'I feel in control when I have a smoke in my hand'

Shame of smoking

Some women, especially a number of young Pacific women, talk about the shame of smoking. Some have not let their families know they smoke, as they know they would be upset with them. It is something they do only with their friends. They know their parents and church disapprove, and the knowledge of this disapproval and deception creates even more tension – which can contribute to increased smoking.

This sense of shame is exhibited, though to a lesser degree, by representatives of other ethnic groups too. Women in the study talk about feeling guilty or shameful, and their smoking behaviour appears to create an uncomfortable state for these women.

Thinking of others

The majority of the women in the study who smoke are concerned about those around them who do not smoke and try to ensure they are respectful of the non-smokers. This is driven partly by a desire to be courteous and not inflict toxic smoke on others, and partly by the belief that bad habits should not be performed in public, especially around children.

*'I don't smoke in the house, not in the car nor around the children,
not in bus stops'*

*'I'm more aware of smoking around other people – I don't smoke in
the house and the car'*

'Don't do it around the little cousins'

Quitting before trying to get pregnant

Quitting before trying to get pregnant is something only a few of these women have done or seriously considered doing. Some did not plan their baby and were smoking in the early stages anyway because they did not know they were pregnant.

In essence, the idea of a future baby is only very slightly more effective in quit motivation than the idea of a future self who suffers a serious smoking-related disease. The implication is that the future baby is not tangible or immediate enough to trigger the same quit motivations that come into play with an actual pregnancy or baby.

'Too hard to have a future baby matter – like a future self'

'In my experience and circle of friends very few babies are planned, so it's a bit pointless to talk about it'

'Not sure if it is motivating enough as the baby is not here'

'90% of pregnancies are unplanned and you don't know you are pregnant until 3 months or so, and by then you've done most of the damage, so there's no point really stopping'

Attitude of ex-smokers

The attitudes to smoking displayed by ex-smokers who have quit during pregnancy can range from still pro-smoking (just not until after the baby is born) to extreme anti-smoking. Some ex-smokers not pregnant are total converts to just how bad smoking is for you, especially during pregnancy. This group now hates the thought of smoking, hates the smell, the effects of smoking, and is quite intolerant of pregnant women who do not quit.

'Society should work to make it totally unacceptable to smoke – for anyone, but especially pregnant women. Use peer pressure, use guilt and humiliation. It's just not OK'

4.2 Attitudes to smoking in pregnancy

Women were then asked questions around their attitudes to smoking during pregnancy and were asked to talk about their own experiences and behaviour.

Recognising the harm

The majority of women know smoking during pregnancy is not acceptable behaviour. As already mentioned, the study does identify a small group of women who do not accept that smoking has adverse health effects on the baby. Māori women are more likely to feel this way than women in other ethnic groups.

Most of the women of child-bearing age who smoke (no children yet) and those pregnant women who are now ex-smokers are united in the belief that smoking during pregnancy is wrong.

'Completely wrong to smoke when pregnant – selfish and damaging'

'Wrong, selfish to smoke while pregnant. If you can't give up for your baby, do you really love it?'

Reasons to continue smoking during pregnancy

A number of the pregnant women who smoke know smoking is probably not wise, but think it is too late to worry about stopping, or it is too dangerous to stop. They may have cut back on the amount that they smoke as a response but have not totally stopped.

This suggests there is a certain point a pregnant woman who smokes reaches where there would need to be extremely compelling evidence to show any benefit from quitting later in pregnancy.

There are also a few women who believe stopping smoking during pregnancy is a bad thing to do. In many cases this is because they are advised not to stop. Some of them say they have even been told this by their healthcare professional: GPs and midwives. This is mentioned by Māori and the European women in the study.

'Quitting during pregnancy is dangerous, can send the body into shock and kill the baby. Better to cut down. You've got to give up everything when pregnant, it's too stressful. Give up smoking, give up eating, give up drinking, give up breathing, give up living'

'Had a friend who stopped smoking halfway through her pregnancy and the baby it had all kinds of things wrong with it. Not sure if it was the smoking or the quitting which was the problem'

'[Quitting] Could kill baby, it puts too much stress on it'

'For my fourth pregnancy my doctor said don't quit, cut down as much as you can and then when the baby is born give it a smoke free environment'

'I smoked through my third pregnancy, my doctor advised me to do this because I was depressed'

Women who have successfully stopped smoking also state that they think that the stress of the quitting process for some women could be as bad, if not worse than, as the effects of smoking, and that cutting back may be a more sensible option.

These sentiments characterise the complexity of some of the barriers that a motivational message has to overcome.

Friends / family can be barriers to quitting

In a number of cases, especially for some Māori women, friends and family are encouraging women to continue smoking while pregnant – not to stop. This encouragement may not be overt but can take the form of raising doubts that it is actually necessary to stop and effectively giving women, who may be struggling to stop, a reason to continue smoking. For Māori women, smoking is an ingrained part of their wider social behaviour.

In some cases the message that smoking is bad for the baby is undermined by older women or friends who cite their own smoking behaviour during pregnancy and the subsequent health of their children. They provide real and convincing evidence that they smoked and their baby is fine.

'I know it can hurt the baby – it's gambling the baby's health to smoke BUT I had friends smoke all through pregnancies and their babies and children were fine. I smoked for 3 out of four of my pregnancies and it was only my last child who was small' [This woman lost her twins to cot death, which she does not link to her smoking]

'I know that it is bad for the baby but I smoked for the first two and they were small but really healthy'

4.3 Effects on self during pregnancy

Specific questions were asked around the perceived effects of smoking on the women themselves during pregnancy.

On the whole, women believe the effects from smoking during pregnancy on themselves will not be different than smoking at any other time in their lives. When asked to describe how smoking during pregnancy affected their own bodies, compared to pre-pregnancy smoking, women often have not given the matter much thought at all. The focus is not on them at all. Most of the effects mentioned are in relation to the baby, not the women.

Effects mentioned include (generally only one by one woman each effect):

- Feeling tired
- Feeling dizzy
- Increased risk of blood clots
- Having harder labour and needing a Caesarean section
- Affecting the placenta.

4.4 Effects on baby during pregnancy

Specific questions were also asked around the perceived effects on the baby during pregnancy.

Women are far more likely to talk about the negative impact of smoking on the baby, although there is a lack of breadth and depth when it comes to specific effects.

The key aspect of the negative impact on the baby that women most readily bring to mind is related to breathing. In general, women who smoke have a good understanding, and often personal experience, of the impact that smoking can have on the lungs and on breathing. Women across the subgroups in this study feel that the key impact of smoking during pregnancy relates to lung problems, asthma and breathing issues for the baby.

Other effects mentioned by women include:

- Poisoning the baby / toxins present
- Deformities
- Cot death
- Low birth weight.

‘Poisons and chemicals the baby is swimming around in would have to affect development and you could have a deformed child’

‘Breathing problems (asthma, bronchitis), everything that goes into your blood stream goes into your babies’

‘Small birth weight common, putting toxins in a tiny little thing’

4.5 Quitting smoking

The interview guide included a section on quitting smoking. If there was a quit attempt during a pregnancy, the interviewer talked to the woman about her experience.

Only two women in the study have not attempted to quit smoking at some point in their lives, with the majority of women having tried before with varying degrees of success. Attempts lasted from two days to 18 months before the woman resumed some degree of smoking. A few of women in the study are currently non-smoking and they are optimistic that this will continue. The social pressures of smoking or the levels of stress in these women’s lives are the main reasons for starting smoking again post-pregnancy.

Motivations for quitting

Pregnant women who smoke and those who have successfully given up describe the factors that relate directly to the health and wellbeing of the unborn baby as being the most motivational in considering or encouraging a quit attempt.

'It's just what you do if you love your baby and want the best for it'

'General smoking is not good for the baby, there is risk of deformities and I didn't want the guilt of causing the baby problems'

'Baby's health, and the lungs and breathing health of the baby'

When women smoke during the early stages of pregnancy because they do not know they are pregnant, they suffer from concerns that even though they have stopped smoking, they may have already inadvertently harmed their child.

'I was shocked I was pregnant, and was worried and guilty that I had already caused damage since I smoked in the first 5 weeks'

Reactions to quitting

When women try to stop smoking, their reaction can range from feeling extremely positive to feeling extremely stressed and unhappy. If they succeed, they can feel enormously proud and experience a real sense of achievement, though this is less evident among those who consider it a temporary change in behaviour.

Those who feel quite positive are glad they are doing something good for their baby. Some find morning sickness actually puts them off smoking, so it becomes an easy decision to stop. Some women are able to stop smoking immediately rather than cut down slowly and often do not experience strong discomfort from side effects.

Actual quit attempt

Women describe a range of different experiences surrounding their attempts to quit smoking. These experiences come from the general quit attempts as well as their experiences of quitting due to pregnancy. They include:

-
- **Stop immediately** – sometimes described as ‘go cold turkey’ – stopping completely without cutting down or after the current pack is gone. This type of attempt is often very successful but works better for those women who have less deeply ingrained smoking behaviour patterns or who are not so physically or mentally dependent on smoking. Their pregnancy may have evoked a physical reaction to smoking that makes it less enjoyable or more repugnant. This type of reaction is likely to be associated with morning sickness, which can make the woman feel less like smoking. For other women the pregnancy just makes them want to stop. They may have strong feelings that smoking in pregnancy is not acceptable behaviour and are just compelled to stop. Typically they give up the moment they find out they are pregnant or start feeling the effects of being pregnant.

*‘Tried to stop at 12 weeks – used the lozenge, but it tasted horrible
– then at 19 weeks I had strep throat, so the GP gave medication.
Decided just to go cold turkey at 19 weeks’*

- **Cutting down slowly** – some women try cutting down as a precursor to actually stopping smoking all together. However, some women who do this have no intention of stopping but consider that cutting back on the amount they smoke is sufficient. This type of behaviour is often tied in to the need to still be able to be included and socialise with friends and family.

*‘Reduced the amount but I always want to have a couple – I have
no intention of cutting down completely’*

Impact of side effects on quitting

Women who do suffer from very bad physical or emotional side effects from their quit attempt often struggle to maintain their change. Their symptoms range from being physically sick to missing the emotional support smoking brings.

‘Angry, irritable, hated every minute of it’

‘Was sick as a dog’

*‘I enjoy smoking. When I try to stop I get very angry and awful to
be around. I don’t believe it will make a difference to stop now –
I’ve already done the damage’*

Impact of family support

The majority of women made the decision to quit or try to quit by themselves. However, there are a few women in the study who had family quit alongside them for support or who gave them strong support into their quit attempt.

‘My mother-in-law quit and encouraged me to quit as well’

‘My first partner made me. He was very controlling’

'My partner from my last three pregnancies offered to quit with me and he did, but he gained lots of weight so he took it back up again'

Impact of healthcare professionals

In terms of healthcare professionals, the midwife is held in high regard by a number of these women. She is considered to be highly experienced and is able to comment and advise women because she knows what she is talking about and because, in the minds of mothers, the midwife has seen it all. This is different to the wider medical experience that is associated with a doctor – the midwife has the kind of experience that creates confidence for a mother-to-be. Although held in this high regard, the midwife does not feature as a strong influence in many quit attempts.

This is likely to stem from the fact that in the first two trimesters visits are infrequent and that without the development of any kind of personal relationship the impact of her advice is weakened. Part of the key to the success of increasing quit attempts is about making women really understand that they are doing real damage to their unborn children.

Reports of using Quitline and help from nicotine gum or patches are sometimes described as quite half-hearted attempts – almost with a pre-conceived expectation to fail.

4.6 When quit attempts do not work

The interview also explores if women have had lapses or relapses during their quit attempts.

Women who have attempted to quit smoking but who have not been successful describe a range of factors that contribute to their inability to succeed:

- Sudden increase in stress levels, e.g. death in the family, relationship break-up, kids becoming too much to deal with
- Not being able to handle the irritability and emotional side effects of stopping
- Being bored and wanting something to fill the time

'The house got completely clean, there was nothing left to do'

'Can't stand the weight gain. Nothing to do with your fingers. Bored being a housewife at home all day'

- Weight gain

'I piled on the weight. My whole family gets fatter when we try to stop smoking'

-
- Belief the pregnancy is far enough along that smoking at that point will not make any difference, or the woman has given birth, thus smoking will not harm the baby anymore

'I stopped smoking during my first pregnancy – cigarettes made me sick. I started smoking again as soon as the baby had 'dropped''

'I started smoking again after the first baby born – my son was taken into hospital and I was stressed, so had a cigarette from friend. My friend did try and tell me I didn't need it'

'Smoked back to pre-pregnancy and in intervening years when I've been not pregnant I've smoked more than ever'

- Being in social situations where smoking is the norm and continuing to have family members smoking around them

'Socialising was the trigger for me smoking again during my last two pregnancies'

'My partner smoking and the socialising and the drinking. Also I just became depressed. Dealing with kids I just had the urge to start smoking again'

A number of women do try to maintain lower levels of smoking, so they try not to return to the original amount of cigarettes that they smoked. However, they often fail to maintain this and gradually return to their previous smoking behaviour.

'Started again but at lower rate – 10/day instead of previous 20-30'

'Thought I could just have one during a stressful period, which gradually just built up'

It helps if women are not pressured or actively encouraged to have a cigarette – other people can help by trying to create a sense that the ex-smoker is still part of the group. Getting overly involved or judgmental only serves to make women 'fight back' and express their right to choose.

4.7 Resistant to quitting / non-quitters

As mentioned, almost all smokers are aware of at least some of the health risks associated with smoking, at least at a general or theoretical level. Some approach their smoking habit from the perspective that they know they should quit but have just not crossed the line from thought to action. Others have tried and failed on many occasions, and have put the problem to one side as just too hard to deal with.

Biggest barrier to quitting – women themselves

The biggest barrier to quitting or thinking about quitting is the women themselves. A number do not want to quit at all, and are only doing it for as short a time as possible for the baby. Many do not plan to stay smokefree once the baby is born.

Some women simply refuse to accept that smoking while pregnant is harmful to the baby. They remain unconvinced that there is a genuine problem for the baby. When the adverse effects of smoking are strongly associated with health problems with breathing and the lungs, it makes women feel that this is not applicable to the unborn child who does in fact not breathe air in the way that they do. For these women it is not as intuitive or believable as the process by which alcohol affects a foetus. These women are more likely to ensure that they keep their smoking away from the baby once s/he is born.

‘Having a few quick puffs doesn’t really get to the baby – it doesn’t get into their lungs’

Barriers mentioned

Barriers to quitting mentioned in this study include:

- Those around them smoking, especially in the household. It is hard to quit when others around you encourage you to smoke and it is part of how you socialise with people. You feel you will be the odd one out. Smoking can be about friends and family and companionship.

‘All of my friends smoke; even though at any given time one is probably trying to give up, there’s a certain amount of deliberate undermining we do and giving a hard time; smoking is about friends and companionship; I get angrier and touchier when giving up’

- Habit – just always do it and do not even think about changing what they do.
- Deferment – there is always another day to quit.

‘Habit, easy to put off until next week, month, pay day, until things less stressful, I lack discipline as I live alone’

- Smoking physically feels good / enjoys act of smoking.
- Smoking relieves stress / helps deal with stress.
- Smoking gives you something to do with your hands.
- Fear of putting on weight if stop smoking.
- Lack of discipline to follow through on desire to quit.
- Helps keep emotions in check, concern about getting more emotional if quit, e.g. angry, more sensitive to things.
- Addiction.
- Lack of belief that stopping will make a difference – it is already too late and the damage is done.
- Smoking gives comfort – is reliable and always there.

- It provides a chance to get away and be by yourself.

'Family and friends smoke, just habit, smoking feels good, you know my stress levels, also what do you do with your hands when you aren't smoking? Plus there is always the fear of gaining weight'

Some women mention that during pregnancy they were advised by 'others' (a mixture of friends, family, and healthcare professionals) that it was better to stop smoking immediately rather than attempt to cut down slowly. They were told they could not use the patches or gum. This is a barrier to quitting during pregnancy.

'Patches worked the first time around, but I didn't think I should use when I'm pregnant and I'm scared of going cold turkey'

'Quitline told me I'm not supposed to use gum or patches when pregnant, that I have to go cold turkey'

4.8 Summary of key subgroup smoking experiences and attitudes



Ethnic groups

Māori women

The Māori women, more than the others, are polarised in attitude along education / socio lines. The findings here need to be interpreted with caution, however, because of the very small numbers involved.

Lower-socio Māori women with little formal education are more likely to live, work, and socialise in environments where smoking is the norm. Some of these women do talk about the possible risks of smoking in pregnancy and accept that it is not a good thing to do, but it is expressed at a much weaker level and without a string sense of commitment to deal with it.

In fact, there is some evidence that quit smoking attempts are actively undermined or at the very least are not taken seriously by friends / family and even from some HCPs: GPs or midwives. Some say they have been told not to stop by their HCP. Friends make jokes about it and speculate how long the person will last *this* time – they have often been in a situation where they have given up and they have then started again. Family and friends will bring up examples of healthy children from smoking parents and vice versa, as well as citing “evidence” for how smoking is only one factor among many that affects health. Undoubtedly there are elements of guilt and self-justification driving this, because smoking during pregnancy and around pregnant women and children is (or has been) common.

The Māori women in the study sometimes take a very fatalistic approach to their health. They hold the view that Māori people have a lower life expectancy and are aware of a range of health problems that are rife within their communities. This type of view is particularly noticeable among Māori women from lower socio-economic backgrounds. When discussing their health in relation to smoking while pregnant, they express their feeling that they cannot possibly avoid every health risk and that they are at risk from strokes, cancer, diabetes, and heart problems anyway. There is a feeling that one might do everything right to avoid one of the diseases, but another one is waiting in the wings. These women do not seem to expect to grow old – they have seen so many of their parents, aunts and uncles, grandparents, and even siblings die in their 30's, 40's, and 50's. This conviction is explicitly discussed with two of the Māori women and they agree that it exists.

Three of the Māori women with higher level educational qualifications in this study are very different. The women we spoke with may be the last in their family or circle of friends to be still smoking. Their families are vocal in their disapproval of smoking and have given up the habit themselves. They are more likely to genuinely believe that smoking is harmful to themselves and to others, especially an unborn baby. They are less resistant to stop smoking messages in general. They seem to believe they are much more in control of themselves and their health, and they are convinced they will give up smoking at some point, they just have not yet. Those in this category who have not yet had children emphatically state that pregnancy will be the end of their smoking.

Pacific women

Similar themes and issues across all women are discussed by Pacific women in the study.

Of specific note is that some of this group, especially a couple of young Pacific women, talk about the shame of smoking within their family group. Some have not told their families they smoke, as they know they would be upset with them. Even an ex-smoker does not want her family to know she has ever smoked. It is something they do with their friends only.

As already mentioned, this sense of shame is exhibited, though to a lesser degree, by representatives of other ethnic groups too.

European women

Again, similar themes for smoking behaviour and attitude to smoking are seen amongst this subgroup of women. The key difference between European women and other Māori and Pacific women is that they are less likely to be in larger households, and thus less likely to have as strong influence of others around them smoking. It is not that the influence does not exist; just that it is often weaker for European women.



The smoker and pregnancy

All the women have smoked from a young age. Attitudes to the smoking behaviour vary across these women. Some find their pregnancy a highly motivating force but have not yet been able to convert that into action. At the other end of the scale are women who feel they will continue smoking regardless of pregnancy or any other factor.

Those who successfully quit during pregnancy say the decision was relatively easy, they understood the need to do it for their unborn child. It is the actual follow through of this decision that is so hard for many women.

'I always wanted to quit but having the baby is just the push I needed to stop'

However, quitting smoking is not hard for everyone. For some the pregnancy itself rejects them as smokers. They feel sick when they smoke and do not enjoy it any more. They give up immediately and feel better for it both physically and emotionally.

When addiction to smoking is strong, stopping suddenly can produce unpleasant adverse reactions. Women are different in how their body responds to quitting at this time. Some just do it and that is it. Others suffer typical withdrawal symptoms and struggle to make it through. For this group it is very easy to fall back into bad habits.

Some smokers consider that partially quitting or just having the occasional cigarette is better for baby. This group is much more likely to go back to full-on smoking once the baby is born.

Post-pregnancy can signal a return to smoking. It can be seen as a way of getting some of the woman's previous life back. With so many changes that result from pregnancy, birth, and looking after a small baby, the return to smoking can be considered an attempt at reclaiming a former lifestyle.

However, this is not to say they do not think of their baby. A number talk about smoking only outside, not in the car, and not near the children.

Among women currently smoking during pregnancy there is a range of attitudes to their smoking behaviour. Some have been thinking about giving up but putting it off for so long that now it hardly seems worth trying, especially if they are likely to start again after the birth. Women who smoked early in the pregnancy because they did not know they were pregnant are also likely to fall into this category – feeling that they may have already done the damage and that quitting is futile. Finally, there is a group of pregnant smokers who just do not accept that this is a genuinely harmful practice and use their denial of the facts as a reason for continuing to smoke.

Women who are not pregnant with their first child and have other children already may have already established a smoking behaviour that they apply during pregnancy. For example, a woman who gave up during previous pregnancies may give up again and may already have a plan to start again afterwards. If the woman smoked during previous pregnancies and considers that this did not have any adverse effects on her child, then she is more likely to think she can smoke during the current or subsequent pregnancies. Few of the women admit or talk about any problems with their babies as a result of smoking in pregnancy. This is true even if it seems, from the outside, that there have been serious consequences of smoking during pregnancy (examples of small birth weights, premature deliveries, and even cot death).



The environment

Almost all of the women smoking have family and friends who smoke. As discussed, a primary reinforcement of smoking is often about fitting in and feeling part of a group in a social setting. This can be at work, in external social situations, or at home. This acts as a major barrier to quitting and this pressure is there constantly during pregnancy as a reminder of what women are missing out on and a strong temptation factor to start smoking again. The size of household plays a role here too; with more people smoking at home, it is harder to stay quit.

In both Māori and Pacific women's families there are older women relating stories about their own pregnancies and just how their babies were fine. They undermine the need to stop smoking and cater to the desires of the women to find a reason not to have to stop. These comments come from aunties, mothers, mothers-in-law, as well as the family friends. They can provide living examples that they smoked and their babies were fine.

Stress is another environmental factor that plays a strong role in the need to either keep smoking or give up the quit attempt. Things get tough at work or they have an argument at home and the temptation to fall back on previous smoking behaviour is hard to resist.



Other factors

Looking at urban versus provincial splits, differences that are present between the areas appear more as a result of ethnicity and whether the woman is a first-time mother or not, rather than location.

In terms of age, more often the younger women tend to be first-time mums, whereas older women tend to be more likely to have more than one child. As a result, there are some differences in their perceptions of smoking while pregnant.

Younger women can bring a sense of rebellion to the issue of smoking while pregnant. Any messages that are considered to be judgemental in nature are more strongly rejected by younger women. They also tend to be more resistant to general messages about the health risks of smoking, as they are less likely to have experienced effects on their own health. This makes them more likely to question the credibility of facts surrounding the risks of smoking while pregnant.

For older women (those aged 30 years and older) previous experience may create a false sense of security. If they have smoked through previous pregnancies and had healthy babies, they can be very resistant to messages that suggest otherwise.

4.9 Section overview

Impact of smoking on self

The majority of women in the study have a reasonable understanding of the real health risks they might face as a result of smoking. A number have seen impacts on their friends and / or family from smoking and cite a range of negative effects of smoking including asthma / breathing issues, lung cancer, and finger discolouration.

Most of the women started smoking at a young age, and some future consequence from smoking is not enough to overcome the addiction. Some of the women do not have a high sense of personal worth; others (especially some Māori women) believe their fate is inevitable.

The majority of women who smoke in this study have friends or family who smoke. This is a primary reinforcement for smoking and often fitting alongside alcohol consumption. A number of Māori women especially mention smoking and drinking alcohol as part of the norm.

Hardly any have tried to quit smoking before getting pregnant for the pregnancy. The concept of a baby is not real enough to stop their smoking behaviour.

Impact of pregnancy on smoking

The presence of the unborn child changes the desire to smoke and smoking behaviour for the majority of the women. The majority of women understand in a general sense that smoking is bad for their baby. As a result, many quit as soon as or shortly after they find out they are pregnant. There is a group who just do not stop. Many of these women say they have tried, but it is too hard, or that the risks are probably overstated.

In a number of situations women have friends / family encouraging them to continue smoking. These people cite their own smoking behaviour and subsequent health of their children; they smoked and their baby was fine. This 'auntie syndrome' ("my aunt / mother / sister / friend smoked through her pregnancy and her babies are fine") or social pressure can also be partly reflective of true lack of knowledge on impacts of smoking at this time.

There are a few women who believe stopping smoking in pregnancy is not good. Some think it is dangerous to stop and some say they or friends of theirs have been advised not to stop.

Pacific women were harder to recruit for this study, as they appeared reluctant to talk about smoking during pregnancy. From feedback during recruitment many in this ethnic group appear insular, not wanting to talk about this kind of behaviour. Pacific women who did participate describe the impact of their extended family groups as mixed in relation to their smoking behaviour:

- Family presenting a supportive non-smoking stance
- Undermining with personal examples or problem-free pregnancies, births and healthy children among smoking mothers.

Most importantly, being pregnant can add significantly to the stress in a woman's life – making her want to smoke more not less.

Motivation for quitting

Women say the motivation for quitting or wanting to quit is not about the impact on the mother, it is all to do with the health and wellbeing of the baby.

Quitting while pregnant – method

Pregnant women in the study describe two key approaches for quitting smoking:

- Stopping immediately or finishing the current pack and then not having any more, sometimes referred to as 'going cold-turkey'
- Cutting down slowly and gradually stopping.

Key barriers to quitting smoking

Women describe a range of reasons for not being able to successfully stop smoking.

- Social situations
- Habit
- Deferment to another time
- Enjoyment of smoking
- Stress release from smoking
- Confidence booster
- Weight control
- Enough drive to make a successful quit attempt
- Emotional impacts of stopping including anger and irritability
- Physical addiction to smoking
- Denial of true impact of smoking
- Emotional comfort from smoking
- Own personal space

For older women (30 years or over) who have smoked for a long time, it is harder to give up. Their own previous experience says smoking has not had an impact on their previous children, so why would it be different now?

The success of the support from friends, family, and organisations like Quitline is really about the desire of the women to give up enough to succeed and overcome the difficulties.

Reasons for lapsing and relapsing

Women in the study describe a range of incidents or factors that contribute to their inability to maintain their smoke-free status.

- Increased stress
- Emotional instability
- Boredom
- Weight control
- Denial
- Social situations where smoking is the norm.

5 Motivational Messages

This section contains the research findings on the types of messages that will and will not work to encourage women to think about a quit attempt or try quitting smoking.

5.1 Spontaneous generation of quit messages (ex-smokers)

Women who had stopped during pregnancy themselves, some of whom were still pregnant, and others who had had their babies in the recent past were asked to spontaneously discuss, without any prompting, possible messages for encouraging women to consider a quit attempt or to quit.

The questioning was framed around convincing other women that quitting smoking when they are pregnant or planning to be pregnant is a good idea and really possible. They were asked to think about themselves and their experiences of quitting, and make suggestions about really strong messages that they feel might make other women want to quit.

Fewer than half of the women are able to offer specific messages. Many struggle with understanding how any woman would **not** quit once she found she was pregnant. They express the belief that if the presence of an innocent baby inside were not enough to get the woman to stop smoking, then no additional information would make a difference.

'If you loved your baby, you'd stop. If you don't give up, you don't care about your baby'

When the ex-smokers are able to generate ideas, these ideas tend to fall in one of two categories: the lack of choice the baby has or a single specific image or effect on the baby from the smoking.

'Smoking during pregnancy is like driving drunk with a passenger who didn't have a choice about being in the car'

'People can choose to harm themselves and that's their right. But a helpless little infant is a different story'

'You need to show a close-up or something of the baby smoking a cigarette when the mother has one. Or coughing'

'You could show a tiny baby in an incubator while the mother looks on, and she has a pack of cigarettes in her handbag'

They are adamant that in order to be effective, any message must go above and beyond the traditional and typical stop smoking messages that have become wallpaper for many smokers. The message must clearly link the action of smoking each cigarette with an adverse effect on the baby to get through the wall of denial that many smokers put up when confronted with anti-smoking communications. They state quite clearly that ignoring potential damage to self is very different from ignoring the one done to a foetus / baby, and that it is much harder to comfortably dismiss the latter.

They are also emphatic about the need to have very graphic messages showing harm to the baby / foetus. They suggest using baby health effects they can visualise easily and have the potential to shock women out of their complacency about the safety of the child in their wombs.

Spontaneous mention is made of the condition of the placenta, once by a non-pregnant Māori smoker and once by a European ex-smoker. Again, the imagery around the message is vivid, with the link between smoking and the 'disgusting' effect very clear, e.g. visually seeing the tar in it.

'Tell them that you can see the layer of tar in the placenta and that the baby is eating the tar'

'You can tell just from looking at the placenta whether the mother smoked. It freaked me out'

5.2 The process to define message communications

All of the women were given a range of messages to look through to assist them in defining the types of messages they feel would be likely to work best in encouraging a quit attempt before and during pregnancy. The messages provided excellent stimuli to create discussion and enable women to focus in depth on the topic.

Messages were presented on individual cards that could be shuffled and grouped. The women used the messages to assist in understanding which types of messages are motivational, which have less motivational impact (neutral), and which are not motivating at all or have an adverse effect on quitting smoking or making them consider a quit attempt during pregnancy. This technique worked well for teasing out the dynamics and key themes from the different types of messages. It also clearly shows the types of messages that work well and those that do not.

When large numbers of messages were selected as motivational, each woman was required to select her top motivational messages from that selection (maximum of six).

The messages provided for review fell into three main categories defined by HSC:

- a) Health of the baby
- b) Effects on the mother
- c) Social stigma / environment.

5.3 Most powerful message themes

It is important to note that pregnant women who smoke in this study are resistant to hearing messages about quitting or attempting to quit; thus messages that are likely to work need to be extremely powerful. Messages focused on the good things that can happen if the smoker stops smoking during pregnancy are generally not strong enough to stop smoking behaviour.

From discussions with the women in this study a successful message needs a number of different components that will make it successful. These components resonate across all women, including current smokers who are pregnant.

These key components are:

- A strong baby focus
- Showing immediate harm to the baby
- Linking smoking to harm to the baby through specific biological mechanisms that cause harm
- Showing certainty in effect – this will or does happen.

Overall, the more of these components within a message, the more likely the message is to be successful.

Each component is now presented and discussed in detail, followed by the specific messages that contain that aspect within them. Obviously some messages have more than one aspect to them to be more successful than other messages. Message examples have been put into a section based on where they can add the best illustration of that component.

Baby focus

As discussed previously, almost all of the women in the study can and do comment at some point in the interview on at least one way in which smoking is bad for them. The smokers in the study, however, go on to say that this effect on themselves is not enough to make them give up their smoking.

The majority of women say messages aimed around the impact on the smoker seem too much like general ‘stop smoking’ messages and are easily tuned out as old news. They are not as unconcerned about potential damage to their babies, though. Women do perceive a baby is blameless, and to some extent, more important than the mother. **Messages about the baby engage a new leverage point – the babies and mothers’ love for their babies.**

Some of the messages shown are judged by the majority of the women to be quite powerful in provoking strong imagery that hits at the core of being a good mother and doing the right thing for the baby. In essence, to quit smoking during pregnancy is about doing the right thing for the baby and putting the baby’s needs above your own.

Analysis of the various comments added to the women’s own conclusions strongly suggesting that messages about the baby hold far more power than messages about effects on the mother or any type of social stigma. This holds true across all women, regardless of ethnicity or other factors.

‘I can imagine a close up of a baby smoking a cigarette – you’re killing your baby’

‘Think about something that’s not yourself. Baby becomes more important than myself. I’m old enough to stop my own habits, but baby doesn’t have that choice. It’s not fair that my habits should be affecting baby. I just want the best for the baby and that should start when baby’s still inside’

Immediate impact on baby

The most powerful messages across all types of women talk about the damage being caused right now to the baby. Messages that talk about the long-term future, although not rejected, are not as strong to motivate towards a quit attempt. Examples of this are listed in the following section in more detail and include:

- *Smoking can harm the development of a baby’s / foetus’s lungs and make it hard for them to breathe.*
- *Smoking restricts the amount of oxygen your baby / foetus is getting.*
- *Toxins from smoking are passed through the placenta to your baby / foetus.*

Another powerful example is:

- *When you smoke your baby is smoking too*

This message does not allow a smoker to ignore her baby’s non-consensual part in smoking. It forces her to face the conflict between her desire to smoke, her love for the baby, and her desire to give it the best start in life. It manages to trigger the awareness without coming across as judgemental or parental, both of which can create feelings of defensiveness and rebellion.

'It makes you imagine a little baby smoking, which is a horrible image that everyone knows is just wrong'

'That is true, when you smoke the baby smokes too. Whatever you have the baby has too – it's not about yourself anymore'

An example of longer-term messaging that does not work so powerfully and the explanation of why it does not work is shown below.

- *If you quit, imagine your baby growing up as a healthy, happy child*

This is not a strong message for the majority of women, as it requires women to think far ahead into the future. Right now pregnant women are busy dealing with the now of being pregnant and making it through the pregnancy. At most they are thinking about the baby as a newborn and in the first months – certainly not as a child.

Furthermore, a lot can happen in between the action of stopping smoking during pregnancy and the health of a child several years ahead. The proof that the outcome is actually related to quitting smoking is weak; there are almost infinite factors that can affect the development of health and happiness.

Messages that focus on showing specific and biological harm to the baby

From analysis of the women's responses to the message stimuli it becomes obvious that specific messages that mention biological facts are regarded as having more potential power to get and hold attention. This is true for pregnant women who smoke, as well as other women in the study because:

1. They lend themselves more easily to a single image or concern.
2. They make an issue explicit, rather than relying on the reader's imagination and knowledge to make the link or come up with examples.
3. The strongest performing messages in this category are the ones that restrict the comment to an observable process that happens each and every time – it does actually happen.
4. The most powerful ones talk about the certainty that the claim or harm is happening right now, not some time in the future.

Examples of messages in this theme that work well are shown below.

- *Toxins from smoking are passed through the placenta to your baby / fetus*

The majority of women consider this message to be a bold statement of the fact. It does not attempt to judge or preach, and leaves no space for dispute. This makes it quietly forceful. It provokes a visual picture of the baby being poisoned, which women talk about as being very disturbing and very graphic. It is expressed as something that DOES happen, not as something that could happen or that happens only in some circumstances. For women who smoke during pregnancy the message is clear that this is something that is happening right now.

The message works well because it actually explains how the smoking passes toxins to the baby.

The women's reaction to this message suggests that the idea of passing toxins through to the unborn child makes a connection to the feelings of guilt that pregnant smokers may experience, and calls on the natural instincts to be a good and protective mother.

- *Smoking restricts the amount of oxygen your baby / fetus is getting*

This message talks of an immediate effect that is real. It is happening right now and does a good job for a number of women of linking the effect with the actual activity of smoking a cigarette (rather than 'smoking' as a concept). This is the strong part of this message. It suggests the woman is actually harming her baby by her actions, and this makes it a powerful motivator. Women naturally feel protective towards the baby, and this message makes it clear that her actions are harmful. This message could be strengthened further by showing the effects of the restricted oxygen supply to the baby.

'I can imagine a mother choking her baby'

'Factual, people understand that oxygen is air and without air we don't survive'

- *Smoking can harm the development of a baby's / fetus's lungs and make it hard for them to breathe*

This message example is the strongest message for pregnant women for quitting or trying to quit, from the examples shown. This includes pregnant women still smoking.

All women in the study know smoking affects their lungs, either because they have been told so, or it seems obvious because of the mechanism of smoking, or they have started to notice it themselves. It is therefore a natural extension for most to assume it affects their baby's lung development. (As mentioned before, a handful of women feel the impact on lungs and breathing happens only after birth.)

The phrase "hard for them to breathe" is highly evocative, especially for those who are beginning to experience their own shortness of breath and exacerbation of asthma. Also amongst the majority of Māori and Pacific women in the study there is recognition of childhood asthma affecting their children or those they know. This message, as a result, can produce powerful imagery of a baby struggling to take a breath.

It also conveys a clear scientific message that is not undermined with any moral messages about smoking. It is purely factual, leaving the reader to draw conclusions about what she should do about it, if anything.

This message could be strengthened further by changing the word *can* to *does*. Suggesting that something can happen leaves an opening for women to think that in their case it might not occur.

- *Smoking increases the chance of cot death*

This message refers to a situation that strikes fear into the majority of mothers' hearts. Women in New Zealand seem very aware that our cot death rate is alarmingly high. This message fits into this section, as it is perceived as a specific biological happening that causes harm to the baby.

For some women, especially those currently pregnant, this is the most frightening message of all. Lung impairment or low birth weight or other complications offer the chance of medical intervention and non-permanence. Death is final.

The majority of women are in favour of strengthening the claim by using additional facts or percentages to support it. They feel that this consequence of smoking, more than any other, really needs to be emphasised regardless of any cost to sensitivities or reluctance to place blame.

A number of women spontaneously start to talk about how to put visuals to it, including focusing on tiny white coffins or mothers with cigarettes checking on their babies to find them dead in their cots.

Changes to the text that would create a more powerful message are mentioned by about a third of the women in the study. Those changes seen as having more impact include wordings like "smoking is a leading cause of cot death", "if you smoke during pregnancy, your baby is x times more likely to die of cot death", "cot death is most frequent in homes with smokers", and "most babies (or x%) who died of cot death had mothers who smoked in pregnancy". Specific dramatic figures add to believability and impact.

'Couldn't imagine anything worse than finding your baby dead and knowing that you might have had something to do with it'

'There is no such thing as making it too strong. If it is true, it needs to be said without sugar coating'

-
- *Low birth weight is a leading cause of infant death and complications*

This is a weaker message amongst the majority of women than those examples given in this section to date. Although this message does not specifically mention smoking, the mention of death has a powerful impact, thus this message is worth discussion. Although it does not say that a low birth weight guarantees infant death or complications, the “a leading cause” is a relatively strong way to present a non-certainty. The idea of linking the effects of smoking to death is a powerful message – death being the ultimate undesirable outcome. However, this message does create a two-step approach; accepting that smoking causes low birth weight and then the resulting consequence.

Correlations and probabilities – it needs to be definite

The implications from this research are that very strong motivating messages tend to say this WILL or DOES happen if you smoke, not this MIGHT happen. If a message says an outcome MAY happen, it comes down to taking chances. This allows women the opportunity to think that this might not happen to them. Women who really want to continue to smoke or who experience real difficulties when they try to stop, are quick to grasp a sense of reassurance that everything will actually work out well for them and their baby even if they do not stop. A message that suggests that there is a chance that harm might not always happen may encourage women to look to their wider family and friends circle for further proof that their baby will not be affected.

A powerful message needs to cut through the ‘myths’ women are sometimes exposed to. It needs to be factual and ideally impossible to ‘debunk’. A message needs to move a woman towards a point where she needs to consciously think about and make the decision on whether to quit or not based on these facts. This will be enhanced by the emotive trigger of the desire to be a good mother and give the baby the best start in life.

Proving beyond any doubt that smoking during pregnancy harms the baby can be difficult. Providing absolute and conclusive evidence of harm in every single case is not possible. However, some ways of communicating the facts have more impact than others. Expressions like “beyond reasonable doubt” or “is the leading cause of” stand up better than a less specific or an easily-downplayed “increases the chances of”. Additionally, it suggests that a presentation of objective and scientific processes (e.g. toxins from smoking are passed through the placenta) holds up to attack and scrutiny. It is a fact that toxins pass through; it is speculation about exactly what damage that might cause.

5.4 Problematic themes

Never too late to quit

Some of the messages shown to the women in the study related to the concept that quitting at some point is better than never quitting – that it is not too late. For some of the current smokers who are pregnant, this type of messaging has some impact and encourages some hope. However, it is dangerous to use, unless qualified with some additional information around the damage women have done to date to their baby as a result of smoking. Including this kind of information is likely to make the message very long and more difficult to process quickly. These types of messages risk being seen to endorse smoking during the early stages of pregnancy.

A number of ex-smokers mention how this type of messaging would possibly make them put off their quit attempt until the last possible moment, as it implies some level of smoking is acceptable during pregnancy. It becomes an easy way to just postpone and put off quitting. Examples of this include:

- *It's not too late to quit if you are still in your first trimester. Most of the damage from smoking happens after 14 weeks.*
- *It is better for your baby's / foetus's health to quit part way through your pregnancy than not at all.*

As mentioned, these messages work moderately well for some women who are still smoking during pregnancy and might think still about giving up. However, women say these messages also tell them it is OK to smoke through part of the pregnancy and makes them think they can put off giving up smoking until the very last minute.

The majority of ex-smokers and those smokers who are not currently pregnant tend to react quite badly to the implied approval of smoking in the early stages. Most of these women comment that they quit as soon as they found out they were pregnant. They want and expect to see the same behaviour in other women.

Additionally, these messages seem to contradict common belief that the first 12 – 14 weeks is a critical time in the baby's development, when exposure to toxins through drinking and eating is especially dangerous.

From the women's comments it is clear that these types of messages are unsuitable by themselves. To work, these messages would need to be coupled with content that show the increasing amount or type of damage being done the longer a woman smokes during pregnancy. They do not encourage women planning to get pregnant to quit either. It implies they can wait and give up at some point during their pregnancy – put it off to do another day.

Judgment by others

The majority of women talk about wanting a message that just gives factual information and accepts them for who they are. They go on to say they do not want to be preached or lectured to, or have other people pass judgement on the kind of person they are. They talk about wanting factual messages that outline the impact of smoking during pregnancy on the baby and leave them to make the decision on whether to quit or not.

In effect, women want to be spoken to on an adult-adult level, not treated as children. They want respect and to retain the power and choice over their own behaviour. Messages are stronger when they inform and do not judge.

Examples of messages in this style that do not work because they are judgemental are shown below, with commentary explaining the issues surrounding the message.

- *Friends who do not support you to quit are not true friends*

Almost all women react to this message negatively. They believe friends and family accept you for who you are and that true friends and family do not judge. It is a hard message to deliver credibly, as a result. It provokes anger in some women in the study due to the presumption of a third party passing judgement on people they do not know. Some Māori women especially do not relate to this message and are sensitive to the implication that friends might not be true. This increased sensitivity may be because smoking in Māori women is more widespread overall and thus it is simply more likely that a woman has friends who smoke. There may also be an aspect (discussed later) that Māori women may be more likely to have friends who undermine quit attempts and therefore the message seems much more pointed.

- *Smoking during pregnancy is not being normal in society*

This message is very polarising. Some women find this message quite stimulating and believe if it were hard-hitting, it could go even further. Many even believe that smoking during pregnancy should be against the law. This type of sentiment is stronger among ex-smokers who have stayed quit rather than current smokers. Women who gave up smoking as soon as they found that they were pregnant do consider the behaviour of women who continue to smoke to be quite abnormal. They simply cannot believe that some women make the choice to continue to smoke.

Current smokers tend to reject this type of message. They feel it is impossible to say what is normal or not normal in society, and who could possibly judge this. Among some Māori women, exposure to a culture that accepts smoking as the norm makes this message unrealistic and, in some cases, offensive.

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- *Family members / friends / people important to you disapprove of your smoking during pregnancy*

This is not a strong motivating message overall, regardless of whether the woman agreed or disagreed with it. A number of women say their friends and family smoke now and do not have an issue with them smoking. For these women this message is not true because their friends and family do not openly disapprove of the smoking behaviour. When family members relate stories about others in the family smoking during pregnancy, and who subsequently went on to have healthy children, there is no sense of disapproval at all.

Even the women who agree with the statement do not feel it is a motivational one. They already know their family and friends wish they would quit – and it is that pressure, rather than the message about it from a third party, that may eventually have some effect. A couple of the women confess that they totally hid their smoking from their families for years. On the positive side, that at least reduces the amount they can smoke, as they need to be alone.

*'I get wild because they are on my case. They can **** off'*

'So what? If they haven't been able to get me to quit, telling me about it isn't going to do anything'

'Very important especially to Pacific Islanders as you try to make your parents and pastor proud of you, to not bring shame on your family'

Message lacking credibility

A key finding from the ways in which women respond to the motivational strength of the messages they reviewed is that women will look for perceived truth. For a message to be motivational in encouraging women to quit smoking, it must first be believed. All claims need to be extremely credible to be successful. Messages lose credibility when the claims about the consequences of smoking in pregnancy cannot be tied solely to smoking. It is highly likely that the reader can think of other factors that affect the likelihood of the particular outcome, and this can provide a justification for disbelieving the claims and continuing to smoke.

The credibility of a message has to be strong enough to override contradictory advice or facts that they may receive from other sources that they trust or what they have seen in their own lives.

Examples of messages which are perceived by women as less credible are shown here.

- *Not smoking means less stress on the baby / foetus*

The suggestion that not smoking means that there is less stress on the baby is not defined enough to have much impact on the women in the study. It prompted some women to ask what kind of stress the baby would experience when the mother smoked, and what effects that stress might have. The message raises questions but fails to tap into the strength of maternal instinct that drives women to protect their baby. They cannot consider the need for protection when the nature of the threat is not well defined.

This message is rejected by a few of the Māori and European women in the study who have been told, either directly by an HCP or by friends and family, that giving up smoking in pregnancy may be harmful. They have been warned that the stress of a quit attempt could harm or even kill the baby, and that they should try to cut down instead of quitting.

- *A smoker's baby is more likely to get asthma and ear infections in childhood*

Although polarising, some women, especially Māori, relate to this message. It is an obvious effect they can understand, and it is linked clearly to smoking. It is general knowledge childhood asthma is a huge issue amongst Māori and Pacific peoples families, so it is something relevant to them and the families / households they live in. They suspect there is a good chance their baby may develop asthma, so are interested in minimising the chances. They also want to know more about the detail behind this message. They look for more information relating to this message and wonder just how much more likely their child is to get these things as a result of smoking during pregnancy.

However, this message is open to contradiction. It lends itself to finding exceptions and rationalisation. A number of women are easily able to cite relatives and friends who smoke and have children without these conditions, and children with non-smoking parents who do suffer from them.

- *A low birth weight baby does not mean an easier birth: actually, a smoker's baby is more likely to have a difficult birth*

Women overall do not believe this message. This message seems to combine too many points and alludes to knowledge that most women do not have. The first phrase is clearly aimed at women who feel that a smaller baby will be easier to give birth to. However, the second phrase clouds the issue – some women are confused about whether this means it is the baby or the mother who will have the difficult birth. It is easier to imagine some impact of a difficult birth on the mother, but there is little understanding of how smoking could affect this. The suggestion of a difficult birth is too broad and could be applied to everything from a long and intense labour, through to serious life-threatening complications.

Similarly, the suggestion that the birth might be difficult for the baby needs further clarification with clear explanation of how the baby might be affected.

- *A smoker's baby has more trips to the doctor*

This message fails to motivate women because it is difficult to categorically tie the consequence to the act of smoking. This is a message that struggles to be credible. Almost all women believe the amount a baby might need to go to the doctor is determined by far more factors than just smoking. They reject this message outright.

There are many things that could cause these trips, and even ex-smokers are quick to give examples of children they have known who have needed frequent doctor visits despite having non-smoking parents.

'Smokers' babies have more trips to the doctor, so what, not going to motivate me to do anything'

'That's not true. My children almost never go to the doctor'

'I'm not sure about that one, it seems exaggerated. There are a lot of reasons why kids need to go to the doctor, not just smoking things'

- *You are far more likely to have a premature or low birth weight baby if you smoke*

This message is weak on a number of fronts. Firstly, it is open to disproof through a woman's experience, be it their own or that of family or friends. A number of women who participated in the study could cite knowledge of babies of smokers who were late and huge, as well as babies of non-smokers who were premature or too small. It is just a maybe – not a certainty. To suggest that something is more likely to happen does not provide sufficient drive towards a quit attempt. A number of the women see there is a possibility that this will not happen to them and reinforce that with what they see has not happened to the women and babies they know.

Secondly, the mechanics of how smoking could cause a low birth weight baby is not understood by some. This message links smoking to a lower birth weight but gives no indication of how this happens or why. This lack of reinforcement weakens the relevance of the message.

Thirdly, it is not obvious that low birth weight (and what exactly low birth weight means) is a real issue for a baby. For a pregnant woman looking ahead to the delivery, a smaller baby may sounds like a good thing.

Ex-smokers tend to find this message more compelling than current smokers. This is probably a reflection on the fact that those who gave up have recognised and believed the risks, and therefore are more receptive to believing this message.

-
- *Babies who are born to women who quit during pregnancy are less moody and are better sleepers and feeders*

This message was completely dismissed, with some women actually laughing at the suggestion. Women believe babies will have different sleep patterns, moods, and feeding patterns as a result of many different things. Moody babies, bad sleepers, and bad feeders are what they think of as a typical baby, not specifically a smoker's baby. Even if it were true, it is too far removed from the perceived impacts of smoking; thus the motivation of this message is weak.

- *Not smoking means less stress at home*

This message is one of the weakest types of messages and prompts significant derision amongst almost all of the women. A number of the women use smoking to help them cope with their stress generally. Stopping smoking would actually raise their stress levels to new and intolerable heights, not lower them. Also, stress around the home comes from many places, with smoking being considered to be one of the less important sources.

- *Quit smoking and reward yourself with a healthy pregnancy*

This message is mostly dismissed by a number of the women as deceitful and untrue – no action, however healthful, can guarantee a healthy pregnancy. It is also logically awkward, as a reward is external and a pregnancy is internal.

In interpretation it is obvious the focus of this message is too much on the mother rather than the baby. If women wanted to quit for themselves they would have done so regardless of whether they were pregnant or not. Only the responsibility for someone else's life adds a new dimension.

- *Quit smoking and reward yourself with a healthy child / baby*

This expands on the problem of the previous message – it is too big a claim to be making. It says stopping smoking will deliver you a healthy baby. Given all the different things that can happen during pregnancy and foetal development, this is not guaranteed. A number of women feel it is too big a statement to make.

Lack of relevancy or importance

A key component in a message that motivates women to consider a quit attempt is relevancy. A message with relevance taps into an emotion or thought pattern by drawing on things that women recognise as being part of their lives. When this is missing, the message fails to make a connection with the women and cannot become motivational.

A successful message needs to include commentary on something that matters to women at that point in time. The following messages lack either relevancy or do not target something important at that moment in time.

- *Quitting smoking means you save money*

Although technically true, almost all of the women feel that this is not a strong motivating message to encourage quitting either before or during pregnancy. The extra money is appreciated by the majority of ex-smokers only after the decision has been made to quit and is reinforcement for maintaining the choice not to smoke. Ex-smokers especially talk about this as an added benefit from quitting, not as a primary reason for the quit attempt. It works as a reinforcement of the decision but does not have a strong impact on making the decision. As a result, this message tends to have low impact and motivation.

- *If you quit smoking you are showing everyone what a great mother you are*

Some of the mothers react badly to the implication that smokers could not be good mothers – that the only judge of good / bad motherhood is smoking status. With the main focus on the message aimed at the mother, this message lacks the motivational impact of other baby-related themes.

Interpreting this, doing the right thing and being a good mother is something that is internal, not external. It involves far more than smoking: expressions of love, provision of food, clothing, support, and so on. Furthermore, showing off to others about being a great mum has an overt competitive aspect that is not highly motivating.

- *Be a great role model for other mothers and mothers to be... Quit smoking*

The majority of women feel the suggestion a woman can be a role model to other mothers does not have strong motivational potential as a quit message. There is no evidence that presenting the woman as a role model to other mothers has any more impact than suggesting that other people in general will think more highly of her if she stops smoking. The message does have slightly more impact when the mother is presented as a good role model to children.

Current smokers say if they are not at a stage when they are willing to quit for their own health, they are certainly not interested in quitting for the sake of what other people might think.

It is possible this message could have real value when the mother is experiencing really strong, almost overwhelming, feelings of guilt. The message works when the prospect of losing the guilt and actually becoming a role model is attractive and suggests a 'feel good' state of mind rather than coping with the feelings of inadequacy created by failure to quit.

-
- *Reward yourself for quitting at regular intervals throughout your pregnancy – you deserve it!*

The idea of a separate reward does not appeal to the majority of the women. Rewarding the mother does not use the strength of the mother and baby bond to create enough motivation to make a quit attempt. Also, it could be interpreted as suggesting the mother could be rewarded by smoking cigarettes occasionally. This message is closer to a general stop smoking message rather than a message about pregnancy.

Indirect or less specific messages

Some of the messages discussed are considered to be less motivational but are still quite well received. This includes messages that do not provide direct or specific links from smoking to the baby but succeed in provoking thought or consideration in a more lightweight manner.

The following examples illustrate the way messages can succeed on a more basic level by creating interest or awareness, but they fail to provide strong motivation for change in current pregnant women who smoke.

- *The womb is your baby's start to life*

This message is not as powerful as the harder-hitting 'shock' messages amongst women who are currently pregnant. It does not work as strongly with pregnant women as some of the more specific direct messages, as it does not talk about the impact on the baby itself. Smoking is not directly harming the baby in this message. This is not to say it is a negative message. It is not just as strong as some of the other message already discussed.

Some women believe it might work for those women planning pregnancy. It is perceived as a pre-pregnancy message more than a 'during' pregnancy message.

As a consequence, this message could be a possible complement to the message **'toxins from smoking are passed through the placenta to your baby / foetus'** (more for pregnant women).

- *Give your baby a smoke-free start to life*

This is too broad to have an impact. It is adequate but is ill defined and ambiguous. It also does not hit an emotive connection with the majority of women. It is possible it could be a supporting message for other stronger messages that are more specific about the impacts on the baby (as per the most motivating messages in the baby-focused message section) rather than a key motivational message in itself.

It is a slightly stronger message for those planning to get pregnant. To be more powerful it needs to become more graphic and hard-hitting in the way it is portrayed. It also needs to ensure that it taps into the woman's desire to be a good mother right from the start by including a connection to the harm that smoking in pregnancy can cause. One interpretation of this could be a message that says "protect your baby from harm by giving it a smoke-free start to life".

- *Light / social smoking is harmful to the baby / fetus*

This is not a powerful message to motivate women to quit or think about quitting. It does not say what it does to the baby or why this message is any different to the general 'smoking is bad for baby' messages.

Furthermore, a common reaction amongst the majority of women is to say "ALL smoking is harmful", which results in the woman's thinking that this message does not make sense to them. An alternative that eliminates the confusion is "even light or social smoking is harmful to the baby / fetus".

- *Quit smoking and take comfort in the idea of a healthy child at the end of your pregnancy*

This is a mediocre type of message, where this style of message is not perceived as especially strong by the majority of the women. There are other messages already discussed that talk about your baby that are stronger. It does not talk about specific impacts on baby. It, again, focuses too much on the mother and not the baby.

5.5 Supportive message themes

Some messages did not resonate as powerful quit messages in their own right but did stand out as possible support messages for a campaign. These messages generally relate to the impact of other people in a smoker's life and the way in which the pregnancy changes the woman's life.

This is especially so for those pregnant women in the study still smoking who relate to the message that friends and family can help you quit by keeping their smoking away from you.

- *Feel better knowing you are a great mother for caring enough to quit*

While this message is not identified as being strongly motivational, it does appeal to women by drawing on their maternal instincts. Its emotive nature appeals to the nurturing women feel for their babies. It taps into the desire to protect and grow their baby, and can work from pre-pregnancy all the way through to post-pregnancy.

This is a message that could be adapted to become more motivational, especially if it is supported by more specific messages around the impacts of smoking on the baby, e.g. impact on lung development, the baby smoking too.

It leverages the primary reason that women do quit in pregnancy – because they love their babies and are putting the baby's needs above their own. It also pats them on the back without the judgment that is present in the similar “if you quit smoking, you are showing everybody what a great mother you are”.

- *Friends / family can help you quit by keeping their smoking away from you*

This message taps into how friends and family can get involved in a positive way. It recognises that people do and will smoke in the environment a woman is in, and rather than trying to force a quit message on everyone, it looks for sensible alternatives.

On the negative side, though, some women belong to social circles and / or whanau where nearly everybody smokes. They are apt to visualise the outcome of this message as being left at home looking after everyone else's children while the others go out and have fun. In other words, they see the natural result of this message as isolation.

- *Be a great role model for the kids... Quit smoking*

The majority of the women already have this in the backs of their minds with their smoking. They frequently try not to smoke around children – partly because they do not want to expose the children to the smoke, but also because they do not want the children to grow up seeing smoking as an acceptable behaviour. **Every single woman says that they do not want their children to smoke.** This taps into the desire not just to be a good mother to one's own children, but also to stand up in the wider community of children.

- *Ask your friends for support to help you quit*

For many of the women giving up smoking is a personal choice, and they want to be in control of this. Asking friends to help does not seem to fit with this, especially since for many of the women their friends are still smoking and, either actively or passively, encouraging them still to join in.

This message performs more strongly as a tip to help the quit attempt, especially if it were to be matched with practical advice about how this could be done, such as Quitline. Some women only want their friends to smoke elsewhere, while others want their friends to take cigarettes away from them and to be far more involved in the attempt. Still others would like to partner with a friend to quit, and it may be helpful to have some structure around the discussion and the process.

5.6 Key differences in subgroups



Ethnicity

Looking at ethnicity, there are only slight differences showing between the groups. All ethnicities believe lung development is a strong message to consider quitting or to quit.

Motivational messages for Māori and Pacific women

Both Māori and Pacific women have ***'smoking increases the chance of cot death'*** and ***'when you smoke your baby is smoking too'*** the next strongest messages, again reflective of the strength of specific messages about harming the baby. For Europeans this is less defined; however, these two messages are certainly in the strongest group of messages, as they meet key criteria around immediacy of message, direct casual link to baby, and physical harm.

However, a few women reject a message theme of 'baby is smoking too' as untrue. Note this is a small number and caution needs to be applied in drawing any conclusion from this. In this study, this group comprises mainly Māori (though not all Māori women are in this group). For them, smoking and its ill effects are almost entirely related to the process of breathing and smelling smoke – and because the baby does not “breathe”, it is not really at risk. These few (three women) need a much clearer message about the poisons that get dissolved into the mother's bloodstream, the fact that the bloodstreams of mother and baby are the same, and that the bloodstream is how the baby gets oxygen (“breathes”).

'I know that carbon monoxide is a gas that gets in my lungs. The baby doesn't breathe air, so it's not getting it. Carbon monoxide has to change in some way to get into my blood and so the baby doesn't get carbon monoxide'

'There's more danger when the baby is out [after birth], breathing and smelling the smoke. I always make sure I'm nowhere near her and not in the house or car. The smoke is very bad, the smell'

'That's not true, I don't believe it'

Looking at some of the other specific message stimulus used, Māori and Pacific women appear to find the message **‘quit smoking now and be a good role model for the kids’** more motivational than European women. Some women spontaneously mention that they are very conscious of the statistics about being brown and smoking, or brown and on the dole with children. A couple have deliberately made life decisions to refute those statistics (waiting to have children until finished education and have a career), and they feel they are letting themselves down with smoking.

‘Reminder not to pass on (the smoking habit) and create another generation of chaos, not just about you, it's the next generation – I don't smoke around children now, who knows what they pick up on’

Less motivational messages among the ethnic groups

Messages that do not work well tend not to work well across the different ethnicities. However, there are two messages that many of the Māori women especially do not relate to. These are:

- *Friends who do not support you are not true friends.*
- *Smoking during pregnancy is not being normal in society.*

Reactions to both are likely to reflect the overall prevalence of smoking in their communities. Two of the Māori women who come from higher educational backgrounds are also the only people still smoking in their families and one of the last smoking in their social groups – these two do not react so negatively to these messages.

Women who may already be feeling marginalised due to ethnicity or economic disadvantage do not respond well to messages that suggest that other people are judging their behaviour



Pregnancy status

Currently pregnant

Without a doubt the strongest message amongst pregnant women for quitting or trying to quit smoking relates to **lung development** – smoking can harm the development of a baby's / foetus's lungs and make it hard for them to breathe. It is immediate, it is an obvious link to smoking, and it taps into the guilt of feeling like a bad mother. It is strong amongst both women who are still smoking during pregnancy and those who have quit. It is strong across different stages of pregnancy. It also works across first-time mothers to second- and third-time mothers.

Other messages that have the most impact clearly communicate the physical harm that smoking in pregnancy does to the baby. These messages are:

- *When you smoke, your baby / fetus is smoking too.*
- *Toxins from smoking are passed through the placenta to your baby / fetus.*
- *It is better to quit part way through pregnancy than not at all.*
- *Light / social smoking is harmful to the baby.*
- *A smoker's baby is more likely to get asthma and ear infections.*
- *Feel better knowing you are a great mother for caring enough to quit.*

Had babies, not currently pregnant

Women who have had their baby are much more concerned about cot death than those currently pregnant. It is more immediate and a possibility right there and then. Lung development remains important, and this message, alongside a cot death message and the concept 'baby is smoking too', is the most powerful for this group of women. Motivational messages for this group are:

- *Smoking can harm the development of a baby's lungs / fetus's lungs and make it hard for them to breath.*
- *When you smoke your baby smokes too.*
- *Smoking increases the chances of cot death.*

Pre-pregnancy

Women who are yet to fall pregnant are resistant to messages about pre-pregnancy smoking and the impact it can have on the baby. Some say pregnancy is still a significant way off yet. Most consider pregnancy to be at least five years away, and this event is not yet sufficiently powerful to motivate them to consider quitting. As a result, messages talking about the baby really do not motivate women to consider a quit attempt in preparation for pregnancy. They only become powerful once women become pregnant. They consider themselves in the target group for general 'stop smoking' messages rather than preparing for pregnancy messages.

Some, especially Māori women, point out that many pregnancies are unplanned, thus you cannot know when to stop or when to prepare. The most powerful message to this group is '**when you smoke your baby smokes too**', but it is unlikely to be effective before pregnancy.

There is a suggestion that the message that cites the womb as the start to your baby's life could have an impact on women who are thinking of starting a family or giving the baby a smokefree start to life. This message could be presented as a way of polarising the woman's mind towards the future environment for her child.



The smoker

Smokers with high levels of dependency on smoking also have high levels of resistance. They know that smoking is bad for them – some do not care about themselves, others just put the possible effects to the back of their mind.

Levels of addiction vary, and this can impact on the type of message required in relation to strength and shock factor required to get attention. Some women are ready to give up, they are just looking for a push. Pregnancy provides that push and they look for messages that reaffirm their decision and support them in difficult times.

Other women are physically and mentally dependent on smoking. Messages about the good things that can happen if you stop are not sufficient to help them deal with the desire to smoke. The best way to reach them is with hard-hitting, simple-to-understand messages that leave them with no doubt about what they are doing and the actual effects it will have.

The strongest message styles for smokers reflect the message styles that are strongest across women overall; they relate to focus on the baby and very specific physical harm shown to baby. Examples of the strongest types of messages are shown below and are similar across the breadth of women in the study:

- *When you smoke, your baby / fetus is smoking too.*
- *Smoking can harm the development of a baby's / fetus's lungs and make it hard for them to breathe.*
- *Low birth weight is a leading cause of infant death and complications.*
- *Toxins from smoking are passed through the placenta to your baby / fetus.*
- *Smoking restricts the amount of oxygen your baby / fetus is getting.*
- *Smoking increases the chance of cot death.*

For a small number of smokers, the reaction to the suggestion of cot death is strong but they question the link to smoking. The causative nature of smoking on the incidence of cot death has not been established strongly enough for them to consider this to be a strong motivator to stop smoking.

Some smokers are also more sensitive to the message ***'friends / family can help quit by keeping smoking away from you'***. This is mentioned across a range of different smoker types. They strongly agree with this statement has potential to provide support to a quit attempt and feel that this action can make the quit process less difficult.



The environment

The sample was deliberately chosen to reflect those with low levels of educational achievement. However, included in the sample were a few with slightly higher levels of education. There are indications from the small number of women we interviewed with these higher levels of education that this factor can impact on how receptive women are to hearing quit messages.

Women with higher levels of educational achievement tend to be more convinced already of the damage smoking causes and it is about when they stop, not if they stop. However, when it gets to the specific messages level, there are no differences.

Where there are other smokers in the household then the pressure on women to continue smoking can increase. This tends to go hand in hand with larger households. Often it is not just the partner that is smoking but the mother or the mother in law, or sisters. This is where social environmental messages around others supporting the decision to quit or not smoking around women once they decide to quit can show through as important. For example: ***'friends / family can help you quit by keeping their smoking away from you'***.

As evidenced from the earlier part of interviews with women in this group, some partners or family members are willing to make active attempts to smoke away from the pregnant women or make a quit attempt alongside the women.

However, these types of messages are often about supporting the decision to quit once it has already been made. These actions help make the decision more bearable and realistic. The key message for quitting though, even in these larger households, in the first instance, still needs to be focused on the harm it is doing to the baby.

The other key impact on women is also their social environment. This is especially when going out socialising and when at work (smoko break). Women who especially mention the stress of giving up smoking related to these situations still find the baby-centred messages the strongest. Again, friends / family understanding support rather than motivate the decision.



Other factors

Looking at urban versus provincial splits, there are not differences from this sample in messaging based on location.

Any messages more judgemental in nature are more strongly rejected by younger women (under 30 years of age), who bring a sense of rebellion to the situation. Also messages talking about health effects tend to need to work harder with this group, as their own general health has not been too affected by their smoking, thus they question credibility of messages more.

For older women (30 years of age or older) previous experience may create a false sense of security. If they have smoked through previous pregnancies and had healthy babies, they can be very resistant to messages that suggest otherwise.

5.7 Section overview

Message generation amongst those who have quit already

Among women who have quit during pregnancy, the strongest types of messages they believe would encourage other women to quit relate to the impact on the baby from smoking. They are specific to pregnancy. Messages are baby-focused, showing strong causation of harm to the baby from smoking. The lack of choice for the baby or a single specific image that represents the harm that smoking can do to an unborn child is perceived as a powerful motivator for a quit message.

Maximising understanding of messages for a quit attempt

The **most powerful message** themes from the women in this study's perspective are:

1. Messages **focusing on the health and the wellbeing of the baby**
2. Messages that especially **focus on showing specific and objective biological facts that show harm to the baby**
3. Messages **immediate and straight to the point**
4. Messages saying this **WILL** or this **DOES** happen if you smoke to your baby
5. Messages showing relevance and easy application within the environment of the person.

Message themes that women consider to be successful in motivating possible quit attempts among pregnant women tend to work consistently well across the subgroups of interest in this study.

Those currently pregnant relate to a lung development message especially, and this resonates across all stages of pregnancy. The lung development message is an immediate, obvious link to smoking and hits hard both smokers and ex-smokers alike, as well as first-time and subsequent mums.

Women with other children are more sensitive to the cot death type of message, as it is more immediate and relevant to the stage of their baby's development.

Those not yet pregnant are a hard group of women to reach. No messages especially resonate with this group, as they are not in the 'pregnancy cycle' yet.

Themes problematic with women are as follows:

1. Messages saying women can **quit later in pregnancy**, unless qualified with some messaging around the damage women have done to date as well to their baby as a result of smoking
2. Messages that are **judgemental**
3. Messages **perceived as dubious**, which struggle to be credible
4. **Lack of relevancy**
5. **Not being specific or direct enough** in a message in delivering impact of the women's behaviour on the baby.

There are some messages that can play a role in supporting a quit message. These are messages relating to the impact of other people in a smoker's life. For example: ***'friends / family can help you quit by keeping their smoking away from you'***.

6 Message Tone and Style

Women were asked to discuss what they perceived as the ideal way to communicate a message to encourage women to quit smoking pre- or during pregnancy. Initially this was done without using any material to prompt or stimulate the discussion.

After the unprompted exercise the women were then shown a range of advertising media created for smoking cessation and other social marketing campaigns. This included pamphlets, posters, and pictures from television advertising campaigns.

Each interviewer had a similar set of material, although there were some small differences between the sets used. Materials used are outlined below, and it is noted for each piece of stimulus if it was seen by all women or a sub-sample of the women. Note for the TVCs women were shown a still shot from the TVC and a description of the TVC:

Material all women saw

- 'Adrian' TVC
- 'Keith' TVC
- 'Smoking not our future' TVC
- 'Face the facts' TVC
- 'Smoking kills 5000 New Zealanders every year' TVC
- 'All cigarettes are deadly no matter how they are packaged' TVC
- 'Kids do what you do' TVC
- 'Patches and gum are safe and double your chance of quitting' TVC
- 'Smoking robs your loved ones of 15 years of your life' TVC
- 'All cigarettes are deadly' TVC
- 'Quitline pregnancy' TVC
- 'Changing smoking in pregnancy' brochure
- 'My baby will be Māori and Smokefree' brochure / poster
- Baby brochure with words showing outcomes of smoking
- 'I'll give him a choice' poster
- 'Never let your child get sunburnt' poster / postcard
- 'Me Mutu – Kia Kaha' postcard.

Material a sub-sample of women saw

- 'Smoking is not our future' posters – all saw a selection of three of the following six posters as listed below:
 - It's never too late to quit
 - Every single person I know that smokes wants to quit
 - The makeup artists on Shortland Street say they can pick a smoker's skin straightaway
 - I was lucky to have a family who would've kicked my arse if they found out I was smoking
 - You know you want to give up
- 'Feeding our futures' – women saw one of the two following posters (half and half split):
 - Snacks don't have to come in packets
 - Tongan version
- 'A guide to making your home and care smokefree' pamphlet – half the women saw
- 'Problem gambling we all lose' bumper sticker – half the women saw
- 'Problem gambling affects us all' pamphlet – half the women saw
- Tear off sheet – 'Aukati KaiPaipa' – half women saw
- 'Feeding our futures' postcard
 - Maori version – half saw
 - English version – half saw.

Women were asked to use these to prompt ideas in terms of tone and style for what would and would not work for the sorts of pre- and during pregnancy messages they had been evaluating.

In this section of the report only a key selection of the total stimuli are shown in the commentary, reflecting where comment is focused amongst the women interviewed. The full set of stimuli is detailed in Volume Two of this report in Appendix D.

Stimulus was used to generate further discussion on tone and style only after interviewers had elicited without any verbal or visual prompting women's ideas and beliefs on the topic. The purpose of this research was not to assess the stimulus itself.

6.1 Tone and style of the message for maximum impact

Women were asked the best and worst ways for messages about quitting to be delivered to them. This meant asking what was the most and the least motivating ways to get them to quit. This section outlines the key tone and style women discussed for maximum impact amongst the pregnant and smoking target group.

Overall, women are consistent in their approach to the tone and style preferred for a campaign like this. This is regardless of whether they are currently pregnant and smoke or not. There is little difference in opinion between subgroups.

Serious, factual tone and style

The majority of the women talk about smoking during pregnancy as something that is a serious topic. As a result, the sort of tone and style women say they want is a serious factual tone and style for communications with quit messages in them.

This is universal across the sample group of women, who are extremely consistent in their viewpoint on the way a message like this should be communicated. There is little room for lightness and even less for levity.

As women discussed the tone and style preferred for a campaign like this, information also continued to be elicited around actual messages also preferred. This information came spontaneously from the women without any prompting. This has been fed back into the previous section (section 6).

Hard-hitting tone and style

Smokers and non-smokers in the study recognise that many women are adept at pushing the adverse effects of smoking while pregnant to the back of their minds or that they do not entirely agree that the effects are real. To counteract these feelings the women describe the tone and style of messages that will motivate a quit attempt as being hard-hitting and strong. However, most women recognise that quitting is not easy and feel that style and tone need to also demonstrate a level of understanding that recognises the challenges many pregnant smokers face.

Tone and style tap into being a good mother

The majority of women say a communication needs to tap into the feelings of being a good mother. A number of women comment as far as saying this should make a woman feel uneasy and guilty about what they might be doing to their child.

A good example of how this is communicated is in the ad shown below, the sunburn ad with the boy showing his back sunburnt. This has the type of graphic imagery the majority of women say they want in a pregnancy and smoking campaign. It shows the impact on the child, and viewers instantly and viscerally understand the pain the child is facing. It taps into the desire to be a good mother and not to let this happen. It says the parents are risking this child getting skin cancer and that it is the parents' responsibility. The messaging is clear, direct, and to the point. It is factual and does not judge, but does link directly to the actions of the parent.

*'Sunburn one – scary, shocking, can relate to it, not compromising
– NEVER let your child get sunburned; straight up, who the hell am
I to do that to this baby? – can imagine the pain'*

*'Sunburn – links it directly and clearly to parents' actions – it's
YOUR responsibility'*

'Sunburn: good visual image, striking colours'

*'Sunburn – that's the only one. It's straight and to the point, not
happy children. Makes you think about it and it doesn't sugar coat
it'*



Look and feel need reflect the truth is being told

When women talk about the look and feel of a campaign like this, comments relate to the need for the campaign to be clean and uncluttered. A few talk about wanting the look and feel to be almost stark, reinforcing the perception that this is just the bare truth. Black and white, or black, white, and red are commonly suggested.

Look and feel need to be real

Almost all women also want a feel of true reality and authenticity coming through in the campaign: real people in real life situations. Some suggest a semi-documentary feel, with posters or billboards that first introduce a real group of smoking women and then track their progress and any consequences.

Look and feel need to connect rationally and emotively

As a result of the feedback from the women, the clear outcome is the look and feel of the campaign must seek to connect on both rational and emotional levels. Women need not just to feel that they *should* quit smoking, but that it is *possible* and they others can do it.

'Tells it like it is, no sugar coating, the harder-hitting the better – the drunk driving ads are good, shocking. Point the finger at "you" as the person who chooses to smoke and possibly harm the baby with each puff, not just a generic smoker who is someone else who doesn't really exist'

6.2 Tone and style of the message for worst impact

This section outlines the key tone and style women discussed for that would be likely to have the worst impact amongst the pregnant and smoking target group.

Lecture or preaching style

Although women want a serious tone and style to the campaign, they also do not want to be talked at or lectured to. Examples of bad tone and style for the campaign would be:

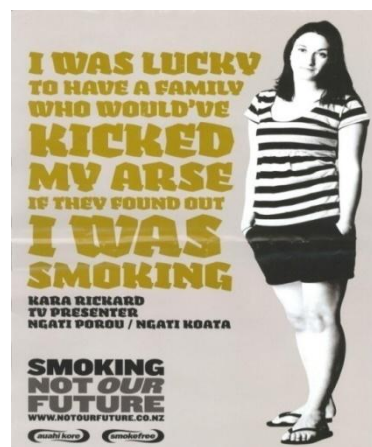
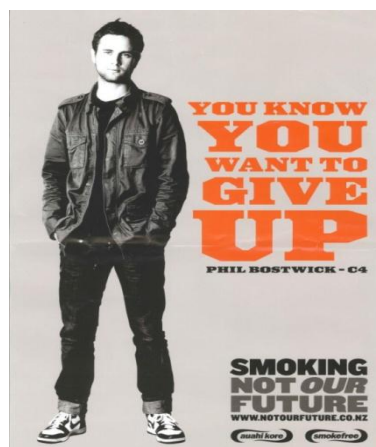
- Using a 'we know better than you', preaching tone
- Talking down at the women, being condescending, as a parent to a child.

Putting humour or being too funky in the campaign

Almost all women do believe there is nothing funny about smoking, especially during pregnancy (there may be some difference for Māori women, see below).

Although being modern and funky has a place, being too modern and funky is not consistent with the place women say their baby has in their lives.

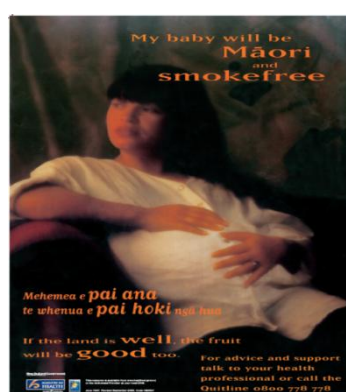
- An example of this is the posters of the celebrities used as stimulus in this research. Women in this study comment that the posters have a feeling that is too removed from reality of having a baby, and the tone and style are too modern and funky for such a serious topic. In some instances the posters are too wordy. However, the language of the messages does have the right tone, talking in the sort of language their family and friends would use, thus making the message more real and relevant. Some women comment they do not know who the different people are in the posters. Younger women are less critical of the celebrity posters



Being too soft – not serious enough

Examples of this given by the women include:

- The postcard with the tree as lungs – women comment this is not specific or graphic enough in imagery to be hard-hitting. Some of the women do not even realise the tree is meant to show lungs.
- The following 'Smokefree' ad shown. A number of non-Māori women comment the ad does not work if you are not Māori. There is also some comment that the woman in the ad does not look real enough, and the style feels a little impressionistic rather than real. A few comment it is not graphic enough, with no baby or impacts on baby from smoking showing. Māori women do like having messages in Māori as well as English suggesting that they are the particular target or the only women who do this. A few women comment the brochure execution is weaker than the poster, as it comes across as an ad for a peaceful retreat or day spa. The Pacific women in this study like the idea of having messages in their languages, but none of them could actually read any of the Pacific peoples' materials shown as examples (this is because it is not in their specific language).



Two Māori women (one respondent and her support person) stand out in their enthusiasm for using black-humour for 'stop smoking' campaigns. They feel that Māori appreciate this side of humour more than other cultures do, and think that messages aimed at Māori ought to be sick, in your face, and funny. This is not found in the other Māori interviews, and although it may be worth exploring as a real difference, this research is unable to recommend black humour as a campaign approach for Māori women. An appreciation of black humour is found in many cultures, and the views may have been driven by individual rather than cultural or ethnic factors.

6.3 Words / images for maximum impact

As well as general tone and the style feedback, interviewers also asked women to comment on the type of words or images that would be best used for maximum impact.

Quick to gain attention

Feedback from women generally is that, it is important to keep the text simple and straightforward. The main message has to leap out at the women to capture their attention. "Death" is particularly powerful; the majority of the women say they cannot but help read the message.

Use of graphic images

In terms of the advisability of graphic images, there is some polarisation of opinion. This split seems to be on individual personality rather than subgroup (e.g. smoking status, ethnicity) lines. One group of women believes shock value will be needed to get attention in the campaign, but a different kind than they have generally seen before. They comment they have seen many ads and communications about smoking, and none of them has stopped them permanently smoking. One (smoking) woman jokes that she and her friends and family have a competition of who can collect a complete set of disgusting body parts pictures first. The only shock ads that have seemed to provoke a thoughtful response while pregnant have been the ones with babies.

The other group believes that shock images just make people angry and turn them off. They have become habituated to graphic images. Again, though, the exception tends to be the images of sick babies. Even those in this group join the rest in suggesting campaigns that portray infant coffins and funerals, smoking mothers who check on their baby to find him dead, small children picking up discarded butts and smoking them, and close-up illustrations of the baby coughing or having a cigarette when the mother does. An example of some graphic images that are having some impact is baby images / pregnant women on cigarette packs. One Pacific woman specifically mentions she felt so guilty she did not buy those cigarettes any more. However, this does not stop her smoking; she just buys a different brand.

To successfully meet the views of both groups, any graphic images must clearly be aimed at women who are pregnant, or it becomes just another smoking campaign, which they will just ignore. Babies and, to a lesser extent, toddlers must be the first thing that a viewer sees – and the more closely and immediately the image ties either into love and protection instincts or to harm and damage caused by smoking, the better.

Examples of impactful ads

In looking at examples of possible style / tone for the campaign two TV ads stand out for their strong impact amongst the women – they come across as being very real.

- **The TV ad showing Adrian.** This image has an immediate physical reaction for many of the women. The ad is perceived as extremely graphic, and some women go as far as to say they turn away from the TV or turn channels when it is on as it upsets them so much. It is perceived as very real and causes an immediate physical and emotional reaction. However, for some there is also a rejection of the ad for themselves as smokers in terms of ‘well, that can’t happen to me’ or ‘I don’t want to think about what is in my future’. This level of graphicness, though, is the level that is wanted to really hit hard about what smoking does to the baby / foetus. Although wanting this strength of graphic presentation, the campaign has to have imagery that women could imagine happening to their baby right now in their womb.



A series of ads showing Adrian, a man in his 50s, he speaks through a hole in his throat (trachy). He has oral cancer and has had radiotherapy and an operation to remove his tongue and can't eat. The end frame of the ad shows a cigarette packet with the 'oral cancer' picture warning. The ad has a tag "It's not worth it eh?"

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- **The TV ad showing Keith.** This advertising is extremely powerful, even more so than Adrian. It uses a different type of shock value, and this is what makes it so powerful. Adrian is shocking as he is such an extreme case, while Keith is shocking as you can see the impact of smoking on him so clearly in everyday life. The sound of his breathing is really effective, especially doing everything things. This immediacy is what women are saying is important in a quit campaign for pregnant women. 'Show how shocking it is for me to do this to my child.' 'Show me what I am actually doing.'



A series of ads showing Keith, a man in his 50s, he is suffering emphysema. The ads showed him having breathing difficulty, wheezing, and having difficulties to do everyday activities (i.e. walking down the neighbourhood, lifting grocery items from a supermarket trolley, etc).

Image of the baby

Having a healthy image of a baby is not what is wanted by most women (unless it is juxtaposed next to an unhealthy one or images of what can go wrong). Women want smokers to see the impact of their actions on the baby. They want to have the baby shown struggling for air, trying to breathe or the toxins passing through to the baby. The image below goes some way towards this – but the baby is too healthy and there are too many words to take it all in (although the 'scary' words jump out). It is not quite graphic and 'in your face' enough. There is also a small group of women (mixed backgrounds) who also want to see the success stories, examples of women who have quit and have healthy babies as a result.



'Smoking mother finding dead baby in cot; otherwise loving mother choking or smothering her baby; smoking mother with cutaway showing foetus smoking too'

'Little baby in incubator with tubes coming out of it; woman crying in the background because her baby has died (like an existing ad); funeral with a baby's coffin; making the 'kids do what their parents do' ad more out there - show little kid 'smoking' a butt discarded by their parents or getting a cigarette out of the pack'

'Smoking babies, baby coffins, anything that packs an emotional punch (but not the graphic gunk)'

'Need to put some ads on TV with the baby choking in the stomach, show them in the womb with the mother and the baby coughing'

6.4 Words / images with lower impact

This section outlines the types of words or images women comment on what they feel would deliver the worst impact for a campaign like this.

A campaign with a lot of words, not simple to read and take in is the opposite of what the majority of women say they want. A few women cite examples of brochures they have been given by their doctor; they all say they throw them away for this reason.

A number of women comment that wordy information does run the risk of becoming boring, bland, and rejected as 'just things we've seen or heard before'.

Other comments from women on worst words / images include:

- Opinions or subjective observations that smoker might disagree with or have different experiences (e.g. 'not all my friends want to quit, that's just rubbish')
- Focusing too much on the woman and not the baby would also reduce impact. The baby is the most powerful graphic device there is.

6.5 Most powerful people to use in delivery

Women were also asked who they believed would be the best types of people, if any, for delivering such quit / attempt to quit messages that they would be most inclined to listen to. This included probing questions around the gender of the person and relationship to the smoker, e.g. friend, neighbour, midwife, GP, celebrity, etc.

Strong preference for use of females – especially real mums

Almost all of the women want to hear a message coming from another female. Ideally they want to hear other women's stories, women who are just like them. They want to be able to relate to the women in the campaign. They want it to be real with everyday people.

As a result, this would ideally be a mother who has gone through and had her baby, and either quit and talks about the difference that makes, or did not quit and talks about what happened as a result.

Example of real mum ad

For a number of the women the 'I'll give him a choice' ad taps into being a good mum, as they get to hear from another mum. This is the other way a campaign could work. Rather than being too graphic and shocking, the campaign can show women who have made the choice to quit.

The majority of women say they want real women and real stories. This poster also works well, as it acknowledges that quitting is not easy and talks about lungs and about the baby's non-consensual smoking. This is a message we know resonates strongly across all women as a reason to quit (see previous section).

The poster works well in three ways:

- Focuses on the fact that smoking might be your choice, but your baby should make his own choices
- Uses straightforward language
- Refers to how hard it is – creates good sense of relevance.

'Give Him a Choice: really good, everyday woman you can imagine seeing walking down the street – very strong emotion – no bullshit – it's about the baby and putting the baby first'



Role of the father

A broad cross section of women explain that motivational messages should be designed to reach fathers too, and therefore that any voice should be male. The thinking is that only women will listen to a female voice, whereas both men and women will listen to a male voice. In this instance the women want the male voices to represent either a father's viewpoint (e.g. 'we knew we should have stopped smoking when Jane got pregnant; every time we see the empty room, we wish we had.') or the voice of scientific fact.

Healthcare professionals

Some of the women relate to healthcare professionals. This is at two levels: mass communication and individual relationship. For general communications, having someone with the weight of scientific knowledge and experience lends credibility and authority to the message. These women talk about this including GPs, midwives, or any scientist who has credentials.

Some of the women say they would pay attention to messages from HCPs if the information is specific and related to their experience. However, it does become trickier in a personal relationship because the needs and dynamics change. For the HCP to genuinely help, they need to have a good relationship with the woman and be willing and able to spend time with them. This is not always practical or possible.

A midwife is suggested as a possibility in the research as a way to communicate with women in the target group. Preference for this is not as strongly expressed as suggestions the best person would be someone just like the women themselves. Although the midwife can deliver a quit message because she has seen the effects first-hand, she is probably not yet a familiar enough figure to be able to motivate the women to quit in the early stages of pregnancy.

Although few women cite the GP or midwife as a good source for the messages, many more seem to actually be taking their advice (this is based on comment of a few women in the study who also make mention of their friends / family taking this advice).

*'Doctors because of the weight of their professional training;
midwives talking about things they notice – like tar in placenta if
true'*

*'Medical and scientific people: respected and with the actual facts
rather than opinions; staff who work in neonatal units; male voice-
overs because then men and women might listen, if woman
probably only women would pay attention'*

*'Midwife: she forms a relationship with the woman and should be
good support. Doctors should do way more talking about it – they
don't, just note that you do and maybe hand you a leaflet'*

6.6 People used who would be least powerful in delivery

Talking about the best types of people to deliver such messages also led the women to talk about the worst types of people to deliver the message. This section examines the types of people women talk about as less appropriate for this type of message delivery.

Having males as focus

In general, the majority of women say using men in the campaign detracts from the message that this campaign is about pregnancy and babies. As previously mentioned, women feel using people who have not actually been through smoking and pregnancy and having to quit detracts as well.

Use of celebrities – unless relevance shown

When specifically questioned on the concept of using sports people or celebrities, before being shown any examples of advertising, the majority of women generally comment that these types of people would not be as impactful as real women who have actually gone through the experience. Comment is made that they would not know what it is like or be able to talk from personal experience. As a result, they would be perceived as not sufficiently serious to be really committed to the cause. It would not be as relevant as a result.

Almost all women are open to the idea of celebrities who can talk from experience. It is the experience component that is important. This comes back to the desire for real women in real situations.

Use of those inexperienced in situation

Some women are very resistant to advice from non-smokers or people who have not smoked – these people lack credibility because they just cannot possibly know how hard it is. These women believe only professionals such as GPs, midwives, or NICU / hospital staff are in the position to be able to speak from experience regardless of their personal smoking history. They must restrict their information only to what they know: the effect of smoking on labour / delivery and the baby.

6.7 Most powerful content / information given

As part of the tone and style section of the interview guide women volunteered information about their preferred content for such a campaign. This section summarises their comments.

Almost all women say the focus of the content needs to be on the impact on the baby. The message needs to say 'this is what will happen to your baby if you continue to smoke' and deliver a clear call to action, including next steps and ideally some tips and tricks.

'Very descriptive; needs to link the actual action (of smoking each cigarette) with the harm (to the baby) – just saying "smoking" does this is too far removed'

'Not too much to read – has to be message absorbed in time looking. I won't take things home with them to read later. The only thing I might look at in a leaflet... needs to be practical help about where to go for help and next steps'

'Blunt statement of effects to shock, make think, then give information about help – HOW to stop, what resources are available'

6.8 Weakest content / information given

This section covers comments women made in passing in discussions on tone and style on the weakest type of content or information for a campaign like this.

Weakest information for the majority of women is information that is too detailed and does not get to the point fast enough. This means:

- It would not show the direct clear link of impact of smoking on the baby.
- It would focus too much on the woman and not enough on the baby.
- It would not have a call to action in the message.

6.9 Strongest channel delivery

Women were asked about the best ways to bring a campaign to their attention. They talked about focusing on areas those women who are pregnant frequent.

Ideally almost all women say they want to see this type of campaign on TV. It is the medium they interact with the most and are most comfortable with, thus is the default medium to want such a campaign to use.

Strongest channels this discussion identified apart from TV are:

- Online campaign, making use of social networking sites. Almost all the women use the internet and there are specific sites, including social networking sites, they go to frequently
- Posters in GPs' waiting rooms, pamphlets to support the posters being handed out by HCPs
- Bus shelters / backs of buses
- Billboards
- Women's magazines / baby magazines
- First pregnancy gift pack.

'Billboards, magazines (That's Life, NW) because will get to maximum people and need the visual images'

'TV, radio, posters. Leaflets with more info in GP's offices to take away for reference for where to get help. Women's magazines.'

'Very public places: billboards, bus stops, backs of buses, supermarkets. On packets. Baby magazines. Pregnancy freebies bag that midwife gives out'

'Billboards seen while driving, bus shelters something to look at while waiting'

'Pamphlet handed over by Plunket Nurse or Midwife on the first visit'

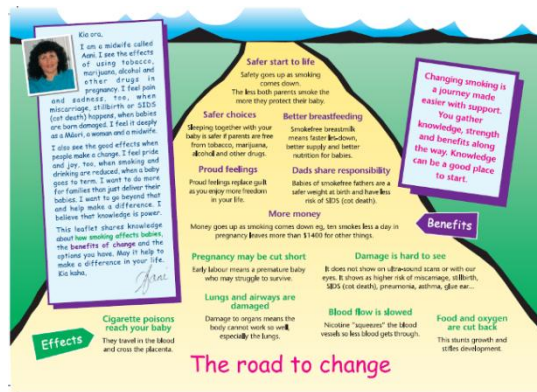
Pamphlets strong second line channel for information

When women talk about pamphlets they tend to talk about these as an addition rather than the focus of a campaign. Almost all women expect there would be something else apart from these as the main communication. They talk about pamphlets acting in the role of providing more detailed information, once they have noticed the campaign.

Although pamphlets are not seen as ideal as a first call to action, they can provide a valuable role in women's eyes as a second line channel for more information. Women perceive them as going hand in hand with a poster or being handed over by healthcare professionals when they visit them.

The pamphlet below has many of the qualities wanted for a quit campaign. Women like that it has a picture of a baby on it, which they say is very important to them. They also like that it supports the women in their choice by showing a healthy baby. In terms of the layout they like the fact the inside is clear, not too cluttered, and that it offers advice and support.





6.10 Weakest channel delivery

When talking about the types of places that the campaign might be seen in, or using different types of media women also naturally discussed some they would not relate to so well. This section provides an overview of these comments.

Radio really is not mentioned as a main channel for this campaign by the women. Also, as evidenced in the profiling section of this report, women are spread in terms of the radio station they listen to, making it hard to target just one station.

The majority of women say specifically they would want a big bold graphic campaign. Any channel that does not support strong visuals is not going to work as well. Only one type of ad is mentioned by a woman with a strong audio – that of overhearing a woman finding a dead baby and screaming and crying, or hearing the sobbing and grief at a funeral.

6.11 Subgroup review

There is no consistent pattern between subgroups in terms of key differences for desired style and tone in a communication of a 'quit smoking' message. There are some specific points mentioned by individual women; however, this is not reflective of specific target groups. Women overall are consistent in their approach to the tone and style preferred, regardless of the subgroup they are part of. Where there are small differences between individual women, these have been noted in the sections above.

It is worth repeating that although two Māori women talked about Māori having a much more graveyard sense of humour (as discussed above), this is not found in the wider Māori sample and may simply be a reflection of individual rather than cultural and ethnic differences. Certainly black humour exists in many different cultures.

6.12 Section overview

The tone and style of a campaign need to be:

- Serious and factual
- To the point / simple
- Showing the woman as responsible in making a decision not just for herself but for her baby, being a good mother
- Graphic
- Showing some shock value, hard-hitting
- Relevant and real in a way a woman can see herself mirrored in it
- Taken in at a glance
- Authentic – reflecting the truth is being told
- Showing clear links to pregnancy
- AND most importantly connect emotionally as well as rationally.

In terms of graphic imagery there is a fine line between being graphic enough to attract attention and being so shocking as to cause women to shy away. Showing women in a case study / mini documentary approach is another way a campaign could work if a graphic route were not preferred. This means showing real women talking about their real experiences.

If there are going to be people shown in the communications, a female (real everyday woman) is more powerful than a male figure. Messages delivery works best when there is a sense *‘that could be me’* and when the situation says *‘that could happen to me’*.

In terms of delivery of the campaign, posters are mentioned as a primary way to communicate. These would be in areas where women are often visiting or waiting, like bus shelters, healthcare waiting rooms, and other public places like backs of buses, Plunket rooms, and shopping malls. Pamphlets also have a role to play, supporting the poster, providing more detailed information.

Use of social networking sites also appears as a good option for a communications channel.

Desired tone and style are consistent across subgroups.

7 Summary and Conclusions

Impact of smoking on self



The women in the study have a good understanding of the personal health risks associated with smoking. Most of the women started smoking while still at school and have just continued to do so. Often when describing their attitudes to smoking they discuss the bad smells associated with it, as well as yellow teeth and fingers. Some of the women have experienced minor health issues such as coughing in the morning or dry and sore throats. The women also explain that there are a range of reasons for continuing to smoke. This diagram above illustrates the negative effects and the positive experiences that form the relationship that women have with their smoking behaviour.

More detailed analysis shows their behaviour, feelings, and actions are similar to smokers generally, but that being pregnant creates a new dimension to this situation.

Impact of pregnancy on smoking

The presence of the unborn child brings a whole new dimension to the decision to smoke and smoking behaviour for the majority of the women. Most women in the study understand in a general sense that smoking is bad for their baby. This awareness makes women confront the consequences of their smoking, and a proportion quit as soon as or shortly after they find out they are pregnant. This is not universal, though. Many women say they have tried, but it is too hard, or that the risks are probably overstated.

In a number of cases (especially among the Māori women in the study), women are encouraged by friends or family to continue smoking – this is usually due to social pressures or the ‘auntie syndrome’ (“my aunt / mother / sister / friend smoked through her pregnancy and her babies are fine”). Sometimes this can be as a result of lack of knowledge of the true impacts of smoking on the baby.

There are a few women who believe stopping smoking in pregnancy is not good. Some think it is dangerous to stop and some say they or friends of theirs have been advised not to stop – and some say they were told this by a healthcare professional. Some Māori and European women relate personal experiences with GPs or midwives in which the professional did not seem overly concerned with their smoking beyond a casual “smoking isn’t really good for the baby”. Even more reports are made about encouragement to continue smoking provided by pregnant sisters or friends.

It is possible that during an initial consultation a midwife or doctor may prefer to take a low-key approach in order to develop a better relationship in the first instance, with a view to helping the woman with her smoking behaviour at a subsequent appointment. However, reports from these women do suggest that stop-smoking and smoking-related health messages are being undermined, or at least not reinforced, by some healthcare professionals.

During the process of exploring motivational themes for communications to help women make a quit attempt, women were sometimes surprised at the information in the statements or questioned if they were true. This suggests that while women feel that they know that smoking during pregnancy is harmful, there are some details of that harm that are not widely known. Examples of this include cot death, impact on lung development, and low birth weight and how that impacts baby.

Motivation for quitting

Women say the motivation for quitting or wanting to quit is not about the impact on the mother, it is all to do with the health and wellbeing of the baby.

Quitting while pregnant – method

Pregnant women in the study describe two key approaches for quitting smoking. Some described stopping immediately or finishing the current pack and then not having any more, sometimes referred to as ‘going cold-turkey’. The majority of these immediate quit attempts tend to be successful. Often the women are aided by their sudden preference not to smoke, with morning sickness often mentioned here as a motivator.

Other women try to cut down slowly and gradually stop. By cutting down slowly some women maintain a very low level of smoking to be able to continue to socialise with friends and family.

Key barriers to quitting smoking

Women in the study describe a range of reasons for not being able to successfully stop smoking. Some of these relate to a weakening of resolve where women use other reasons for supporting the choice they have made. The order that they are presented in this summary does not denote any order of importance, as this vary among women in the study.

- **Social** – smoking often takes place in a social setting, particularly when combined with drinking alcohol. Smoking gives some women the chance to retain a sense of connection to their social circle.
- **Habit** – smoking is sometimes simply part of a well-established routine.
- **Deferment** – smoking must just be one of number of things that need to be addressed and it can be put off hoping that it will be easier at another time.
- **Enjoyment** – smoking is something that is enjoyed, and some women want to hold to something that gives them pleasure.
- **Stress release** – women sometimes use smoking to calm themselves in stressful situations, and with some women feeling stressed by the circumstances of their pregnancy, this adds to the difficulty of quitting.
- **Confidence** – smoking is used as a way of hiding nervousness, keeping the hands busy, or as a confidence booster.
- **Weight control** – gaining weight is something pregnant women have to face, and if they feel that smoking might make this worse, it can be used as a reason not to stop.
- **Drive** – breaking a habit or addiction requires discipline, and some women are just not sufficiently driven to make a successful quit attempt.
- **Emotional factors** – sometimes the withdrawal symptoms of stopping or reducing smoking can be very emotional. Women who stop sometimes talk about feeling irrational and angry.
- **Addiction** – the physical craving caused by stopping smoking may just be too strong to bear.
- **Denial** – women sometimes feel that the health risks are overstated, not proven, or just not true, and this creates enough doubt for them to continue smoking.
- **Comfort** – smoking can provide a comfort to women who are experiencing extreme changes to their lives.
- **Personal space** – for some women smoking provides them with an excuse to spend time by themselves.

The success of support from friends, family, and organisations like Quitline is really all about the degree of inner motivation. It really is about wanting to give up so badly and having the will to succeed and overcome the difficulties.

Reasons for lapsing and relapsing

When quit attempts fail, women either revert to their previous smoking behaviour or restart smoking to a lesser degree. Women in the study describe a range of incidents or factors that contribute to their inability to maintain their smokefree status.

- **Increased stress** – incidents such as a death in the family, relationship problems or increased strain from other children in the family can all increase stress levels to the point at which women revert to smoking.
- **Emotional instability** – when women in the study experience fluctuations in their emotional state and attribute these effects to not smoking, they then feel that smoking would help to calm them. These types of feelings can encourage women to start smoking again.
- **Boredom** – pregnant women may experience changes in their lives that result in them having extra time on their hands, and smoking is just something to do at these times.
- **Weight control** – when pregnant women become concerned about their weight gain, they can view not smoking as contributing to this. They use their smoking as way of controlling their weight.
- **Denial** – as women progress through their pregnancy, they may feel that it is now safe to start smoking again, believing that harm is caused only in the early stages of pregnancy. In these situations women may also believe that they can safely return to smoking if they limit the number of cigarettes they smoke.
- **Social** – the pressure of situations where smoking is the social norm can just build up to the point where the woman cannot sustain her resolve not to smoke.

Subgroup review based on women in study

A number of Māori women highlight smoking and drinking alcohol as part of the norm – and this being quite hard to break away from. Some lower-socio Māori women are fatalist – they do not expect to live to an old age – accepting their people die young anyway.

Pacific women who participated in the study describe the impact of their extended family groups as positive and negative in relation to their smoking behaviour. In some cases the family presents a supportive non-smoking stance, while others undermine health messages with personal examples of problem-free pregnancies, births, and healthy children among smoking mothers. However, for Pacific women the church is seen as a powerful agent for positive change.

For older women (30 years or over) who have smoked for a long time, it is harder to give up. Often they have had children before who have been fine. They do not perceive it would be different now.

Most importantly, being pregnant can add significantly to the stress in a woman's life – making her want to smoke more not less.

7.1 Motivational messages

Message generation amongst those who have quit already

Amongst women who have quit during pregnancy the strongest types of messages they believe would encourage other women to quit centre around showing the harm done to the baby / foetus from smoking. They go beyond traditional 'stop smoking' messages. These message approaches are mentioned by the women without any prompting.

This means messages do need to be baby-focused and show strong causation of harm to the baby from smoking.

Typically when talking about the motivational impact a message might have, many women think about the lack of choice the baby has or they may envisage a single specific image that represents the harm that smoking can do to an unborn or the effects on a newborn baby.

Maximising understanding of messages for a quit attempt

Women who participated in the research were provided with message stimuli to create in-depth discussion on the topic. This technique worked extremely well for teasing out dynamics / key themes from different types of messages. It also clearly showed message types that worked well and those that did not.

The **most powerful message** themes from the women in this study are:

1. Messages need to reflect **focus on the health and the wellbeing of the baby** rather than the mother. Women tend to reject messages focussed on them rather than the baby. A baby is blameless and does not have a choice. The mother needs to make a choice for the baby. Using a baby-centric message also connects emotively to the growing love or feeling a woman has for her unborn child. An especially powerful example of a message showing clearly the baby's non consensual part in smoking is '**when you smoke your baby is smoking too**'.

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2. Messages that especially **focus on showing specific and objective biological facts that show harm to the baby** hold far more power than other message types. They work more easily to convey a single focused image or concern and make an issue very explicit. Messages that intuitively link to smoking inherently make sense. Examples of strong message in this type of style are: ***'toxins from smoking are passed through the placenta to your baby / foetus', 'smoking can harm the development of a baby's / foetus's lungs and make it hard for them to breathe', and 'smoking increases the chance of cot death'.***
 3. Messages need to be **immediate and straight to the point**. The message has to be about the here and now, more than some distant point in the future. It needs to make the women feel uneasy and evoke the desire to protect the baby. The first two messages shown as examples in point two above demonstrate immediacy.
 4. Messages that are most motivating tend to say "this **WILL** or this **DOES** happen to your baby if you smoke", not "this might or could happen".
 5. Messages also need to show relevance and easy application within the environment of the person. A woman needs to be able to imagine this happening within her own environment.

Themes problematic with women are as follows:

1. Messages saying women can **quit later in pregnancy** are dangerous to use, unless qualified with some messaging around the damage women have done to date as well to their baby as a result of smoking. This means it becomes a complex message – the opposite of what women say they want a message for an attempt to quit smoking to be like. For example: ***'it's not too late to quit if you are still in your first trimester', 'most of the damage from smoking happens after 14 weeks', or 'it is better for your baby's / foetus's health to quit part way through your pregnancy than not at all'.***
2. Messages that are **judgemental** – women will ignore them. This is especially so amongst women who may already be feeling marginalised due to ethnicity or economic disadvantage. For example: ***'smoking during pregnancy is not normal in society'.***
3. Messages that **perceived as dubious**, which struggle to be credible. Two-way evidences in this research are when claims are made that cannot be solely tied to smoking or when the claims are contradicted by what they have been told by other 'trustworthy' sources or what they have seen in their own lives. For example: ***'a smoker's baby has more trips to the doctor'.***

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4. **Lack of relevancy** in a message or lack of targeting something important at that specific point in time undermines a message's success. For example: ***'be a great role model for other mothers and mothers to be. Quit smoking'***.
 5. **Not being specific or direct enough** in a message in delivering impact of the women's behaviour on the baby. For example: ***'not smoking means less stress on the baby / foetus'***.

Some messages that do not create strong motivation to stop smoking can play a support role in encouraging changed behaviour. These tend to be messages that relate to the impact of other people in a smoker's life. For example: ***'friends / family can help you quit by keeping their smoking away from you'***.

Looking at subgroups

Message themes that women consider to be successful in motivating possible quit attempts among pregnant women tend to work consistently well across the subgroups of interest in this study. There are generally small differences in subgroups in terms of the key messages and themes they relate to.

Those currently pregnant relate to a lung development message especially, and this resonates across all stages of pregnancy. The lung development message is an immediate, obvious link to smoking and hits hard both smokers and ex-smokers alike, as well as first-time and subsequent mums.

Women with other children are more sensitive to the cot death type of message, as it is more immediate and relevant to the stage of their baby's development.

Those not yet pregnant are a hard group of women to reach. No messages especially resonate with this group, as they are not in the 'pregnancy cycle' yet. Many say pregnancies are unplanned, thus do not know when to stop until it is too late anyway. Any successful message aimed pre-pregnancy will most likely affect those planning hard for a baby, and they probably are planning to stop anyway.

7.2 Message tone and style

The majority of women in this study perceive smoking as a serious issue to make a decision about, especially when they are pregnant. As a result, they want the tone and the style of the campaign to reflect this.

Therefore the tone and style of a campaign aimed at motivating a quit attempt need to show understanding and a human face as well, but also reflect the seriousness of the actions of the women regarding whether they choose to stop smoking or not.

Women say they want a campaign that presents messages in a tone / style that:

- Is serious and factual, blunt and to the point, delivering hard, undisputable facts.
- Clearly shows the woman is responsible for her baby and is making a decision not just for herself but also for her baby.
- Is graphic and has some shock value around it to ensure women do sit up and listen. A sense of shock can be created by showing graphic images or by creating situations that resonate so strongly with the woman that she can see herself in that very situation.
- Can be taken in at a glance and is simple and straightforward.
- Has a true authenticity about it – real life, creating relevance by using people and situations that women see as being part of their world.
- Differentiates itself from general ‘quit smoking’ campaigns by showing clear links to pregnancy. This means having a baby as part of the visual is key, grounding the campaign in reality as well as showing outcomes from smoking or quitting smoking.

In terms of the graphic imagery, there is a balance between being so extreme that a campaign may turn some women off and being so soft that the point does not show through clearly enough. Care needs to be taken to hit exactly the right note with this, although the indications are that the majority of women are more supportive of the hard-line approach because the subject is considered to be so important it is worth the risk of offending a minority.

If there are going to be people showing in the communications, a female is more powerful than a male figure (the only exceptions are for healthcare professionals or dads). They want a real everyday woman, similar to the women themselves. Showing women in a case study / mini documentary approach is another way a campaign could work if a graphic route were not preferred; showing real women talking about their real experiences – either positive, as a result of giving up smoking during pregnancy, or negative, showing the harm they have done to their baby as a result of smoking.

In terms of delivery of the campaign, posters are mentioned as a primary way to communicate. These would be in areas where women are often visiting or waiting, like bus shelters, healthcare waiting rooms, and other public places like backs of buses, Plunket rooms, and shopping malls. Pamphlets also have a role to play, supporting the poster, providing more detailed information.

Use of social networking sites also appears as good option for a communications channel.

Desired tone and style is consistent across subgroups.

7.3 Conclusions

The act of smoking in pregnancy is a difficult issue for women to deal with. It can create a huge sense of guilt and the ways in which women deal with this are varied.

However, there is a very strong feeling the decision on whether to quit or not during pregnancy is an individual problem – something that the woman has to deal with herself. Support and advice may help to some degree, but it is a personal lifestyle choice, and interfering in this can create more stress and the woman can feel quite persecuted.

There is little suggestion that most women do not believe that smoking is bad for their unborn child. There is a high degree of acceptance that since it does affect their unborn baby, they need to face the implications full on. This is where successful messages come in. Messages have to be unequivocal – simple, realistic, and clearly telling the mother exactly what she is doing to her child.

The strongest messages for a quit or attempt to quit while pregnant campaign are the ones that tap into a woman's feelings about being a good mother and giving her baby the best start in life. Messages need to be baby-centred and specifically state that smoking **does** cause physical harm to the baby. These messages have universal strength across all types of women who are pregnant or have babies, regardless of ethnicity, age, socio level, or smoking status. The message makes the woman think about the fact she is making a choice not just for herself but also for her baby.

For the pre-pregnancy stage it is difficult to find a message relevant beyond general non-smoking messages. These women only pay attention to the quit messages around pregnancy once they are actually pregnant. To get action based on getting pregnant is likely to be extremely difficult. None of the message generated or assessed here is strong enough to do that.

Although most of the social environment messages are not especially strong quit messages, some do have a role to play for the smoker. An example of this is the message ***'friends / family can help quit by keeping smoking away from you'***.

7.4 Recommendations

The strongest style of messages recommended for an attempt to quit / quit campaign is a style that clearly communicates the immediate physical harm to baby from smoking. The highly motivational messages within the different themes which should be given strong consideration to carry forward into a communications brief are shown here:

- *When you smoke, your baby / fetus is smoking too.*

This message taps into the core of being a mother. A good mother would not **poison** her baby with smoke. The impact is immediate, it is happening right now, thus cannot be disputed. It needs immediate action.

- *Smoking can harm the development of a baby's / fetus's lungs and make it hard for them to breathe.*

The effect on lungs is a well-known link to smoking. It draws on personal experiences or the experiences of those around them who smoke and develop breathing problems. With high levels of asthma amongst their own wider family and friends, plus some of the women themselves experiencing the effects of smoking, it is extremely believable. The thought of inflicting these types of problems on the child makes this message very powerful.

The lungs message carries through from pregnancy to post-pregnancy as an especially powerful message. Post-pregnancy consideration needs to be given to the **cot death** message: *smoking increases the chance of cot death*. This message is shown to be extremely relevant to mothers of newborns, regardless of the number of children they have. Cot death can strike any time, and when mothers have a clear understanding of the love they feel for their existing children the thought of increasing the risk through smoking while pregnant is a powerful motivator to stop.

Other physical impact on baby messages which show as powerful from this research and need further consideration in a campaign are:

- *Low birth weight is a leading cause of infant death and complications.*
- *Toxins from smoking are passed through the placenta to your baby / fetus.*
- *Smoking restricts the amount of oxygen your baby / fetus is getting.*
- *Smoking increases the chance of cot death.*

The tone and style of the campaign need to be serious and factual, blunt and to the point, delivering hard and undisputable facts. They need to clearly show the woman is the one who is responsible for her baby and that her actions can nurture or damage it.

The strongest campaign is likely to be graphic and have some shock value in the imagery. This is needed to make women stand up and take notice. The message and images need to be able to be taken in at a glance. Another route would be a campaign showing real women in real situations talking about their experiences quitting smoking.

A pregnancy quit campaign needs to differentiate itself from the general quit smoking campaigns by showing clear links to pregnancy. Having a baby visual is a key way to do this.

Grounding the campaign in reality is vital. It needs to present real situations, real people where outcomes from smoking or quitting smoking are shown.

Appendix

8 Profile of the Women

As part of the interview, researchers at the completion of the in depth interview guide administered a profile questionnaire. This can be found in Appendix C in Volume Two of this report. This questionnaire asks about some basic background information, basic media and shopping habits, and some questions on awareness and usage of smoking cessation products and services. This information was to assist in understanding the women in the research and also the key areas / ways these women can be accessed.

8.1 Number of people living in the household

The table below shows the number of people normally living in a household for each of the women in this study. Fewer than half the women in the study (46% or 14 out of 30 women) are in households of five or more people. Only one woman is living by herself.

Number of people living in household	Number of women	% of women (n=30)
1	1	3%
2	3	10%
3	5	17%
4	6	20%
5	2	7%
6	3	10%
7	4	13%
8	3	10%
9	1	3%
10 or more	1	3%
No response	1	3%
Total Respondents	30	100%

The following tables show the spread of age groups in the household across the number of adults in the household aged fifteen years or older. Most often there is between one and three children in the household.

Number of people living in household aged 15 years or older	Number of women	% of women (n=30)
1	4	13%
2	8	27%
3	4	13%
4	5	17%
5	4	13%
6	4	13%
No response	1	3%
Total Respondents	30	100%

Number of people living in household aged under 15 years	Number of women	% of women (n=30)
0	6	17%
1	5	17%
2	10	33%
3	7	23%
4	0	0%
5	0	0%
6	1	3%
No response	1	3%
Total Respondents	30	100%

8.2 Household situation

Just under half of the women in the study (43% or 13 out of the 30 women) are living at home with parents or extended family. Women were not asked to specify exactly who lived in their households. Nine women (30%) are living with their partner / husband. There are three solo mothers in the research. Five women cited a different household situation but did not disclose details of this.

8.3 Others in household smoking

Seventeen (57%) of the women have others in the household smoking. Main smokers at home are the partner (or other family members). See the table on the next page for further details.

Others smoking in the household	Number of women	% of women with other smokers in household (n=17)
Partner	11	65%
Parents	4	24%
Other family	8	47%
Friends	4	24%
Other	0	0%

8.4 Number of children

The table below shows the number of children the women in this study have. Five women (17%) did not comment on the exact number of children in their household. Just under a quarter of the women have no children (23% or seven women). Of those with children, the majority of women have one to three children (49% or 15 women). Two women have six children.

Number of children	Number of women	% of women (n=30)
None	7	23%
1	7	23%
2	4	13%
3	4	13%
4	1	3%
5	0	0%
6	2	8%
No response	5	17%
Total Respondents	30	100%

8.5 Pregnancy profile

Of those 17 pregnant women in the study, six women (35%) were in their second trimester and eight (47%) in their third. Three (18%) declined to comment.

Eight (47%) of the women said their pregnancy was unplanned, while six (35%) said it was a planned pregnancy. Three women (18%) did not comment on this.

8.6 Women not pregnant

This section refers to women who are not currently pregnant – either women of child-bearing age who smoke (but have no children yet) or women who have had children and have quit smoking during pregnancy but are not currently pregnant. This section was asked of thirteen of the women.

Six of the women declined to comment on their thoughts on having children in the future. Of the seven who did, six of the women who were not pregnant (46% of total not pregnant women) had thought about having children at some point. Only one had not (8% of total not pregnant women). Of those women thinking about having children, three were thinking about doing so within the next five years, two were thinking about doing so in the next ten years, and one was undecided as to timing.

The consequences of such long time frames or uncertainty of when these women might have children mean this group is very hard to target with an effective quit smoking message aimed at future pregnancies.

8.7 Radio stations listened to

There is not a common pattern amongst this group of women in terms of radio station they listen to. The stations are diverse. Trying to target a specific station for media would be best done through media profiling by a media agency.

The stations receiving highest number of mentions are:

- Classic Hits (23% or seven women)
- Mai FM (17% or five women)
- ZM (13% or four women)
- The Edge (13% or four women)
- More FM (13% or four women).

8.8 Newspapers / magazine regularly read

The daily papers across the country are read regularly by just over half of the women (63 % or 19 women). The *NZ Herald* is the most popular, reflective of more women being interviewed in Auckland.

About a half (52% or 16 women) read women's magazines regularly, with these including titles such as *Woman's Day*, *New Idea*, *That's Life*, and *Woman's Weekly*.

There are no other publications that significantly stand out. A fifth (20% or six women) read their local papers and 13% (four women) the Sunday papers.

8.9 Main shopping areas

The main type of shop women go to on a regular basis is the supermarket. Over half of the women go to Pak'n Save (63% or 19 women), and just under a quarter go to New World (23% or seven women). Some 17% (five women) mention Foodtown and 10% (three women) Countdown.

The Warehouse is also mentioned by just under a quarter of the women (23% or seven women).

General shopping areas are mentioned most after this; for instance, Lynmall, Sylvia Park, St Lukes (20% or six women).

In terms of other main shops, baby shops (17% or five women mentioning TNT / Baby Factory / Baby City) and Farmers (13% or four women) are mentioned.

8.10 Internet access and top sites visit

Twenty-four of the thirty women have internet access (80%).

The site that has the highest mention for being in the top-five sites regularly visited is TradeMe (67% or 16 women put this in their top-five sites).

In terms of main types of sites visited, the key focus is on:

- Banking sites for online banking (42% or 10 women)
- Email sites, the top site being MSN / Hotmail (42% or 10 women)
- Social networking sites – Facebook (42% or 10 women), Bebo (29% or seven women)
- Search engines – Google (29% or seven women), Yahoo (8% or two women)
- News sites – NZ Herald (17% or four women), Stuff (8% or two women), The Sun (8% or two women), BBC (8% or two women).

8.11 Smoking cessation products and services

Quitline is the main service women mention (63% or 19 women mention this service when prompted on what products or services they know of that are offered by the government or private organisations which help people stop smoking). However, in this study only one woman claims to have used this service. There is no awareness of other services.

Nicotine patches were the products most often used, mentioned by nine women (30%), while five women mentioned using nicotine replacement gum (17%).