KNOWLEDGE, ATTITUDES, BEHAVIOUR
AND NEEDS OF PACIFIC PEOPLE
ON TOBACCO SMOKING AND QUITTING

February 2010

Prepared by K'aute Pasifika Services for the Ministry of Health
KNOWLEDGE, ATTITUDES, BEHAVIOUR AND NEEDS OF PACIFIC PEOPLE ON TOBACCO SMOKING AND QUITTING

February 2010

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ACKNOWLEDGEMENTS

K’aute Pasifika gratefully acknowledges the considerable support afforded by the New Zealand Ministry of Health which enabled this study. The contribution of the many people in Tokoroa and Hamilton who were consulted and who gave freely of their time, views, knowledge, and vision, is greatly appreciated. Acknowledged also are the contributions of Dr. Tabwe Bio, Associate Professor Annemarie Jutel, Mary LaPine (Waikato DHB), other health professionals, and organisations consulted. We are grateful to Pacific students who have helped out in the collation of survey data. Special thanks to K’aute Pasifika staff for their cheerful assistance throughout the study.
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<tr>
<td>AKP</td>
<td>Aukati Kai Paipa</td>
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<tr>
<td>ABC</td>
<td>Ask, Brief advice, and Cessation. A smoking cessation approach that is based on asking the smoking status of a person, giving a clear brief advice, and providing support or making a referral.</td>
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<tr>
<td>ALAC</td>
<td>Alcohol Advisory Council of New Zealand</td>
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<tr>
<td>CHANCES</td>
<td>Cambridge, Hamilton and Huntly, And Ngaruawahia Coalition Ending Smoking</td>
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<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary airway diseases</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>ENSP</td>
<td>Ex-smoker that has never been on a smoke-free programme</td>
</tr>
<tr>
<td>ESP</td>
<td>Ex-smoker previously on a smoke-free programme</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NS</td>
<td>Non-smoker</td>
</tr>
<tr>
<td>NSP</td>
<td>Smoker not on a smoke-free programme</td>
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<tr>
<td>PTCIG</td>
<td>Pacific Tobacco Control Interim Group</td>
</tr>
<tr>
<td>SP</td>
<td>Smoker on a smoke-free programme</td>
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<tr>
<td><strong>KEY TERMS</strong></td>
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<tr>
<td><strong>Aukati Kai Paipa</strong></td>
<td>A smoking cessation intervention developed in a Maori health setting which is acceptable, accessible, culturally appropriate, and particularly effective for Maori and their whanau. An Aukati Kai Paipa programme is delivered via face to face by quit coaches who offer support, advice, and a range of effective options including nicotine replacement therapy and motivational coaching services (Ministry of Health, 2003; <a href="http://terunanga.org.nz">http://terunanga.org.nz</a>).</td>
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</table>
| **Cigarette smoking** | Refers to the active smoking of one or more manufactured or hand rolled tobacco cigarettes, from purchased or home grown tobacco, per day. Cigarette smoking does not include:  
  - the smoking of tobacco in cigars, pipes and cigarillos  
  - the smoking of any other substances, e.g. herbal cigarettes or marijuana, or  
  - the consumption of tobacco products by other means, such as chewing  
  (New Zealand Statistics Census, 2006) |
| **Community fono** | Referred to a Pacific community meeting |
| **Ex-Smoker** | Someone who used to smoke one or more manufactured or hand rolled tobacco cigarettes per day, but who does not smoke now  
  (New Zealand Statistics Census, 2006) |
| **Fa’aaloalo** | Samoan word for respect |
| **Faikava** | Refers to Kava cultures of Pacific islands which consume kava and the religious and cultural traditions associated with it. There are similarities in faikava between the different cultures, but each one also has its own traditions. Kava is a non-alcoholic stimulant beverage made from the roots of Piper methysticum (A Dictionary of Food and Nutrition, 2005, http://www.encyclopedia.com). Faikava forms part of traditional ceremonial events such as the welcoming of visitors and also commonly used in political and social events. People drink kava to relax and while drinking kava, normally talk about politics, sports, tradition and culture, tell jokes, and sing together harmoniously |
| **Fagerström Test** | A frequently used tool in the form of a questionnaire for assessment of nicotine dependence |
| **Non-Smoker** | Someone who does not smoke at all or have never smoker at all in their lifetime |
| **Pacific People** | People of Pacific Island ethnicities and origin. Pacific people include ethnicities of Samoan, Tongan, Niuean, Cook Island, I-Kiribati, Fijian, |
and Tuvaluan.

<table>
<thead>
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<th>Term</th>
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<td>Roll-your-own cigarettes</td>
<td>These are also known as hand-rolled cigarettes or casually as rollies. They are the same as manufactured cigarettes except that loose tobacco, cigarette papers and/or filters are purchased separately and hand-rolled by the smoker. Roll-your-own cigarettes include cigarettes rolled using hand-held rolling machines (New Zealand Statistics Census, 2006).</td>
</tr>
<tr>
<td>Smoker</td>
<td>Someone who currently smokes manufactured or hand rolled tobacco cigarettes per day. <em>(Statistics, New Zealand).</em> A smoker in this study includes a heavy and a light smoker (someone who smokes, but never daily) (New Zealand Statistics Census, 2006).</td>
</tr>
<tr>
<td>Smoking</td>
<td>Refers to the active smoking behavior, that is, the intentional inhalation of tobacco smoke. Smoking does not refer to or include passive smoking (the unintentional inhalation of tobacco smoke), (New Zealand Statistics Census, 2006).</td>
</tr>
<tr>
<td>Talanoa</td>
<td>Samoan word describing a face-to-face discussion</td>
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<tr>
<td>Tatalo</td>
<td>Samoan word for prayer</td>
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EXECUTIVE SUMMARY

K’aute Pasifika is a Pacific community-led one-stop shop initiative based in Hamilton. The organisation was established in 1999 under the leadership of seven Pacific community groups namely; Samoa, Tonga, Cook Island, Niue, Fiji, Kiribati and Tokelau with the aim of addressing inequality and barriers to accessing services. Language and culturally inappropriate services were most concerning to them.

For this reason the organisation has dedicated and experienced nurses and community support workers from each of the Pacific ethnic groups. Health is the organization’s core business but it also provides services in areas of social services, education and job training. Since establishment K’aute Pasifika has rapidly become the leading Pacific provider in Waikato for the provision of culturally appropriate health services but lacks a general practitioner (GP).

There is a growing acceptance that there are multiple factors that impact on health quality including education, housing, employment and other social influences relating to ethnicity and poverty. International research findings are increasingly showing that people in the lower socio economic groups have higher prevalence of smoking. This is borne out in New Zealand where Pacific have 27 % of its population living in severe hardship compared to 8 % of the total population and one in three Pacific adults smoke suggesting that social deprivation must be tackled if we are serious about lowering smoking prevalence amongst Pacific, Māori and other lower socioeconomic groups.

Smoking behaviour among different ethnic populations may be strongly influenced by unique socio-cultural factors, factors not often addressed by traditional smoking cessation programmes. Such factors have been addressed by Kaholokula et al., (2004) for indigenous Hawaiians. Little is known about such factors among Pacific Islanders; however a study of the “Aukati Kai Paipa” programme, a culturally appropriate and integrated behavioural counseling and pharmacological cessation programme for Māori women found that 29 % of women in the programme quit smoking compared with 12.5 % of women not in the programme (Aukati Kai Paipa, 2000).

There are current smoking cessation programmes for Pacific people that are viewed as culturally informed because they are being delivered in Pacific communities by Pacific quit coaches who are knowledgeable about Pacific cultures and languages but lack formal evaluation. Smoking cessation
programmes that yield the highest 6 to 12 month abstinence rates use a combination of strategies such as nicotine replacement therapy (NRT) and individual or group behavioural strategies. Treatment outcome studies have yielded 23 % - 35 % abstinence rates for multi-component cessation interventions that include pharmacotherapy and behavioural strategies compared with only 17 % for NRT alone, 14 % - 20 % for brief interventions, 10 % for self-help approaches, and 10 % for physician advice programmes (Kaholokula et al., 2008). The modest abstinence rates even with multi-component interventions illustrate the difficulty people experience in quitting and the multi-factorial nature of smoking.

The Tobacco Control Update (2005) reported New Zealand’s position as being among the world leaders in tobacco control. National initiatives including the world class smoke-free environment law, social marketing campaigns, education campaigns and restrictions on tobacco sales have contributed to a reduction in smoking. This success however has not extended to the Pacific populations in the same way as non Pacific populations. Smoking continues to be of high prevalence (30 % for the past 10 to 15 yrs) (MOH, 2008) and a major contributing factor to poor quality of health among Pacific people (Lanumata & Thompson, 2009). This suggests that the range of tobacco control initiatives that have been effective in smoking cessation for the general population may not be as effective for the Pacific population and may require an approach that not only assigns a high priority to reducing smoking among Pacific people but one with a strong Pacific focus.

One of K’aute Pasifika’s key roles is the delivery of tobacco control services to the Pacific communities in Hamilton and Tokoroa. Over the last six years, through a contract with MOH, “the organization has consistently delivered strong services in tobacco control promotion and cessation services” (MOH, Hamilton 2009). Commissioned by MOH, K’aute Pasifika undertook consultation with Pacific communities, Pacific consumers and health specialists on how tobacco cessation services may potentially be more effective and more responsive to the needs of Pacific peoples.

The primary aim of this study is to investigate attitudes, perceptions, knowledge and behaviour of Pacific people relating to tobacco smoking and quitting. More specific objectives are to:

- Enhance the understanding of the status and needs of Pacific people, the effects of their smoking on them, their families, and the wider community
- Identify issues regarding accessibility to available services, and barriers and supports to quitting
Identify opportunities and strategies to improve effectiveness of current smoking cessation programmes to Pacific people

Methodology

The study method involved:

- An analysis of literature relating to Pacific people and smoking cessation.
- Interviews with health professionals, smoking cessation specialists, quit coaches and smoke cessation providers in Hamilton.
- Focus groups with community representatives.
- Community Survey

The study was the first undertaken in Hamilton and Tokoroa targeting Pacific peoples. Quantitative and qualitative data and information were collected from Pacific people of different age groups, gender, and smoking status through survey questionnaires, focus groups, discussions and interviews with key informants. Whilst the use of surveys successfully extended the reach of the study, we relied heavily on focus groups for a detailed exploration of Pacific people’s stories about their lived experiences of smoking and quitting. Interviews lasting between 1-1.5 hours were held with health specialists and quit coaches from smoking cessation providers with the aid of a semi-structured interview schedule, although participants were encouraged to talk freely about other issues that were of concern to them.

Data Analysis

Quantitative data collected through the surveys were summarised using summary sheets, entered, and analysed using Microsoft Excel. The initial focus group discussions were recorded by one of the researchers who concentrated on field note taking while the other facilitated group discussions. The last focus group conversations were audio taped for transcribing.

Two researchers read and discussed the transcripts and field notes for possible meanings and interpretations. Emerging themes were identified and grouped together under broad categories of psychological, social, physical, cultural and environmental factors. For example, themes relating to physical health, nicotine addiction and medication were grouped under a physical component.
whereas those relating to family support, social & peer pressure, partners not smoking, were grouped under a social component and themes relating to prayer and spirituality were grouped under religion. Kaholohula (2008) demonstrated this clearly in his study of native Hawaiians.

These themes were then further categorised into sub-themes of what supports and what inhibits smoking cessation. For example, improving and maintaining health and family support are themes that would aid quitting (support) while those such as peer pressure, stress and family members smoking, are themes that inhibit cessation (barriers).

**Findings**

The key findings are as follows:

- Most participants believed that cigarettes are harmful with the three most frequent effects on health being heart attack, lung cancer and asthma. There was limited understanding among participants of the relationship between smoking and some associated diseases particularly emphysema. The participants, whilst knowledgeable about smoking being harmful, did not alter their behaviour towards quitting because of their knowledge.

- Smoking is still very much part of Pacific peoples social life styles although most did not think that smoking was part of Pacific cultures. Most started smoking before the age of 20 yrs with peer pressure being the most prevalent reason followed by family members that smoke and stress.

- Participants are all highly motivated to quit with concerns for health being the primary reason and personal commitment and importance of family as other motivations for wanting to quit.

- Quit rate is low amongst the participants but there is a significant reduction on daily cigarette consumption by smokers particularly those who have been exposed to smoke-free programmes. Relapsing is common and those who
relapsed identified socializing, peer pressure, family members smoking and craving for a smoke as risk factors for relapsing.

- Doctors, Pacific community leaders and family members were identified as the most preferred to deliver smoking cessation messages to people.

- In our community a Pacific GP is needed. The doctor’s brief advice to quit while only 10 % is effective is very cost effective compared to a structured quit programme.

- Social, psychological and physical factors were the main supports for quitting and remaining quitting.

- Family offers strong social support for most smokers to quit by maintaining strict family rules and positive role modelling. The involvement of family elders and church ministers were also important support strategies identified by the participants.

- Religion was also found as a social support and was regarded by most smokers and ex-smokers as having a strong impact on their attempts to quit smoking and why they continued not to smoke.

- Community and church leaders are strong supporters of smoke free environment regulations. The participants felt that there is a significant increase in people smoking outside of homes, church halls and at faikava as a result of strict smoking restrictions imposed by these leaders.

- A large number of participants showed a higher degree of nicotine dependence as particularly indicated by their first cigarette of the day (within thirty minutes of waking based on Fagertsröm Test (MOH, 2007) indicating addiction although a few recognised that they may be addicted.
• Most participants did not seek help to quit. Those who have successfully quit (95%) made only one quit attempt and without treatment (cold turkey).

• Participants had varied views on the use of NRT. Most thought the word ‘treatment’ was daunting and is associated with being ill. Cost was also identified as a barrier to accessing NRT.

• Non Pacific Smoking Cessation Service Providers and Health Professionals have accepted their limitations in providing services to Pacific people which is also reflected in the significantly low numbers of participants that actually use these services.

• Faikava and churches are ideal locations for delivering health and smoking cessation programmes.

• Quitline usage amongst the participants is found to be significantly low. Those who made contact are generally happy with the service but found that by the time Quitline responded the urge to quit has been lost.

• Awareness of smoking cessation services was low amongst the participants. However, participants were very interested to know about smoking cessation services and what they can provide. Some of them gave up smoking and continued not to smoke during the course of this study. Those who have received help to quit from smoking cessation services spoke favourably of the support and educational sessions they have received.

• A large number of participants were smokers who were mostly low income earners and live with children and have large extended families.
**Conclusion**

Smoking is still very much part of Pacific people’s social life. The attitudinal and behavioural changes which are the ultimate intention of smoking cessation will take a considerable time and varied types of interventions to accomplish. Tobacco control for Pacific people needs to remain a government priority with a broadened responsibility extending from health to other sectors including immigration, housing, education/training and community.

Smoking cessation programmes which are culturally appropriate are needed, to better target the Pacific population in New Zealand affected by tobacco smoking. Such programmes to be more successful should address social, psychological, and physical factors that maintain the culture of smoking and include family, community and religion as support mechanisms for quitting. NRT and other types of pharmacotherapy should also be included and strongly promoted amongst Pacific people as aid to cessation.

There is also paucity of relevant research specific to Pacific tobacco use particularly ethnic specific studies. These include but are not limited to the nature of addiction among Pacific people; the multi-factorial life issues that have influence on the uptake of tobacco smoking, and culturally appropriate approaches needed for smoking cessation to different age groups among Pacific people.

**Strengths and Limitations:**

There are limitations to our study in the actual sample. Firstly, there may have been an unintentional bias towards urban Pacific population as about two thirds of participants lived in Hamilton city. Secondly, there may have also been unintentional bias towards the K’aute Pasifika Smoking Cessation Programme as half of the participants recruited were either on the programme or have been on the programme. These limitations were due to unavailability of willing participants, limited time for travelling to rural areas and resources available for the research. Nevertheless, our results were similar to findings of previous studies on smoking cessation including those of Kaholokula (2008), Jarvis (2004), and Chen (2001).

We believe that despite its limitations, the study has made some contributions to the understanding of smoking initiation and cessation and highlights strategies and potential directions for development of culturally informed smoking cessation interventions for Pacific people.
Our study recommends that:

- there is a need for evaluation of current smoking cessation programmes and to develop a national programme for Pacific people to maintain consistency in how tobacco control is approached in New Zealand.

- further work is needed to explore the effectiveness of future smoking cessation programmes focusing more on reduction of cigarette consumption and other harm reduction methods prior to quitting, as most appropriate to adopt for Pacific smokers.

- Smoking cessation programmes for Pacific people are culturally appropriate. Such programmes to be more successful should address social, psychological, and physical factors that maintain the culture of smoking and include family, community and religion as support mechanisms for quitting. NRT and other types of pharmacotherapy should also be included and strongly promoted amongst Pacific people as aid to cessation.

- a Pacific GP is needed for the Pacific community of Waikato to address barriers to access, cost effectiveness, and improve cessation rate.

- more creative awareness and education strategies need to be explored and tried. These include capitalising on and encouraging doctors’ to increase their involvement in giving out messages relating to smoking and quitting; ways to work with people who refuse to use NRT; including religious beliefs in smoking cessation messages where appropriate; and using television advertising to target Pacific people by using Pacific faces and languages.

- Services will consider establishing community and family based support systems particularly for programmes targeting pregnant mothers and youths’ uptake of smoking.
2. LITERATURE REVIEW

SMOKING AMONG PACIFIC PEOPLE AND TOBACCO CONTROL IN NEW ZEALAND

2.1. INTRODUCTION

The prevalence of smoking among Pacific Island communities in New Zealand remains a problem that needs to be investigated and understood further. Research into the attitudes and behaviours of Pacific people toward smoking needs to be conducted in more depth in order to generate a more accurate understanding of the motivations behind why Pacific people are highly represented in smoking statistics. A critical analysis of literature regarding the smoking patterns of Pacific people in New Zealand indicates that the cessation services available are not being utilised to their full capacity. Support services in regional and national capacities are focusing on targeting Pacific Islanders through promoting a culturally tailored cessation programme. The objectives of this study are based on appraising the attitudes and behaviours Pacific people have toward smoking cessation, evaluating the current situation, comparing Pacific Island smoking attitudes with other indigenous cultures and recommending the cessation service that is going to be the most effective long term.

2.2. PACIFIC DEMOGRAPHIC IN NEW ZEALAND

There are more than 22 different Pacific communities in New Zealand - each with its own distinctive culture, language, history and health status. The biggest Pacific groups in New Zealand are the Samoan, Cook Islands, Tongan, Niuean, Fijian, Tokelauan, and Tuvaluan communities. The 2006 Census recorded 265,974 individual Pacific people, comprising 6.9 % of the total New Zealand population. The number of people identifying with the Pacific peoples ethnic group was up 14.7 % from the 2001 Census, which was the second-largest increase among all ethnic groups. As of 2006, 60 % of the Pacific population was reported as have been born in New Zealand (New Zealand Statistics Census, 2006).

The Pacific population is very youthful. In 2006, 37.7 % of Pacific people were aged under 15 years, compared to only 21.5 % of the total population, while the median age was 21 years,
compared to 35 years for the total population. In contrast, only 4 % of Pacific people were aged over 65 years, compared to 12.3 % of the total population. The Auckland regional DHBs (Waitemata, Auckland, Counties Manukau) collectively account for 178,000 (67 %) of all Pacific people. The next biggest Pacific populations were found in the Capital and Coast, Hutt Valley, Waikato and Canterbury DHBs (New Zealand Statistics Census, 2006).

2.3. PREVALENCE OF SMOKING AMONG PACIFIC PEOPLE

Findings from the New Zealand Tobacco use survey in 2006 show that smoking rates are significantly higher among Māori (45.8 %) and Pacific Island (36.2 %) ethnic groups. The prevalence of smoking has decreased in New Zealanders since the 1970s, yet approximately one in every four New Zealanders remains a current smoker. For Pacific peoples, 28 % of females smoke compared to 46 % males. Nonetheless, more Pacific female youth (17 %, aged 14 to 15) smoke daily compared to 10 % Pacific male youth.

In 2005 a Pacific Tobacco Control Interim Group was formed to supervise the drafting of the Pacific Peoples Action Plan toward smoking cessation. Data from this group’s report shows that:

- One in three Pacific adults, smoke, which equates to 76,000 Pacific smokers.
- 102 die from ischemic heart disease each year.
- 36 die from lung cancer each year
- 26 die from stroke each year
- An estimated 3 Pacific children die each year from SIDS as a result from exposure to adult smoking

Statistics from the New Zealand Tobacco Use Survey 2006 (Ministry of Health, 2007a) illustrated that around 65 % of smokers in New Zealand have made a quit attempt in the last 5 years. Of smokers who had ever deliberately quit for more than a week, 36 % did not make any quit attempts in the last five years and around 33 % quit once in the previous 12 months. The survey reported high percentages of Māori, (68 %) and Pacific smokers (60 %) that have made quit attempts in the last 5 years. Around 26 % of smokers received some form of advice on how to quit smoking and 27 % of smokers used some form of quitting product during their last quit attempt. Around 38 % of people agreed that smokers who failed to quit do not really want to quit, and they also believed that people should be able to quit without the help of
programmes or products. On the other hand, 28% of people in the survey thought otherwise that people who want to quit should be supported through programmes or the use of treatment products.

2.4. PACIFIC PEOPLES’ SMOKING SITUATION IN THE WAIKATO

The population of Hamilton is approximately 129,249 (New Zealand Statistics Census, 2006). Approximately 4% are of Pacific Island ethnicity, 65% are European, 20% Māori, and 10% Asian. The Waikato DHB population has a higher than national average of smoking prevalence at 22% of its residents, while the national average sits at 20%. Higher still, is the percentage of admissions to Health Waikato services who are smokers, at approximately 24%. There are 6,873 of Pacific people in the Waikato that are smokers.

2.5. SOCIO-ECONOMIC STATUS

Smoking is a significant and potentially reversible contributor to ethnic and socioeconomic inequalities. According to calculations by Blakely, Fawcett, Hunt, Wilson (2006) smoking led to an 8% difference in standardised mortality rates for Māori and Pacific Island women compared with non Māori and Pacific women in 1996-99. Despite the statistical evidence that smoking is a major contributor to morbidity and mortality rates among Pacific people, there are very few initiatives that exist to address the problem in a Pacific way. It is only in recent years that research has commenced to investigate Pacific people’s attitudes towards smoking to develop an understanding of why smoking is a prevalent habit in the Pacific community. With a better understanding of the contributing factors toward smoking and the interplay between them, it will be possible to tailor solutions to the chronic disease problem among Pacific peoples. Research by the Pacific Tobacco Interim Group demonstrates that the reduction of Pacific peoples smoking prevalence rates is dependent on a comprehensive Pacific people’s tobacco control programme being sustained and strengthened over a number of years.

The social and economic factors that have been shown to have the greatest influence on health are income and poverty, employment and occupation, education, housing, and ethnicity. It has been reported that:
• 27% of Pacific peoples meet the criteria for living in severe hardship compared to 8% of the total population. In addition, 15% of Pacific peoples live in significant hardship, with only 1% enjoying 'very good living standards'.

• Pacific peoples are less likely to own their own homes (26% compared to 55% nationally) and more likely to live in overcrowded households.

• Unemployment rate for Pacific is nearly twice the national unemployment rate.

• Lifestyle factors, including values and preferences, can influence how Pacific peoples view health care.

• Primary and preventative health care services have been under-utilised by Pacific peoples and they have lower rates of selected secondary care interventions.

2.6. PACIFIC SMOKING AND PREGNANCY

Research by Butler, Williams, and colleagues, shows that the behaviour of partners and other family members can influence the smoking behaviour of pregnant women. This study conducted among mothers of a Pacific Island cohort in New Zealand show that pregnant women who were living with their smoking partners or were exposed to passive smoke were less likely to stop smoking. The same study further demonstrated that mothers who were living with at least one other smoker significantly increased the likelihood of smoking during pregnancy. This information highlights the importance of partner support in smoking cessation and shows that the smoke-free message has to be promoted beyond women who are pregnant. Factors identified as associated with smoking during pregnancy can be used to better target mothers for smoking cessation programmes. Research conducted by the Pacific Island health review indicates the smoking is common among pregnant Pacific women. Approximately 25% of Pacific Island mothers smoke during pregnancy and 75% of women who smoked before pregnancy continued to smoke during pregnancy.

Statistics are indicative of the fact the smoking cessation support needs to extend to family members of the pregnant women as well as the women themselves. Smoking cessation needs to be encouraged as early as possible when a woman is pregnant. Wong et al suggests that for the mothers who are not motivated or are unable to quit, education on ways to reduce the damage done by passive smoke to infants needs to become a priority. Research on Pacific Island women who smoke during pregnancy suggests that intervention programmes need to be tailored specifically to target these women. Conventional cessation services and smoke-free messages are not working on Pacific women and emphasis needs to be placed in investigating
an extensive approach which will generate improved cessation results. Researching the attitudes Pacific women have toward smoking before, during and after the child bearing phase needs further investigation.

2.7. SMOKING AMONG PACIFIC YOUTH

The youth of New Zealand have relatively easy access to cigarettes in communities. Studies conducted by Wong, Glover, and colleagues (2007) indicated that despite strict tobacco sales laws and strong disincentives to buy cigarettes, children continue to buy cigarettes from both commercial and social sources. The study showed that Pacific people represented the highest percentage of ethnic smokers under the age of 15 with a bartering and borrowing system of cigarettes being the most popular way to access them. Findings from this research showed that Pacific Island children said it was easy to buy cigarettes in the Islands and it was hard when they couldn’t buy them in New Zealand. Research in the Pacific Health Review 2008 indicates that smoking among Pacific boys and girls remains higher than other young New Zealanders, with Cook Island girls and Niuean boys having the highest prevalence of smoking (Scragg et al., 2007).

Information from the MoH shows that most Pacific youth have a strong cultural and religious value base that provides a good foundation for life and citizenship. However, they found aspects of their culture of hard work, having to work twice as hard, sometimes living two lives satisfying the requirements of family and Pacific community life as well as living in the Palagi world. Youth smokers were strongly influenced by people around them that smoked: fathers, mothers, siblings, partners, and this contributed to the initiation of smoking at a young age. This indicates that smoking is a part of a social context and environment. It is not what brings people together but it is something that happens when people come together. The acceptance of smoking in social interactions in previous years appears to have created the mindset that interacting and smoking are simultaneous activities. Overall, about 40% of adolescent daily smokers could be attributed to parental smoking (Scragg et al., 2007).

2.8. TOBACCO CONTROL PROGRAMMES FOR PACIFIC PEOPLE

Research by the Pacific Islands Heartbeat and Quit Group (2003) shows that there is awareness about the effects of smoking among Pacific peoples, yet the message and the way it is
currently presented is not felt to be relevant. Due to this there has been an emphasis on tailoring the nature of smoking cessation campaigns to create a more positive response from the Pacific community. The Pacific Islands Heartbeat and Quit Group (2003) indicated that the support for a Pacific-specific general awareness campaign about the dangers of smoking are needed in addition to face-to-face or group initiatives developed by Pacific health providers. Pacific-specific programmes will encourage an increased understanding of health and well-being in the Pacific community and will be designed to develop and implement health initiatives that benefit the Pacific people. Understanding the attitudes and behaviours Pacific people have toward smoking is imperative in achieving successful initiatives. The collaboration of national and regional health providers is needed to provide effective smoking cessation programmes.

2.9. GOVERNMENT'S ROLE IN SMOKING CESSION

The Ministry of Health is responsible for the allocation of funding to a significant number of smoking cessation services in the community. The MoH works in conjunction with District Health Boards to achieve improved health outcomes for the population and to create targets which monitor smoking cessation progress in different districts. The MoH has strategies which encompass New Zealanders as a whole. Ethnic specific smoking strategies have only been a recent concept and the Pacific Tobacco Control Interim Group (2004) identified that there is minimal funding available for Pacific peoples’ tobacco control in New Zealand. In light of this, a Pacific peoples tobacco control advocacy at a national level was seen as necessary as well as a workforce dedicated to Pacific peoples tobacco control and awareness.

The focus that the MoH currently has is to “increase quitting”, getting more smokers making more quit attempts. Research suggests that the average smoker will attempt to quit around 14 times before successfully quitting long term. The objective of the MoH is to provide smoking cessation advice and support reliably and repeatedly across the health sector. There are three areas which the MoH targets which fundamentally encompass all smokers. The first area is primary care which implements smoking cessation guidelines and support in the community. The second is targeting priority groups such as Māori and Pacific Islanders, particularly parents who have high rates of smoking with the aim of including parents as an attempt to reduce the initiation of smoking by children. The third area is pregnancy which is concerned with increasing the awareness of the impact of smoking during and after pregnancy on infant and child health.
The Waikato DHB has Pacific people in its strategic plan as one of the priority populations needing health improvement. The MoH and Waikato District Health Board have developed strategies to strengthen the capacity of the tobacco control sector to reduce inequalities. The MoH and Waikato DHB have the responsibility of aligning the services so that they are more responsive to priority groups and cessation services are readily available in the high need communities.

One of the milestones that Government has achieved was passing an amendment to the Smoke-free Environments Act 1990 on 3 December 2003. This is important as before this amendment, around 350 New Zealanders died each year because of exposure to second-hand smoke, and many others became sick. These new requirements are designed to protect non-smokers from second-hand smoke which contains poisonous chemicals such as arsenic, hydrogen cyanide, ammonia and carbon monoxide (www.moh.govt.nz).

2.10. PACIFIC-SPECIFIC SMOKING CESSATION PROGRAMMES

Research from PTCIG shows that although tobacco control is identified as a priority in the New Zealand Health Strategy, there are very few tobacco control initiatives in place which are designed for Pacific people. Due to this inadequacy, it is reported that Pacific peoples smoking rates have remained at over 30% in New Zealand for the past 15 years. In collaboration with research conducted by PTCIG, The Quit Group identified that although Pacific peoples view their personal health as important, it is a lower priority than obligations such as church, family and work. With health being a lower priority than the other commitments, it can result in health issues only being addressed when ill health occurs and other obligations have been fulfilled. Another key finding is that smoking in the islands is viewed by some as part of the culture as tobacco growing was common and smoking was considered a social way of keeping people together. Subsequently, for Pacific people, it is common to smoke in environments such as church, family or Pacific events because smoking is seen as a normal part of the interaction.

There is an awareness in the Pacific Island community of the effects of smoking but PTCIG states that the message and the way it is currently presented is not felt to be relevant. Furthermore, support for Pacific-specific general awareness campaigns about the dangers of smoking are needed, in addition to face-to-face or group initiatives developed by Pacific health providers. Research conducted in America which analysed the smoking habits of the Chinese
community suggests that the approach of use of the language of the culture being targeted is imperative in the strength of the message (Chen et al., 2001).

2.11. SMOKING CESSATION MEDIA CAMPAIGNS

Due to the fact that there is a need for a Pacific voice in tobacco control in New Zealand campaigns, social marketing strategies such as television campaigns have been employed to address the tobacco use prevalence among Pacific people at a community level. A trial using television to target smoking cessation by Pacific people has been launched recently. It has been shown by Statistics New Zealand that Pacific people equate to over 30% of New Zealand’s smokers yet this ethnic group only makes up 3% of the callers to Quitline. Raising awareness of the benefits of smoking cessation in Pacific Island communities and promoting a smoke-free lifestyle is crucial in addressing the issue of tobacco use among Pacific people. Research by Linda Tasi-Mulitalo (2006) of Quit Group illustrates that minority groups frequently miss out on targeted television campaigns because of the high costs of television advertising. In addition to this, the lack of Pacific faces in the smoking cessation advertisements and campaigns may have resulted in Pacific people not understanding that they could access free cessation support.

To counteract this, Quit group has launched campaigns that feature Pacific Island people in cultural contexts which are aimed at increasing awareness in the Pacific community about the health risks associated with smoking. The first television campaign targeting Pacific people was launched by Quit group in March 2006 in the hope that it may generate questions from Pacific smokers about the health effects of smoking, as well as an interest in quitting. The smoking campaign commercial triggered high response throughout the Pacific including in news items (John and Tasi-Mulitalo, 2006).

2.12. SMOKING CESSATION SERVICES CURRENT FOCUS

The most recent focus of the MoH and Quit Group has been to encourage people to make more quit attempts. Research by the MoH indicates that it takes people approximately 14 attempts of quitting before they can quit long term. The new focus has paved the way for new initiatives to be developed by smoking cessation services, yet cultural factors still have to be
considered to analyse whether this method is appropriate for all people. Recommendations made in the Pacific Peoples Action Plan (Pacific Tobacco Control Interim Group, 2004) explain that action needs to be taken to promote more support for Pacific people who want to quit smoking. Promoting and strengthening existing cessation services including encouraging the development of Pacific specific cessation resources and messages is vital in reducing the number of Pacific people that smoke.

2.13. PREVALENCE OF SMOKING IN INDIGENOUS COMMUNITIES & INFLUENCES ON SMOKING BEHAVIOUR

The social context has implications on the prevalence of smoking and this can be seen as a similarity across indigenous cultures. Smoking is viewed by some people as part of the culture and is seen to be a normal part of social interaction at Pacific gatherings and in day to day living. Findings by the Pacific Islands Heartbeat and Quit Group (2003) indicated that for Pacific peoples, it is common to smoke in settings such as church venues, family or Pacific events. Literature on Australian indigenous communities indicated that initiation for smoking begins at a younger age and is influenced by factors such as peer pressure, smoking among family members and parents, socio-demographic factors where smoking is deemed as the norm, for historical as well as cultural reasons (Cancer Council Victoria, 2009). This is similar to trends among the Pacific Island youth where the uptake of smoking is strongly influenced by the social context. Acculturation was a variable that featured in the literature examining the smoking prevalence among Pacific Island youth in New Zealand. “Although smoking takes place in the Islands, more Pacific peoples start smoking when they arrive in New Zealand” (Pacific Islands Heartbeat and Quit Group, 2003). Factors such as the stress of moving to a new country were a contributing factor to either the initiation of smoking or the lack of smoking cessation.

Socio-economic factors are also aligned with the majority of the literature regarding indigenous cultures and smoking. International research shows that people who have a lower socio-economic status have a higher prevalence of smoking. Australia cancer society findings indicate that Aboriginal people say that smoking is a way of coping with hardship and being at a disadvantage. This is reinforced by New Zealand statistics which showed that Māori and Pacific Islanders have a lower socio-economic status and a higher smoking prevalence. Literature by Australian researchers says that Aboriginal and Torres Strait people use smoking as a way to suppress the appetite because they didn’t feel like cooking or there wasn’t enough
money for food (Cancer Council Victoria, 2009). Research on Pacific Islanders in New Zealand and health inequalities does not suggest that this is the case among Pacific communities here. The stronger indicators for smoking initiation and lack of smoking cessation are acculturation, cultural, and socio-economic factors.

2.14. SMOKING CESSATION SERVICES

Smoking Cessation Support Services are available for Pacific people in New Zealand on a regional and national basis. These services include the: Smoke-free Pasifika Action Network, Pacific Smoke-free Health Promotion, Countries Manukau Lotu Moui church based health promotion, Pacific Islands Heartbeat Pacific smoking cessation training programmes, K’aute Pasifika Services, Counties Manukau Smoking Cessation Services, Quit card registered providers, and the Quit Group Services which includes Quitline.
3. RESEARCH DESIGN & METHODOLOGY

3.1. INTRODUCTION

The primary aim of this study is to find out more about the knowledge, behavior and attitudes of Pacific people, health professionals and service providers relating to tobacco use and quitting. Two Pacific researchers were involved both fluent in their own Pacific languages and also knowledgeable about the cultural backgrounds of Pacific people. When considering an appropriate framework for this study, two distinct considerations were made. Firstly, we needed to decide whether the study should have a Pan Pacific or ethnic specific approach given that Pacific peoples belong to different ethnic groups with diverse sets of cultures, languages and homelands (Health Research Council of New Zealand, 2004). Secondly, as Pacific researchers we were aware of the centrality of using a design method that would work well cross culturally. We decided that the study would increase its scope to capture rich and unknown data that may be characteristically specific to each ethnic group by adopting an ethnic specific approach and that focus groups would be the most appropriate method to use particularly when trying to learn about a specific phenomenon as Kaholokula (2008) has emphasized in his study of the lived experiences of Native Hawaiians relating to smoking cessation.

The main sources of data and information for this study were:

- survey questionnaires completed by individuals and assisted by community support workers
- Focus groups discussions with community representatives
- Interviews with health specialists and providers of smoking cessation services
- Analysis of Smoke related literature and documentation

3.2. DESIGN

This study employed both qualitative and quantitative methods. It involved the collection of data from Pacific peoples of all age groups via focus groups with community and consumer representatives, interviews with health professionals and smoking cessation providers and survey. Whilst the survey expanded the reach of the study, focus groups were considered the most appropriate approach that would work well cross culturally and would yield more accurate and reliable data (Otsuka, 2005) In this context, the participants were able to talanoa
(face to face discussion) and communicate freely about their individual experiences with researchers probing and stimulating conversations backwards and forward ‘allowing unknown aspects of the topic to emerge. (Glover et al., 2005). In-depth interviews with Pacific leaders, health professionals and providers of smoke cessation programmes were carried out to explore their perspectives and knowledge about smoking and quitting amongst Pacific peoples.

3.2.1. PARTICIPANTS

Participants for the survey and focus groups were recruited from K’aute Pasifika’s Smoking Cessation Programme and by K’aute Pasifika staff from their own networks. Participants were selected purposely to reflect ethnic diversity and gender balance. The participants were of mixed ethnicities, aged from 12 yrs to 60 yrs who have been identified as smokers, ex-smokers and non-smokers.

Respondents that were smokers and ex-smokers were further categorised to ‘smokers on a programme’ those who have and are currently participating in a smoke-free programme, ‘smokers not a programme’ where they have not participated in a smoke-free programme, ‘ex-smokers on a programme’ where they were previously on a smoke-free programme, and ‘ex-smokers not on a programme’ where they have not participated in any smoke-free programme. This was to identify whether there was a difference in responses from those that attended a smoking cessation programme and those that didn’t in their level of knowledge, attitude and behavior relating to smoking and quitting.

3.2.2. QUESTIONNAIRES

Questionnaires were completed by participants from Tonga, Kiribati, Samoa, Cook Island, Fiji, Niue, and others from Tuvalu and Solomon Island. The names of current smokers and ex-smokers were extracted randomly from the K’aute Pasifika Smoking Cessation Programme. This meant that every second name on the list was marked for recruitment and allocated to an ethnic group list, matched with a community support worker of the same ethnicity’ to enhance cultural validity (Glover, 2004). The community support workers sought consent from those on the list and helped distribute questionnaires to others not on the list but interested in participating in the study.

The questionnaires were developed after a series of consultations among the research team, health professionals, quit coaches and community support workers. The first questionnaire
was developed from a generic smokefree questionnaire. It was then tested on two different groups, before and after additional questions were included (refer to annex 1). Questions were also edited, formatted and some rephrased to improve clarity and precision. For example, the question, “Which of the following have you utilised in the last 12 months was changed to “To help you quit, which of the following have you accessed in the last 12 months?”; “Do you consider your religious faith or prayer as may be able to assist you to quit?” was changed to “Do you consider your religious faith or prayer as a way of helping you quit?” New questions were also added regarding form of medication used and a question on the first smoke on waking as these were omitted.

The completing of the questionnaires was accomplished by individuals themselves or being assisted by K’aute community support workers. The participants were also encouraged to write their views and comments in their own Pacific ethnic language if it was easier for them. These questionnaires were then translated back to English by the community support workers who are of the same ethnic group. Participants who did not have time to complete questionnaires when visited were requested to have them completed within two days and to be collected by the community support workers within the time specified.

Surveys were carried out either at peoples’ homes, other venues such as education institutions, or at work places to increase participation in the study. This was done during normal working hours and also after normal working hours which included evenings such as after church services and during Yaqona and faikava sessions. Most youth participants were visited either at their homes after school, during breaks at tertiary institutions, and after evening classes e.g. driver license group.

Participants were offered a packet of tea at the completion of a survey or following focus group discussions in the spirit of reciprocity, a common practice among Pacific peoples to acknowledge ones contribution to the issue on hand.

3.3. FOCUS GROUPS

It is recognised that for Pacific peoples, face to face consultation is the most preferred way of communicating with each other. Effective face to face consultation is critical to establishing meaningful relationships with Pacific peoples. (Health Research Council of New Zealand, 2004).
When planning the focus groups there were a number of issues that had to be considered. These issues included how to recruit participants, agreeing on whether to use Pacific languages or English language; how to address the diversity of Pacific people, gender and age variations.

A further consideration was given to ensuring that times which suited participants were acknowledged and that transport for the participants was available to ensure people were able to attend.

All focus groups were conducted in the English language. An interpreter was offered for those who could not communicate in English.

A clear explanation of the study and its aims were given, followed by information regarding consent issues, confidentiality, ability to withdraw at any stage and the sharing of the findings once the final report is completed.

The focus groups were facilitated by one Pacific researcher while the other attended to recording and taking field notes. Each focus group started with a prayer usually by a community elder or church leader generally asking God to bless those present and help ensure the meetings were successful. Focus groups lasted three hours including time dedicated to greetings and introductions. This was an important time for participants as they would discover for themselves who, where and how they were connected to one another. This might be considered a breach of privacy but for Pacific people it is normal and essential for relationship building. In addition, the researchers in addressing and talking with participants, cultural values such as faaaloalo (respect in Samoan) and humility underpinned every act and movement. It has been the case that Pacific people will often disengage if respect and humility are not demonstrated by the researchers (Health Research Council of New Zealand, 2004). Following this, a closing prayer (tatalo) and blessing of food is given before a shared meal was offered for time taken to be part of the study. The gifting and sharing of food was an expected act of respect and reciprocity which cements satisfactory continuation of engagement with the participants in the future.

We convened three focus groups, one in Tokoroa and two in Hamilton. The focus groups were of mixed ethnicities, genders, and age groups. There were 22 participants including: 4 Tongans, 3 Kiribati, 5 Samoans, 2 Fijians, and 8 Cook Islanders.

The participants of the Tokoroa focus group were mainly Cook Islanders. There were 9 participants with 7 smokers, 1 former smoker and 1 nonsmoker. We decided to have a specific focus group for the Cook Island community as it reflected the Pacific population in that area. A
set of questions was compiled to prompt the facilitators of recurring themes that needed to be discussed. These included questions on attitudes, knowledge and perceptions about smoking and quitting; treatment; technology use; cultural practices/faikava; and religion. (refer to annex 2.1. and 2.2.)

The first Hamilton Focus Group comprised five heavy smokers including a seven month pregnant mother, and 1 ex-smoker.

The second Hamilton Focus Group was the third and last of the focus groups. Participants included 1 male and 6 females including, 3 Tongans, 2 Samoans and 2 Kiribati. The unique aspect of this group is the involvement of academics with education and health backgrounds. They are well known to their own ethnic communities and are heavily involved in activities pertaining to their ethnic groups. We were interested in finding out whether being educated and having had better access to information made any difference to their attitudes and behaviour towards smoking and to those that smoke if they didn’t smoke themselves. One of the participants, a smoker regularly takes part in the faikava sessions.

Additional information relating to participants, for example, name, ethnicity, gender, age and smoking status were recorded at the beginning and during all of focus group discussions.

3.4. INTERVIEWS

These interviews involved arranging meetings with participants at places and times of their choosing. Meetings were held in places where people gather, for example, cafes, peoples’ homes, faikava and churches to ensure people can attend.

To gauge individual perspectives on smoking and quitting relating to Pacific people, in-depth Interviews were conducted with quit coaches from organisations who are currently providing smoke cessation services to Maori and Pacific people. Additional interviews were held with community leaders, church ministers, health professionals and staff of Pacific Heart Beat Smoking Cessation Training Unit.

Topics included: routinely checking on smoking status of Pacific clients and advice given during consultations; experiences of Pacific peoples’ responses to advice given; referral processes; communicating with local smoking cessation providers; treatment provided and opportunity for further comments.
3.5. DATA ANALYSIS

Quantitative data collected through the surveys were summarized using summary sheets, entered, and analysed using Microsoft Excel.

The initial focus group discussions were recorded by one of the researchers who concentrated on field note taking while the other facilitated group discussions. The last focus group conversations were audio taped for transcribing.

Two researchers read and discussed the transcripts and field notes for possible meanings and interpretations. Emerging themes were identified and grouped together under these broad categories of psychological, social, physical, cultural and environmental factors. There were robust discussions about how these themes should be grouped for clarity. We decided that themes relating to physical health, nicotine addiction and medication could be grouped under the physical component whereas those relating to family support to quit and social inhibitions (friends) to quit could be grouped under the social component and themes relating to prayer and faith can be grouped under the spiritual component, similar to decisions made by Kaholohula (2008) in his study of native Hawaiians. Qualitative decisions about where themes should be grouped under were made by the two researchers and two research assistants.

These themes were further categorised into what supports and what inhibits smoking cessation. For example, benefits to quitting such as improving and maintaining health and family support are themes that would aid quitting and those such as peer pressure, stress and family members smoking are themes that inhibit cessation. This helped us to identify explicitly the main components to focus on when developing a culturally appropriate smoking cessation programme for Pacific peoples.
4: RESULTS & FINDINGS

SURVEY:

4.1. INTRODUCTION

This chapter presents the analysis of results and findings from the survey conducted through the use of questionnaires to 106 respondents of different Pacific ethnic groups. The findings consisted of demographics, awareness, knowledge and perception of smoking across different groups in the Pacific communities. The findings also present the questions targeted specifically for smokers, ex-smokers, and non-smokers, and comparisons between smokers and ex-smokers on or previously on a smoke free programme and those not on any smoke free programme.

4.2. DEMOGRAPHICS

4.2.1. ETHNICITY

Pacific communities that participated in the survey through the use of questionnaires were Samoan, I-Kiribati, Tongan, Cook Islander, Fijian, Niuean, Tuvaluan, and Solomon Islander classified as ‘Others’. The proportion of each ethnicity depended on people’s availability in participating in the survey. Respondents were mostly from Hamilton and a few from Tokoroa.

![Figure 4.1: Proportion of respondents for different Pacific ethnic groups](image)
4.2.2. GENDER, BIRTH PLACE, and AGE GROUP

Out of the 106 respondents, 98 identified their gender. Of these, 50 % were males and 50 % were females. Ninety two identified their birth place where 76 % were born in the Pacific and 24 % were born in New Zealand. Ninety six respondents revealed their ages which ranged from the age groups of 12 to 19 up to over 60 years old.

![Age Group Distribution](image)

Figure 4.2: Distribution of respondents according to age groups.

4.2.3. CATEGORIES OF RESPONDENTS

Of 106 respondents from the different Pacific ethnic groups, 59 were smokers, 22 were ex-smokers, and 25 were non-smokers (Figure 4.3).

![Proportion of Main Categories](image)

Figure 4.3: Categories of respondents as smokers, ex-smokers, or non-smokers
Respondents that were smokers and ex-smokers (Figure 4.3) have been further categorised in addition to ‘non-smokers’ (total of 25), as ‘smokers on a programme’ (20) where they have or are currently participating in a smoke-free programme, ‘smokers not a programme’ (39) where they have not participated in a smoke-free programme, ‘ex-smokers on a programme’ (8) where they were previously on a smoke-free programme, and ‘ex-smokers not on a programme’ (14) where they have not participated in any smoke-free programme (Figure 4.4).

![Respondent Categories](chart.png)

**Figure 4.4:** Proportion of respondents according to their sub-categories either as ‘non-smoker’ (NS), ‘smoker on a smoke-free programme’ (SP), ‘smoker not on a smoke-free programme’ (NSP), ‘ex-smoker previously on a smoke-free programme’ (ESP), or ‘ex-smoker not on a smoke-free programme’ (ENSP).

### 4.2.4. FAMILY DYNAMICS

Out of 106 respondents, 93 provided information on their household situation. Pacific communities live in household situations as nuclear families with children (34%), extended families (30%), nuclear families with no children (24%), and also a few on their own (12%).

![Household Situation](chart2.png)

**Figure 4.5:** Distribution of respondents’ household situations where most live in nuclear families with

* families with
4.2.5. EMPLOYMENT STATUS

Out of 106 respondents, 94 provided their employment status as such:

- 39 are employed full-time (30 hours or more a week)
- 8 are employed part-time (less than 30 hours a week)
- 16 are unemployed and actively seeking work
- 8 are not in the labour force including the elderly
- 23 are students

From all respondents, 53 described their line of work: 19 worked in factories including pack houses, 12 as professionals including nurses, accountants, teachers, and managers, 7 in the trade industry including machinery operators, 5 in the sales and hospitality industry, 4 in transportation mainly as drivers, 4 in cleaning, 1 in administration, and 1 in care-taking. The other 52 respondents stated their occupational status other than those specified above, which included house wives, students, and community support workers.

4.2.6. TECHNOLOGY ACCESS & COMMUNICATION PREFERENCE

Most Pacific people in this study selected at least one type of infrastructure that they have. The most possessed infrastructure was TV (90), followed by phone (82), vehicle (75), radio (69), and computer with internet (51). Some people have computers but without internet connection.

Pacific people identified various forms of contact ranging from the most to the least preferred means which were: phone call, home visit, texting (via cell phones), email, and community meeting. Many people preferred more than one form of contact and many preferred both phone calls and home visits.

4.2.7. GROUP AFFILIATION

Pacific people in this study have identified themselves as affiliated to a church, community, cultural, sports, fundraising and other groups (Figure 4.6). Most people showed that they belonged to more than one group. A large proportion (47 %) of respondents identified themselves as belonging to a church, followed by community (24 %) and cultural group (14 %).
4.3. AWARENESS, KNOWLEDGE AND PERCEPTION ON SMOKING

4.3.1. SOURCES OF SMOKE RELATED INFORMATION

Pacific people in this study have identified different sources of information about smoking and quitting (Table 4.1). Information sources include radio, TV, newspaper, doctor, nurse, health worker, friends, school, workshops, quit coaches, and others which include parents and other family members, churches, and people who used to smoke and have quit. The three most popular sources ranging from the most frequently identified, were TV, Health Workers, and Doctors.
**Table 4.1:** *Total responses for the different sources of smoking cessation information*

<table>
<thead>
<tr>
<th>Sources of Information</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>TV</td>
<td>60</td>
</tr>
<tr>
<td>Health Worker</td>
<td>38</td>
</tr>
<tr>
<td>Doctor</td>
<td>35</td>
</tr>
<tr>
<td>Friends</td>
<td>31</td>
</tr>
<tr>
<td>Newspaper</td>
<td>30</td>
</tr>
<tr>
<td>National Radio</td>
<td>28</td>
</tr>
<tr>
<td>Workshops</td>
<td>22</td>
</tr>
<tr>
<td>Quit Coaches</td>
<td>22</td>
</tr>
<tr>
<td>School</td>
<td>19</td>
</tr>
<tr>
<td>Community Radio</td>
<td>16</td>
</tr>
<tr>
<td>Nurse</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>

### 4.3.2. SMOKING AND CULTURE

Most respondents (87%) did not think that smoking is part of their Pacific culture, while a small proportion (10%) stated that smoking is part of their culture, and 3% do not know (Figure 4.7).

![Figure 4.7: Total responses from respondents on whether smoking is part of their Pacific culture](image-url)
4.3.3. BELIEFS IN CIGARETTE HARM

The majority of people from smokers, ex-smokers, and non-smokers believed that cigarettes are harmful. Out of 95 responses, 82% believed that cigarettes are harmful, while only 18% did not think that cigarettes are harmful.

The study asked people of their opinion on this statement: "Roll-your-own cigarettes are safer than tailor-made cigarettes". Of the 102 that responded, approximately 21% agreed to the statement, 35% disagreed, and 45% did not know.

4.3.4. EXISTING KNOWLEDGE

a. Health Problems of Smoking

Problems and diseases associated with smoking were identified across respondents: ‘smokers on a smoke-free programme’, ‘smokers not a smoke-free programme’, ‘ex-smokers previously on a smoke-free programme’, ‘ex-smokers not on any smoke-free programme’, and ‘non-smokers’ (Table 4.2). The commonly cited diseases ranging from the most frequent responses were lung cancer, heart attack/disease, asthma, cancer (in a broad sense), dental or teeth problems, and breathing problems.

Between the different respondent categories, lung cancer was mostly cited by smokers not on a smoke-free programme. The high number of responses mainly correspond to the higher number of ‘smokers not on a smoke-free programme’ compared to other categories in the survey (Figure 4.4). Lung cancer was also the highest mentioned disease by non-smokers. Generally there is not much difference in responses between ‘smokers on a smoke-free programme’ and ‘smokers not on a smoke-free programme’. Most other responses were also very similar between smokers, ex-smokers, and non-smokers for other diseases identified including cancer, asthma, coughing, headache, heart problem, oral disease, mouth cancer, and eye problem. Therefore, these groups were analysed as smokers, ex-smokers and non-smokers only (Table 4.2). Eleven questions received so few responses that they were not analysed. Included was a question about emphysema and clearly it is not understood that smoking is almost the only cause of emphysema.
Table 4.2: Frequencies and total responses from respondent sub-categories on health problems associated with smoking.

<table>
<thead>
<tr>
<th>Health Problems of Smoking</th>
<th>Smokers</th>
<th>Ex-Smokers</th>
<th>Non-Smokers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Cancer</td>
<td>38</td>
<td>7</td>
<td>9</td>
<td>54</td>
</tr>
<tr>
<td>Heart attack/stroke/problem/disease</td>
<td>23</td>
<td>3</td>
<td>8</td>
<td>34</td>
</tr>
<tr>
<td>Asthma</td>
<td>26</td>
<td>6</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>Cancer</td>
<td>26</td>
<td>3</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Dental/rotten teeth/tooth decay/yellow or stained teeth</td>
<td>13</td>
<td>5</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Shortness of Breath/Impotent/breathing problem</td>
<td>15</td>
<td>2</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Mouth/oral cancer/tongue and gum disease</td>
<td>9</td>
<td>-</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Coughing/Incessant coughing</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Skin cancer/skin disease</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Ugly skin/yellow fingers</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Blood clot/clogged arteries/poor circulation</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>4</td>
<td>-</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 4.2 cont: Frequencies and total responses from respondent sub-categories on health problems associated with smoking (continued).

<table>
<thead>
<tr>
<th>Health Problems of Smoking</th>
<th>Smokers</th>
<th>Ex-Smokers</th>
<th>Non-Smokers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad breath/smell</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Dizziness/headache</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Harmful to development of foetus/Infertility/fertility problem</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td>5</td>
</tr>
</tbody>
</table>
b. Social Problems of Smoking

Social problems associated with smoking were identified across respondents: ‘smokers on a smoke-free programme’, ‘smokers not a smoke-free programme’, ‘ex-smokers previously on a smoke-free programme’, ‘ex-smokers not on any smoke-free programme’, and ‘non-smokers’ (Table 4.3). Social problems for smoking that were commonly cited ranging from the highest frequent responses were financial burden, passive smoking, unpleasant smell, and the cause of violence, anger, and family disputes.

Between the different respondent categories, the cost of cigarettes as a financial burden was highly cited by smokers only (both on a smoke-free programme and not on a smoke-free programme). Responses for passive smoking were highest for non-smokers and also for smokers. Unpleasant smell from smoking was highly mentioned by ‘smokers on a smoke-free programme’ compared to ‘smokers not on a smoke-free programme.’ Unpleasant smell was also one of the common responses by non-smokers. Non-smokers only, compared to smokers and ex-smokers, mentioned smoking as being influential to others. Being shunned, out casted, or labeled by others were mentioned only by smokers. The frequencies of other responses were very similar across most respondent categories for smoking as an environmental hazard, a cause for crime, non-activeness, and wasting of time. Therefore the analysis was reduced to three categories i.e. smokers, ex-smokers, and non-smokers (Table 4.3). Three questions had so few responses they were deleted from the analysis. This included a question on physical appearance. It is not commonly known that smoking causes wrinkling or ageing of the skin.
Table 4.3: Frequencies and total responses from respondent sub-categories on social problems associated with smoking.

<table>
<thead>
<tr>
<th>Social Problems of Smoking</th>
<th>Smokers</th>
<th>Ex-Smokers</th>
<th>Non-Smokers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial burden/Affects budget/Costly</td>
<td>23</td>
<td>4</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>Passive Smoking/Second hand smoking</td>
<td>14</td>
<td>1</td>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td>Unpleasant smell/stink</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Violence/Anger/Family dispute/Marriage breakdown</td>
<td>9</td>
<td>-</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Being shunned/out casted/lost friends/labeled by others</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Environmental Hazard (litter and fire risk)</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Laziness/Non-activeness</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

**c. Benefits of Quitting**

The benefits of quitting smoking were identified across respondents: ‘smokers on a smoke-free programme’, ‘smokers not a smoke-free programme’, ‘ex-smokers previously on a smoke-free programme’, ‘ex-smokers not on any smoke-free programme’, and ‘non-smokers’. It can be seen that the largest proportion of responses (69 or 44 %) from all groups, specified health benefits when quitting while financial savings was the next main benefit identified.

The benefits of better breaths, nicer smell, improved taste of food and appetites, and setting a good example to family members, were mentioned by smokers only. Increase in life expectancy was mentioned by smokers and ex-smokers only. The highest responses for ex-smokers only were on the improvement of their health followed by financial savings. Ex-
smokers only, also mentioned that they have decreased time wasted and improved their work productivity. Improved fertility and sexual activeness were mentioned by smokers and ex-smokers only. Improved social life, happiness, and emotional wellbeing were mentioned by ex-smokers and non-smokers only.

Generally, ex-smokers and non-smokers have very similar responses. The analysis is reduced to three categories i.e. smokers, ex-smokers and non-smokers (Table 4.4). Eight questions received so few responses they were deleted from the analysis including questions on mood and time wasting.
Table 4.4: Frequencies and total responses from respondent sub-categories on benefits resulting from quitting.

<table>
<thead>
<tr>
<th>Benefits of Quitting</th>
<th>Smokers</th>
<th>Ex-Smokers</th>
<th>Non-Smokers</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health/maintain health and fitness/more active/preventing lung cancer/breathe easily/not tired/decrease risk of lung cancer and heart disease</td>
<td>50</td>
<td>13</td>
<td>6</td>
<td>69</td>
</tr>
<tr>
<td>Save money/Improve savings</td>
<td>27</td>
<td>7</td>
<td>8</td>
<td>42</td>
</tr>
<tr>
<td>Good breath/don't smell/smell nicer</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>Increase life expectancy</td>
<td>7</td>
<td>1</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Good appetite/taste food</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
</tbody>
</table>
### 4.3.5. SMOKING MESSAGE DELIVERY

When asked who would be the best people to deliver messages to Pacific people regarding smoking, most respondents selected more than one preference which included doctors, Pacific community leaders, community nurses, church leaders, local health workers, youth leaders, family members, and quit coaches (Table 4.5). Other people specified include those that have been affected by smoking and who used to smoke and quit successfully. The top four people identified (from highest response frequency) were local health workers, doctors and family members, and Pacific community leaders.

<table>
<thead>
<tr>
<th>People Identified for Smoke Message Delivery</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>35</td>
</tr>
<tr>
<td>Pacific Community Leaders</td>
<td>34</td>
</tr>
<tr>
<td>Family Member</td>
<td>34</td>
</tr>
<tr>
<td>Local Health Workers</td>
<td>30</td>
</tr>
<tr>
<td>Quit Coaches</td>
<td>26</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>20</td>
</tr>
<tr>
<td>Church Leaders</td>
<td>22</td>
</tr>
<tr>
<td>Youth Leaders</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>

### 4.3.6. SMOKING & PREGNANCY

Participants were asked of their opinion about smoking, conception, and pregnancy, and provided different opinions to the following statements:

\[ a. \text{“Smoking has a negative effect on female fertility”} \]

Out of 94 responses, 67 % strongly agreed and basically agreed to this statement, about 5 % strongly disagreed and disagreed only, while 28 % did not know or were not sure.
b. “Smoking has a negative effect on male fertility”

Out of 93 responses, 62 % strongly agreed and basically agreed to this statement, 42 % strongly disagreed and disagreed only, while 28 % did not know or were not sure.

c. “Smoking during pregnancy puts the baby’s health at risk”

Out of 92 responses, the majority (96 %) strongly agreed and basically agreed to this statement, only 1 % strongly disagreed, while 3 % did not know or were not sure.

d. “Smoking during pregnancy increases the risk of miscarriages”

Out of 89 responses, 66 % strongly agreed or basically agreed to this statement, only 1 % disagreed, while 33 % did not know or were not sure.

For both males and females that smoke, 27 out of 67 (approximately 40 %) admitted that they have smoked around pregnant women, while 40 out of 67 (approx. 60 %) stated they have not smoked around women that were pregnant.

For females only that smoke, 13 out of 47 (about 28 %) admitted that they smoked during their pregnancy, while the majority (about 72 %) stated they did not smoke while they were pregnant.

4.4. NON-SMOKERS

Some non-smokers provided reasons for not smoking (Table 4.6). The most common reason was that they did not like the smell of smoke or simply do not like it at all.

<table>
<thead>
<tr>
<th>Reasons for not smoking</th>
<th>Total Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t like the smell including on clothes/hate it/don’t like it</td>
<td>5</td>
</tr>
<tr>
<td>I don’t want to waste money</td>
<td>1</td>
</tr>
<tr>
<td>Not allowed in the family environment</td>
<td>1</td>
</tr>
<tr>
<td>Heard a lot about negative effects on health</td>
<td>1</td>
</tr>
<tr>
<td>Never tried to</td>
<td>1</td>
</tr>
<tr>
<td>Because play sports and need to be in shape, and smoking is extremely unhealthy and wouldn’t be my best interest</td>
<td>1</td>
</tr>
</tbody>
</table>
4.5. EX-SMOKERS

Ex-smokers were assessed on their quitting, factors including support received that contributed to the success of their quitting, changes they experienced and risks of relapse after quitting, services including the role of families and faith groups needed to support them to continue not to smoke.

4.5.1. QUIT PROFILE

a. Time period since quit

Out of 22 ex-smokers in this study, 21 provided responses on the period of time they have quit which ranged from 1 to 6 months to more than 20 years. There were eight that quit 1-6 months ago, one within 6 months-1 year, five within 1-4 years, two within 5-9 years, and three have quit for at least 20 years.

b. Triggers for Quitting

Ex-smokers were asked what prompted them to quit and most provided more than one answer: 12 out of a total of 42 responses were concerned about their health, 10 stated it was their own idea, 6 stated it was their families that made them quit, 5 identified the cost or constraints on their family budget, while 4 were concerned about the adverse effects of their smoking on their family’s health and others. Generally, a total of 15 responses were family related, that of respecting family wishes, their health, and for difficult financial situations.

c. Quit Attempts

Out of 20 responses from those that have quit, the highest number of those that quit stated that they only had one quit attempt (Figure 4.8).
4.5.2. TREATMENTS USED

Out of the 22 ex-smokers in this study, 20 provided a response whether they used medication or nicotine treatment for quitting. The largest proportion (95%) of responses was that most ex-smokers admitted that they did not use any treatment to help them quit, most just went cold turkey (Figure 4.9). Only about 5% stated that they used treatment (patches) to help them quit smoking.

![Quit Attempts Before Successful](image)

**Figure 4.8:** Total responses for the different times of quit attempts before one become successful in quitting.

![Medication/Treatment for Quitting](image)

**Figure 4.9:** Proportion of responses from ex-smokers for treatments they used for quitting.
4.5.3. SMOKE CESSATION PROVIDERS ACCESSED

Out of 22 ex-smokers, 10 did not access any services to help them quit, 7 accessed K’auite Pasifika, 2 received help from GPs, 1 from a nurse, and 1 from Quit line.

4.5.4. OTHER METHODS USED

The large proportion of ex-smokers that did not use any treatment particularly NRT, claimed that they just went cold turkey. Some shared that they prayed during their attempts to quit. One ex-smoker successfully quitted after reading a book by Allen Carr – “The easy way to stop smoking”.

4.5.5. KEYS TO QUITTING

From the 22 ex-smokers in this study, 18 identified key reasons for them to quit (Table 4.7). Over half of responses stated the key reason for them to quit was because of concern of their health, and 6 out of 18 stated that it was their own personal commitment that was key for them to quit. Importance of family, having faith, and education were also key to quitting to a few ex-smokers. Among those concerned about their health many admitted they have had coughing, asthma, and shortness of breath, agina, and heart attack.

Table 4.7: Total responses from ex-smokers for the varying factors identified as key to their quitting.

<table>
<thead>
<tr>
<th>Key factors to quitting</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern about health/maintain good health and physical alertness</td>
<td>9</td>
</tr>
<tr>
<td>Nothing, just willingly quit/ Strong belief in own self/Wanted to quit/make up own mind to stop/Just stop, that’s it/It must be a conscious and personal decision/Realising you do not enjoy smoking, you do not want to smoke and you do not need to smoke</td>
<td>6</td>
</tr>
<tr>
<td>Listened to family and keeping promises; husband/wife support</td>
<td>2</td>
</tr>
<tr>
<td>Faith and education</td>
<td>1</td>
</tr>
<tr>
<td>Financial</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>
4.5.6 EXPERIENCES AFTER QUITTING

a. Changes

Ex-smokers shared mostly positive changes after they quit smoking with regards to their health, physical form, economic status, and general wellbeing:

- Improved health/felt healthier/Don’t see the doctor
- Felt more active/increased energy levels/less sleepy/mentally improved
- Better breathing/never short of breath/not using inhaler daily for asthma/no complications when exercising
- Eat well/can taste food/enjoy eating
- Improved savings/financially secure
- Improved looks/smoothier facial appearance
- Better sense of smell
- Lower blood pressure
- Family are happier/Healthy home environment
- Gained weight

The more prevalent changes were found to be of increased energy levels and activeness, improvement of general health followed by improvement of breathing, taste of food and hence appetite, and financial savings. Weight gain, however, was one effect that was quite commonly experienced among some of ex-smokers.

b. Risks of Relapse

Twenty one ex-smokers responded to the risks of relapse to smoking again. Ten stated that they have been tempted to smoke again while 11 stated they have not been tempted to smoke again. Those that have been tempted to smoke again stated their risks of relapsing to smoking would increase when they were socialising, where drinking would often be associated, from peer pressure, when a family member smokes, and from their own craving.
4.5.7. RELIGIOUS FAITH & QUITTING

Out of 22 ex-smokers, 20 provided responses on the impact of their religious faith on their attempts to quit smoking. Of the 20 responses, 5 classified the impact of their religious faith on their attempts to quit smoking as very strong, 5 as strong only, 5 as not strong, and 5 did not know. Overall, half of the respondents believed that their religious faith has a very strong or strong influence on their attempts to quit smoking.

4.5.8. FAMILY & QUITTING

All ex-smokers provided responses on the impact their family have on their decision to continue not to smoke. Out of 22 responses, 12 identified the support from their families as having a very strong impact on their decision not to smoke, 5 as strong only, 1 as not strong, and 3 did not know. Overall, most responses (17) believed their families had a very strong or strong effect on their decision to continue quitting.

4.5.9. NEED OF CONTINUOUS SUPPORT

The ex-smokers recommended that they would still benefit in continuing support. Most (8) of those that needed continual support, preferred follow up visits, 1 preferred phone calls, 3 preferred counseling, and 2 from the continuous provision of NRT.

The other 7 respondents stated that they would not need assistance and 1 stated that they need to believe in their own self to continue not to smoke.

4.6. ALL SMOKERS

All smokers were assessed on their smoking history, smoking profile including daily cigarette consumption, smoking at homes, their consideration of quitting and quit attempts, reasons for failure to quit, factors affecting their habit of smoking, and support they accessed from smoke cessation providers, family, community, and faith groups.
4.6.1. SMOKING HISTORY

a. Age When Smoking Started

All smokers indicated their age when they first started smoking (Figure 4.10). It can be seen that the majority of people started smoking before they reach 20 years old, with the most common age of 16 years old. The youngest starting age for smoking found was 10 years old.

![Age When Started Smoking](image)

**Figure 4.10:** Distribution of total responses from smokers showing their stated ages when they first started smoking.

b. Reasons for First Smoking

There are various reasons by Pacific people for starting smoking (Figure 4.11). Peer pressure was the most prevalent reason, followed by family members that smoke, and stress. Other reasons include curiosity and wanting to try, while some did not know why they started smoking.
4.6.2. SMOKE PROFILE

a. Smoking Methods and Brands

Out of 72 Pacific people in this study, 56% smoke tailor-made cigarettes, 40% smoke roll-your-own, and only 4% smoke pipes. Different tobacco brands were frequently smoked (Figure 4.12) with ‘Holiday’ as the most commonly smoked brand, followed by ‘Roll-your-own’ (or Port Royal), and ‘Pall Mall’. Other smoked brands include ‘Camel’, ‘John Brandon’, and ‘Park Drive’ (rolls).
b. Daily Cigarette Consumption

Pacific smokers in this study have different daily cigarette consumption rates which range from on average of less than 5 cigarettes a day (16 %), 5 to 10 (49 %), 11 to 15 (14 %), 16 to 25 (11 %), and more than 26 cigarettes a day (7 %) (Figure 4.13). The highest number of smokers consume on average 5 to 10 cigarettes a day. The remaining 3 % did not know or were not sure of their daily cigarette consumption.

Out of 54 smokers that provided responses that indicated the change in number of cigarettes smoked over the last 12 months, 33 stated they have cut down the number of cigarettes while 21 stated they have not reduced the number of cigarettes they smoked over the past year.

Out of the 54 responses, 35 indicated the actual number of cigarettes that they have cut down: 25 (71 %) have cut down between 1-5 cigarettes a day, 4 cut down to one packet or approximately 20-25 cigarettes a day, 3 cut down to half or approximately 6-10 cigarettes a day, and 3 cut down to amounts other than those listed which including having 1 cigarette every second day.

![Figure 4.13: Total responses from smokers for average number of cigarettes smoked per day](image_url)
c. Nicotine Dependence Assessment

Those that smoke stated the times when they usually have their first cigarette after waking up which ranged from within 5 minutes, between 6 to 30 minutes, 31 to 60 minutes, and more than 60 minutes (Figure 4.14). A large proportion (41 %) of smokers usually has their first cigarette between 6 to 30 minutes after they wake up, followed by 29 % who have theirs within 5 minutes after they wake up. Overall, about 70 % of Pacific smokers in this study smoke within 30 minutes of waking, which indicates that they have a higher degree of nicotine dependence based on Fagerström Test for Nicotine Dependence (Ministry of Health, 2007).

![Figure 4.14: Total responses from smoking respondents for the different times of their first cigarette smoked after waking up.](image)

4.6.3. SMOKING IN HOMES

Among those that smoke, 34 out of 56 (approximately 61 %) stated that other household members do not smoke, while 22 out of 56 responses (approx. 39 %) have other household members that smoke.

All of the 58 respondents that smoke provided rules of smoking in their homes. About 72 % stated that smoking was not or never allowed in their homes, 22 % stated that smoking was allowed, 3 % stated that there was no rules, and 2 % did not know. Some people admitted that even though smoking was not allowed in their homes, the smoke-free rule would
sometimes be relaxed to allow visitors or guests to smoke inside their homes. While most smokers do not smoke inside their homes, about 9 out of 58 people stated they smoke daily in their homes, 2 out of 58 people smoke weekly, and only 1 smoke about once a month inside their homes.

People smoke at different places within their homes (Figure 4.15). The most common place for smoking is outside of homes, while some people still smoke in the kitchen, living room, bedroom, bathroom, dining room, and other places such as not within the vicinity of their homes.

![Figure 4.15: Total responses from smokers for the different places for smoking at their homes.](image)

### 4.6.4. REASONS FOR FAILING TO QUIT

Smokers identified a range of reasons for failing to stop smoking (Table 4.8). The more prevalent reasons (from the highest frequency of responses) were those related to social surroundings and peer pressure, stress, addiction, and the lack of personal commitment to quitting.
Table 4.8: Total responses from smokers for the varying reasons identified for failing to stop smoking.

<table>
<thead>
<tr>
<th>Reasons for failing to stop smoking</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social surroundings/ Peer pressure/ People around who smoke makes me want to smoke again/ Friends who smoke/ tempting when too many people around are having one/ Everyone else is smoking around you/ People I work with are smokers/ Always around people who smoke in the workplace/ I go to the faikava and my friends gave me smoke/ I smoke when drink kava</td>
<td>14</td>
</tr>
<tr>
<td>Stress/ Too much pressure/ worry/ I feel very depressed/ I needed it to calm me down</td>
<td>10</td>
</tr>
<tr>
<td>Addicted to it/ Really like it more than food/ I love the smell/ It is hard/ A habit/ I still enjoy smoking</td>
<td>9</td>
</tr>
<tr>
<td>Failed to stop because not committed to it/ Have not attempted to stop smoking/ I’m not ready to quit/ Didn’t keep to it/ No will power</td>
<td>6</td>
</tr>
<tr>
<td>Never thought of quitting/ Don’t know</td>
<td>4</td>
</tr>
<tr>
<td>Alcohol/ Feel like smoking when drinking</td>
<td>3</td>
</tr>
<tr>
<td>Would not work properly without a cigarette/ Lack of concentration</td>
<td>2</td>
</tr>
<tr>
<td>I eat more and gained weight when I stopped smoking, so I have to smoke again/ I eat more if I don’t smoke</td>
<td>2</td>
</tr>
<tr>
<td>Availability of cigarettes/ I kept on buying smokes</td>
<td>2</td>
</tr>
<tr>
<td>Because all my family smoke/ Husband/wife smokes</td>
<td>2</td>
</tr>
<tr>
<td>When bored</td>
<td>1</td>
</tr>
<tr>
<td>No one tells me, no education</td>
<td>1</td>
</tr>
<tr>
<td>Might be because your family and friends ground you</td>
<td>1</td>
</tr>
</tbody>
</table>
4.6.5. TRIGGERS FOR INCREASED SMOKING

Pacific respondents that smoke identified a range of factors or situations that usually increase the amount of cigarettes that they smoke (Figure 4.16). Stress was the major factor (about 29 %) claimed to increase the amount of cigarettes consumed a day, followed by anger (19 %), and alcohol drinking (18 %).

![Triggers of Increased Smoking](image)

*Figure 4.16: Total responses from smokers for varying identified triggers of their increased smoking.*

4.6.6. CONTEMPLATION FOR QUITTING

All 58 smokers provided different stages of their thoughts about quitting: 26 (45 %) thought that they need to consider quitting smoking someday, 21 (36 %) have no thoughts of quitting smoking, 19 (33 %) thought they should quit smoking but were not quite ready, 14 (24 %) did not know where they stand, 12 (21 %) thought about doing things that would help them quit smoking, and 9 (16 %) stated that they were doing things that would help them quit smoking.

4.6.7. QUIT ATTEMPTS

Out of 58 smokers, 56 responded on their quit attempts, where 36 stated that they have attempted to quit, while 20 have not tried to quit. Quit attempts ranged from over a year ago.
to as recently as the previous months (June/July 2009). Only 21 out of the 36 provided the number of times that they have attempted to quit:

- 11 attempted to quit once
- 5 attempted to quit twice
- 4 attempted to quit more than twice
- 1 could not remember the number of times quitted

Thirteen smokers that have attempted to quit stated that they have stopped smoking for:

- 6 months (1 response)
- Between 3 to 5 months (6)
- Between 1 to 2 months (3)
- Between 1 to 7 days (3)

Only five of smokers that have attempted to quit stated the number of times they have stopped smoking for at least 2 weeks. Three people stopped smoking only once for at least 2 weeks, and two people stopped twice for at least 2 weeks. However, it can be seen from the 13 people that stated the time period that they have quitted, that there was 10 in total that have attempted to quit for at least 2 weeks (i.e. one for 6 months, six for 3-5 months, and three for 1-2 months). There could be more who have attempted to quit for at least 2 weeks, out of the 36 responses, but they have not stated the time period that they stopped smoking for.

4.6.8. ACCESS TO SMOKE CESSATION PROVIDERS

Out of 58 smokers in this study, 51 responded on their accessibility to smoke cessation providers. About 23 out of 51 (45%) responses stated that they have accessed K’aute Pasifika Services to help them quit, 21 (41%) have not accessed any smoke cessation services, 4 people accessed Quitline, 2 received help from nurses, 1 from a GP, and none from other Providers (Te Runanga o Kirikiriroa, Te Kohao Health, Nga Miro Health, and a Hospital).

A large proportion (75%) of Pacific people that smoke in this study was aware of Quit line while the remaining 25% were not aware of it. Only about 13% have contacted Quit line, while the majority (87%) has not sought any help from Quit line. About 25% of those that have not sought any help from Quitline, stated that they have sought assistance elsewhere.
Generally, 27 smokers in this study stated their satisfaction with smoke cessation services that they have received from Providers. Most of the responses (21 out of 27) were satisfied while few (6 out of 27) stated that they were not satisfied with the services they have received for smoke cessation.

### 4.6.9. CONSIDERATION OF QUITTING & ASSISTANCE

Out of 58 smokers in this study, 53 provided responses to consideration to quitting in the next six months. Out of 53 responses, 27 were considering quitting and 26 were not yet considering quitting for the next six months.

Out of 51 that provided responses on the need for help in quitting, 17 (33 %) stated that they needed help, while 34 (67 %) did not need help to quit.

Some smokers that are considering quitting provided the following reasons for preferring to quit:

- Health problem/My health’s deteriorating/ To support wife who was sick/ My children get sick
- Very costly/Wastes money/Needed to save to buy other things/ Because expense was mostly on smoke and wanted to quit for the sake of the children
- Being over 40 years old/To live longer/ I don’t want to die young
- Not worth it

The responses for preference to quit was highest for financial followed by health reasons.

### 4.6.10. POTENTIAL ASSISTANCE FROM GROUPS

Out of 58 smokers, 40 identified groups that they consider would be able to assist and support them to quit. Out of 40 responses, 18 selected their community/cultural groups as able to provide assistance for them to quit, 11 selected their churches, 4 for sports groups, and 1 for their fundraising group. Six other groups that were considered include families and quit coaches for potential assistance and support for quitting.

Fifty six smokers expressed their views on the effect of being in a larger group and their quitting. Over half of responses stated that being part of a larger group would not make it easier for them in their quitting attempts. Some that provided reasons stated that it has to
come from them and they should quit on their own because it would be more sustainable and their quitting would be for a longer term.

Twenty smokers stated that it would be easier to quit as part of a larger group because most thought that there would be more support and encouragement by quitting together, including with group of friends, people that really care for them, and those going through the same situations. Others felt more motivated when there’s competition in a group on quitting and would feel encouraged through sports and church group activities.

4.7. SMOKERS ON SMOKING CESSATION PROGRAMMES

Nineteen smokers out of 23 that have accessed K’aute’s smoke free programme including those currently on K’aute’s smoke free programme (see 4.8.2), provided responses for this section. Out of 19 people, 11 have been on the smoke free programme for less than a year, 4 between 1-3 years, and 4 did not know or could not remember.

4.7.1. SMOKING STATUS

Out of the 19 responses from smokers on K’aute’s programme, 18 indicated they were still smoking. However, 65 % of smokers that have accessed K’aute Pasifika’s smoke free programme, for those that participated in the research, stated that they have cut down on their daily cigarette consumption. Of this group (65 %), 69 % have cut down by between 1 to 5 cigarettes per day.

4.7.2. ISSUES IN QUITTING

Smokers who are currently on K’aute’s smoke free programme provided reasons why they are still smoking and problems they have in quitting:

- They were still trying to get the time to give up/some have registered (with Quit Coaches) but still not sure when to quit/ not ready to quit/ they have not set their minds to quitting
- Family members smoke
- Social/peer pressure
• They were stressed
• They found it hard to quit/addicted
• It's their fix
• They still enjoy it and have nothing to replace it with
• It is their choice

4.7.3. SATISFACTORY WITH SMOKE-FREE PROGRAMME

• Sixteen people provided responses on their satisfaction with the programme where 13 were satisfied and 3 were not satisfied. Those that were satisfied found follow ups and reminders as more helpful compared to the use of NRT and workshop presentations.

4.7.4. RELIGIOUS FAITH & QUITTING

Seventeen people responded on the strength of their religious faith on their quitting. About half of the responses considered their religious faith or prayer as a way of helping them to quit, while the other half thought otherwise. Fourteen people rated the impact of their religious faith on their attempts to quit smoking, as very strong and strong only (7), not strong (2), or did not know (5).

Smokers that found their religious faith as having a very strong or strong impact on their quitting shared their beliefs that:

• Churches challenge and encourage people to commit and help themselves
• they believe that by the power of prayer, things are possible
• the Bible says that your body is the temple of God

4.7.5. FAMILY & QUITTING

Eighteen people responded on the support their family would have on their quitting. Out of the eighteen people, 13 stated that the support from their families would help them quit, while 5 did not think that support from their families would help them quit.
The strength of family influence on affecting the decision of these smokers to quit smoking was found to be very strong (5), strong (5), not strong (5), and others did not know (4).

Smokers that found the support of their families as having a very strong or strong impact on their quitting expressed that:

- families offer more support
- partners not smoking would also help them continue quitting
- their family being very strict for not smoking
- they love their families and want their children to be happy
- their parents or children were concerned about their health
RESULTS & FINDINGS

FOCUS GROUPS:

4.8. INTRODUCTION

Three focus groups with an average of seven people each, all of Pacific Island (PI) origin, were conducted: one in Tokoroa and two in Hamilton. All focus groups included varying age groups, and educational backgrounds as well as a mixture of smokers, ex-smokers, and non-smokers. The first focus group in Hamilton had a mixed ethnic and gender distribution; the second had mixed ethnic distribution, but was predominantly female (one male only); and the Tokoroa group had mixed gender distribution, but was comprised of one PI ethnic group only (Cook Is). The detailed design and aims of the focus groups were described under the methodology section.

4.9. AWARENESS, KNOWLEDGE ATTITUDES, AND PERCEPTION ON SMOKING

4.9.1. SMOKING & CULTURE

Smoking was identified by participants in the focus groups as associated with Pacific Island traditions, practices and social lifestyles. Smoking was considered as not part of the Pacific culture but most people agreed that it has become an integral part of customs and traditional protocols. Examples of these include gifting tobacco as a gesture of hospitality by visitors to villages and indigenous shrines; smoking being adopted and associated with gatherings of a political and social nature (such as village meetings, alcohol and kava drinking); and giving of packets of cigarettes to reciprocate for favours (such as people helping out in the garden).

Most participants agreed that tobacco and cigarette smoking were introduced to Pacific islands by early foreign travelers to Pacific islands. This also included the planting of tobacco in some islands such as in Fiji. Most also agreed that although tobacco smoking was not originally part of the Pacific Islands cultures, the traditional practices and protocols that integrate tobacco gifting and consumption, has become a “social norm” over time.
Smoking is commonly associated with drinking alcohol and kava. Some participants stated that they would smoke only when they drank or they would smoke more when they were drinking. “Beer and cigarettes go very well” as one participant puts it.

Controlling kava drinking to control smoking would not be a helpful strategy according to some participants. One participant stated that “kava is very much involved in our culture”, and that in Tonga, people even normally have kava before the church service on Sundays, hence he thought that it would be very difficult to try and stop kava drinking.

Some participants who identified themselves as smokers came from families of smokers. One participant stated that “everyone smokes in the family of 11. My dad also smoked and he never told the family to stop smoking.” This participant thought that the fact that her father did not seem to suffer any ill effects from his smoking, even though he worked in a chemical factory, made it alright for her to smoke too. Another participant shared that when her family comes together, smoking would automatically become part of what they do, particularly when she chats and has coffee with her sister.

Three participants explained that they saw smoking as part of social interaction and culture in the workplace. One participant stated that she eventually picked up a cigarette and started smoking in order to join her friends at the workplace who would go outside when smoking.

Some participants perceived smoking as bad and that they would not be able to smoke and simultaneously practice their spiritual/religious faith. Rather they felt that people make a choice either to smoke or practice their religious faith which included going to church. One participant admitted that she stopped going to church as soon as she started smoking again.

Health workers in one of the focus group meeting admitted being self-conscious about their smoking habits which contrast sharply with the role they play in health promotion within their communities, “how can I tell people not to smoke and yet I’m doing it?”.

4.9.2. **ARE CIGARETTES HARMFUL?**

Most participants thought that with the amount of health promotion messages about smoking, most people would be aware of the harmful effects of cigarettes. Most agreed that smoking was bad for their health and the health of others. Some participants that smoke acknowledged that they were responsible for their smoking problem.
Five participants have had immediate family members who almost, or have died from smoking related illnesses. Three of these participants lost their fathers and one lost his mother from smoking related diseases including lung cancer and other respiratory diseases. A fifth participant has a sister who had undergone throat (larynx) surgery and has been warned by doctors that this surgery was required as a result of her heavy smoking.

Three participants have become very sick as a result of smoking. Three participants have had to stop smoking when their health conditions were bad, and one ex-smoker actually quit because she became very sick too. Other participants that smoke related that their family members have been adversely affected by their smoking. One woman explained that she had such serious mood changes when she had gone too long without smoking that she had physically hurt her children by throwing objects at them in anger.

However, some participants thought that some people may not see smoking yet as a problem but rather it was more for enjoyment, and relaxation. Few participants’ reactions were immediate denials that cigarettes were harmful. One participant claimed that her coughing was not from her smoking but was from another medication she was taking. Another participant shared her experience of encountering a person who died from cancer yet was not a smoker. Another participant who smokes stated that she didn’t feel sick because physically she was still functioning well. Generally, people that smoke were not concerned about their health or the length of their life span. One participant had a friend who told her that she didn’t want to stop smoking because she would rather die early and not be a burden to her family when she lived long and old. One other participant currently just could not see smoking as a problem, other than a financial one.

4.9.3. PASSIVE SMOKING & SMOKE-FREE PLACES

All focus group participants were generally aware of the effects of smoking. Those who smoked in the groups generally seemed to be more concerned about the effect of their smoking on others than on themselves. They agreed that more places were becoming smoke-free including homes. It is increasingly common to see smokers at faikava to go outside and smoke but in the islands, smokers would continue to smoke at the faikava without separating themselves from the group. Some thought that this difference may be the result of the more intense smoke campaigns and available information in New Zealand.
4.9.4. WOMEN SMOKING

In total, there were eight women who smoke in the focus groups, including one pregnant woman. These women were mothers and grandmothers and two were health workers. Six of these women stated that they have quit before, some several times (ranging from 1 to 3 times) and for varied time periods (ranging from a few days to a month, and up to five years) before they returned to smoking again.

Some women shared that smoking was a way of social attachment to one another. Others thought that smoking was psychological and often associated it with different life situations such as before starting the work of the day, when socialising with friends and families, or when drinking coffee or alcohol. Most women also smoke when they were emotionally, mentally, or physically stressed such as when a partner passed away.

Smoking and Pregnancy

Two women from the focus groups shared their experiences of smoking and pregnancy. One participant was approximately six months pregnant at the time of the meeting.

a. Case A:

This PI mother has been smoking increasingly more often as part of her social life. Most of her sisters smoke but not her brothers. She tried quitting three times before, twice when she was pregnant and breastfeeding. However, in one of her pregnancies, she smoked throughout the first four months of her pregnancy, as she stated that she was not aware then that smoking was harmful.

She recently became aware of the treatments and support available including Quitline, however, she has not tried seeking help for quitting. She would also get frustrated when reminded by her son not to smoke. She felt that she was still not ready yet to quit and that it has to come from herself.
b. Case B:

This PI mother has four children and was also approximately six months pregnant at the time of the meeting. She was a heavy smoker and has to smoke one cigarette every few minutes. She even admitted that she craved smoking more than food. She said she has been told before that smoking is not good for her, particularly when she is pregnant, however, she admitted that she has never tried to quit. Nonetheless, she thought her husband (also a smoker) and she could stop smoking also because they found the cost of cigarettes a financial burden on their family. Both she and her husband have been hassled about quitting from their family. Despite her awareness on the negative effects of smoking on health, she still has doubts that smoking alone was to be blamed as the cause of cancers leading to deaths e.g. she shared of having seen a person that died of cancer and was told that the person never smoked.

4.9.5. Youth Smoking

Several views were presented about youth and smoking. Some mothers stated that they have found out about their children asking for money for lunch or mobile phone top up, but instead have been using the money they asked for to buy cigarettes from the shops through friends or other adults.

Some women that smoke thought that it was not cool to smoke with their own children and rather believed that young people should smoke with their own age group level.

4.9.6. What Triggers Smoking?

Participants described why they started smoking, what triggers them to smoke, and what increases the amount of cigarettes they smoke.

People first started smoking for a range of reasons:

- Work pressure
- Physical, emotional or other stress (e.g. the death of a partner)
- Not knowing at the time that smoking was bad
- Because it was part of their social life with friends and family

Factors that trigger smoking and increase the amount of cigarette consumption:
• There were more options (cigarette brands) that they have not tried before in the islands
• It is much cheaper to buy cigarettes here in New Zealand compared to some PI countries such as in Tonga and Samoa, hence economically the cost of cigarettes to some people was not a barrier
• Social gatherings including the drinking of kava and alcohol. There were several faikava groups in New Zealand which normally rotated around different venues including people’s homes or garages.

4.9.7. QUITTING

a. Quit Attempts and Experiences
Of 11 smokers in the focus groups, eight (six women and two men) stated that they have previously quit but have came back to smoking again. Four quit once before, one quit twice, two quit more than two times, and one was not sure but it was several times and usually when he was sick. Quit attempts ranged from a few days only, up to a month, 2 years, and 5 years. Four people stated that they have quit for more than two weeks i.e. 28 days, 9 months, 2 years, and almost 5 years. Other participants could not remember the length of time they have quit for.

Some participants shared their experiences when they were in the process of quitting. One woman experienced bad moods and where she used to take it out on her children. Another common response was the replacement of smoking with sleeping and eating, and consequently, participants stated that they have actually gained weight when they were not smoking. One participant tried to get busy in doing other activities to get her mind off smoking.

b. Sources of Help and Treatments Used
Few smokers have actually sought help for quitting. Three have contacted Quitline. Of these three smokers, two received patches but admitted that they have never used them, and one stated that he has cancelled his request for patches. Two of these smokers stated that they decided they wanted to quit on their own, and the others chose to approach a local provider instead. One participant has also been approached by a Quit coach but has not decided to use
the treatment yet. Overall, for the eight smokers (that quit and smoked again), one used hypnotherapy while the other seven just went cold turkey. Some of those that went cold turkey also resorted simultaneously to their religious faith and prayer life.

One ex-smoker in the focus groups shared that she just went cold turkey even though she was warned about it. She found that she has been able to keep off from smoking for 5 years now because she found that it worked when she replaced her smoking with her consumption of chocolates. One mother also shared that her daughter actually quit after reading an inspirational book on quitting smoking.

c. **Attitude towards NRT Treatment**

Most participants thought that the word ‘treatment’ was daunting and associated it with diseases. Some thought that to receive treatment, including NRT (for quitting) may not be preferred by some people because they would see it as a form of medication, and associated with being ill. One participant thought that a person using treatment (including NRT) would normally be considered as having a problem, and some people do not want to be seen as having a problem. One participant suggested using the term ‘nicotine replacement’ and omitting the word ‘treatment’ would make it more acceptable.

Some participants who smoke thought that having to pay for NRT after the first free set of NRT provided, would put them off of wanting to use the treatment. Some agreed to the contradiction in their situation where they would not think of the costs involved when buying cigarettes but they would think twice or be unwilling to pay for the treatments.

Some participants thought that some smokers would respond more favourably to being referred to health workers or quit coaches by the doctors, than by being approached by the health workers or quit coaches first. The medical message would be given higher priority, and would make the individuals more likely to cooperate.

d. **Key Reasons for Failing to Quit**

The key reasons cited by the participants for failing to quit revolved around physical addiction, beliefs about smoking and social practices. The physical addiction reasons for failing were reported as strong cravings that made smoking more important than food, being unsuccessful when using “cold turkey” as an approach, or having too little energy to work without
cigarettes. Those who failed to quit based on beliefs about smoking were those who reported that smoking is not a problem; that because they don’t feel sick hence they shouldn’t stop; and that being asked to quit annoys them. Finally, the social reasons included wanting to smoke when drinking alcohol or coffee, being bored, being in a family of smokers, and the cost of NRT.

e. Key Reasons for Quitting or Wanting to Quit

The key reasons for quitting or wanting to quit revolved around the actual presence of illness in the individual or someone close to them, coming to a realisation point, or being open minded to what their family has to say to them about smoking. One participant was told by his father, as he lay dying from a smoke-related disease, to quit smoking. Others have quit when their own health condition was impaired, or when smoking was banned by a doctor before surgery. Participants also came to realisation points, when they knew that they could no longer afford to smoke, and that their family wellbeing (including health and cost of food) is a priority compared to smoking. Participants who smoke also realised that they did have some control, e.g. one participant stated: “I’m the one that decided to smoke so I think I should be the one deciding to quit too.” A few participants have changed their attitude to become more open minded by listening and taking note of what children were telling them about smoking e.g. One participant has started to smoke outside after being told by her granddaughter that smoking inside their house is bad. Another participant said that she is thinking of quitting after receiving notes by her nephews and nieces requesting her to stop smoking.

f. Key Factors In Quitting Success

It is interesting that whilst “cold turkey” was identified as a reason for failing to quit successfully, it was also cited by some participants as a reason for their relatively long-term success. These participants, however, acknowledged that it was their spiritual faith that carried them smoke-free for more than two weeks including one participant that carried her smoke-free for five years until she started smoking again. Another participant who went “cold turkey” said she ate lots of chocolate to replace the cigarettes. She has been smoke-free for five years, and does not think of smoking even when with friends. She admitted that it was hard work for her but she nevertheless tried.
Overall, issues and barriers identified across all focus groups ranged from physical addiction, beliefs that promote smoking and constraints to treatment. The following issues were identified throughout the focus groups:

- Addiction to smoking
- Social lifestyles, cultures, and stress resulting from other life situations that are affecting quit efforts
- Negative attitude about NRT treatment and support available
- Harsh/scare tactics taken by GPs on people that smoke
- Youth are getting less instruction and direction from senior citizens, leaders, and their own parents
- Not walking the talk (health promoters smoking)
- Smokers were not personally ready to quit
- Harsh approach on smoke cessation advice used by health workers/quit coaches
- Communication barriers e.g. some people living in remote areas could only be reached on landlines

Generally, participants agreed that everyone needs to be happy and people including smokers need to be encouraged and supported in quitting.

**4.9.8. WHAT PARTICIPANTS THOUGHT THEY NEED TO DO**

When asked what they thought they needed to do to stop smoking, participants identified both behavioural and cognitive changes. The changing of routines was identified as an important step. By reducing drinking (alcohol), they could reduce smoking. Similarly, they could change daily routines to cut down on activities that increase smoking, like coffee breaks, and they could “get busy” at home to fill up what would have otherwise been smoking break times. However, there also needed to be a changing in thinking. They need to use their will power to quit, and listen to and take note of the advice of elders on giving up smoking. “You need to help yourself first, stop smoking, and then you can help others”, said one participant.
4.9.9. SUPPORT NEEDED

Participants that smoke identified the following supports and approaches that they need to help them quit smoking:

- To promote and have more focus group and also one-on-one sessions as participants found these avenues more effective. There’s more opportunity for talking, sharing, connecting with others, and understanding other peoples problems and experiences. Participants thought that focus groups are more culturally appropriate and also therapeutic to everyone.
- That health care promoters including quit coaches need a lot of patience and need to keep trying to provide the support needed. Participants wanted health workers to recognise that the change needed is a slow process and a quick fix solution cannot be expected, because it is not easy to change behaviours of people particularly those that have been smoking for many years.
- That there should be more flexibility in approaches used for smoke cessation e.g. to use approaches that are more on the ground and not classroom like.
- The collective support of family and friends

4.9.10. OTHER IDEAS TO BE EXPLORED

Some ideas discussed in the focus groups which could be explored further in the future to support smoke cessation include:

- The use of technology available such as mobile phones in providing support in smoke cessation e.g. texting of smoke cessation messages. Most participants agreed that their mobile phones are practically on them all the time. Some thought that texting would help encourage them to quit, “It shows that this person really cares enough for me”, according to one participant.
- One participant thought that smoking to him was a mental, emotional, and a spiritual issue, which needed to be satisfied. Few others have actually resorted to their spiritual faith including prayer life in their process of quitting, while one actually sought spiritual healing before coming to the meeting. Thus, the use of mental, emotional, and spiritual approach needs to be explored further.
- A few participants suggested the Government close down tobacco companies as the ultimate solution.
4.9.11. IMMEDIATE CHANGES AFTER THESE FOCUS GROUP MEETINGS

- One couple including the pregnant woman registered straight away after the focus group meeting with K’aute’s Smoke free programme, where they were provided with patches. The couple has been followed up since and they have not been smoking ever since on the smoke free programme.

- One participant met up with K’aute’s Quit coach after the focus meeting in Tokoroa, signed up on to the smoke free programme and has been supplied with NRT (patches and gum). The Quit coach in charge reported that he has been in regular contact with this participant ever since the focus group meeting.

4.9.12. ANALYSIS OF FOCUS GROUPS

Data and findings from the focus group sessions were further analysed by grouping together emerging themes under broad categories of psychological, social, physical, spiritual/religion, and cultural. These themes were then further categorised into sub-themes of what supports and inhibits smoking cessation. For example, improving and maintaining health and family support are themes that would aid quitting (support) while those such as peer pressure, stress and family members smoking, are themes that inhibit cessation (barriers).

**Barriers and Supports to Quitting:**

Notably there were more barriers found under the social, psychological, physical, and cultural components. There were no cultural supports to quitting compared to barriers only that were identified. A distinct difference could be seen for spiritual support compared to its barriers.

Social supports for quitting include aspects such as provision of awareness, education, and reminders on smoke cessation to smokers by health workers, quit coaches, family members (“she got reminded not to smoke by her son”), other health professionals, and not smoking around children. On the other hand, social barriers include situations such as young people getting cigarettes from adults, smoking during social gatherings and events including during alcohol drinking, or family and community gatherings (“it became a social norm to smoke with family”).
Psychological supports for quitting include circumstances such as feelings of guilt by smokers (“started smoking again at uni but would wake up with strong feelings of guilt”), not wanting to smoke even when with friends that smoke, acknowledging the role of will power to succeed, thinking of replacing lifestyles or habits that triggers increase in smoking e.g. cutting down drinking, and placing families as higher priority in their lives and as a motivational factor for quitting. Psychological barriers include situations such as having to smoke to fit in with the peer group, having to smoke when drinking (alcohol or kava), not wanting to be told to stop smoking, not able to see smoking as a problem, thinking it is hard to change people’s smoking behavior, not wanting to use medication (NRT), being put off by approaches taken by doctors in giving smoke cessation advice.

Psychological effects of nicotine have been documented in some studies. Nicotine has been reported as having persistent effects on brain neurochemistry i.e. having effects on a person’s nervous system (Wikipedia, 2009), and that it is highly addictive probably because it is transported so quickly to the brain (Jarvis, 2004). Most smokers in our study reported that cigarette smoking helped them concentrate and work more effectively, and also calmed them down or relaxed them when they are in stress, however, a clinical review study (Jarvis, 2004) reported that little evidence exists for nicotine providing effective self medication for negative mood states or for coping with stress.

Physical aspects that support quitting include promotional messages that are anti-smoking, stopping smoking because of health problems (“he normally gives up when he is sick”), and delivering education to families. Physical barriers identified include smokers not feeling sick from smoking, cravings for tobacco (“she literally ate tobacco because she craved for it”), the physical sensational urge to smoke when drinking kava, and inappropriate delivery of messages that can drive smokers to smoke more.

Economic supports identified include situations such as smokers realising the increasing cost of cigarettes, being able to see the impact of the cost of cigarettes on family finance, and evaluating where money would be better spent such as on food for children. On the other hand, economic barriers to quitting include increase in smoking because of the availability of cheaper cigarette brands as also reflected in our data (Figure 4.12), and the reluctance to pay for NRT treatment.

We found in our survey data that a large proportion of Pacific people were affiliated to a church. Our focus groups discussions found that reference to spiritual support to non-smoking was also frequently cited e.g. rules existing in some churches such as LDS of not allowing
smoking, people quitting smoking including those that went cold turkey by practicing their religious faith and prayer life, and believing that praying and their faith has actually helped them to quit ("Her uncle prayed for her smoking behaviour during family prayer"). The only spiritual barrier identified was that some people would revert back to smoking when they stopped going to church.

Cultural practices mentioned in our study that were barriers to quitting were faikava as this is commonly associated with smoking where people smoke when they drink kava, using faikava as a form of fundraising activity, and regularly having faikava before or after church services in some churches.

Table 4.9: Proportion of response occurrences for supports and barriers determined according to the different identified factors.

<table>
<thead>
<tr>
<th>DETERMINANT FACTOR</th>
<th>SUPPORT FOR SMOKING CESSATION (%)</th>
<th>BARRIER TO SMOKING CESSATION (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>20.5</td>
<td>34</td>
</tr>
<tr>
<td>Social</td>
<td>20.5</td>
<td>21</td>
</tr>
<tr>
<td>Physical</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Spiritual</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Cultural</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Environmental</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Economical</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Political</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
RESULTS & FINDINGS

SPECIAL FOCUS GROUP - WOMEN IN A FAMILY

4.10. INTRODUCTION

A special focus group meeting with Pacific women in one family was conducted with a mother and her two daughters both of whom are mothers themselves and also smoke.

4.10.1. MOTHER’S VIEW ON SMOKING AND HER FAMILY

A mother interviewed shared her background as coming from one of the Pacific islands. She is a retired nurse and does not smoke. She used to talk to her daughters when they were young, about smoking, the diseases they would have from smoking such as lung cancer, asthma, and black teeth. She also noted that knowledge about smoking and health already existed in the islands where she grew up. Women used to tell men about health problems they would have from smoking and that they did not want to be burdened when the men became sick.

4.10.2. DAUGHTERS’ VIEWS ON SMOKING

The daughters explained how and why they started smoking and what their experiences and thoughts were on quitting. The first daughter stated she first started smoking despite what her mother had always told them about smoking, because her husband’s family smoked and she was trying to fit in with that new family. She admitted that she did not enjoy smoking and the smell of it, however, she smoked because she was stressed, and thought that she was now addicted to it. Smoking relaxes her from her stress, however, her cigarette consumption was only moderate, that is to say, one cigarette packet per week or 3 to 5 cigarettes per day.

She described her stress as caused by financial and family burdens and felt that there was nothing she could do to fix them. If she wasn’t smoking, she tended to sleep or worry instead. On the positive side, she had quit once and she recently has contemplated quitting again. She believed that she needed to be strong spiritually to restart the process of quitting and combining the power of her mind, body, and soul, she could do it. However, the barrier she
found was that she could not understand the Pacific language used in her mother’s Pacific congregation church, which she used to attend when she was younger. She needed to be busy and doing other activities such as weaving to help her get away from the smoking. She thought that smoking media campaigns had been helpful, particularly for her children. Her oldest daughter has begun smoking too but she does not want her children to smoke.

Her previous quit experience came about after contacting Quitline. She was satisfied with how they dealt with her on the phone, however, it took five days to wait before she could get the patches, and during that time she lost much of that “enthusiasm” of quitting.

The second daughter began smoking as a result of peer pressure. She was introduced to smoking from a friend. She smoked when she was bored, when drinking, and sometimes after having coffee and a big meal. She was a heavier smoker than her sister, smoking one packet of cigarettes (approx. 25-30 pieces) in 3 days. She found that when not smoking, she tended to be in mad moods and would often yell and scream.

She has tried giving up once when she had breathing problems, however, she started again once her breathing problem eased. She has quit for one and half days by trying to go cold turkey. She chose to go cold turkey because she found that using nicotine patches before gave her headaches and she did not like the taste of the gum. Unlike her sister, she has not contacted Quitline but has previously received help from a smoke cessation coach. She has contemplated quitting again is willing to receive the treatment again.

4.10.3. SUGGESTIONS AND RECOMMENDATIONS

The three women in the family interviewed made some suggestions and resolutions:

- They supported the need and importance of group and also one-on-one discussions to be more therapeutic to them. They believed that through such avenues, smokers may discover things that would trigger something in them making them change their smoking behaviour
- They agreed to the important role of elders in giving of advice and positive mentoring to younger generations
- There is a need for Pacific culture in particular the languages to be reinforced to younger generations who are born or have grown up in New Zealand and are in high risks of losing their Pacific language because it can provide access to the elders and to the spiritual component of their culture
• For better and timely access to smoke cessation, Quitline should refer people to local providers for NRT treatment
• The Government should continue smoke-free policies and regulations in public places including cafes and bars
• The continual dissemination of smoke information such as through leaflets and handouts is vital for smoke cessation within families
• The family would get together to have discussions about issues around stress as they have not really done this before
• The two daughters have re-enlisted again with K’aute’s smoke free programme and have been provided with nicotine patches.
RESULTS & FINDINGS

HEALTH PROFESSIONALS

4.11. INTRODUCTION

Several health professionals were interviewed from Hamilton and from the Waikato region. A General Practitioner of Pacific Island descent, a Respiratory Physician, a Smoke-free Nurse Coordinator (Waikato District Health Board), and an Adviser/Health Promoter (Health Promoting Schools), were interviewed about their roles and experiences with smoking patients and smoke cessation programmes with a focus on Pacific people.

4.11.1. VIEWS AND EXPERIENCES ON PACIFIC PEOPLE SMOKING

All of the health professionals interviewed believed that many of the Pacific people smoking were mostly young. Many were under 20 years of age, and also many were young parents. The doctors reported that many young Pacific smokers smoke as part of socialising and bonding, and also in association with drinking alcohol. Some smoke and share cigarettes while working and relaxing.

They believed that smokers tended to have lower levels of education, usually came from family environments in which stress was high including financially because most were generally of lower income groups, and were easily targeted by tobacco media campaigns. Most of these smokers smoke to de-stress themselves. The increase in influx of Pacific people to NZ could explain a high level of smoking because of the stress of relocation, a way of passing time, and a way of fitting into society.

4.11.2. CLINIC AND HOSPITAL PACIFIC ISLAND PATIENTS

Smoke-related Diseases and Cases

Both doctors interviewed identified respiratory illnesses of almost every kind aggravated or caused by smoking particularly chronic obstructive pulmonary airway diseases (COPD) and asthma, lung cancer, bronchitis, and to a lesser extend pneumonia and tuberculosis (TB). Also associated with smoking are coronary artery disease such as heart attacks and angina (chest pain related to heart), oral health (cancer of lip, tongue, and larynx), bladder cancer, neonatal illness, and breast disease.
Cases experienced by the health professionals interviewed with Pacific Islanders showed that they were more prone to the same illnesses, but respiratory infections such as bronchitis and pneumonia have been found to be more common. These conditions are closely related to active and passive smoking (Karalus, pers. comm., 3.9.09).

One health professional used to work for “Quit for our Kids” project (2001 – 2003), a project which actually kick-started smoking cessation. The project supported parents of children that were usually hospitalised for cases such as bronchitis, and she stated that there were a significant number of Pacific children found from these cases whose parents smoke.

4.11.3. ASSESSMENT AND ADVICE ON SMOKING BEHAVIOUR

Patients were checked and assessed whether they smoke or not but only if their conditions were related to smoking e.g. coughing and shortness of breath, as a standard current practice by a GP. Enquiry on smoking on the other hand, is routine, when assessed by a respiratory specialist, according to one GP interviewed.

Smoking cessation advice was normally given by doctors to smoking patients. Family members were also asked not to smoke inside homes. The respiratory physician interviewed, reported that there was no difference in the uptake of advice regarding smoking cessation between cultures, except that doctors advice was generally found to be considered more important by Pacific Islanders compared to Māori and Europeans. The GP also reported that advice given about smoke cessation has been followed by Pacific Island patients particularly when they were in critical conditions and were suffering such as from asthma. However, he stated that the majority would neglect the advice given and would start smoking again once they recovered from their illness. One of the respondents also found, that during the time when their medical centre used to provide smoking cessation, pakeha patients were more likely to return for follow ups for NRT treatment than for Pacific Island patients.

Pacific Island patients do not hesitate to return to the doctors however, with repeat illnesses associated with smoking. Normally the doctors would continue to encourage and remind patients about the effects of smoking. Some patients did not mind being told not to smoke, however, other patients did not like being told (Bio, pers. comm., 27.8.09). The doctors have used different approaches and techniques to give advice, depending on the type of patients and their characters.
4.11.4. **EXTENT OF PACIFIC PATIENTS SEEN**

The GP (of Pacific Island descent) had seen a lot of Pacific Island patients from around the North Island (including from Hamilton, Ohaupo, Auckland, Warkworth, Papamoa, Te Puke, Hastings, New Plymouth, and Wellington). The patients who came from his own country (Kiribati) chose him, he believed, because they felt that they could talk and explain their health issues more easily in their own language. However, other Pacific ethnicities (Samoans and Tongans) felt, the GP believed, that they could approach him more easily perhaps because of the similarity in Pacific situation and cultures. On the other hand, some Pacific Island patients were seen at the hospital (either in or outpatients), while some others (new immigrants) were seen privately, according to the respiratory physician.

4.11.5. **SMOKE CESSATION SERVICES AT CLINICS AND HOSPITALS**

Provision of smoke cessation used to be part of GPs’ clinics but they no longer provide smoke cessation services. Informants saw this as a barrier to treatment, as clinics now have to refer smoking patients to smoke cessation contracted providers instead of giving them the treatment right then. Alternatively, smoke cessation coaches are available in hospitals and NRT are normally provided to inpatients who smoke.

Health professionals working at hospitals believed that their services were accessible and appropriate. Most nurses do not specialise in NRT treatment, however, some hospital staff have been trained to give NRT treatment. According to a smoke-free nurse informant, her experience with hospitals in Auckland was that approximately 49% of outpatients do not usually return for smoke cessation programmes. Hence, patients being discharged from hospitals would normally be asked whether they would prefer to talk to a smoke cessation person in their community and were normally referred to the appropriate provider if they consented. Trained hospital staffs are required to follow up on outpatients that smoke to provide them with the treatment. Lack of follow up from hospitals would be considered as “clinically neglectful” according to a smoke-free nurse informant.
4.11.6. SERVICES AVAILABLE AND ACCESSIBILITY

a. Smoking Cessation Providers

There are four smoke cessation providers in Hamilton and Tokoroa, three are Māori providers (Nga Miro, Te Runanga, Te Kohao Health), and K’aute Pasifika. Hospitals also generally have smoke cessation persons. However, there have not been sufficient resources and awareness specifically for Pacific people compared to Māori on smoke cessation, according to a health promotion adviser.

The health promotion adviser informant believed that the effectiveness of the services particularly from the mainstream was viewed as poor to Pacific people. The referral system mainly focused on Māori and the current Ministry of Health’s smoke programme was too restrictive and not very flexible. The informant interviewed believed that even the District Health Board (Waikato) claimed they provide support to Pacific providers through the “smoking cessation plan”, however, there is no specific focus for Pacific people in the plan. The health promotion adviser interviewed reports that people have told him of frustrating experiences with Quitline which include not being able to return calls to patients who rang from mobile phones, and the long wait time (approximately one week) before people could get nicotine patches. As reported in the previous section, most people interviewed found that by the time the quit cards actually arrived, most have lost motivation for quitting.

b. Constraints of Service Providers

The smoke free nurse and health promotion adviser felt that there were a number of constraints that impacted on the effectiveness of their programmes on Pacific people. These included:

- Lack of ethnic specific resources in Pacific languages
- None or limited workforce development for Pacific Island peoples
- Insufficient research done on Pacific people compared to Māori, and also on youth as the next generation of smokers
- Poor documentation (including ethnicity) in hospitals and sometimes also in the new documentation system utilising the “green form”
- Lack of referrals from Tokoroa hospital in particular
- Lack of referrals from Quitline
• Some people in the service are just not ready to receive or use the treatments provided

c. Potential Risks for Service Providers

The smoke free nurse informant expressed fear that there is increasing competition for provision of smoke cessation services and also between themselves and Quitline, and also larger medical centres. The emerging Ministry of Health approach which tends to be shifting away from small providers in favour of larger providers was seen as having potential adverse impacts on different communities including Pacific people.

4.11.7. SUGGESTIONS AND RECOMMENDATIONS

The health professionals interviewed affirmed their support of the need to tackle smoking. Their general recommendations were that:

• more research was needed to help justify and tailor programmes to be more culturally appropriate
• a Pacific Islands framework utilising an holistic approach for health and smoking needs to be put in place
• Cultural training particularly for improving language skills needs to be encouraged from older to younger generations
• a smoke cessation contract need to be enhanced in Tokoroa where there is also a significant Pacific population
• Staffs need to be trained and systems implemented for improved documentation at the hospitals. Also documentation for ethnicity needs to be improved particularly as Māori and Pacific people have been identified as priority groups (for smoking cessation)
• Systems for coordination and monitoring need to be put in place or improved at the hospital level including for monitoring of referrals
• Quitline should link up people (smokers) with their local providers
• For Service Providers:
  o To enhance their exposure, such as by:
    ▪ Raising their profiles, improve their networking and relationships with key influential people
  o To make their smoke cessation programme unique on its own, such as by:
- Identifying their point of difference, programmes tailored to the needs of their communities, and to build trust with their communities
- Creating targeted and strengthening smoke harm reduction messages
  - To steer their programmes with flexibility encompassing Government’s expectations, but also to have a strong business, cost effective, and holistic social approach e.g. integrating whanau ora, and improve linkages in areas of health and education.
COMMUNITY LEADERS

4.12. INTRODUCTION

Seven community leaders were interviewed; six were church ministers and one a community president. There were more church ministers/leaders interviewed because a lot of Pacific people are affiliated with churches, thus the researchers wished to gauge leaders’ interest in participating or implementing smoke cessation programmes that may result from this research.

4.12.1. SMOKING STATUS

Six community leaders were interviewed with varying smoking status. Two are still smoking, two have quitted, and two have never smoked. Of the two smokers, one stated he is a light smoker, and the other a heavy smoker but has recently registered with K’aute Pasifika smoke free programme and is now on NRT treatment.

Some leaders came from heavy smoking families and one shared that his father died from a heart attack and was a heavy smoker too. One ex-smoker had smoked for about 25 years and the other for almost 50 years before they quit.

4.12.2. KNOWLEDGE AND VIEWS ON SMOKING

All Pacific community leaders interviewed agreed that smoking is harmful, bad for people’s health, and could cause death. The leaders were able to identify diseases associated with smoking generally providing two to three answers only. The most common diseases identified were lung cancer, followed by teeth problems, and respiratory diseases such as breathing problems and asthma. The Pacific community leaders also identified the benefits of quitting smoking which was most commonly for improvements of health and financial savings.

These leaders believed that smoking was more prevalent with adults than with youth members. Most strongly agreed with Government’s policy on banning smoking in public places. The church leader from LDS believed that members that have deviated away from the church may have started smoking again. Another leader did not approve the idea that adults
could smoke where children would be able to see them. Some leaders believed that the majority of their members that are non-smokers may eventually drive smokers to stop smoking.

4.12.3. KAVA AND SMOKING

Only one church occasionally has kava before and after their church service. Three other churches have kava outside their church’s schedule and usually at community members’ houses or garages. Our respondents report that Kava drinking was mainly undertaken by men and was held for various reasons including for socialising, fundraising, and traditional welcoming of visitors. The leaders stated that some members that drink kava also smoke but it is more common now to see people smoking outside the kava drinking areas.

4.12.4. EFFORTS TO STOPPING SMOKING

All of the community leaders expressed a desire that members of their congregation or community groups would stop smoking. None of the churches, however, except for the Latter Day Saints (LDS) church, have strict or binding rules for their members not to smoke. Most of the leaders have made some efforts to combat smoking within their communities. Most have put in place non-smoking rules in their public places such as church halls, during faikava, and during their meetings. The two non-smoking (i.e. never smoked) leaders stated that their members used to smoke in church halls during housie games (e.g. bingo, etc), but they have now banned smoking in the halls since they arrived in Hamilton. Most of the leaders stated that members that smoke would smoke only outside public places. There were visible “no smoking” signs placed in two church halls and two homes including home verandahs and doors of two church leaders.

Some of these leaders said they gave ad hoc advice and encouragement to members to stop smoking through discussions at faikava (for men) and brief advice on health issues during Sunday schools and youth activities.
4.12.5. **EXISTING NON-SMOKING PROGRAMMES**

None of the leaders interviewed had current smoking specific programmes in their communities to support not smoking. Most however, have mechanisms that already existed mainly for youth and children’s groups. Two churches have active youth programmes which included a sports programme held twice a week, and regular youth group activities. Most have Sunday schools where some leaders have presented brief health talks to children. However, there have not been actual presentations or education specifically delivered on smoking and they have not been visited by smoke cessation coaches and promoters.

4.12.6. **SUPPORT AND SUGGESTION FOR FUTURE SMOKING CESSATION PROGRAMMES**

All Pacific community leaders interviewed were very supportive of smoking cessation and smoking education programmes in their communities. Half of the leaders preferred that the education programmes use ‘face the facts’ approach where their members would be provided with direct messages and examples of real life experiences of the negative effects of smoking, for example, picture of diseases caused by smoking, and the effects of passive smoking on families and other non-smokers. Other ideas suggested include smoking information dissemination through pamphlets, engaging communities in sports programmes and other positive activities, competitions among smokers to promote quitting, regular visits and follow ups to communities by Quit coaches, more encouragement for quitting at faikavas, parents education to be able to discuss smoking with children, and being able to combine smoke education and spiritual healing.

4.12.7. **SUGGESTIONS AND RECOMMENDATIONS**

General recommendations made by the Pacific community leaders were that:

- For smoking cessation programmes and promotion of the use of NRT to be continued. They believed that the continual presence of the programmes within the communities would encourage Pacific people to quit and that more positive results would eventually be seen
- Education to parents be promoted and family discussions with children about smoking be encouraged for prevention of starting smoking and support for quitting
• New programmes and activities be put in place for older members of the communities and for youth groups for churches that do not yet have existing or active youth programmes, to be able to promote non-smoking and healthy lifestyles
• Smoking education to be promoted to all age groups through existing mechanisms
• Support to be provided to them (from K’aute Pasifika) for developing their plans for smoking cessation in their communities.
SMOKING CESSATION TRAINERS

4.13. INTRODUCTION

This section is based on an interview with three Smoking Cessation Trainers from Pacific Heartbeat (PHB) in collaboration with the Heart Foundation. The interview was conducted during the course of a two day smoking cessation training held in Hamilton (August 2009). One of the researchers was able to observe for a half day in the training delivered to Waikato smoking cessation providers.

4.13.1. DEVELOPMENT OF PACIFIC HEARTBEAT TRAINING INTERVENTION

The Pacific specific smoking cessation training provided by Pacific Heartbeat (PHB) in collaboration with the National Heart Foundation, aimed to address the needs of Pacific tobacco control service providers. Previously, access to training opportunities by Pacific providers was minimal; all providers were expected to attend mainstream training, the only training available. The development of the Pacific Heartbeat Training intervention involved consultations with a range of Pacific providers including K’aute Pasifika. PHB works in partnership with the mainstream in particular District Health Boards (DHBs) and the Waikato smoking cessation coalition, CHANCES.

4.13.2. SERVICE COVERAGE

Smoking cessation training is conducted throughout the North and South islands. Approximately 200 providers, including Pacific Islanders, Māori and mainstream were registered with PHB services. According to the smoking cessation trainer, approximately 80 % of their participants were from the mainstream and included GPs and nurses. Our respondents reported that the PHB worked closely with national Quit groups to monitor active and non-active participants. Referrals were received from DHBs, however, the PHBs found that referral cases for Pacific were not very effective in the Waikato compared to Wellington. They have also found that GPs tended not to make enough referrals.
4.13.3. MODE OF TRAINING

The training approach reported by our respondents followed the ‘ABC’ approach, as promoted by national guidelines, however, ensuring that they were not being prescriptive in their approach. They did not believe there was a clear cut “Pacific approach” or “models” for smoking cessation to Pacific people. Rather, they tended to utilise a “case study” approach to convey information along with existing guidelines and principles, and would encourage participants to formulate their own ways in tackling smoking cessation, keeping in mind lessons from presented case studies and guidelines.

One of the researchers was able to attend and observe for one half day in their two day training conducted in Hamilton (August 2009). Although the trainers reported that they promoted the generic ‘ABC’ approach for smoking cessation in their training instead of a specific Pacific approach, the researcher found that the delivery of the training itself incorporated culturally appropriate strategies. For example, pictures of Pacific people smoking were used in the trainers’ presentations, examples and case studies used were mostly based on the social context and lifestyles of Pacific people, Pacific Island language and words were sometimes used, and also the reasonable pace at which the trainers speak and explain things. It was also observed that participants on the other hand seemed be comfortable and had confidence for example, they did not hesitate to ask questions or interrupt at anytime during the presentations for clarifications or elaboration of the issue at hand. The researchers also received very positive feedback from some participants (who are quit coaches) that attended the training.

Being Pacific people and having extensive knowledge and experience with Pacific cultures, way of doing things, lifestyles, and combined with their experience in delivering smoking cessation training, the trainers have demonstrated the uniqueness of their smoking cessation training that is culturally appropriate for Pacific people and targeted clients.

4.13.4. CHALLENGES AND SUGGESTIONS

The PHB smoking cessation trainers voiced some of the challenges they face which include:

- The lack of clarity in their direction from their executive
- The lack of monitoring of the linkages between DHB and providers
• The need to protect the uniqueness of Pacific providers against the mainstream

• The need to understand more and accommodate Pacific younger generations, including Pacific and New Zealand born children, into their programme

The trainers interviewed believed that there is a need for a ‘Pacific Framework for health and wellbeing’ to be put in place, and that similar research efforts needs to be pulled together to be able to provide evidence for the needs of Pacific people including for smoking cessation.
5. DISCUSSION

5.1. INTRODUCTION

In this section we will discuss key findings, implications, and recommendations for improvement of current smoking cessation programmes and future research for Pacific people. Our study examined the attitudes, beliefs and knowledge of Pacific peoples relating to smoking and quitting.

The multi-factorial nature of smoking cessation made it difficult for participants to quit smoking. Interestingly, the study found that social, psychological, physical, and spiritual factors could provide the best support for smoking cessation. However, with the exception of religion or spirituality the same factors also offer the main barriers to smoking cessation. The participants believed that the main supports for quitting included maintaining the importance of family (social), health improvement (physical) followed by positive role modeling (psychological) and prayer (spiritual) while barriers identified included social situations (social), stress (psychological) negative feelings (anger) and addiction (physical).

Sociocultural factors also influenced smoking behaviour and maintained smoking cultures amongst the participants such as, the gifting of tobacco during ceremonial activities, especially when welcoming visitors and ‘faikava’. The study also found that there is a strong association of increased smoking and drinking kava which needs to be further investigated in addition to other unique sociocultural factors that aid the normalisation of smoking. Our findings were consistent with a previous study (Abrams and Niaura, 2003, as cited in Kaholokula et al., 2008) that demonstrated the multi-factorial nature of smoking cessation and the need for a multicomponent strategy that may be beneficial to Pacific people as he identified in his study of native Hawaiians.
5.2. KNOWLEDGE OF MEDICAL ISSUES IS GOOD BUT MAKES NO DIFFERENCE TO BEHAVIOUR RELATING TO SMOKING

Contrary to common perception and previous studies that Pacific people have low levels of knowledge about the harmful effects of smoking (Lanumata, 2009), our study has found that most participants (82%) believed that cigarettes are harmful with three most frequent effects on health being lung cancer, heart attack/disease and asthma. There was limited understanding among the participants of the relationship between smoking and emphysema. The participants, whilst knowledgeable about smoking being harmful, did not alter their behavior towards quitting because of their knowledge.

This suggests that current educational programmes and mass media advertisements successfully raise awareness of health risks associated with smoking but are too brief and too short term to change peoples’ smoking behaviour. Alternatively, education of health risks alone is relatively ineffective in changing behavior and so new ways of working with smokers who are not prepared to change their behaviours need to be explored further.

Whilst this might be the case, our study shows a significant reduction on daily cigarette consumption by smokers. This is also true of those smokers on K’aute Pasifika’s smoking cessation programme where more participants have cut down on their daily cigarette consumption with fewer quitting.

This is suggestive of participants progressing towards quitting completely. The need to focus more on reduction of cigarette consumption prior to quitting is probably the most appropriate strategy to adopt for Pacific smokers and may need further investigation.

5.3. THE ROLE OF FAMILY & RELIGION IN SMOKING CESSATION

The role of social support in successful smoking cessation is well documented (Kaholohula et al., 2008). The study found that family offers the strongest social support for most smokers and ex-smokers to quit smoking and to continue not to smoke mainly by families offering more support, maintaining strict family rules and positive role modeling. Participants suggested an approach that
would permit and foster family ownership of family members’ problems. This would mean family meetings to discuss issues and coping mechanisms relating to discouraging smoking for all family members with leadership being provided by family elders and church ministers. An important feature of Pacific culture is family and community involvement and this should be exploited more in smoking cessation interventions for Pacific people.

Religion was also found a main social support and was regarded by most smokers and ex-smokers as having a strong impact on their attempts to quit smoking and why they continued not to smoke. Given that half of participants found spirituality and religion as pivotal to their successful quitting attempts, it suggests that future interventions employ religion as another strategy or support for smoking cessation. In addition, with the strong support offered by Pacific church ministers, church based support should be encouraged especially for those that may find religion beneficial to quitting.

5.4. ADDICTION & LACK OF INTEREST IN MEDICATION

A large number of participants had their first cigarettes within thirty minutes of waking. This factor has been used as one of the strong indicators of a higher degree of nicotine dependence based on Fagerström Test (Ministry of Health, 2007). Hence, even though most smokers in this study claimed they were not smoking heavily (i.e. less than 11 cigarettes a day), their smoking behaviours particularly indicated by the time of their first cigarette of the day, suggests addiction. Furthermore, it could also mean slow metabolism of nicotine as shown before in Māoris. In stating this, the need to determine the rate of nicotine metabolism in Pacific Island people’s blood should be tested as this has not been done previously.

A novel finding of our study is that most of the participants may be viewed as highly motivated smokers because they all want to quit in the future. Of relevance is the finding that most participants (95 %) that have successfully quit made only one quit attempt and without treatment (use of NRT). The study also found that quit rate was generally low and relapse was common. Most participants had negative views of NRT including costs for treatment and not using NRT was identified as one of the key reasons for failing to quit. Yet the literature indicates that the most successful smoking cessation interventions to date for individuals that want to quit are likely to be those that involving Nicotine Replacement Therapy combined with culturally appropriate quit
support intervention with some counseling component. To increase the Pacific quit rate, innovative ways of promoting the use of NRT amongst Pacific people should be identified. NRT should be offered free of costs to assist those Pacific people who cannot afford NRT but have a strong desire to use NRT as their main support to quit.

5.5. LIMITATIONS IN PROVIDING SERVICES TO PACIFIC PEOPLE

Non Pacific Smoking Cessation Service Providers and Health Professionals have accepted their limitations in providing services to Pacific peoples and know that access to their services is significantly low. With language and culture being identified as the largest barriers to access, cultural training for all non Pacific health staff may be beneficial. Given the success of Aukati Kai Paipa in increasing the quit rate of Māori people who smoke, more culturally appropriate services for Pacific people should be given serious consideration. According to a review of published literature and documentary material related to smoking cessation by Pacific peoples, there is extensive evidence of the need to echo the call “by Māori for Māori” with “by Pacific for Pacific” and the need to productively increase tobacco control interventions specific to Pacific peoples’ (Lanumata & Thompson, 2009). The use of innovative ways to communicate key information and using Pacific languages may also encourage people to seek help.

5.6. QUITLINE USAGE AMONG PACIFIC PEOPLE IS LOW

Our study shows that a large number of Pacific people are aware of Quitline but access to Quitline Services is found to be significantly low refuting an earlier study by (Li & Grigg, 2007) which reported an increase in the number of Pacific callers to Quitline. Furthermore, the low response may be related to the fact that most of our participants were born in the Pacific islands which implied their relatively strong connections with their cultures and their preference for face to face contact for assistance compared to seeking help over a telephone.

Participants who have contacted Quitline although generally satisfied with the response felt that assistance needed to be timely. This suggests that Quitline may need to refer to local cessation providers to ensure the timeliness of services to Pacific people.
5.7. COMMUNITY AVENUES

Use of faikava and church gatherings has also been highlighted as successful avenues for delivering of general health issues and smoking cessation programmes. Kava sessions are held sometimes before and after church services but mostly at community members’ houses. Interestingly, our study found that smoking goes hand in hand with drinking kava wherever people gather but there is less smoking inside faikava homes and churches currently due to strict non smoking rules imposed on them by their leaders. This suggests that smoking cessation providers should explore further appropriate ways of reaching out to this targeted group and how to best capitalise on the enthusiasm of church and community leaders to further promote smoking cessation amongst their members.

5.8. SOCIAL DEPRIVATION & SMOKING PREVALENCE

The survey findings revealed that most participants were either low income earners or unemployed. Most lived with children and extended families. Over half of the participants were smokers and a large proportion (70%) smoke within thirty minutes of waking, indicating a higher degree of nicotine dependence. These findings suggest that participants have high smoking prevalence (most addicted but may not know) and have a lower socioeconomic status. These findings echoed those of the Scottish Executive 2000a, the Scottish Health Survey, 1996 (as cited in Brown and Kemp, 2005) highlighting a strong correlation between smoking and deprivation and people on low income being more likely to smoke and smoke more on average. These findings emphasised the importance of developing and providing smoking cessation programmes and treatments for Pacific people appropriate to their needs and social situations. A multiagency, multidisciplinary approach may be beneficial given the many factors that influence smoking issues and tobacco use amongst Pacific people.
Smoking is still very much part of Pacific people’s social life. The attitudinal and behavioural changes which are the ultimate intention of smoking cessation will take a considerable time and varied types of interventions to accomplish. Tobacco control for Pacific people needs to remain a government priority with a broadened responsibility extending from health to other sectors including immigration, housing, education/training and community.

Smoking cessation programmes which are culturally appropriate are needed, to better target the Pacific population in New Zealand affected by tobacco smoking. Such programmes to be more successful should address social, psychological, and physical factors that maintain the culture of smoking and include family, community and religion as support mechanisms for quitting. NRT and other types of pharmacotherapy should also be included and strongly promoted amongst Pacific people as aid to cessation.

There is also paucity of relevant research specific to Pacific tobacco use particularly ethnic specific studies. These include but are not limited to the nature of addiction among Pacific people; the multi-factorial life issues that have influence on the uptake of tobacco smoking, and culturally appropriate approaches needed for smoking cessation to different age groups among Pacific people.

**Strengths and Limitations:**

There are limitations to our study in the actual sample. Firstly, there may have been an unintentional bias towards urban Pacific population as about two thirds of participants lived in Hamilton city. Secondly, there may have also been unintentional bias towards the K’aute Pasifika Smoking Cessation Programme as half of the participants recruited were either on the programme or have been on the programme. These limitations were due to unavailability of willing participants, limited time for travelling to rural areas and resources available for the research. Nevertheless, our results were similar to findings of previous studies on smoking cessation including those of Kaholokula (2008), Jarvis (2004), and Chen (2001).

We believe that despite its limitations, the study has made some contributions to the understanding of smoking initiation and cessation and highlights strategies and potential
directions for development of culturally informed smoking cessation interventions for Pacific people.

Our study recommends that:

- there is a need for evaluation of current smoking cessation programmes and to develop a national programme for Pacific people to maintain consistency in how tobacco control is approached in New Zealand.

- further work is needed to explore the effectiveness of future smoking cessation programmes focusing more on reduction of cigarette consumption and other harm reduction methods prior to quitting, as most appropriate to adopt for Pacific smokers.

- Smoking cessation programmes for Pacific people are culturally appropriate. Such programmes to be more successful should address social, psychological, and physical factors that maintain the culture of smoking and include family, community and religion as support mechanisms for quitting. NRT and other types of pharmacotherapy should also be included and strongly promoted amongst Pacific people as aid to cessation.

- a Pacific GP is needed for the Pacific community of Waikato to address barriers to access, cost effectiveness, and improve cessation rate.

- more creative awareness and education strategies need to be explored and tried. These include capitalising on and encouraging doctors’ to increase their involvement in giving out messages relating to smoking and quitting; ways to work with people who refuse to use NRT; including religious beliefs in smoking cessation messages where appropriate; and using television advertising to target Pacific people by using Pacific faces and languages.

- Services will consider establishing community and family based support systems particularly for programmes targeting pregnant mothers and youths’ uptake of smoking.
REFERENCES


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Ministry of Health (n.d.). New Zealand Ministry of Health, Manatū Hauora. Accessed August and


PEOPLE AND ORGANISATIONS CONSULTED

Anatu Reupena (Reverend), Congregational Christian Church of Samoa, Hamilton., 16.9.09

Anthony Leaupepe, Smoking Cessation Training Facilitator for the central region and the south island., 6. 8. 09

Asola Fagalima (Brother), LDS Samoan Sunday School Leader, Rototuna ward, Hamilton., 16.9.09

Charlene Lester, Nawton, Hamilton., 20. 8. 09

Dora Lester, Nawton, Hamilton., 20. 8. 09

Haiku H Baiabe, Pacific Heartbeat Tobacco Control Services Team Leader., 6. 8. 09

Heber Fruean, Pacific Smoke-free Promotion Services Coordinator., 6.8.09

Kate Dallas, Smoke-free Nurse Coordinator, Waikato District Health Board., 20.8.09

Kerry Huaki, Professional Adviser, Health Promoting Schools, Waikato., 4.8.09
Noel Karalus (Dr), Respiratory Specialist, Waikato Hospital., 3.9.09.

Tabwe Bio (Dr), General Practitioner, Te Kuiti Family Health Centre., 27.8.0

Rose Whanga, Smoking Cessation Practitioner, Nga Miro Health, Ngaruawahia., 14.8.09

Shirley McIlroy, Co-ordinator and AKP Practitioner (Waikato and Raglan)., 11.8.09

Sione Filimoto (Reverend), Free Church of Tonga, Hamilton

Sione Molitika, Steward for St John Methodist Tongan congregation, Hamilton East, Hamilton., 1.9.09

Talavou Afualo (Reverend), Methodist Church of Samoa, Hamilton., 24.9.09

Taniwha Williams, Smoking Cessation Iwi Health Worker, Te Kohao Health., 13.8.09

Tapu Lester, Nawton, Hamilton., 20. 8. 09

Tematang Rotaria, President, Kiribati Waikato Association Inc., 11.9.09
ANNEXES:
ANNEX 1:

SMOKEFREE PACIFIC QUESTIONNAIRE

“Kia orana, Talofa, Malo e lelei, Taloha Ni, Bula Vinaka, Fakalofa lahi Atu, Mauri, Warm PacificGreetings”

K’aute Pasifika is currently conducting a survey with the Pacific Peoples in Hamilton City and Tokoroa regarding Pacific Peoples’ attitudes, behavior and knowledge relating to tobacco smoking and quitting. This information will form the basis for the development of culturally informed tobacco cessation programmes for Pacific Peoples. This information will also be the basis for future studies.

PLEASE ANSWER THIS QUESTIONNAIRE AS FOLLOWS:
(You may also write your answers in your own language if you prefer)

1. NON-SMOKERS: PART A for all Respondents (Qns 1 – 27) and PART B for Non-Smoker (Qns 28 – 32)

2. EX-SMOKERS: PART A for all Respondents (Qns 1 – 27) and PART C for Ex-Smokers (Qns 33 – 47)

3. ALL SMOKERS: PART A for all Respondents (Qns 1 – 27) and PART D for all Smokers (Qns 48 – 75)

4. SMOKERS IN SMOKE-FREE PROGRAMME ONLY:
   PART A for all Respondents (Qns 1 – 27)
   PART D for all Smokers (Qns 48 - 75) and
   PART E for Smokers in Smoke-Free Programme (Qns 76 - 83)

Consent given: ☐ Yes ☐ No

Name of Person Interviewed: ______________________________

Name and Signature of Parent/Guardian (for participants under 16 years old):

Suburb/Area: ______________________

Date: ___________________ Interviewer: _____________________

Time (Start – Stop): ____________________
PART A

DEMOGRAPHICS

ALL RESPONDENTS

1. Sex: □ Male    □ Female

2. Marital Status: □ Married /Partnership    □ Single

3. Age Groups  □ 12 – 19 years old    □ 40 – 49 years  
                □ 20 – 29 years    □ 50 – 59 years  
                □ 30 – 39 years    □ 60 years and over  
                □ Refused

4. Ethnicity: □ Tonga    □ Fiji    □ Cook Island  
               □ Samoa    □ Niue    □ Kiribati  
               □ Tokelau    □ Other (please specify) ___________________

5. Are you NZ or Pacific Island born? □ NZ born    □ Pacific Island born

6. Are you? □ Employed Full-time (30 hours or more)  
             □ Employed part-time (less than 30 hours)  
             □ Unemployed Actively seeking work  
             □ Not in the Labour Force  
             □ Student  
             □ Don’t know/Refused

   (Please note if employment has been affected by the recession):________________________

   If employed which of the following best describes your line of work
   □ Labourers (pack house, factory)    □ Sales/Hospitality  
   □ Admin    □ Technician-Trade    □ Cleaning  
   □ Machinery operator    □ Driver    □ Care-taker (Rest home)  
   □ Professionals (nurses, doctors, accountants, managers, teachers, IT, communication, etc)  
   □ Other: _________________________________

7. What type of accommodation do you have?
   □ Own home    □ Rent
Number of Rooms?
☐ 1-2       ☐ 3-4       ☐ 5+

8. Which of these statements best matches your household situations?
☐ Live on own       ☐ Live in nuclear family (husband/wife/partner)
☐ Live in nuclear family       ☐ Live in extended family (nuclear family plus grandparents/
                    (husband/wife/partner          cousins/aunties/uncles/other relatives)
                    and kids)

9. Do you have any of the following? (Please tick)
☐ Vehicle       ☐ TV       ☐ Radio       ☐ Computer with internet access
☐ Phone

10. Do you belong to any of the following?
☐ Church    __________
☐ Cultural group
☐ Sports group    __________
☐ Community group
☐ Fundraising group (bingo, housie, etc)
☐ Other:    __________________

11. Which form of communication would you prefer?
☐ Phone call       ☐ Texting       ☐ Email
☐ Community meeting       ☐ Home visit
☐ Other:    __________________

12. Have you ever smoked?       ☐ Yes       ☐ No

13. Do you smoke?       ☐ Yes       ☐ No

AWARENESS, KNOWLEDGE and PERCEPTION ON SMOKING/ASSESSMENT of SMOKEFREE SERVICES

14. Do you think that smoking is a part of your culture?
☐ Yes       ☐ No       ☐ Don’t know       ☐ Not Applicable
If YES, please explain why
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

15. Would you agree or disagree that smoking is considered as a normal way of bringing people
together (like a social ‘norm’)?
☐ Agree       ☐ Disagree
If disagree, please explain:

_______________________________________________________________________________
_______________________________________________________________________________

16. Do you believe cigarettes are harmful?
   ☐ Yes    ☐ No

17. Would you agree or disagree to this statement:
   “Roll-your-own cigarettes/rollies are safer than tailor-made (or factory-made) cigarettes”
   ☐ Agree    ☐ Disagree    ☐ Don’t know

18. What are health problems you know that are caused by smoking {Up to 5 responses}
   1_________________________  4_________________________
   2_________________________  5_________________________
   3_________________________

19. Name any social problems caused by smoking? {Up to 5 responses}
   1_________________________  4_________________________
   2_________________________  5_________________________
   3_________________________

20. What are the benefits of quitting? {Up to 4 responses}
   1_________________________  3_________________________
   2_________________________  4_________________________

21. Where did you hear about the above issues (Qns 18 to 20) ?
   ☐ National Radio    ☐ TV    ☐ Newspapers
   ☐ Local community radio    ☐ Doctor    ☐ Nurse
   ☐ Local Health Workers    ☐ Friends    ☐ School
   ☐ Workshops    ☐ Quit Coaches    ☐ Others (please specify) ___________

22. Who would be best to deliver the message to you (Pacific People) regarding smoking?
   ☐ Doctor    ☐ Pacific Community Leaders
   ☐ Community Nurse    ☐ Church Leaders
   ☐ Local Health workers    ☐ Youth Leaders
   ☐ Family member    ☐ Quit Coaches
   ☐ Other (please specify) ________________
SMOKING AND CONCEPTION

23. Smoking has a negative effect on female fertility (Tick one only)
   □ Strongly Agree
   □ Agree
   □ Disagree
   □ Strongly Disagree
   □ Not sure/Don’t know

24. Smoking has a negative effect on male fertility (Tick one only)
   □ Strongly Agree
   □ Agree
   □ Disagree
   □ Strongly Disagree
   □ Not sure/Don’t know

25. Smoking during pregnancy puts the baby’s health at risk
   □ Strongly Agree
   □ Agree
   □ Disagree
   □ Strongly Disagree
   □ Not sure/Don’t know

26. Did you ever smoke during pregnancy? (For female only)
    □ Yes □ No □ Not Applicable
    AND/OR
    Smoke around someone who is pregnant? (female and male)
    □ Yes □ No □ Not Applicable

27. Smoking during pregnancy increases the risk of miscarriage
   □ Strongly Agree
   □ Agree
   □ Disagree
   □ Strongly Disagree
   □ Not sure/Don’t know
PART B

QUESTIONS FOR NON-SMOKERS

28. Why don’t you smoke? (Please specify)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

29. Do other members of your household smoke?
☐ Yes  ☐ No

30. Which of the following best describes the rules about smoking inside of your home?
☐ Allowed
☐ Not allowed, but exceptions
☐ Never allowed
☐ No rules
☐ Don’t know

31. Where at home do smokers normally smoke?
☐ Garage  ☐ Kitchen  ☐ Sitting/Living Room
☐ Bathroom  ☐ Bedroom  ☐ Dining Room
☐ Outside  ☐ Other (please specify) _______________

32. How often does anyone smoke inside your home? Would you say daily, weekly, monthly, less
than monthly or never?
☐ Daily  ☐ Weekly
☐ Monthly  ☐ Less than monthly
☐ Never  ☐ Don’t know

Thank you for completing the questionnaire
PART C

QUESTIONS FOR EX-SMOKERS

33. How long ago did you quit smoking? (tick first category that applies)
   - □ In the last month
   - □ 1 – 6 months
   - □ 6 months – 1 year
   - □ 1 year – 4 years
   - □ 5 – 9 years
   - □ 10 – 19 years
   - □ 20 + years
   - □ Don’t know

34. Who or what prompted you to quit? (Tick as many as applies)
   - □ Own idea
   - □ “Quit line”
   - □ Seemed a good idea
   - □ Smoking Warnings on package
   - □ Cost/Constraints on family budget
   - □ Anti-smoking advertisements
   - □ Friends/Work colleagues
   - □ Doctor
   - □ Family
   - □ K’aute Pasifika
   - □ Concern about health
   - □ Other health professionals
   - (please specify) ___________________
   - □ Concern about smoking on family and others
   - □ Church belief and practice e.g. Lent, Retreat, Prayer
   - □ Can’t remember/don’t know

35. How many quit attempts did you try before you become successful?
   - □ One attempt
   - □ Two attempt
   - □ More than two attempt
   - □ Don’t know
   If more than 2 attempts, how many times have you tried? ________

36. Which of the following form of medication (including NRT) did you use to help you quit?
   - □ Patches
   - □ Gum
   - □ Losenges
   - □ Zyban or antidepressants
   - □ Used nothing

   How long did you use any of the above medication for?
   _____ days  _____ weeks  _____months  _____years

37. What is the key to you quitting smoking?
   ____________________________________________________________________
   ____________________________________________________________________

________________________________________________________________________

________________________________________________________________________
38. What are some of the changes/improvements that you experience after you quit smoking?
_____________________________________________________________________________
_____________________________________________________________________________

39. To help you quit, which of the following did you access?
☐ Kaute Pasifika      ☐ Quitline
☐ Te Kohao Health (Maori provider) ☐ Te Runanga o Kirikiriroa (Māori provider)
☐ Nurse              ☐ Nga Miro Health (Māori provider)
☐ GP                 ☐ Did not access any services
☐ Other: __________________________

40. Were you satisfied with the service you have received from these groups?
☐ Yes          ☐ No

What improvements do you think could make these programmes more effective?
_____________________________________________________________________________

41. Do you ever get tempted to smoke again?
☐ Yes          ☐ No
If Yes how?
☐ Own craving    ☐ Peer group
☐ When family member smoking ☐ Social functions
☐ When drinking    ☐ Stress
☐ Other: __________________________

42. What services would you recommend to help you continue quitting?
☐ Follow up visits  ☐ Provision of NRT supplies
☐ Counselling      ☐ Other: __________________________
☐ None

43. Do you consider your religious faith or prayer as a way of helping you quit?
☐ Yes          ☐ No

44. If you are an active member of your church, how strong does your religious faith impact on
your attempts to quit smoking?
☐ Very strong
☐ Strong
☐ Not strong
☐ Don’t know
If Very strong/strong please explain:

_______________________________________________________________________________
_______________________________________________________________________________

45. Would support from family members (partners, children, etc) help you continue not to smoke?
   □ Yes   □ No

46. How strong does your family affect your decision to continue not to smoke?
   □ Very strong
   □ Strong
   □ Not strong
   □ Don’t know

If Very strong/strong please explain:

_______________________________________________________________________________
_______________________________________________________________________________

47. Do other members of your household smoke?
   □ Yes   □ No

Thank you for completing the questionnaire
PART D

QUESTIONS FOR ALL SMOKERS

48. What is your method of smoking?
   [ ] Pipe          [ ] Tailor-made cigarette   [ ] Roll-your-own cigarette

49. What brand do you smoke most often?
   [ ] Dunhill       [ ] Pall Mall           [ ] Benson & Hedges
   [ ] Marlboro      [ ] Holiday            [ ] Rothmans
   [ ] Horizon       [ ] Winfield           [ ] Roll your own
   [ ] Other (please specify) ________________________________

50. What kind do you smoke most often?
   [ ] Regular       [ ] Menthol            [ ] Roll your own
   [ ] Mid, Light or Low Tar [ ] Other (please specify) __________

51. How long have you been smoking?
   [ ] Less than 1 year [ ] 1 – 4 years
   [ ] 5 – 10 years    [ ] 10+ years
   [ ] Don’t know

52. How old were you when you first started smoking daily?
    _____ Years old    [ ] Don’t know/don’t remember

53. Why did you start smoking? (Tick as many as applies)
   [ ] Family Members Smoke [ ] Bored
   [ ] Peer Pressure        [ ] Forced To
   [ ] Stress              [ ] It is cool
   [ ] Other (please specify): ________________________________

54. How many cigarettes do you smoke on average a day?
   [ ] Under 5          [ ] 16 – 25 a day
   [ ] 5 – 10 a day     [ ] 26 or more a day
   [ ] 11 – 15 a day    [ ] Don’t know

55. Have you cut down the number of cigarettes that you smoked over the last 12 months?
   [ ] Yes             [ ] No   If No go to 57

   If Yes, how many cigarettes have you cut down?
☐ 1 to 5 cig a day
☐ Half packet a day/6-10 cig a day
☐ 1 packet a day/20-25 cig a day
☐ Other ________________

56. How many cigarettes did you used to smoke on average a day?
☐ Under 5  ☐ 16 – 25 a day
☐ 5 – 10 a day  ☐ 26 or more a day
☐ 11 – 15 a day  ☐ Don’t know

57. How soon after you wake up do you usually have your first smoke? Would you say within 5 minutes,
   6 to 30 minutes, 31 to 60 minutes, or more than 60 minutes?
☐ Within 5 minutes  ☐ 6 to 30 minutes
☐ 31 to 60 minutes  ☐ More than 60 minutes

58. Do other members of your household smoke?
☐ Yes  ☐ No

59. Which of the following best describes the rules about smoking inside of your home?
☐ Allowed
☐ Not allowed, but exceptions. Please specify:
____________________________________
☐ Never allowed  ☐ No rules
☐ Don’t know

60. Where at home do smokers normally smoke?
☐ Garage  ☐ Kitchen  ☐ Sitting/Living Room
☐ Bathroom  ☐ Bedroom  ☐ Dining Room
☐ Outside  ☐ Other (please specify) _______________

61. How often does anyone smoke inside your home?
☐ Daily  ☐ Weekly
☐ Monthly  ☐ Less than monthly
☐ Never  ☐ Don’t know

62. What are some of the things/situations that usually increase the amount of cigarettes you smoke? (Tick as many as applies)
☐ Stress  ☐ Loss of job
☐ Work  ☐ After work
63. Which of these statements best describes you?
   - I have no thoughts of quitting smoking
   - I think I need to consider quitting smoking someday
   - I think I should quit smoking but I’m not quite ready
   - I think about doing things that will help me quit smoking
   - I’m doing things that will help me quit smoking
   - Don’t know

64. Are you aware of the “Quit line” and free 0800 778 778 service available to help people quit smoking?
   - Yes
   - No
   a. If yes, have you ever sought help/assistance from Quitline?
      - Yes
      - No
   b. If no, have you ever sought help/assistance from elsewhere?
      - Yes
      - No
   c. If yes, where have you sought help from? ____________________________

65. Are you aware of any services available to help Pacific people to quit smoking in your region?
   - Yes
   - No

66. Have you ever tried to quit smoking?
   - Yes
   - No
   How many times have you attempted to quit? ____________________________
   If Yes, how long did you stop smoking for? ____________________________
   How many times have you stopped smoking for at least 2 weeks? ________

67. How long ago did you last try to quit smoking?
   - In the last month
   - In the last 6 months
   - In the last year
   - Over one year ago
   - Don’t know

68. What do you think was the reason you failed to stop smoking?
69. To help you quit, which of the following have you accessed in the last 12 months?

☐ Kaute Pasifika  ☐ Quit line
☐ Te Runaga (Maori provider)  ☐ Te Kohao (Aukati Kaipaipa, Maori Provider)
☐ GP  ☐ NgMiro (Aukati Kaipaipa, Maori provider)
☐ Hospital  ☐ Nurse
☐ Have not accessed any services yet (Go to 71)

70. Were you satisfied with the service you have received from the group(s) indicated above (Q69)?

☐ Yes  ☐ No

What improvements do you think could make these programmes more effective?

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

71. Are you thinking about quitting smoking cigarettes in the next six months?

☐ Yes  ☐ No

If yes please explain why:

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

72. Do you need help to quit?

☐ Yes  ☐ No

73. Would you consider any of the following groups to assist and support you to quit?

☐ Church  ☐ Community group
☐ Cultural group  ☐ Fundraising group (bingo, housie, etc)
☐ Sports group  ☐ Other: ___________________

74. Would you find it easier to quit if you are a part of a larger group attempting to quit together?

☐ Yes  ☐ No

If Yes, please explain: ___________________________________________________________
_____________________________________________________________________________
75. Are you currently participating in any Smoke Free Programme?

☐ Yes  ☐ No

If Yes please continue to 76.

Thank you for completing the questionnaire
PART E

QUESTIONS FOR SMOKERS (Currently in Smoke Free programme)

76. Are you still smoking?
   □ Yes  □ No
   If yes please explain why:
   ___________________________________________________________

77. Which of the following providers are you currently participating in their smoke free programme?

   □ Kaute Pasifika
   □ Te Kohao (Maori provider)
   □ GP (medical centre)
   □ Hospital
   □ Quit line
   □ Te Runanga (Aukati Kaipaipa, Maori Provider)
   □ Nga Miro (Maori provider)
   □ Other: _______________________

78. How long have you been in the smoke free programme?
   □ Less than 1 year
   □ 1-3 years
   □ 4+ years
   □ Don’t know

79. Were you satisfied so far with the services you have received from the provider indicated above (Q77)?
   □ Yes  □ No
   If Yes, which services do you find more helpful for you in quitting smoking?
   □ Workshops presentations  □ Use of patches
   □ Use of Gum  □ Use of Losenges
   □ Follow ups/Reminders (visits, phone calls, etc)

   What problems are you still having in quitting smoking?
   ___________________________________________________________

   What improvements do you think could make these programmes more effective in helping you quit smoking?
   ___________________________________________________________
80. Do you consider your religious faith or prayer as a way of helping you quit?
   ☐ Yes ☐ No

81. If you are an active member of your church, how strong does your religious/prayer faith impact on your attempts to quit smoking?
   ☐ Very strong ☐ Strong ☐ Not strong ☐ Don’t know

If Very strong/strong please explain:
________________________________________________________________________________________
________________________________________________________________________________________

82. Would support from family (partner, children, etc) help you quit?
   ☐ Yes ☐ No

83. How strong does your family affect your decision to quit smoking?
   ☐ Very strong ☐ Strong ☐ Not strong ☐ Don’t know

If Very strong/strong please explain:
________________________________________________________________________________________
________________________________________________________________________________________

Thank you for completing the questionnaire
ANNEX 2.1:

QUESTION FOR FOCUS GROUPS

[Tokoroa and Hamilton (1)]

AIM:
To find out

- Attitudes, beliefs, and knowledge towards smoking and quitting, health and wellbeing
- What makes Pacific people smoke?
  - Assumption: Mostly to do with relationships when there is a breakdown somewhere, hence leading to stress.
- What do they think they need to do to stop smoking so that they can go back on track to good health and improved wellbeing?
- What do they want providers to do?

Part A: DEMOGRAPHICS

1. How many were born:
   - a. In the Pacific? __________
   - b. In NZ? __________
   - c. Other? __________

2. Gender:
   - a. Male: __________
   - b. Female: __________

3. Age Group:
   - a. 12-19 yrs: __________
   - b. 20-29 yrs: __________
   - c. 30-39 yrs: __________
   - d. 40-49 yrs: __________
   - e. 50-59 yrs: __________
   - f. 60 yrs+: __________

4. Ethnic group:
   - Cook Is: __________
   - Samoan: __________
   - Tongan: __________
   - Kiribati: __________
   - Niuean: __________
   - Fijian: __________
   - Other: __________
5. How many belong to the following:

- [ ] Church ____________
- [ ] Community group
- [ ] Cultural group
- [ ] Fundraising group (bingo, housie, etc)
- [ ] Sports group ____________
- [ ] Other: ____________________

6. If we are to contact you, which would you prefer?

- [ ] Phone call
- [ ] Texting
- [ ] Email
- [ ] Community meeting
- [ ] Home visit
- [ ] Other: ____________________

7. How many are current smokers:______________
   How many have quitted but started again: __________
   How many are ex-smokers:______________
   How many are non-smokers: _______________

8. Age when started smoking?
   Why did you start smoking?
   Did you carry on smoking?

Part B: AWARENESS, KNOWLEDGE AND PERCEPTION ABOUT SMOKING

9. Do you think smoking is part of your culture?
10. Tell us what you know why smoking is harmful?

10.1. Explain further some of the health problems caused by smoking?

10.2. Are there any issues relating to smoking that you can tell us about?
   a. in the home?
   b. in the work place?
   c. in the church and community environment?

10.3. Passive Smoking:
   Some people are not allowed to smoke in the home. Why?

11. Some people say stress causes people to smoke but they think they should give up – why do you think this is?

12. Did you try to quit smoking, and how long ago?

13. What could be the reason for failing to stop smoking?

14. Why do you think some smokers would listen and more likely to take action if instructed by a doctor compared to a community health worker, such as in the case for quitting smoking?
Part C: TREATMENT

15. Which would you consider to be the best way to help and support you to quit?
   a. NRT – patches, lozenges, gum?
   b. What do you understand about the proper use of NRT?
   c. If use NRT treatment, was it properly explained and demonstrated to you?
   d. Did you get follow ups, reminders, and counseling on your progress when using NRT?
   e. Did you feel any side effects when using NRT?
   f. Were you satisfied with the services you have received?

16. Have you sought help from Quitline?
   a. If yes, do you find it helpful and effective?
   b. Were you satisfied with the services you have received?
   c. If No, why have you not used it?
   d. What do you think could improve Quitline services?

17. It seems that more Pacific people choose to go cold turkey, why is this? And how effective would this be for them quitting smoking?

18. What side effects do you experience when you stop smoking, particularly when you try to go cold turkey?

19. Do you seek help through prayer?

20. How would you feel about smoke cessation promoters/health workers that smoke?

Part D: TECHNOLOGY USE

21. Do you think the use of texting would help in smoke cessation?

Part E: SUGGESTIONS FOR PROVIDERS

22. What three things can Providers do to help people to quit?

Part F: GOVERNMENT POLICY AND LEGISLATION

23. What do you think of Government’s policies and legislation on tobacco control and smoke-free places?
ANNEX 2.1.1:

TOKOROA FOCUS GROUP

SWIPEC

12.8.09

1. **Aim and Questions:**
   - To find out if they see that smoking is bad for them.
   - Do they see it as an illness? What is their perception of people smoking?
   - Need to understand how cigarettes come about.
   - What are their attitudes towards smoking, quitting, and good health?
   - To assess the level of their knowledge – how much do they know of the effects of smoking on their bodies, health, others, etc.
   - What makes them smoke?
     - To explore more about smoking and relationships.
   - If they think smoking is bad, what do they think they need to do to go back on track to stop smoking and to have good health again?
   - What do they think they should do to get there?
     - Would traditional ways of healing help?
     - If so, what kind?
     - Explore the means of prayer?
   - What do they want providers to do?

2. **Demographics:**
   - Gender: Male = 4, Female = 5
   - Age Groups: 1 (30-39 yrs), 4 (40-49), 4 (50+)
   - Ethnic Groups: 5 (Cook Is), 1 (Samoan), 3 (Other – Maori)
   - Smoking status:
     - Current smokers = 6
     - Those that have quit and started again = 4
     - Ex-smokers = 2
     - Non-smokers = 1
   - Quit Attempts: 2 (twice), 1 (three times), 1 (once).

3. **Smoking, stress, socialisation vs Health and Wellbeing:**

   **Group stories:**
   a. Smoked, quit, and smoked again. She did not use any treatment, just went cold turkey. She stopped for 28 days. She started again when visited her family, when having coffee and
chatting with her sister, automatically picked up a cigarette, and just carried on from there and now become a habit. She doesn’t smoke at her home as her husband doesn’t like it. She hides when smoking, however she doesn’t miss smoking when at home. She admitted that she is also coughing.

b. She started 2 years ago because of work and stress particularly when her husband passed away. She thought she could go without smoking again as she has tried it. She has gone without cigarettes in days before. She thought it is a culture thing which is a part of social interaction and culture in the workplace.

c. One who has tried quitting by reaching out for help through hypno-therapy. Before he sought help, his father just died. His father also smoked but was told by him to quit. He learned of the therapy on TV and decided to approach the therapist. The therapy was done by one person to a group of about 20 people. Part of the process was the therapist talking to patients and telling them to throw their cigarettes in the bin during the session. He stopped smoking for 2 years after the therapy, then he started smoking again. He has been back to the therapy again however he found that it has not worked again.

d. One has sought help from Quitline and was sent NRT. However, she thought she could do it on her own. She tried quitting 3 times.

e. One thought that getting help from Quitline was psychological. She went home with the patches but only really stopped smoking when she got sick. “Everyone smokes in the family of 11. My dad worked in a chemical factory and also smoked too. He never told the family to stop smoking.” She thought that if her father can do it (not affected by smoking) perhaps she would also has no problem with it. She admitted however that she loves her family and so she needed to do more about smoking.

f. Smoking is part of her social life. Most of her sisters smoke but her brothers don’t smoke. She has quitted 3 times before, twice when she was pregnant and breastfeeding. Now she is smoking again. She started by just picking up the cigarette. She did not know that smoking is bad and she used to smoke all throughout the 4 months she was pregnant. She got reminded not to smoke by her son but would get frustrated by it. She understood about the treatment available. She has been offered to try NRT but those in charge never came or followed her up. She didn’t know which one to take help from. She already knew about Quitline even before smoking but has not sought help from it because she felt that she was not ready yet i.e. it has to come from herself.

g. People knew about Quitline from TV. However, some were put off when they were told the first set of treatment was free but the following ones would cost.

a. Some pointed out of the contradiction that they don’t think of the costs involved when buying cigarettes, but they are unwilling to pay for the treatments.

h. His mum and family wants him to stop but admitted that he enjoys smoking eventhough he agreed of the health problems associated with smoking.

i. The group generally thought that smoking was bad. Some who are health workers are conscious because of the role they play in health promotion i.e. not walking the talk, “how can I tell people to do this and yet I’m not doing it?”
4. Reflections, thoughts, and suggested resolutions to quitting:

- One suggested that you have to “help yourself first, stop smoking, then you can help others”

Q. Do you seek help through prayer?

- “I haven’t stopped but I have prayed about it.”
- “Yeah, we do, but He hasn’t done anything yet.”

- “I have responsibility for my problem; I know smoking is not good for my health.” She said it is her choice, although she should be treating her body before her operation as patients to undergo operation are required to stop smoking.

- Normally smoke when drinking coffee. Now trying to change her daily routine i.e. to detach herself and trying to go at her own pace.

- Simple solution is for Government to close down tobacco companies. Discussions on the profits of these companies and contradictory also for Government who receives income on taxes from tobacco companies.

- People thought that it is easy to contact Quitline – two participants have actually contacted Quitline. One have signed up for the patches but will now be switching to K’aute (Emry) for the NRT treatment. Generally, people agreed that they are not using Quitline.

5. Side effects of Quitting:

a. One who tried to go cold turkey experienced bad moods and used to take it out on her kids (hit or throw things at them). She realized that it was the effect of the smoking when her son pointed out that since she was not smoking she became more angry and short tempered. She has also been told by her GP about her mood problems that it was because of the smoking.

The smoking also affected the family financially. Usually she waited until the next pay to buy cigarettes.

Before she came to this meeting she was touched by what her son told her about her problem. She has talked to a colleague and thought about trying to get spiritual healing.

6. Attitudes on Treatment:

- Generally the word ‘treatment’ to Maori is sort of scary as it is associated with diseases. There is a need to explain it more or mellow it down.
- SWIPC (Emry) suggested the use of ‘nicotine replacement’.
- One that smokes used to take other medication. She found that she was coughing because of the pill and not the smoking. Her coughing stopped after she changed the pill she was taking.
- Those that have been sick and seen doctors (as first point of call) were reminded for not smoking
• Peta: common responses to health workers when they visit people is that they are not ready or do not want to really cooperate. However, when a referral letter from the hospital/doctor is shown to them, they immediately became very interested and positive about the visit.
  o They could see it as associated with being ‘sick’
  o People see that going to doctors is the normal thing to do but could think otherwise for other organizations/health workers as not a priority to them.
• Some said what they are told by GPs for not smoking still doesn’t work for them
  o Sometimes it is the way some doctors talk e.g. very rough and strict – “you got to stop smoking”. It is how they approach patients. Some doctors put off patients by their approach that patients just continue to smoke.
  o Some people said that it has to come from them.
• Good GPs have good tone of voice and gave good reminders instead of pressuring patients.

7. Quitting vs Cultural Approach
• Cultural sensitivity – answerable to own culture
• Peta: when reaching out for a cigarette, usually means not being well, relates to health and wellness, to living life i.e. when there is a breakdown somewhere and situations are abnormal.
• Some smokers quitted but went back to smoking again because they have started to eat more and gained weight, which is bad for their breathing, etc.
• Peta: testimony on her daughter who used to smoke and now quitted with no treatment except after reading a book – must be something about this book that changed her.

8. Passive Smoking
• All generally aware of the effects of smoking. They agreed that it is becoming more noticeable i.e. more homes are becoming smokefree. Smokers are generally have concern about others but still not for themselves.

9. Youth vs Smoking
• Maori view:
  o Thinks it is a social attachment to one another
  o Thinks it is not cool to smoke with their own children, so children would smoke with their own level
  o Youth tends to help each other; some asked for top up or lunch money but when away from home they would usually wait for an adult to buy the cigarettes for them
• The importance of children saying things to their nana. One nana now always goes outside to smoke.
• One participant said that her nephews and nieces have written notes asking her to stop smoking which made her think of quitting even though she is still not ready.

10. Technology and Smoke Cessation
• Most use mobile phones but only two do not use it.
• Preferred forms of contact include:
  o Mobile phones – on them all the time
    ▪ Texting would help encourage some e.g. remind or encourage him every second day – “it shows that this person really cares enough for me.”
- Landline phones – live in remote area
- One on one – have more time for discussion and clarity, tend to ask more questions on the phone as sometimes people talk very fast.
- Wider community through meetings

11. **Three things Providers can do to help**

- Most recommended ‘Education’ on the use of NRT, how it works, and why it is important to use it. Education should not be limited to individuals but to be extended to the families.
  - E.g. To put education on the marae. This relates to the support you have that is around you (24/7).
  - It is important that health/quit coaches actually visit and sits at the level of the family.
- Quit Coaches to continue working with smokers to give help and encouragement. They should have sufficient knowledge about smoking and treatments. It is important that coaches build and continue good relationships with clients and communities.
  - People may prefer to use NRT when given as it will be in their face all the time and they can use it at their own pace.
- The use of other strategies for smoking cessation such as texting should be explored further.
ANNEX 2.1.2:

HAMILTON FOCUS GROUP (1)
KAUTE PASIFIKA
21.8.09

1. **Aim and Questions:**
   - To find out if they see that smoking is bad for them
   - Do they see it as an illness? What is their perception of people smoking?
   - Need to understand how cigarettes come about
   - What are their attitudes towards smoking, quitting, and good health?
   - To assess the level of their knowledge – how much do they know of the effects of smoking on their bodies, health, others, etc.
   - What makes them smoke?
     - To explore more about smoking and relationships
   - If they think smoking is bad, what do they think they need to do to go back on track to stop smoking and to have good health again?
   - What do they think they should do to get there?
     - Would traditional ways of healing help?
     - If so, what kind?
     - Explore the means of prayer?
   - What do they want providers to do?

2. **Method:**

   The focus group sought to use a Pacific approach which includes understanding of cultural and spiritual aspects, and engage discussions amongst a range of groups such as the elderly, youth, academics, family (recently migrated from the islands), and the pregnant.

   This group was of mixed ethnicity and the forum/meeting provided insights/closer look of differences/similarities in Pacific history, cultures, experiences, current situations, and smoking.

3. **Demographics:**
   - Gender: Male = 2, Female = 4
   - Age Groups: 3 (30-39 yrs), 3 (40-49)
   - Ethnic Groups: 2 (Fiji), 2 (Samoan), 1 (Kiribati), 1 (Tonga)
   - Smoke characteristics:
     - Current smokers = 4 (including 1 pregnant lady smoking)
     - Those that have quitted and started again = 1
     - Ex-smokers = 1
4. **Smoking and Culture:**

Q. *Is smoking part of your culture?*

**Kiribati rep:**

Part of hospitality and have been incorporated into traditional protocol in the giving of gifts by visitors to the islands at meeting halls ‘mwaneaba’ and shrines (indigenous gods). However it is different here in NZ.

**Tongan rep:**

Definitely not part of the culture but it has been adopted and associated with social gatherings including alcohol drinking.

Generally people that smoke do not have concern about their health. Usually people buy duty free cigarettes or purchase from the islands as they are much cheaper and bring them here to NZ.

If people work for you, it is a normal practice to give them food, drink, or cigarettes. About 50% of Tongans smoke.

There are more options here for smokers to explore that they have not tried before as not available in the islands. In Tonga it was usually benson & hedges, but this brand is considered cheap here and if given as gift would not be considered a very valuable gift.

Cigarettes are increasingly getting expensive in Tonga e.g. a port royal packet is now being sold in pieces in Tonga and people are finding it as cheaper here to buy a similar packet.

Here in NZ kava drinkers are normally affiliated with a faikava group. Kava drinking are normally held at people’s garages. A distinct difference here in NZ is that a lot of kava drinking are now smoke free. Smokers would go outside to smoke. She thought it may be the impact on the more intense smoke campaigns and information here in NZ.

Tongan Royals do not smoke in public and people never knew that they smoke.

**Samoan rep:**

Why do ‘matais’ smoke?

Didn’t understand the reason why.

He preferred cigarettes here because they were more expensive in Samoa. Cigarettes are a must item in the shopping list. Brands smoked in Samoa are Consulate, Rothman, and Grays. Pall mall is now replacing Rothmans because it is now being manufactured in Samoa.

Beer and cigarettes goes very well.

Peta: nurses also smoke and have known those that would smoke on their duty breaks—see it as a social ‘thing’.
Fijian rep:

It has become a ‘norm’. One of the reasons could be traced back to the planting of tobacco and comparatively with kava. The giving of tobacco has been a normal practice too when visiting villages. It has also been a form of gifts for appreciation e.g. if people have been helping you weed your garden, then it is normal to give them a packet of cigarettes after their work, “it is better to go with a cigarette than empty handed.”

It has also become part of traditional practices over time that cigarettes would follow after kava ceremonies and social/political gatherings.

It has become a social ‘norm’ with family e.g. would smoke when get together with cousins.

5. Treatment (NRT) and ‘Cold Turkey’

Fijian rep:

Thought that treatment would not be preferred by some people because they would see it as a form of medication hence associated with illness/sickness. A common attitude towards a person using treatment including NRT as has a problem. Because of being proud, some people do not want to use medication or NRT.

Thought that people do know of the effects of smoking since there’s a lot of promotion. However, people also have a choice for their own actions. Was not sure if people can see it yet as a problem, rather it is more for enjoyment (social).

Samoan rep:

He understood that it is not good for them but cannot stop. He admitted not knowing why as he wants to smoke and that smoking relaxes him. He would get angry if he doesn’t smoke over a period of time. However, he normally gives up when he is sick. Once in the hospital he has been told off. But he would go back smoking again once he recovered from his illness.

His mum died of cancer of the lungs.

Wife (Pregnant and smokes):

Thought she could stop. She has been told that smoking is not good for her particularly when pregnant. She admitted crave more for smoking than food. She is a heavy smoker (1 cig about every 3 mins). She has never tried to give up. However, they found that cigarettes are expensive and they want to give up. Their family has been hassling them about smoking.

Observed that in Samoa, a doctor has reported of people dying of cancer, but these people never smoked.
**Tongan rep:**

If really wanted to quit then she would go cold turkey. She has tried it before and stopped smoking for 4 years, smoked for 3 years, went cold turkey and stopped for 5 years, and started smoking again. She thought she could do it again. She knew that personally she wanted to quit again.

However, she would not try NRT, she thought it was her pride and didn’t want to be dependent.

“I’m the one that decided to smoke so I think I should be the one deciding to quit too.”

She would replace smoking with eating and sleeping. Most of her weekends are smoke free as she tried to be busy. However, would smoke again when drinking alcohol and coffee.

She knew her smoking is a problem but doesn’t want to admit it – ‘denial’ – thought of her stubbornness.

She related it to drug addiction.

She doesn’t feel sick because she thought that physically she is functioning well.

Doesn’t like to be asked/followed up as get annoyed by it. Thought that it is important to know one’s limit. Usually both hands are occupied, one for the drink (alcohol) and the other with the cigarette. Thought that reducing drinking would also reduce her smoking. Would not continue drinking when cig finished.

6. **Perception on Smoking**

*(Do we see it as a problem, unhealthy, etc?)*

**I-Kiribati rep:**

She smoked, quitted and smoked again. The main reason was being bored eventhough she found it expensive.

**Tongan rep:**

Her line of families died of cancers (breast and lung cancers). 5 out of 7 of her siblings smoke eventhough they have literally watched their dad died of cancer where he came to the state of coughing up blood. They would help their dad in the hospital with his nebulizer but would go outside and smoke again. They were told by the nurses about their smoking. Her sister who is a doctor is also a heavy smoker.

Thought it is a mental thing/psychological e.g. she would pull out a cigarette as soon as she sees the work building and would feel good after smoking.

When went cold turkey she went back practicing her faith again but would stop as soon as she started smoking again. She said it worked before when in a family prayer and her uncle indirectly prayed for her to do the things she has been told to do. She acknowledged that it was the ‘spiritual faith’ that carried her smoke free for 5 years.
General agreement that:

- Everyone needs to be happy, people need to be encouraged and supported. Generally agreed and believe in the collective support including by family.
- See here the role of family leaders and also prayer
  - As in Tongan rep’s case.
- Nowadays people particularly youth are getting lesser and lesser instructing and directing by senior citizens, the elderly, leaders, and parents.

Fijian rep:

She smoked and then went cold turkey eventhough she was told not to.

Some underlying factors would be:

- A matter of replacing one habit with another e.g. drinking and consuming chocolate most of the time when not smoking, but sometimes she was not conscious of her habits.
- She has not been smoking for 5 years now and hopes to stay that way. She said as not thinking about smoking even when she was with friends.
- She said it was hard work and for her she replaced smoking with high consumption of sugar.

Samoan rep:

Have seen a lot of promotion including diseases and harm of smoking but still continues. He would be reluctant to do anything if he doesn’t have cigarettes. However, he admitted that won’t be able to afford it. He had discussions with his wife about family budget including necessities such as food for children. He tends to replace smoking with sleeping as a way of not spending on cigarettes.

- A mental/emotional/spiritual issue – as needs to satisfy emotions, etc.

7. Three things/recommendations to support smokers to give up:

- To sort out the social/mental/emotional areas
- Need to their ‘will power’ to quit
- Need the support of family and friends
- Have received a lot of advice from elderly people to give up smoking so it is important to listen and take note of the advice of elders.
- Health care promoters to have a lot of patience, to keep trying even if it doesn’t/hasn’t worked yet and to recognize that the change needed is a slow process and would not expect a quick fix solution. A lot of people have been smoking for many years and so changing of their behavior would also take time. Need to use approaches that are more on the ground and not classroom-like approaches.
- Approaches such as focus group sessions are more effective than one-on-one because there is more connection, opportunity to talk/share and be listened to, and provides a platform for
understanding of each other’s problems and experiences. Focus groups are more culturally appropriate and also therapeutic for everyone.

8. **Final comments:**
   - I-Kiribati rep: Thankful for meeting and now she wanted to try to quit again as feel encouraged and motivated again after this group meeting.
   - Samoan rep: His church (Catholic) doesn’t advise on smoking. It is mostly from elderly people that he received advice for giving up on smoking. Personally for him with a very strong desire for smoking, and a very heavy smoker, he would want some powerful drugs (from hospital, etc) to help him quit.
KAUTE PASIFIKA SMOKEFREE RESEARCH
FOCUS GROUP QUESTIONS – Hamilton (2nd meeting)

AIM:
To find out

- Attitudes, beliefs, and knowledge towards smoking and quitting, health and wellbeing
- What makes Pacific people smoke?
  - Assumption: Mostly to do with relationships when there is a breakdown somewhere, hence leading to stress.
- What do they think they need to do to stop smoking so that they can go back on track i.e. good health and wellbeing.
- What do they want providers to do?

Part A: DEMOGRAPHICS

4. How many were born:
   a. In the Pacific? __________
   b. In NZ? __________
   c. Other? __________

5. Gender:
   a. Male: __________
   b. Female: __________

6. Age Group:
   a. 12-19 yrs: __________
   b. 20-29 yrs: __________
   c. 30-39 yrs: __________
   d. 40-49 yrs: __________
   e. 50-59 yrs: __________
   f. 60 yrs +: __________

4. Ethnic group:
   Cook Is: __________
   Samoan: __________
   Tongan: __________
   Kiribati: __________
   Niuean: __________
   Fijian: __________
   Other: __________
24. How many belong to the following:

☐ Church ____________  ☐ Community group
☐ Cultural group  ☐ Fundraising group (bingo, housie, etc)
☐ Sports group ___________
Other: ___________________

25. If we are to contact you, which would you prefer?

☐ Phone call  ☐ Texting  ☐ Email
☐ Community meeting  ☐ Home visit
Other: ___________________

26. How many are current smokers:______________
   How many have quitted but started again: __________
   How many are ex-smokers:______________
   How many are non-smokers: _______________

27. Age when started smoking?
   Why did you start smoking?
   Did you carry on smoking?

Part B: AWARENESS, KNOWLEDGE AND PERCEPTION ABOUT SMOKING

28. Do you think smoking is part of your culture?
29. Tell us what you know why smoking is harmful?

10.1. Explain further some of the health problems caused by smoking?
10.2. Are there any issues relating to smoking that you can tell us about?
   a. in the home?
   b. in the work place?
   c. in the church and community environment?

10.3. Passive Smoking:
   Some people are not allowed to smoke in the home. Why?

30. Some people say stress causes people to smoke but they think they should give up –
   why do you think this is?

31. Did you try to quit smoking, and how long ago?

32. What could be the reason for failing to stop smoking?
33. Why do you think some smokers would listen and more likely to take action if instructed by a doctor compared to a community health worker, such as in the case for quitting smoking?

Part C: TREATMENT

34. Which would you consider to be the best way to help and support you to quit?
   a. NRT – patches, lozenges, gum?
   b. What do you understand about the proper use of NRT?
   c. If use NRT treatment, was it properly explained and demonstrated to you?
   d. Did you get follow ups, reminders, and counselling on your progress when using NRT?
   e. Did you feel any side effects when using NRT?
   f. Were you satisfied with the services you have received?

35. Have you sought help from Quitline?
   a. If yes, do you find it helpful and effective?
   b. Were you satisfied with the services you have received?
   c. If No, why have you not used it?
   d. What do you think could improve Quitline services?

36. It seems that more Pacific people choose to go cold turkey, why is this? And how effective would this be for them quitting smoking?

37. What side effects do you experience when you stop smoking, particularly when you try to go cold turkey?

38. Do you seek help through prayer?

39. How would you feel about smoke cessation promoters/health workers that smoke?

Part D: TECHNOLOGY USE

40. Do you think the use of texting would help in smoke cessation?

Part E: SUGGESTIONS FOR PROVIDERS

41. What three things can Providers do to help people to quit?
Part G: OTHER QUESTIONS/POINTS FOR DISCUSSION

5. Some people do not think that ‘Pacific Community Leaders’ are the best ones to deliver smoke/health messages because some leaders also smoke.

What do you think community leaders should do to help their communities smokefree?

(Can start by listing current social programmes e.g. kava drinking, fundraising, celebrations, etc; which activities tend to trigger more smoking?; what steps/interventions/policies can be integrated into these activities to decrease smoking?)

6. Most Pacific people belong to a church, however some people don’t see their religious faith as a way of helping them to quit.

Why is this? What ways can be explored to make churches more effective to active smokers at all levels?

(Can discuss existing systems and programmes in churches e.g. for youth, parents, elderly, etc; what is not there yet, and what improvements can be done)

7. Pacific people centre their lives around family (nuclear and extended) and a lot agreed that support from families would help them quit.

Q. What do you think families should do to help a smoker in their family to quit?

Q. What support would Pacific families would like to help them help their own family member that smokes? (e.g. parenting course, virtues workshops, education on smoke effect, etc)
ANNEX 2.2:

QUESTIONS FOR FOCUS GROUP

[Hamilton (2)]

AIM:

- To build on from the previous focus groups and findings from the survey by further generating in-depth discussions on why Pacific people smoke
- To gain more understanding of psychological, mental, physical, and social needs and reasons that influence smoking behaviours of Pacific peoples
- To find out appropriate strategies that would work best for smokers to quit and also what support they would like from providers

Part A: DEMOGRAPHICS

1. How many were born in the:
   - Pacific? ________ In NZ? ________ Other? ________

2. Gender: Male: ________ Female: ________

3. Age Group:
   - 12-19 yrs: ________
   - 20-29 yrs: ________
   - 30-39 yrs: ________
   - 40-49 yrs: ________
   - 50-59 yrs: ________
   - 60 yrs +: ________

4. Ethnic group:
   - Cook Is: ________ Samoan: ________ Tongan: ________
   - Kiribati: ________ Niuean: ________ Fijian: ________
   - Other: ________

Part C: KNOWLEDGE AND BELIEFS ABOUT SMOKING

5. Why do we need to smoke?

6. What is it about cigarettes that make smokers want to smoke?
7. How is this affecting the family?

8. Do you think smoking is bad for you? Why are you still smoking when you think it is bad for you?

9. If we were to help you, probably we’ll raise the price of tobacco. Do you think it would help you?

10. So for now you don’t think it’s a problem for you and that in your heart you would stop when you want to?

11. Going back to the faikava, what do you think if we were to create something that would not make you go to the faikava? But then would you still drink at home and still reach out for a cigarette?

12. How can we help those people to realise that it is not a good thing to continue smoking? Can they just have the kava without the smoking?

13. But why is the smoking there? Why do you attach the smoking to the kava? How is the smoking related to the kava ceremony?

14. Have you ever talked to a coach about stopping smoking? Have you seen your doctor and does your doctor knows that you smoke?

15. How can the needs of smokers be met (in terms of quitting)?

16. Do you think that will work? If we come all the time and talk?

17. Smoking prevalence has decreased, however 15 + group is still increasing, same with women it is also increasing, why is it that more of our women are smoking?

18. How would you feel when your children are following your steps? Would you advise them not to smoke and about the effects of smoking like lung cancer? Or would you just leave them to do their own thing?

19. Specifically for Pacific people, are there any things that are unique about us because of who we are, and where we come from?

20. When you are stressed and there are no cigarettes around you, what would you do?
ANNEX 2.3:

QUESTIONS FOR FOCUS GROUP –

WOMEN IN A FAMILY

1. When, how, and why did you start smoking?
2. When you started smoking did you know that it is bad for you?
3. Do you have a family history of smoking?
4. Did your parents ever talk to you about the effects of smoking?
5. Do you smoke roll-your-own or tailor made cigarettes?
6. How many do you smoke per day?
7. Have you ever tried to quit? When, why, how?
8. Right now how do you feel about NRT treatment i.e. nicotine patches and gums?
9. Would you like to try and have a go again using the treatments available?
10. Do you think prayer would help in your quitting?
11. When you say “stress” what are the causes of the stress you had?
12. What do you do if you feel anxious?
13. Have you ever sought help from Quitline or from other Quit coaches?
14. Were you satisfied with the service you received?
15. From what you have experienced, what do you think the services you have had accessed to could do to improve smoking cessation?
16. How do you feel about the introduction of smoke-free policies and regulations?
17. What do you think of the smoking cessation awareness around e.g. through the media? Do you think other forms of information dissemination e.g. through pamphlets, would help?
18. What do you think would work best for you to make you quit?
19. What would you like smoking cessation providers to do more to be able to support you towards quitting?
20. Do you have any other comments or suggestions?
ANNEX 3.1:

QUESTIONS FOR HEALTH PROFESSIONALS

Q.1. What is your opinion, attitude, and observation on Pacific people smoking?

Q.2. Do you routinely check your patients if they smoke?

Q.3. What advice do you give to your patients that smoke?

Q.4. What disease are associated with smoking?
   What are the common ones you see with Pacific patients?

Q.5. Are Pacific patients following the advices you gave them for not smoking?

Q.6. Have Pacific patients come back to you with similar diseases associated with smoking?
   If yes, what do you tell them and how do you go about telling them?

Q.7. Do you see a lot of Pacific patients? What’s your referral procedure like?

Q.8. Do you have smoke cessation coaches at your centre? And do you give out NRT?

Q.9. Do you have other comments that you would like to make?
ANNEX 3.2:

QUESTIONS FOR HEALTH PROMOTION ADVISER (WAIKATO)

Q.1. What has been your involvement in the tobacco control (which includes cessation and promotion)?
Q.2. What is your opinion on the accessibility for Pacific people to the service?
Q.3. What are the constraints/barriers that are experienced by service providers?
Q.4. Knowledge and view on effectiveness of services to Pacific people?
Q.5. What 3 things to focus on to improve the service of Providers?
Q.6. Do you have other comments that you would like to make?

ANNEX 3.3:

POINTS FOR DISCUSSION WITH WAIKATO SMOKE-FREE NURSE COORDINATOR

- Statistics of Pacific people relating to smoking
- Smoking cessation services in Hamilton and Tokoroa
- Referral procedure/process & accessibility of services to Pacific people
- Issues Experienced with the delivery of smoking cessation to Pacific people
- Current smoking cessation programme
- Training/resources
- Recommendations/plan of action
ANNEX 4:

QUESTIONS FOR SMOKING CESSATION SERVICE PROVIDERS – QUIT COACHES

PACIFIC PEOPLE ACCESSING AND THE SERVICE

1. What type of service does your organisation provide for Pacific people?

2. Do you have Pacific people in your Smoke Cessation team?

3. How many Pacific people access your service annually?

4. Has there been an increase or decrease in the number of Pacific people accessing your service?

5. How do Pacific people access your services?

6. Do you refer Pacific people to Pacific Smoking Cessation providers?
   If not, where do you refer them?

7. What are some constraints that you face in providing smoking services specifically to Pacific people?

8. How effective are your services to Pacific people?

9. In your opinion how successful are Pacific peoples that choose to go ‘cold turkey’ when quitting?
   What about people taking up treatment as a preferred option?
RESOURCES

10. Do you have specific resources for Pacific peoples to support the following:
   a. Smoke cessation programme
   b. Promotion and education relating to harm of tobacco and benefits of quitting

TRAINING

11. Do you have training opportunities for staff to undertake Pacific culturally informed programmes?

12. In your view, is there a need for your smoking cessation staff to access cultural training?

13. If you were to improve your services to Pacific people, what three things would you focus on?
ANNEX 5:

QUESTIONS FOR COMMUNITY LEADERS

Q.1. What are your views about tobacco smoking including in your church grounds?

Q.2. Do you smoke?

Q.3. Do you have kava before/after church? And do members smoke at faikava?

Q.4. What would you like to see happening to your church members that smoke? Do you have programmes that supports quitting and not smoking?

Q.5. Do you think smoking tobacco is harmful to people? What diseases are associated with smoking? What are the benefits of quitting?

Q.6. If we were to develop a programme to help Pacific people quit, what would you like to see included in it?

Q.7. Would you support a smoking cessation programme in your church?

Q.8. Do you have any other comments that you like to make?
ANNEX 6:

POINTS FOR DISCUSSION WITH SMOKING CESSATION TRAINERS

- Background on the development of Pacific Heartbeat Training Intervention
- Aims
- Partners in the delivery of training
- Service Coverage
- Training Approach
- Challenges
- Further Comments and Suggestions