

# **PREGNANT WOMEN'S ACCESS TO, AND USE OF, THE QUITLINE**

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- Quitline Caller Topic Guide
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- Health Professional Topic Guide

# Executive Summary

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## 1. Introduction and Method

The Quit Group has commissioned research to understand how the Quitline could better work with pregnant callers and attract more pregnant women to use the service for support and advice. The following research objectives have been established by The Quit Group.

1. Explore the barriers and motivations for quitting and any resistance to using Quitline during pregnancy.
2. Explore expectations and experiences of pregnant women of the Quitline service.
3. Investigate views of GPs and midwives about Quitline and why they would or wouldn't refer pregnant women to Quitline.
4. Investigate perceptions of nicotine replacement therapy (NRT) use during pregnancy among women and health professionals.

The findings presented in this report were obtained from a series of semi-structured face-to-face interviews with:

- currently and recently<sup>1</sup> pregnant women who had called the Quitline (n=8 participants, sourced from Quitline's database);
- currently and recently pregnant women who had not called the Quitline (n=10 participants, sourced through advertising, networking and snowballing through other participants); and
- health professionals working with pregnant women with a recent history of smoking (n=4 independent midwives, n=2 community midwives, n=2 general practitioners and n=2 practice nurses – sourced via cold calling, personal contacts of the interviewing team and networking through health professionals already interviewed).

Each interview was conducted at a time and place to suit the participant. Interview lengths ranged from 30 minutes to one and a half hours. All interviews were audio-taped and later transcribed for analysis. Given the sensitive nature of the topic, all interviews were conducted by women. As part of the recruitment process, Maori and Pacific women were offered the opportunity of being interviewed by a Maori/Pacific researcher. All women participants were offered a \$50 voucher<sup>2</sup> in recognition of their contribution to the research. All health professionals were offered \$50 cash, which they could nominate to be donated to a charity of their choice (n=2) or to keep themselves (n=8).

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<sup>1</sup> In the previous six months

<sup>2</sup> A choice of vouchers from The Warehouse, Farmers, Baby Factory and Pumpkin Patch were offered.

## **2. Motivations and Barriers to Quitting Smoking – and Staying Quit**

### **A. Risks to the Unborn Baby**

For almost all women, a desire to minimise the negative health risks to their unborn baby was the key motivator in wanting to quit smoking. This desire was reported to be particularly strong when the pregnancy was first confirmed (provided the pregnancy was wanted), at the first scan, and once the woman's belly started growing/when she started to show.

However, most women's knowledge of the actual risks of smoking to foetal health was limited to the possibility of low birth weight and premature delivery, with most unsure how smoking actually caused or contributed to these conditions. As well as a lack of information, motivation to minimise risks to the baby was reduced by:

- an awareness that growth-restriction is not confined to babies of smokers;
- a perception that, due to advances in neo-natal care, premature babies have relatively few long-term health or development issues;
- (apparently) positive familial experiences of smoking during pregnancy;
- a perception that light/social smoking is not harmful to the unborn baby;
- a lack of ante-natal care, particularly among high-risk women;
- a perception that smoking can have positive impacts on childbirth; and
- a fear of the baby being born with nicotine cravings.

In addition, those women who had relapsed after giving birth felt their contribution to their child's health had been achieved by being quit whilst carrying the child. These women demonstrated little understanding of the harmful effects of second hand smoke and smoking whilst breastfeeding.

### **B. Social Factors – The Smoking Environment and Culture**

All women interviewed were conscious of the social stigma associated with smoking when pregnant. However, the extent to which this was actually a motivator to quit varied, with New Zealand European and older women most likely to feel the pressure to conform to societal norms. Women were influenced to quit by their social contacts – particularly their partner, parents, siblings and close friends. In some instances this was expressed (and felt by the woman) as enthusiastic encouragement and in other cases expressed more as (negative) pressure.

Where the woman's partner had attempted to quit (generally occurring early in the pregnancy), women reported that it had been relatively easy to quit too due to there being no cigarettes or smell in the house. Being able to support and have empathy with one another was a key aid in staying quit.

In contrast however, a lack of support from the woman's social circle is a strong barrier to quitting. While there were few reported instances of family or friends actively encouraging the woman to continue smoking or offering them cigarettes, women reported that smokers among their social circle tended not to support them; neither refraining from smoking near the woman nor quitting smoking themselves. Some women were dissatisfied that the quitting decision had been left solely to them whereas they would have liked their social circle – and particularly their partner - to be more involved and to take more responsibility (ideally quitting themselves, but even not smoking around the woman, or removing cigarettes from view). Consequently, choosing to quit smoking was noted as essentially choosing to isolate oneself from established social circles – and in some cases, participants reported that they weren't prepared to do this, or felt that others wouldn't let them.

As well as some women feeling unsupported by their social circle in their decision to quit smoking, the research has found that health professionals – particularly those working with a high caseload of pre-natal maternal smokers - become somewhat desensitised to the issue of smoking during pregnancy and therefore may not always offer as much support as they could. Women participants generally had an expectation that their Lead Maternity Carer (LMC) would offer advice and support about smoking cessation. While some women reported being relieved when this advice and support was not always forthcoming, there was surprise among pregnant women that some LMCs did not place more emphasis on this aspect of their pregnancy.

### **C. Risks to the Mother**

Compared with minimising the health risks to the unborn baby, a desire to minimise risks/yield benefits to the mother was significantly less of a motivator to quit. The health benefits to the mother of quitting smoking (minimising skin problems, reducing asthma and dizziness) were most likely to be mentioned by older New Zealand European participants and, while not a key motivator, the financial savings associated with quitting were also appealing.

Stress felt by the mother (particularly related to poor interpersonal relationships, financial hardship and dealing with other social realities) was identified as one of the main contributors to not quitting, and also to relapse after the birth. Similarly, boredom experienced by the woman (both during pregnancy if she wasn't working, and post-natally) is both a key barrier to quitting and a key trigger to relapse. Women also expressed a concern about weight gain as a result of giving up smoking.

Finally, some participants viewed smoking as a comfort or reward. These participants felt that they had already made sufficient (and significant) sacrifices for their unborn baby – not drinking alcohol, not eating certain foods, and in some cases having to stop exercising/playing sport – and felt that it was unfair that they should have to give up smoking as well (which they perceived as less detrimental to the baby than alcohol and drugs).

Some women reported continuing to smoke during their pregnancy as a comfort to deal with the effects of withdrawal from these other influences.

#### ***D. The Role of Health Professionals in Smoking Cessation***

The extent to which the issue of smoking – and quitting - was addressed and proactively dealt with by midwives varied considerably. In a small number of cases, the issue was touched on only fleetingly during the first visit and was not addressed by the midwife subsequently. Most participants had been asked about their smoking status at later visits and, if relevant, if they had followed up on cessation advice. Considerably less common was the experience of assertive midwives offering proactive referral to smoking cessation programmes.

Most women expressed surprise that their midwife had not made a bigger deal of their smoking and been more assertive about them quitting. However, the small number of women whose midwife had emphasised the need for them to stop smoking reported feeling chastised and nagged rather than interpreting it as someone taking an interest in protecting their health and the health of their baby.

Midwives also commented that, in assisting women who want to quit, it can be challenging to find the balance between saying and doing enough to motivate behaviour change while not adversely affecting the long-term relationship by being perceived as pushy. In particular, midwives whose caseload included women from a different cultural and/or socio-economic group to themselves felt the need for caution with smoking cessation issues, with most admitting to a very conservative approach. Because of the difficulty finding a balance, all midwives stated that they tend to focus – at least during the first visit – on encouraging and assisting the woman to reduce her smoking rather than quitting altogether.

Women reported that, during the GP visit where their pregnancy had been confirmed, there had been very little discussion about smoking, some being surprised that the GP had not even asked them if they smoked. GPs said that, because they typically have limited contact with pregnant women after the visit where the pregnancy is confirmed – and also because appointment times are so brief - they consider their opportunity to influence pregnant smokers' behaviour to be limited and therefore tend to spend the limited time on other issues.

### **3. The Decision to Use the Quitline**

#### ***A. Perceptions of Alternative Cessation Aids***

Of the ten non-Quitline callers interviewed, four had used **Smokechange**. In addition, one Quitline caller had also used Smokechange (after not receiving any follow-up from the Quitline).



Appeals of the programme included:

- informative and motivating initial home visit using a range of visual materials;
- option of home visits – perceived to build rapport, provide regular support and frequent reminders of quitting strategies, and ensure appointments are kept;
- consistent Smokechange staff member throughout, allowing rapport to be established;
- Smokechange staff provide supplies of free NRT as part of the initial and follow-up visits;
- cessation support is also available to partners; and
- midwives receive regular feedback from Smokechange on the women's quit status.

However, all non-Quitline callers who had used Smokechange reported that they had relapsed. Those who had relapsed once their baby was born attributed this, at least in part, to insufficient post-natal follow-up. Smokechange generally provides clients with one post-natal follow-up (generally at around four to six weeks). Both participants reported that they were still quit at the time of this follow-up.

Of the ten non-Quitline callers, five had attempted to quit by going 'cold turkey'. The key appeal was the perceived sense of personal achievement. Getting it 'over and done with quickly' also appealed. Quitting 'cold turkey' is also free, and doesn't involve the use of NRT.

However, the key drawback of going 'cold turkey' is that it requires considerable self-control. Smokers often find this very difficult, particularly if they are unable to remove themselves from other smokers. Participants also reported that the symptoms of withdrawal experienced via 'cold turkey' can be very intense – and without adequate support and personal willpower, can be very difficult to endure, particularly when coupled with the physical and emotional challenges of pregnancy.

## **B. Decision to Use the Quitline**

Awareness of the Quitline was high, including among those who had not called. Awareness was derived from a range of sources, predominantly television advertising, advertising on cigarette packets, and friends and family who had registered with the Quitline.

The advice of health professionals, encouragement from non-smoking partners and family members, and positive recommendations from those who had registered were key influences on the decision to call.

Most health professionals said that they advise pregnant women who are smoking of the need for them to quit or cut down. With the exception of those who referred women on to Smokechange and one community midwife who reported difficulties accessing smoking cessation information within the hospital environment, all reported that they provided women with information about the Quitline, although, in some cases, this was just a card with the Quitline number.

While not all Quitline callers told their partner and family that they were considering using the service (fearing they would be criticised for not being able to quit on their own), those who had said that partners and family were very positive and encouraging about their decision.

Some Quitline callers reported being uncertain and nervous about making the initial call, being concerned about embarrassing questions or being made to feel guilty. Reassurances from family and friends already registered with Quitline about the ease of answering the questions and the encouraging, non-judgemental manner of the Quit Advisors were significant influences for some.

Despite these influences, barriers to the use of the Quitline (listed by frequency of mention) include:

- uncertainty as to the relevance of the service for pregnant women, given its perceived emphasis on the use of NRT;
- poor previous experience using the Quitline, particularly dissatisfaction with a lack of pregnancy-specific information and support received;
- perception that quitting 'cold turkey' is the healthiest quit option for baby;
- lack of recommendation from health professionals, due to a lack of time, lack of information and/or greater awareness of alternative programmes;
- too lazy to call;
- fear of being judged by the Quit Advisor for being pregnant and smoking;
- language barrier, particularly for Pacific, Indian and Asian women;
- lack of a telephone;
- lack of awareness of whether the Quitline can be contacted outside working hours; and
- concerns about confidentiality and who will have access to their personal information.

#### 4. The Quitline Experience

**Positive aspects** of the Quitline experience include:

##### 1. *Accessibility*

- The service uses a (free) 0800 number and can be accessed from a cellphone.
- Locating the 0800 number is easy as it is found on cigarette packets and/or the advertisement on television.
- Some Quit Advisors offer their extension numbers.

##### 2. *Understanding The Caller*

- Quit Advisors are non-judgemental, very friendly, easy to talk to, come across as open and positive, and are appropriately enthusiastic and encouraging.
- Callers are dealt with respectfully/as equals.
- Quit Advisors speak empathetically about the struggles of quitting.
- Callers are treated as individuals, not as numbers.

### 3. *Providing Appropriate, Effective Support*

- Quit Advisors are knowledgeable.
- The availability of on-going support is positively received.
- Being re-contacted by Quit Advisors is considered an additional motivation to quit and stay quit. The reliability of Quit Advisors keeping their promises by re-contacting callers is significant in building trust in the relationship.
- The cost of the patches and gum are subsidised.

**Drawbacks** of the Quitline experience include:

#### 1. *Accessibility*

- Participants perceive that Quitline registrations can only be made by telephone, this being considered a significant barrier to those without telephones.

#### 2. *Understanding The Caller*

- Participants familiar with the Smokechange programme feel that the lack of opportunity for face-to-face interaction with Quit Advisors reduces their ability to build rapport.
- Lack of female Quit Advisors.

#### 3. *Providing Appropriate, Effective Support*

- Long registration interview.
- Lack of follow-up from the Quitline for some participants – exchange cards not received as promised, no follow-up telephone calls.
- Insufficient information provided about NRT, both by Quit Advisors and as part of the Quit Pack.

## 5. **Perceptions of Nicotine Replacement Therapies**

There is considerable confusion around the safe use of NRT ante- and post-natally, among both pregnant women and health professionals. This confusion is a strong barrier to quitting, with women who perceive that NRT is inappropriate for them feeling helpless at the thought of having to quit without this support.

About half the women interviewed perceived that the small doses of nicotine received through NRT were less detrimental than the other harmful chemicals inhaled when smoking tobacco. In contrast however, younger and provincial women were of the view that NRT provided high doses of nicotine at uncontrolled levels in comparison to smoking cigarettes in a controlled way. They therefore perceived that NRT was more risky than smoking.

Packaging which warns that patches/gum should not be used by those who are pregnant or breastfeeding is a key barrier to use of NRT. This acts as a very strong deterrent to the use of NRT, despite reassurances from Quit Advisors.

The perceived vagueness of some Quit Advisors' responses when questioned about whether NRT can be used during pregnancy further discourages use. The negative side-effects women had experienced when using NRT during previous quit attempts also acted as a barrier to use during pregnancy. These women felt that the side effects of the NRT (nausea, dizziness, nightmares), coupled with pregnancy-related complications such as morning sickness and light-headedness would be too taxing on them and their baby.

As a result of their concerns, some of the women who had received NRT exchange cards (Quitline) or the patches or gum themselves (Smokechange) reported that they never actually used them, whilst others delayed their use for some time, hoping that they would be able to quit alone. The success of NRT was mixed, with participants reporting patches not sufficiently addressing the need for them to do something with their hands or have something in their mouth, while the ash-y taste of the gum was a deterrent to use for some and actually encouraged others to want to smoke more.

Health professionals reported that there was insufficient information available about the appropriateness of NRT for pregnant and breastfeeding women. This, combined with a preference to err on the side of caution, resulted in health professionals generally believing that cold turkey was the best quitting option for pregnant women. GPs in particular recommend this method to their patients over NRT based smoking cessation services.

## **6. Enhancing Pregnant Women's Access to, and Use of, the Quitline**

While those who have used Quitline are very positive about the service provided, the research suggests that more could be done to enhance awareness and use (thereby increasing the number of pregnant women registering) and also expanding the types of support offered (in order to maximise successful outcomes).

### **Awareness and access to the Quitline can be enhanced through:**

- raising awareness of the specific negative health implications of smoking during pregnancy, ideally through television advertising. A combination of graphic images, appeals to the emotions of the woman and showing the positive effects of quitting for both mother and baby is likely to be most successful in educating the woman and motivating a desire to quit;
- raising awareness of the possible use of NRT by pregnant women, thereby reducing the fear of having to 'go it alone' when quitting, and positioning the Quitline as a feasible support option for those wanting to quit;
- depicting the Quitline as a smoking cessation service that is relevant to pregnant women, ideally through featuring pregnant women in advertisements;

- raising health professionals' awareness of what the Quitline entails through the provision of training days/seminars. To be most successful, these training sessions should focus on the practicalities of the service (rather than the background and philosophy) so that health professionals can respond to pregnant smokers' queries with confidence;
- incorporating an option for health professionals to refer consenting pregnant women; and
- the provision of bi-lingual Quit Advisors.

Suggestions for expanding the **types of support** offered by the Quitline include:

- tailoring the service to address the unique barriers to quitting faced by pregnant women (see below for suggestions);
- enhancing the range of Quitline touch points available, including the introduction of chat rooms/message boards for pregnant women, text messaging and a multi-lingual service;
- enhancing links with health professionals through the provision of regular feedback on the quit status of patients and support provided;
- establishing local support groups for pregnant women and a local Quitline office; and
- enhancing the role of health professionals in smoking cessation support, through the provision of education resources (including post-natal information and advice), a designated Quit Advisor and offering more smoking cessation training.

## 7. Conclusions and Recommendations

The following conclusions can be drawn from the research:

1. While a desire to minimise the health risks of the unborn baby is the key motivator to quitting among pre-natal maternal smokers, the actual risks to the baby are poorly understood. In some cases, this has resulted in smokers playing down the risks to justify their decision not to quit or, more concerningly, has led to some risks being mistakenly regarded as benefits. The reasons why quitting during pregnancy is beneficial need to be clearly established. This could be achieved through:

- television advertising/'advertorials' featuring pregnancy case studies;
- more resources (booklets, posters, DVDs, wallet cards) to support health professionals; and
- more pregnancy-specific resources included in Quit Packs.

2. There is a very poor understanding of the appropriateness of the use of NRT during pregnancy and when breastfeeding among both pre-natal maternal smokers and health professionals. Furthermore, because the use of NRT is perceived as a core component of the Quitline, there is a perception that the service is not appropriate for pregnant women. This suggests a need to provide more information about the safe use of NRT.

This could be achieved through:

- more information made available to health professionals (through training days for midwives and practice nurses, and in GPs' industry magazines);
- Quit Advisors being more confident when informing pregnant women about use of NRT and having sufficient knowledge to address their concerns; and
- reconciling the conflict between the information Quit Advisors provide to callers (that NRT is okay to use when pregnant) and the warnings on the NRT packaging (that NRT should not be used when pregnant).

3. A strong attitude exists among pregnant smokers, their social circle and health professionals that pregnant women 'should be able to do it alone', that the fact that a woman is pregnant should be sufficient motivation alone. The lack of cessation support women receive from their social circle – particularly their partner – results in them either choosing to isolate themselves from their social context and quitting, or fearing this isolation, continuing to smoke. A pregnant woman who may already be feeling isolated, risks exacerbating these circumstances by quitting and/or feels weak and lonely because she can't quit.

These findings point to the need for health risk education and cessation support to the smoking partner, family and friends of the pregnant smoker. A programme of social marketing which emphasised the ways in which people around pregnant women could and should support their decision to quit would be valuable, providing positive reinforcement of a non-smoking environment for women and their babies. Such a programme should emphasise that the responsibility for quitting is a shared one and help women to accept that it is okay both to get and to expect help.

4. There is not a strong culture of encouraging quitting in health circles. This can be complicated, especially in circumstances where there may be other perceived threats to the woman and her baby which are seen as more significant than smoking. Nevertheless, health professionals working with ante-natal and post-natal smokers need more support, resources and guidance about when to give smoking cessation advice and support, and how this can be most successfully achieved. The research suggests that there is much more potential in the role of all health professionals – GPs ('planting the seeds of quitting' by notifying of the health risks of smoking and referring those who express an early interest in quitting, then following up on quit status and offering further support at the baby's six-week health check), practice nurses (further explaining the health risks of smoking, ideally through the use of culturally and age-specific resources, making referrals and following up on progress one or two weeks after visit) and midwives (recommending referrals to cessation programmes, monitoring of quit status at each visit, offering advice and support to deal with barriers to quitting such as stress and boredom and ensuring the home and car remain smoke-free as a minimum).

5. The fact that pregnant smokers' key motivation for quitting is unique, and that many of the barriers to quitting smoking are heightened due to the physical, emotional and lifestyle changes associated with pregnancy, suggests the need for pregnant smokers to be treated as a special client group by the Quitline. Examples of how this might be achieved include:

- offering specialist 'maternity' Quit Advisors;
- an option for Quit Advisors to make home visits;
- an option for cessation support to be offered to others in the woman's social circle, particularly those living in the same household;
- offering comprehensive post-natal support; and
- greater tailoring of the Quit Pack to the needs and circumstances of pregnant smokers, including more information about the negative effects of smoking on unborn and newborn babies, the relative benefits and/or lower level risks of NRT and the inclusion of success stories of other pregnant smokers.

In summary, enhancing pregnant women's awareness and use of the Quitline through a social marketing campaign should consist of three key strands:

1. **Environment and context for the women** – using social marketing to improve support for pregnant women to quit and to make it clearly a shared responsibility, paired with increased support and education to health professionals.
2. **Awareness of appropriateness of Quitline** – while awareness of the Quitline itself is high, there is a need to promote the service's appropriateness for pregnant women, including addressing the appropriateness of NRT or at least its merits relative to smoking;
3. **Service delivery** - developing specific treatments and resources for pregnant women such as support groups, specialist Quit Advisors and pregnancy-specific Quit Packs.

The first two strands should be targeted at pregnant women, the pregnant women's social circle and at health professionals. The third strand is predominantly internal, but also should consider the three target groups independently.

# 1. Introduction and Research Objectives

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## 1.1. Introduction

While the percentage of pregnant women registering with the Quitline has increased since 2001, the overall proportion of callers who are pregnant is low. In 2005, only 2.5 percent of callers were pregnant<sup>3</sup>. The current situation is of concern to The Quit Group. Smoking during pregnancy is a priority issue in public health and the potential for the Quitline to play a more significant role in assisting pregnant women to quit smoking is recognised.

## 1.2. Research Objectives

The Quit Group has commissioned research to understand how the Quitline could better work with pregnant callers and attract more pregnant women to use the service for support and advice. The following research objectives have been established by The Quit Group.

1. Explore the barriers and motivations for quitting and any resistance to using Quitline during pregnancy.
2. Explore expectations and experiences of pregnant women of the Quitline service.
3. Investigate views of GPs and midwives about Quitline and why they would or wouldn't refer pregnant women to Quitline.
4. Investigate perceptions of NRT use during pregnancy among women and health professionals.

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<sup>3</sup> Li, J. & Grigg, M. (2007). Changes in characteristics of New Zealand Quitline callers between 2001 and 2005. *NZMJ* 15 June 2007, Vol 120 No 1256. <http://www.nzma.org.nz/journal/120-1256/2584/>



## 2. Methodology

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### 2.1. Research Approach

A qualitative methodology was adopted for this research. Qualitative research involves talking to people in depth, and provides an understanding of the attitudes, perceptions, emotions and motivations that drive people's behaviour. For exploratory work such as this, qualitative research also provides an open forum where participants can raise issues the client or researcher may not have considered. The aim of qualitative research is not to represent the population of clients, but to identify and understand issues in depth.

The findings presented in this report were obtained from a series of semi-structured face-to-face interviews with pregnant women (Quitline callers and non-callers), those who have recently given birth (Quitline callers and non-callers) and health professionals who have contact with pregnant women and who can potentially refer pregnant women to the Quitline.

In-depth interviews were chosen as the primary qualitative methodology for consultation with all stakeholder groups. In-depth interviews offered a number of advantages to this research, including:

- The use of one-on-one consultation gave greater scope and flexibility to the interviewer, allowing them to tailor the discussion to the particular demographic characteristics, smoking behaviour, background and experiences of each participant;
- It is likely that participants felt freer to express their true feelings about quitting smoking and the Quitline than they would have in a group situation, particularly if they were embarrassed about their inability – or lack of desire – to quit smoking despite being pregnant;
- In a one-on-one environment, there is less risk the discussion will be dominated by the most articulate participants;
- The phenomenon of “group-think” is eliminated. This occurs when a group's desire for consensus overrides the critical evaluation of unusual or unpopular views and opinions expressed. In research such as this, it is essential the full breadth of attitudes and opinions are raised and discussed;
- From the participants' perspective, in-depth interviews are more convenient as they are conducted in a familiar environment (generally in their own home or office), and take less time than a focus group. This convenience was particularly important for health professionals, pregnant women in their third trimester and those who had recently given birth; and
- Participant confidentiality can be assured.

To build rapport with participants, to understand more about their home/working environment, and also to give a greater sense of professionalism (particularly in the case of health professionals), as many interviews as possible were conducted face-to-face.

## 2.2. Sample

Three stakeholder groups were included in the research:

### ***Currently/Recently Pregnant Women Who Have Called the Quitline***

Eight semi-structured interviews were conducted with a purposefully selected sample of currently or recently pregnant<sup>4</sup> women who smoked and who called the Quitline at some stage during, or no earlier than three months before, their pregnancy.

The Quit Group provided contact and relevant other details of all pregnant women who had called the Quitline since March 2007. As far as possible, potential participants were purposefully selected to ensure a mix by ethnicity, age, residential location, pregnancy and smoking status.

Given the success of the prior notification postcards used in the Quitline longitudinal survey, Gravitas sent a letter to all eligible participants explaining the objectives of the research, informed consent provisions and the likelihood of being contacted about participation. Gravitas then followed up selected participants by telephone seeking their participation. Those agreeing to participate in an interview received a letter confirming all interview details.

### ***Currently/Recently Pregnant Women Who Have Not Called the Quitline***

Ten semi-structured interviews were conducted with a purposefully selected sample of pregnant women who smoked and who had not called the Quitline during their pregnancy or up to three months prior. Potential participants were sourced via a range of means:

#### 1. Advertising for Participants on Online Message Boards

Advertisements were placed on a range of parenting and community online message boards, encouraging those who were currently or recently pregnant and who had smoked during their pregnancy or managed to quit, to make contact with the research company. Women identified as living in the three study areas were contacted and taken through a recruitment script to assess their eligibility for the research.

**Six** of the ten non-Quitline callers were sourced this way.

#### 2. Networking and Snowballing through the Pregnant Women Who Had Called the Quitline

This approach utilised the personal connections of those who had called the Quitline. At the end of their interview, Quitline caller participants were asked to approach anyone they knew with a smoking history who was currently or recently pregnant but who had not used the Quitline, and encourage them to contact Gravitas with a view to participating in the research.

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<sup>4</sup> In the previous six months.

*Note: To thank them for their assistance, Quitline callers recommending non-callers who were eligible and ultimately interviewed received \$30.*

**Three** of the ten non-Quitline callers were sourced this way (each from separate Quitline callers). **One** non-Quitline caller was networked through a Gravitas staff member.

All potential participants were recruited by telephone using a screening questionnaire to achieve purposeful sampling which ensured a mix by age, ethnicity, residential location, pregnancy and smoking status and other cessation support used. Those recruited for an interview received a letter confirming all interview details.

### **Health Professionals**

In a recent study<sup>5</sup>, 80% of surveyed GPs and 78% of surveyed midwives indicated that they would be likely or very likely to refer pregnant women to the Quitline for cessation support. The extent to which the researchers sought qualitative explanations or reasons for referral practices is unclear from the reported findings from the study.

To understand more about pregnant women's barriers and motivations to quitting smoking and the current smoking cessation support and referral practices of health professionals, 10 interviews were conducted with purposefully selected samples of independent midwives (n=4), community midwives (n=2), GPs (n=2<sup>6</sup>) and practice nurses (n=2).

Five of the health professionals were identified through 'cold calling' of GPs and midwives listed in a range of online databases. A further two participants (one GP and one midwife) were identified through personal contacts of the Gravitas executive interviewing team, while the final three were networked through the professional and/or personal connections of health professionals already interviewed.

The pre and post-selection process for all health professional groups was the same as for the other participant groups (i.e. prior letter of introduction and endorsement, telephone follow-up by Gravitas, confirmation letter).

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<sup>5</sup> Glover, M. Paynter, J. Bullen, C. & Kristensen, K. (2008). Supporting pregnant women to quit smoking: postal survey of New Zealand general practitioners and midwives' smoking cessation knowledge and practices. NZMJ 14 March 2008, Vol 121 No 1270.

<sup>6</sup> Note that it was initially intended to include five GPs in the research. However, early research findings suggested that midwives have a considerably longer and more intimate relationship with pregnant women than GPs do – and therefore more opportunity to influence smoking behaviour. Consequently it was decided to decrease the number of GP interviews in favour of more interviews with midwives (and also to allow adequate coverage of both independent and community midwives). In addition, GPs tended to be reluctant to participate in the research. Some stated that they were too busy. However, others felt that they would have nothing to contribute to the research, that because they tended to only see pregnant women to confirm their pregnancy before they moved on to be cared for by their midwife, and because their appointment times were so brief, they felt that they did not have a role in smoking cessation.

## Sample Profile

Tables 2.1 and 2.2 provide a profile of the three stakeholder groups.

**Table 2.1: Sample Profile of Currently/Recently Pregnant Women**

	Quitline Callers (n=8)	Non-Quitline Callers (n=10)
<b>Location</b>		
Auckland	4	6
Bay of Plenty	2	2
Canterbury	2	2
<b>Age</b>		
Younger than 20 years	1	3
20-29 years	4	5
30-39 years	3	2
40 years or over	0	0
<b>Ethnicity</b>		
New Zealand European	3	6
Maori	3	2
Pacific Peoples	2	2
<b>Pregnancy Status At Time Of Interview</b>		
First trimester	0	1
Second trimester	4	1
Third trimester	1	3
Baby younger than three months old	1	1
Baby three to six months old	2	4
<b>Gravidity<sup>7</sup></b>		
Primigravid <sup>8</sup>	4	5
Multigravid <sup>9</sup>	4	5
<b>Smoking Status At Time Of Interview</b>		
Stopped smoking	4	4
Stopped smoking but have started again (during pregnancy)	1	2
Stopped smoking but have started again (after birth)	1	3
Not stopped smoking	2	1

<sup>7</sup> Number of pregnancies a woman has experienced, including her current one.

<sup>8</sup> Woman in her first pregnancy.

<sup>9</sup> More than one pregnancy.

	Quitline Callers (n=8)	Non-Quitline Callers (n=10)
<b>Use of NRT</b>		
NRT Used	5	2
NRT Not Used	3	8
<b>Use of Smoking Cessation Aid<sup>10</sup></b>		
Cold turkey	0	5
Smokechange	1	4
Nothing (not quit)	0	1

**Table 2.1: Sample Profile of Health Professionals**

	Health Professionals (n=10)
<b>Location</b>	
Auckland	6
Bay of Plenty	2
Canterbury	2
<b>Ethnicity</b>	
New Zealand European	7
Other	3
Maori	0
Pacific Peoples	0
<b>Occupation</b>	
Independent mid-wife	4
General Practitioner	2
Community mid-wife	2
Practice nurse	2

## 2.3. Interview Process

Semi-structured topic guides for all participant groups were developed by Gravitas and reviewed and approved by The Quit Group. The topic guides contained both closed and open-ended questions, with structured and unstructured probes used to elicit full and detailed information on all open-ended questions. Appendix One provides copies of the topic guides.

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<sup>10</sup> Other than the Quitline.

Interviews were conducted between the 20<sup>th</sup> of May and the 3<sup>rd</sup> of July 2008. Each interview was conducted at a time and place<sup>11</sup> to suit each participant. Interview lengths range from 30 minutes to one and a half hours. All interviews were audio-taped and later transcribed to assist with data analysis. Given the sensitive nature of the topic, all interviews were conducted by female executive research staff within Gravitas. As part of the recruitment process, Maori and Pacific women were offered the opportunity of being interviewed by a Maori/Pacific researcher.

All women participants were offered a \$50 voucher<sup>12</sup> in recognition of their contribution to the research. In recognition of their contribution, all health professionals were offered \$50 cash, which they could nominate to be donated to a charity of their choice (n=2) or to keep themselves (n=8).

As stated above, as far as was practical, all interviews were conducted face-to-face. However, due to the limited and changeable availability of some health professionals, two of these interviews were conducted by telephone.

## **2.4. Report Structure**

### **Sections Three to Seven: Motivations and Barriers to Quitting and Staying Quit**

Section Three provides a brief overview of the smoking and quitting history of women participants. Sections Four to Seven then outline the motivations and barriers that influence a pregnant woman's decision to quit smoking – the perceived risks to the unborn baby (Section Four), the women's smoking environment and culture (Section Five), the perceived risks to the mother (Section Six) and the role of health professionals (Section Seven).

### **Sections Eight and Nine: Decision To Use The Quitline**

Section Eight explores the strengths and weaknesses of alternative smoking cessation services, programmes and techniques considered and used by participants, while Section Nine discusses the decision process of those who called the Quitline, including their awareness of the service and key influences. Barriers to the use of the Quitline are also outlined.

### **Sections Ten: The Quitline Experience**

This section outlines users' perceptions of the strengths and weaknesses of the Quitline with respect to accessibility, understanding the caller and the provision of appropriate, effective, support.

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<sup>11</sup> All interviews with currently/recently pregnant women were conducted in their own home/current place of residence. In addition, five of the interviews with health professionals were conducted in their own homes. Three were conducted at their places of work while two were conducted via telephone.

<sup>12</sup> A choice of vouchers from The Warehouse, Farmers, Baby Factory and Pumpkin Patch were offered.

**Section Eleven: Perceptions of Nicotine Replacement Therapies**

This section examines women's and health professionals' perceptions of the appropriateness of NRT as a smoking cessation aid for pregnant and breastfeeding women. This section discusses the perceived barriers to the use of NRT as well as the motivations. Pregnant women's actual experience of using NRT is also discussed.

**Section Twelve: Enhancing Pregnant Women's Access To, And Use Of, The Quitline**

This section provides suggestions for how the Quitline can be enhanced to better meet the needs of pregnant women. This section includes suggestions for enhancing the motivation to quit when pregnant, increasing awareness of the Quitline among both pregnant women and health professionals, possible changes to the referral process, greater tailoring of the service to the needs and circumstances of pregnant women, and enhancing the involvement of health professionals.

***A Note On Verbatims***

Throughout this report, the verbatim comments of participants have been provided, to give emphasis to points made and to add colour to the text. It should be noted that, while these comments were made by individual participants, they have been selected as being representative of the general feeling of participants. Each comment has been annotated with the stakeholder group, quit status (where appropriate), ethnicity (where appropriate) and residential location of the participant.

## 3. Smoking and Quitting History

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### 3.1. Smoking History

All participants had started smoking in their teens. Most reported that they had been encouraged to smoke by their friends, with some stating that their decision to start was also motivated by a desire to rebel, particularly against their parents. Others discussed notions of wanting to fit in with their peers and wanting to be ‘seen to be cool’.

### 3.2. Quitting History

Participants in their 20s and 30s generally reported having attempted to quit smoking at least once prior to becoming pregnant. While most women had attempted to quit by going ‘cold turkey’, some had used patches and/or gum (often borrowing from family or friends, rather than having their own prescribed). However, all these women reported negative side effects from NRT (nausea, headaches and light-headedness associated with using patches and the unpleasant taste of gum) and had consequently stopped using these cessation aids. These women tended to blame the ‘failure’ of the NRT for their relapse back to smoking. In addition, for Quitline callers and those using Smokechange (see Section Eight), the negative experience using NRT made them very reluctant to use patches or gum again when trying to quit whilst pregnant:

*“Before [I called] the Quitline, I tried patches but that is no good for me. I got sick, really sick. I got the headache and my whole body ached. I was just really sick so I took them off straight away.”* (Quitline caller – relapsed, Pacific, Canterbury)

*“Oh just the headaches, just the big withdrawal symptoms they go through and dizzy. Feeling dizzy, weak...”* (Quitline caller - quit, Pacific, Bay of Plenty)

Other triggers to starting smoking again, prior to their most recent quit attempt whilst pregnant, included (listed by frequency of mention):

- being around a partner that smokes;
- being around smokers in a social situation e.g. party;
- encountering emotional, financial or social stress;
- routine associations with smoking re-established – e.g. alcohol;
- returning to work and being around smokers;
- weight gain.

*“You always end up going back to it. It was hard because my husband smokes and I could always smell it and I would think ‘I will just have one, just have a half’ and then I am like ‘why bother?’ And my girlfriends smoke and you sit around with friends and smoke and gossip, it’s terrible.”* (Non-Quitline caller – quit, New Zealand European, Auckland)



In contrast, participants in their teens generally tended not to have attempted to quit – or even to have considering quitting – prior to falling pregnant.

### 3.3. Desire to Quit Once Pregnant

Most women agreed that they were more motivated to quit smoking once they found out they were pregnant than they had been on previous attempts. Midwives also felt that the motivators to quitting smoking are perhaps at their strongest during (a wanted) pregnancy (and felt that more should be being done by smoking cessation service providers to exploit this motivation):

*“[Pregnancy is] a process of change for a woman – a change in her relationship, a change in her body, and change in her lifestyle, a change in her future, and at that point that is a really good time [to raise the need to quit smoking]. They are more receptive to suggestion and information.”*  
(Independent midwife – Canterbury)

However, one woman who had quit when pregnant with her first child reported that she was less motivated to quit when she found out she was pregnant again as she had found it so difficult to quit – and stay quit – last time.

### 3.4. Quitting Completely Versus Cutting Down

In almost all cases, participants motivated to quit expressed a desire to quit completely rather than reducing the amount they smoke. Participants were aware that the baby would still be exposed to the adverse effects of tobacco if they just cut down; there would still be a health risk to the baby. Some women also perceived that it would be easier to stop smoking completely than to cut down as, with cutting down, there was still a temptation to smoke:

*“I think it’s harder to cut down in the long run. It’s getting over that mentality. Sometimes it almost makes you smoke more because you think it’s going to be so long until you can have another cigarette, and that can make you more stressed. It is easier in the long run just to stop.”*  
(Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“I just thought, if I go one less a day, then it would make it easier, but it didn’t actually. It just made the whole process harder because I’d look forward to that next cigarette.”* (Non-Quitline caller – not quit, New Zealand European, Auckland)

*“Yeah at first I cut down, I thought I’d cut back and we’ll see how that goes...and then I thought about it a bit more, and thought ‘Bugger it, I’ll ring up and get the patches...”* (Quitline caller - quit, New Zealand European, Bay of Plenty)

### **3.5. Participants' Quit Status**

Eight of the 18 women who participated in the research were still quit at the time of the interview. Four had used the Quitline while a further four had quit by going 'cold turkey'.

Three participants – two of whom had called the Quitline - had not managed to quit – although two were still optimistic that they would be able to quit prior to the birth of their baby (one was in her first trimester and the other in her second). Two of these participants were teenagers while one was in her early 20s. All three were New Zealand European.

Seven of the 18 women who participated in the research had quit at some point during their pregnancy but had relapsed, three of these during their pregnancy and four within three months of the birth of their child. The following sections outline the key triggers to relapse.

## 4. Motivations and Barriers: Risks to the Unborn Baby

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A range of motivations to quit and stay quit were identified by participants, by far the strongest motivator being the desire to minimise health risks to the unborn baby. However, as discussed in this section, a widespread lack of awareness of how smoking actually affects an unborn and newborn baby, and the perceived advances in neo-natal medicine, means that the desire to minimise health risks is not as strong as it could – or should – be.

### 4.1. Motivation: Minimising Health Risks to the Unborn Baby

For almost all women, a desire to minimise the health risks to their baby was the key motivator in their desire to quit smoking:

*“I wanted to give [my children] the best start, make sure they are healthy when they are born.”*  
(Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“I want my baby to have all its fingers. With smoking, my baby could come out asthmatic and have future lung problems and stuff like that and I didn’t want that to happen because it’s my first child.”* (Quitline caller – quit, Maori, Auckland)

*“I couldn’t imagine smoking when you’re pregnant. [Your baby] doesn’t have a choice to smoke. I don’t think you have a right to do that [to your baby]. They say that it’s your body or whatever, but it’s not really because it’s your baby’s as well, a separate person, so you don’t really have the right to inflict that upon them when they are trying to grow.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

*“Every time I hear of people whose children have asthma and have smoked during their pregnancy, I always think that [the smoking] must have had something to do with it. I’d rather not run the risk of thinking that I did them the damage. If [my children] have something wrong with them I want to know that it wasn’t anything that I did.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

Participants who had been working as midwives for ten years or more felt that, over time, the desire to minimise the health risks to the baby had become a stronger motivator to quit, most likely due to women become more aware of the health risks, particularly Sudden Unexpected Death in Infancy (SUDI):

*“[Smoking during pregnancy has] curtailed an awful lot over time. I think women know that it’s not a kosher thing to do, and the ones that do [continue to smoke], they’re guilty. They are very scared of what they might be doing to their babies.”* (Community midwife – Canterbury)

*“I can remember when I first came here [to the hospital] 30 years ago, the women on the wards used to breastfeed and fag at the same time. They used to have ashtrays beside their beds – the women would sit up, plonk the baby on the breast and have a fag. They just didn’t see it as being a health hazard. How times have changed!”* (Community midwife – Canterbury)

Sources of information women were exposed to that emphasised the need to quit smoking to minimise the health risks to their baby included (in order of frequency of mention):

- Family and friends;
- Bounty book (a comprehensive pregnancy resource booklet);
- Lead Maternity Carer – including discussions and the provision of pamphlets;
- Internet;
- Cigarette packets;
- Posters:
- Television programmes (particularly talk shows such as ‘Oprah’)
- Doctor/practice nurse;
- School (health classes, childcare classes);

*“I saw this picture once – it was like a silhouette of a woman and she was smoking, and there’s a picture of this baby in her stomach and the smoke was going directly from her mouth into the baby. That has always stuck in my head – like ‘You’re making the baby smoke as well’. That is what has motivated me to quit for all three of my pregnancies.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

A desire to minimise the health risks to their baby was particularly strong among women who had smoked during a previous pregnancy and attributed their children’s health problems to their smoking:

*“[My first daughter] has respiratory problems, she is more prone to asthma, she has eczema during the summer and things like that and I think it is my fault because I smoked. I don’t know exactly, but maybe if I didn’t smoke she would be a little bit healthier.”* (Quitline caller – quit, Maori, Auckland)

*“I swore after I had him that, if I fell pregnant again, I will not smoke. When he was born his placenta was half dead because of smoking.”* (Non-Quitline caller - quit, New Zealand European, Bay of Plenty)

The desire to minimise the health risks to baby is a particularly strong motivator at three key points during the pregnancy:

- When the pregnancy is first confirmed (particularly if the pregnancy is planned and wanted);
- At the first scan – where the woman gets to see the baby for the first time; and
- Once the woman's belly starts growing/when she starts to show.

*“I think it becomes a lot easier [to quit] after you've had a scan and you can see the baby, or if you're getting a stomach and you can see that you are pregnant. Once you see the baby, it's a lot more real.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“When I had my first scan at eight weeks and I saw my baby for the first time on the screen, I felt really sorry for it. I thought of all the damage I could be doing to her. Then I was like ‘Oh my gosh, I've got a baby, I've got to do right by her’ so that's when I fully stopped and I haven't touched a smoke since.”* (Non-Quitline caller – quit, Maori, Auckland)

## 4.2. Other Aids to Quitting: Having a Definite ‘Relapse’ Date

Some women motivated to quit exclusively by the desire to minimise health risks to their baby reported that they had always intended for their quitting to be temporary, that once the baby was born, they intended to start smoking again. These women reported that, having a definite date when they could start smoking again (that is, the baby's due date) motivated them to stay quit for the duration of the pregnancy:

*“After the first few weeks it was easy [to stay quit]. I didn't have any problem after that, after I got it out of my system. I didn't really think about it again because I knew that, after [the baby] was born, I could light up. I lasted [for the entire pregnancy] but it was never going to be long-term. I couldn't think of a reason why I would want to stop once [the baby] was born. It's an enjoyment thing.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

## 4.3. Barrier: Misperceptions about Health Risks to Unborn Baby

Whilst most participants stated that they wanted to quit ‘for baby’, the research found that, despite what some long-time midwives perceived, most had very limited awareness of the actual effects of smoking on their baby:

*“I wanted to stop smoking for the baby; health-wise I know it was not good for her. I don't really know how exactly the smoking is bad for her, I just know. You just see it on the smoke packets that it's not good.”* (Quitline caller – relapsed, Maori, Auckland)

While awareness that smoking during pregnancy can lead to under-weight/growth-restricted or a premature delivery was high, many were unsure as to what this actually meant for the health and development of the baby.

There was also some awareness that smoking during pregnancy is linked to miscarriage, asthma/respiratory problems, and SUDI but most participants were unsure as to how smoking actually caused or contributed to these conditions:

*“I think you sort of know, at the back of your mind, that [smoking] could do harm. There is premature birth and low birth weight, but I have always believed that surely it can do other things other than that. I am not sure what they are but I assume that there must be something else as well.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

Coupled with this lack of more specific ‘causal’ information is an awareness that growth restriction is not confined to pregnant women who smoke, leaving women to question whether smoking is really to blame. In addition, the perception that, due to advances in neo-natal care, premature babies have relatively few long-term health or development issues, means that protecting the baby’s health is not as strong a motivator to quit for some women as it could be:

*“I don’t exactly want to have either a short pregnancy or a prem. baby, but my sister had a prem. baby but she didn’t smoke, and the baby is as bright as a button now...”* (Quitline caller - not quit, New Zealand European, Canterbury)

*“Most people know that premature babies have a really good chance of survival anyway. They can be born at 24 weeks and still be alright, so I don’t think [the risk of premature birth] is enough to motivate people.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

The lack of visible evidence of the impacts of smoking on a baby’s health, coupled with familial experience also significantly affects the strength of desire to minimise health risks. Younger participants in particular gave examples of family members and friends who had smoked through their pregnancy and who had given birth to what they saw as very healthy babies. For these women, minimising the health risks to their baby was not a strong motivator for quitting:

*“I know other people who have smoked and their babies were fine when they were born.”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“You see all the babies born [to women who smoke] who come across as absolutely fine. It is not like every time you get a smoker, you get this really growth-restricted sick baby. You can’t really see the effects necessarily.”* (Community midwife, Auckland)

*“I said to my friends ‘I am going to quit smoking’ and they were like ‘Oh, it’s okay to smoke when you are pregnant’. My friends were like ‘I smoked during all my kids’ pregnancies and they turned out fine.’ So that’s why I kept on smoking [initially]. I thought it would be all cool.”* (Non-Quitline caller – quit, Maori, Auckland)

In addition, some women are less motivated by a desire to minimise the health risks to their baby as they perceive that they don't smoke enough to cause harm. Midwives noted that, most likely due to embarrassment, women tended to under-report how much they actually smoked and therefore under-estimated the potential harm that they were doing to their baby:

*"I always justify it, you know – it's not like I am smoking a pack a day. I always think 'That sort of stuff [low birth weight, premature birth etc] happens to people who smoke a pack or two a day'. I think 'I only smoke ten or so a day. I'm sure I'll be fine'."* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

*"Women know they shouldn't be smoking so they tend to play it down. They say they don't smoke very much but, when they are honest with themselves, they do really. They always tend to underestimate [how much they smoke] by about 50%. It's actually facing up to how many you smoke because it can be quite a scary thought really."* (Independent midwife – Auckland)

In addition to there being very limited awareness of the actual effects of smoking on unborn babies, midwives commented that there is also a significant variation in women's desire for information about this. Midwives noted that, generally, older and higher socio-economic women were interested in finding out about the impact of smoking on their baby whereas younger (particularly teen) and lower socio-economic women tended to be less so.

### ***Barrier to Staying Quit After Birth: Minimising Health Risks to Baby No Longer a Motivator***

Those women who had relapsed after giving birth reported being of the view that, once having birthed, their contribution to their child's health had been achieved through a process of being quit whilst carrying the child. The sacrificial view of ensuring that the child's health was not placed at risk had been achieved. These women demonstrated little understanding of the harmful effects of second hand smoke and smoking whilst breastfeeding.

*"When I was pregnant, I really think about inside me. If I smoke then the smoke will go inside me and I am not going to do that to my child when I am carrying them. But after I had the baby, now I think 'Nah, it is out, it is fine to smoke'."* (Quitline caller – relapsed, Pacific, Canterbury)

*"I think I may start smoking again after my pregnancy because I'd think 'I don't have a baby inside of me now so I can smoke'. I'll probably be like that. I feel a bit guilty but I think it's realistic."* (Non-Quitline caller – quit, Maori, Auckland)

*"[The women think] 'The baby is a separate entity now. I can go outside and smoke and it's not going to hurt the baby anymore.' They come back in stinking of smoke, pick the baby up, give it a big kiss and stick it on the breast. I think that's so disgusting, but that just doesn't seem to compute. All they see is that the baby is separate from them now."* (Independent midwife – Auckland)

#### 4.4. Barrier: Lack of Ante-Natal Care

Midwives noted that some pregnant women – particularly those that are high risk – do not receive any ante-natal care. Indeed, one community midwife working in South Auckland reported cases of women arriving at the birthing suite in labour, having had no ante-natal care and no allocated LMC. Without ante-natal care, there is very limited opportunity for anyone to inform the pregnant woman of the health risks of smoking during pregnancy or to offer them cessation support and referral advice. Because independent midwifery is bulk funded (that is, midwives receive the same amount per woman, irrespective of the number of appointments and home visits the woman requires), independent midwives state that there is no incentive for them to take on women who have multiple risk factors (alcohol and/or drug problems, poverty, family violence etc) – who are almost always smokers:

*“You would need to spend more time and more energy with these women. You end up getting more call outs because they have reduced immune systems. They have chaotic lifestyles, they are not well nourished, they get sick more often, but we get paid a set fee to look after them. It doesn't matter whether you see them 10 times or 20 times in their pregnancy. Those women that are high risk – who are usually always smokers – are often not particularly welcome to a lot of midwives. You wouldn't want a whole case load of women like that – you would go nuts. So when you do get the phone calls from people, you are screening them just to see whether or not they are going to be a huge problem to look after. Because of that, there is a chance [that they will fall through the system].”* (Independent midwife – Canterbury)

Midwives also note that women who have had dealings with Child, Youth and Family tend to avoid nominating an LMC as they dislike having someone screening them in an ongoing way and monitoring their health problems and social issues. Consequently, these women tend to have limited opportunity to receive information on the health effects of smoking and cessation advice and support.

#### 4.5. Barrier: Perceived Positive Impacts of Smoking on Childbirth

The antithesis of being motivated to quit by a desire to minimise the health risks to the baby was a perception among some women that smoking can actually aid their pregnancy, particularly the experience of childbirth. Two women participants and at least two midwives reported cases of women, aware that smoking during pregnancy can result in growth-restricted babies, had continued to smoke throughout their pregnancy, believing that it would be less painful to give birth to a small baby:

*“My friend smokes a lot and when she is pregnant, she smokes more because she reckons that she wants to keep the birth weight down. I mean, if you think about it, why wouldn't you do what you can to make the baby small?”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)



*“Women will say [Smoking during pregnancy] means my baby doesn’t grow as big’ and they say ‘Oh well, that’s better because I’d hate to push out a big baby.”* (Independent midwife – Auckland)

One further participant perceived that, nowadays, children born prematurely appear to have few developmental problems and therefore suggested that there may be some benefits to having a premature birth:

*“[With a premature birth], it’s like ‘sweet, I get a shorter pregnancy and I get to go home and leave my baby in the hospital and get some good sleep.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

In addition, two participants who had continued to smoke through their pregnancies reported that they had been reluctant to quit as they had been told (by friends and family) that if they stopped smoking part-way through their pregnancy, the baby would be born with nicotine cravings. One further participant who described themselves as being quit reported having the occasional cigarette in order to avoid stressing the baby:

*“I don’t know how true it is, but I remember reading in a lot of places that they don’t like you to give up; they would rather you cut down. I don’t know how true that is, but they say that [giving up] stresses the baby and stresses you.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“I had [a cigarette] a few weeks ago when I was really stressed. My doctor told me ‘if you ever feel like a cigarette when you are pregnant, it is better to have one or at least attempt to have one because you are going to stress your baby out more if you sit there thinking ‘I want a cigarette, I want a cigarette’. It is going to increase your blood pressure and everything else.”* (Non-Quitline caller – quit, New Zealand European, Auckland)

## **4.6. Barrier: Characteristics of the Pregnancy**

### ***The Length of the Pregnancy***

For a small number of pregnant participants, their goal seemed to be to stop smoking by the time the baby was born, and consequently they believed that they had eight to nine months to cut down and ultimately quit. Where these participants were in their first or second trimester, there was little sense of urgency around quitting, and a lack of commitment to any cessation aid, including the Quitline:

*“It’s not too late for me to stop smoking. My doctor says it is not too late. I am only four and a half months’ pregnant so I’ve got about five months to go. I’ve got all that time to quit so I am reading a few books about stopping smoking ...”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“Some of [the pregnant smokers] will be a bit shocked when I talk to them about quitting. Some of them are surprised that they really have to start [quitting] at such an early stage, like as soon as they find out [they are pregnant]. Some of them will say ‘maybe in two or three months I will look at stopping or cutting down.’” (Practice nurse – Auckland)*

### **Unexpected Pregnancy**

Some participants, aware of the health implications for the baby and themselves of smoking during pregnancy, reported that their intention had been to quit smoking prior to getting pregnant. However, in a small number of cases, participants reported that they had fallen pregnant unexpectedly – and in one case, the pregnancy was not confirmed until relatively late in the first trimester. These participants questioned the value of trying to quit once they had fallen pregnant, suggesting that *“much of the damage had already been done”* and that it was *“probably too late”* to take any action to positively influence the health of the baby:

*“My doctor asked me if I was smoking. He said ‘You should stop now before you get pregnant’. It was quite hard for me to stop and then, when I did get pregnant, well it was really too late. The pregnancy was planned but unexpected and because I thought I wasn’t pregnant, I kept on smoking when I should have actually stopped. By the time they confirmed it, it was too late.” (Quitline caller – not quit, New Zealand European, Canterbury)*

### **Unwanted Pregnancy**

Health professionals note that, where a pregnancy is unwanted, it can be difficult to get the woman to consider the health of the baby and stop smoking, both because the woman often does not care about the baby’s health (at least initially) and also because they tend to be dealing with so many other issues at the same time:

*“I think it’s presumptuous to assume that it’s instantly a wanted pregnancy and that the mother is instantly concerned about the baby and the baby’s health. Some of these women are absolutely miserable when they find out they are pregnant.” (Community midwife, Auckland)*

*“[When I first found out I was pregnant] I thought ‘I hate this. I don’t want to be pregnant and I didn’t really care about the baby.’ I just felt so sick [with morning sickness] and I didn’t care about the baby so I just kept smoking.” (Non-Quitline caller – quit, Maori, Auckland)*

Midwives note that, for these women, attempts to encourage quitting early on in the pregnancy (for example, by a GP at the visit where the pregnancy is confirmed) are generally futile as the woman is often still struggling to come to terms with being pregnant and deciding whether to keep the baby.

## 5. Motivations and Barriers: Social Factors – The Smoking Environment and Culture

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While a pregnant woman's social circle may express a desire for her to quit, if this expression is not backed up with support then there appears to be little actual motivation – or ability – to quit. Thus, lack of support from the woman's social circle – and an inability and/or unwillingness to distance oneself from this social circle if it is unsupportive – is a significant barrier to quitting. This section discusses this in more detail.

### 5.1. Motivation: Social Influences on Woman to Quit

All women interviewed were conscious of the social stigma associated with smoking when pregnant. However, the extent to which this was actually a motivator to quitting varied between women, with New Zealand European and older women most likely to feel the pressure to conform with societal norms:

*“Everyone puts the pressure on you when you are smoking while pregnant. I just felt I was getting it from everyone.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

*“You hear it from everybody and you read it everywhere and everyone is advertising that it is wrong. I just didn't want to hear about all the stuff that [smoking] does.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

Women were influenced to quit by their social contacts. In some instances this was expressed (and felt by the woman) as enthusiastic encouragement and in other cases expressed more as (negative) pressure.

Most women participating in the research reported that their partner also smoked. However, where the partner was a non-smoker, they were often said to be anxious for the woman to quit. These women felt that the strength with which their partners expressed their views about smoking was both appropriate and very influential, particularly as they were aware that the partner was motivated by a genuine desire to protect the baby and the mother:

*“My partner always says to me ‘You are killing my baby right in front of my eyes’ and stuff like that. It is quite full on but it has got through to me. I don't take offence because I know that he is being protective of the baby rather than growling at me. If you tell me things straight, I will take it on board a lot easier.”* (Quitline caller – quit, Maori, Auckland)

Other participants reported being similarly influenced by close friends:

*“It was actually one night I was out with friends and I had a cigarette and they told me in no uncertain terms how they felt about me having a cigarette when I was pregnant. That is what did it for me in the end. I felt pretty bad after that actually.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

Others were influenced by other family members:

*“My parents were very encouraging. I would have been very frightened if I had continued smoking actually. There wasn’t even a question of whether I was going to quit or not.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

*“When I came to my sister’s house to stay here, I wasn’t allowed to live here unless I stopped smoking. I remember her telling me that. My sister kept saying ‘Your baby might get Down’s Syndrome’ or something like that’ and I couldn’t handle looking after a Down’s Syndrome baby. My sister just kept on making me feel guilty about harming the baby.”* (Non-Quitline caller – quit, Maori, Auckland)

One Quitline caller participant reported that, when she told her parents that she was pregnant, her father who had smoked for 30 years, agreed to quit smoking if she did. At the time of the interview (29 weeks into the woman’s pregnancy), the father was still quit. The woman reported having been inspired by her father’s will-power and used this as motivation to stay quit herself.

Women who had given birth before reported that their other children were a strong motivator to quit. These participants reported being motivated by the disparaging comments their children made about their parents’ smoking. Others reported being concerned about seeing their children imitating their smoking behaviours – for example, holding crayons like cigarettes. Finally, women were aware that, because they were conscious of keeping their house smoke-free, time spent smoking was time away from their children. Quitting was therefore seen as an opportunity to spend more quality time with the children, particularly before the baby arrived.

Nevertheless, while the active encouragement/pressure from the woman’s family and social circle was a motivator to quit completely for some, a small group of participants reported becoming an ‘at home in private pregnant smoker’ as a coping mechanism – that is, letting their family and social circle think that they have quit or not admitting that they have relapsed, whilst continuing to smoke when at home.

*“I knew that my daughter would be gutted and I’d get up at six in the morning and go outside and have a quick smoke. And then just drown myself in spray, shower, brush the teeth until one day I felt the nerve to smoke in front of them.”* (Quitline caller - quit, New Zealand European, Bay of Plenty)

## 5.2. Other Aids To Quitting

Participants reported that, whilst not motivators in themselves, having their partner attempt to quit, and receiving positive reinforcements from their social circle assisted them in quitting and in some cases, staying quit.

### ***Partner Also Attempting To Quit***

Very few participants reported that their partner had attempted to quit smoking during their pregnancy. However, where the partner had attempted to quit (generally occurring early in the pregnancy), women reported that it had been relatively easy to quit too, and to stay quit, due to there being no cigarettes in the house, and no smell of cigarette smoke. Being able to support and have empathy with one another was also a key aid in staying quit.

*“[My partner] cut back. The patches really worked for him. If he put the patches on, he can go without a cigarette all day – and that makes me go without a cigarette too.”* (Quitline caller – relapsed, Pacific, Canterbury)

However, in all cases, the women reported that their partners had been unable to stay quit for the duration of the pregnancy, and the re-introduction of cigarettes (and cigarette smoke) into the house then became a barrier to them staying quit themselves.

### ***Positive Reinforcement From Social Circle***

Younger participants with close ties to their family who had managed to quit reported that they had received a lot of positive reinforcement from family members (particularly non-smokers). One participant felt that her family treated her with more respect since she quit – and this had motivated her to stay quit:

*“[My family] look at me different now. Before they used to think I was a useless girl smoking and stuff, but now they look at me like this open person who is healthy and outgoing.”* (Quitline caller – quit, Maori, Auckland )

*“When I told [my four year old daughter] I stopped smoking, she would come around the corner and follow me and be like ‘You are not allowed to do that.’ She would say ‘No smoking Mum’. She would always be on my back about it. I slipped up a couple of times and she would say ‘No smoking Mum’.”* (Quitline caller – quit, Maori, Auckland)

Other participants discussed their social circle giving respect to their decision to quit, making adjustments to their own smoking in the presence of the pregnant woman.

*“When [my friends] pull out a packet of smokes and I ask for one, they won’t give me one now.”* (Non-Quitline caller – quit, Maori, Auckland)

*“Like me and my sister we are the only smokers in our family, and she lives next door and she always used to come here, and me and her would sit there and have a smoke. Since I’ve given up she hasn’t come over here for smokes anymore.”* (Quitline caller - quit, Pacific, Bay of Plenty)

### **5.3. Barrier: Lack of Support from Social Circle**

#### ***Lack of Support from Partner***

Around half of participants stated that, once they found out they were pregnant, their partner had either asked them, or told them, to quit smoking. However, in almost all cases where the partner was a smoker themselves, it was a case of ‘do as I say, not as I do’ with very few making any real attempt to support the pregnant woman by quitting smoking themselves or even not smoking in front of their partner:

*“[My partner] tells me off for smoking – ‘You shouldn’t be smoking’ – He says it’s all right for him [to smoke] because he is not pregnant but he wants me to quit for the baby.”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“When we both gave up, there was no tobacco and we weren’t buying any so there was no temptation around. [But since my husband started smoking again], just having the smell of it around the house ... Since I have had [my baby] I have started smoking again because my husband has been around and I can smell the smoke and the temptation is there.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“Because [my first partner] smoked, it was just too easy to smoke again. It would be ‘Come outside. I am having a smoke. You don’t have to smoke but come out with me’ then ‘Do you want a puff?’”* (Quitline caller – quit, Maori, Auckland)

*“I said to my partner ‘We should try and give up smoking’ and I said ‘No more smoking in my car’ but he doesn’t listen. I said ‘I want to try and give up smoking now that I am pregnant’ and he said ‘That’s good’ and then lit up a smoke. He said ‘I should try and give up smoking too’ then lit up another smoke.”* (Quitline caller – relapsed, Maori, Auckland)

The other participants reported that their partner had left them to it with regards to their quitting decision. For the most part, these participants commented that they would have liked their partners to be more involved in their quitting decision and to take more responsibility for helping the woman quit and stay quit (ideally quitting himself, but even not smoking around the woman, or removing all cigarettes from view).

### ***Lack of Support from Woman's Mother***

When asked how their extended families had influenced their decision to quit smoking, responses were mixed. Women whose mothers were smokers reported that their mother tended to be reluctant to discourage them from smoking during their pregnancy. In most cases, the mothers had smoked through their own pregnancies, with no reported ill effects on their children. As a result, the women felt their mothers were concerned about appearing hypocritical if they tried to encourage their daughters to quit:

*“I think my parents feel that they can't say a lot because Mum smoked through her pregnancies back in those days.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“I thought it was alright to smoke while I was pregnant because [my mother] did.”* (Non-Quitline caller – not quit, Pacific, Auckland)

### **5.4. Barrier: Inability and Unwillingness to Distance Oneself from Smoking Social Circle**

Participants reported that the most significant barrier to quitting smoking and staying quit was being around other smokers. Some participants reported instances of family or friends actively encouraging them to continue smoking or offering them cigarettes:

*“[My friends] are not really supportive of me [having quit]. They still get me to smoke. They are people who like to go out and drink, smoke, all that kind of stuff and don't get that I am not into that any more.”* (Quitline caller – quit, Maori, Auckland)

Pregnant women discussed smoking as a social behaviour that equated in most cases with friendships with peers. Smoking was discussed as being an activity that occurred over a cup of coffee at home, at work tea breaks and whilst consuming alcohol.

*“Then I just went out partying and there would be one person that doesn't know that you have quit and offers you that one cigarette and that's it.”* (Non-Quitline caller-relapsed, Pacific, Bay of Plenty)

Consequently, choosing to quit smoking was noted as essentially choosing to isolate oneself from established social circles – and in some cases, participants reported that they weren't prepared to do this, or felt that others wouldn't let them. In some cases, notably in rural/provincial areas where social circles were typically limited due to a small population and restricted by income, to establish a non-smoking social circle, women were essentially choosing to relinquish their support and social system for themselves and their baby.

*“When I got pregnant, my partner and I made an agreement to stop smoking, but our neighbours next door, they smoke too and they always come over and want to have a chat and a cigarette. I tried just sitting outside with them but I ended up smoking with them again.”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“I managed to stay off [cigarettes] for four to six weeks after [the baby] was born and then my mother-in-law arrived from England and she smokes. So she and my husband would be out there in the garage having a cigarette and I am sitting in here with the baby, sort of missing out.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“We usually have friends over here, we usually have a big hoo-ha and the music is going and everybody is drinking – except me – and then they start smoking and that is the hardest time. It is incredibly hard to just sit there and be 100% sober and see people smoking.”* (Quitline caller – quit, Maori, Auckland)

Some (particularly older New Zealand European) women reported having been very assertive with their social circle in asking them not to smoke around them:

*“I banned everybody who smokes. I would say ‘You have to go and stand on the driveway, you’re not allowed to smoke on the deck, you are not to smoke around me.’”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

*“I became like a sniffer dog. [My husband] would be outside on the veranda smoking and all the windows would be closed but I would still be able to smell it and I would be like ‘Get off the property!’ Now he goes out in the garage.”* (Non-Quitline caller – quit, New Zealand European, Auckland)

However, most women (particularly Maori, Pacific and younger women) reported that smoking was such an entrenched part of their social circle’s culture that they found it almost impossible to avoid being around smokers:

*“My friends haven’t been too easy to deal with. They know I have stopped smoking, but they don’t try very hard not to do it around me. They still do it around me, or if they go outside to have a smoke, I might go outside to talk to them and they will look at me strangely. Am I supposed to sit inside while you do your little smoking ritual and wait for you to come back? That was the worst thing – I would just sit here and they would all disappear and have a smoke and a chat and leave me behind. I don’t think they realise that it makes me feel left out because they are outside.”* (Quitline caller – quit, Maori, Auckland)

*“The younger ones have a lot of peer pressure I think. They’ve got party stuff going on. I think they are less likely to stand up for themselves and say ‘Hey, I need to look after my baby.’”* (Independent midwife – Bay of Plenty)



*“They think about what they’ll be missing when they stop. I think, if you are in an environment where everybody smokes and you’re the only one not smoking, then it’s very very hard. And for our [lower socio-economic] women, where everyone’s at home all day, that makes it even harder.”*  
(Independent midwife – Auckland)

### **Barrier to Staying Quit After Birth: Influence of Social Circle**

Combined with the fact that they were no longer as motivated by the desire to minimise the health risks to their baby, participants who had managed to stay quit throughout their pregnancy reported that the temptation of their partner smoking was very difficult to resist after the birth:

*“If [my partner] had quit, maybe I wouldn’t have started smoking again after [the birth] because we smoke together generally, at night time. That would have made [staying quit] a lot easier.”*  
(Non-Quitline caller – relapsed, New Zealand European, Auckland)

Relapsed participants reported that, after the birth of their child, they tended to socialise with friends more, whether this be meeting up for coffee (and often a cigarette) or attending parties/social drinking (which is almost always associated with smoking).

### **5.5. Barrier: Guilt Admitting Relapse**

Some participants who had used either Quitline or Smokechange to assist with their quitting reported that, once they had relapsed, they were very reluctant to re-contact the service provider and seek further support as they felt guilty that they hadn’t managed to stay quit despite the often quite comprehensive assistance and support they had received. Those who had used Smokechange were particularly reluctant to seek further support after relapse as they were aware they would have to admit their failure directly to the person who had given them the support – and often with whom they had built a good rapport:

*“I know that I could go back on Smokechange at any stage, but I don’t think I would. It’s like ‘Oh my God, how do I ring up and tell her that I have started smoking again?’ There is a bit of guilt there.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

## 5.6. Barrier: Desensitised Health Professionals

The share of each participant midwife's case load who were smokers ranged from 10% (in rural Canterbury) to 90% (in the Bay of Plenty). Those with a very high proportion of smokers among their case load admitted (albeit regretfully), that they had become somewhat desensitised to the issue of smoking during pregnancy:

*"I think it is quite sad but you sort of get desensitised to it. Unfortunately it becomes quite normal and you just get used to it. You see so many women that smoke that it becomes normal. Now when I see a woman who smokes I don't think 'Shall I address this?' It's more like, if they don't smoke, you go 'Are you sure? Oh, that's great. How refreshing!'"* (Community midwife, Auckland)

*"[My midwife] just said to me 'It's your baby, it's your choice' and left it at that."* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

*"The doctor [who confirmed my pregnancy] didn't say anything [about my smoking]. He didn't say anything about smoking and the harm and danger it could cause. I don't think smoking was even mentioned. He just said I needed to take folic acid, take it easy and not lift things."* (Non-Quitline caller – quit, Maori, Auckland)

Health professionals also noted that the women they dealt with often had a range of other social realities they were dealing with (drinking, drug use, violent relationships, poverty, gang connections etc) and consequently felt it was not realistic to focus predominantly on smoking issues. When asked how they prioritised support for a woman's social realities, health professionals admitted that they would place more priority on addressing a woman's alcohol consumption than her smoking behaviour as they felt the negative impacts of heavy drinking on not only the baby but others in the household, were more impactful:

*"She might be smoking like a chimney and you think 'Oh, that's not good for the baby' but if she's drinking a lot, I would be wondering, 'Is she going to neglect her kids, or what if she drives or is she depressed, or will she be inappropriate with her baby if she is drunk?' To me, that is worse than them being addicted to nicotine."* (Community midwife - Auckland)

*"It depends a lot on their home life and situation. If smoking three cigarettes a day stops them killing their husband or hurting their children, or both ... If it relieves your stress to that degree, then keep doing it. If stopping smoking is going to cause you more stress at home and it's going to impact on the rest of the family in a negative way, then I don't see the point in nagging people to stop."* (Independent midwife – Auckland)

## 6. Motivations and Barriers: Risks to the Mother

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Compared with minimising the health risks to the unborn baby, a desire to minimise risks/yield benefits to the mother was significantly less of a motivator. While improved health, the financial benefits of quitting health and the satisfaction and boost in self-esteem associated with being a positive role model for their children were cited as motivating factors by some women, a concern about weight gain, and the stress and boredom associated with pregnancy and having a baby at home are very strong barriers to quitting and staying quit.

### 6.1. Motivation: Minimising Health Risks to the Mother

Compared with minimising the health risks to the unborn baby, minimising the health risks to the mother was significantly less of a motivator for quitting smoking, being mentioned predominantly by older New Zealand European participants, particularly those who had already had at least one child. Motivators included:

- minimising skin problems, including acne and wrinkles;
- reducing asthma;
- reducing dizziness/light-headedness.

*“I had an asthma attack in the summer, due to the humidity and smoking and pregnancy all rolled into one. I was like ‘Oh God, I have to address this’ so that was a big motivation because I had to lug around a nebuliser with me, including on my honeymoon.”* (Non-Quitline caller – quit, New Zealand European, Auckland)

### 6.2. Motivation: Financial Costs of Smoking

Whilst seldom the key motivator for quitting smoking when pregnant, some participants (particularly those on lower incomes) reported that the financial savings associated with quitting smoking were appealing. These women noted that saving money was more of a motivator to quit when pregnant as they could use the money saved to purchase baby equipment and clothing (that is, they had something positive that they could put the additional money aside for).

*“I am very motivated by money – who isn’t? – and I was like ‘Okay, I’ll be saving \$100 on average a week. I will go and buy baby stuff.’ All the money I spent on cigarettes I spent on the baby.”* (Non-Quitline caller – quit, New Zealand European, Auckland)

Health professionals working with lower socio-economic women (particularly those in South Auckland) reported that they often emphasise the financial benefits as a way to motivate quitting.

However, those women from higher socio-economic backgrounds reported that financial savings were not a significant motivator for them, particularly if their partner was a heavy smoker.

### 6.3. Motivation: Desire to Be a Role Model for Their Children

Whilst no women stated that it had been a motivator for them, some midwives reported that they often try to encourage women to quit by emphasising what a good role model they will be for their children if they are smoke-free. It is reported that this can motivate quitting, and can also have positive benefits for the woman's self-esteem if she manages to quit.

*“Just showing my daughter that I can because unfortunately she started smoking, which grates me.”* (Quitline caller - quit, New Zealand European, Bay of Plenty)

### 6.4. Other Aids to Quitting

#### *Morning Sickness*

Participants who experienced morning sickness during their pregnancy reported that this had significantly assisted them in quitting smoking:

*“With one of my pregnancies, every time I even smelled cigarette smoke it made me feel sick so that made it really easy to give up.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“After the second month I started getting really severe morning sickness but it was like all day sickness, and one day I woke up and if anyone came near me with a cigarette I was like ‘Oh God, get away from me.’ The smell of it was revolting.”* (Non-Quitline caller – quit, New Zealand European, Auckland)

These participants also noted that having morning sickness (and therefore not wanting to – or being able to – eat) reduced their concern that, if they quit smoking, they would put on weight.

*“I was violently ill with morning sickness so I couldn’t keep anything down anyway, What I have put on has been all baby. It has not been excess weight which has been good for me. It is probably the best way to quit actually.”* (Non-Quitline caller – quit, New Zealand European, Auckland)

Those who had used the Quitline or another cessation service and had managed to stay quit throughout their pregnancy, reported that morning sickness had been a useful aid in the early stages of their quitting, reducing their cravings and discouraging them from being around other smokers. These participants reported that, by the time their morning sickness subsided, with the support of the cessation service, they had established new behaviours and routines that helped them stay quit.

In contrast, for those who had attempted to quit without the assistance of a cessation service, the period of morning sickness tended to lull them into a false sense of security, making them believe that they had succeeded in quitting. However, once the morning sickness subsided, they tended to revert to their previous behaviours and started smoking again or increased the amount they were smoking to pre-pregnancy levels.

## 6.5. Barrier: Stress

Participants typically identified stress as one of the main contributors to relapse and/or continuing to smoke.

*“They are scared to stop because they don’t have a lot of coping skills and mechanisms to get through their crises and their daily dramas.”* (Independent midwife – Canterbury)

Causes of stress included:

- poor relationship with partner and/or in-laws/partner’s family;
- financial hardship;
- challenges of raising other children; and
- dealing with other social realities such as alcohol, drug-use, gang violence etc.

*“I don’t think that [smoking during pregnancy] is a good idea but to be honest, if I wasn’t smoking I think I might have lost it. I have had lots of stressful times lately. At my old place I had a flatmate who was into drugs. He was completely insane and stressed me out completely. When I was crying, the only thing that would stop me was a cigarette.”* (Quitline caller – not quit, New Zealand European, Auckland)

*“Well probably back then it was financial matters that were coming up at the time. Being a single mum and trying to juggle work as well as looking after the kids. All of that was playing a big part in it.”* (Quitline caller - quit, Pacific, Bay of Plenty)

*“We’ve got one lady, she is saying she is stressed, mentally stressed. She has got three or four kids and she says that smoking relieves her stress.”* (General Practitioner – Auckland)

Some women reported being hesitant to quit smoking as they were concerned about how it would affect their mood (which were already being adversely influenced by hormones anyway) particularly when they encountered stressful situations. These participants expressed particular concern at how their mood swings might affect their children and partner.

### **Barrier to Staying Quit After Birth - Stress**

For some women, increased stress after the arrival of their baby had caused them to relapse:

*“[My son] had reflux. It was horrible, and I remember my sister came around who is a smoker and she gave me [a cigarette] and after that, it was all over. I remember saying ‘I will only have one’ but I think I knew that once I had one, that was it.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“After I had [my baby] I thought I’d try to stay quit. But the tiredness and the stress of having a newborn baby makes it so easy to start again. And my husband was away working when [the baby] was born until he was seven weeks old and he’d just come home for weekends so I’d be at home by myself with three children. It was terribly tempting to have a cigarette because you nearly go mental.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

*“It is so isolating being at home with a new baby, especially if you have got a baby with high needs or colic or keeps you awake half the night and you get stressed and you are home alone. There is not that extended family situation that there used to be, and if you are stressed then you are more likely to relapse.”* (Independent midwife – Canterbury)

### **6.6. Barrier: Boredom**

Particularly for participants who were not employed outside the home, boredom was a key barrier to quitting smoking.

*“I sit outside a lot with our neighbour having a talk. That’s what we do every morning. If you took that away, I don’t know what we’d do. Smoking takes up a lot of our time and it fills in time. If you’re not doing it, what do you do? You’d end up sitting in here watching TV and staring at the four walls.”* (Quitline caller – not quit, New Zealand European, Canterbury)

Some participants reported that their boredom tended to increase near the end of their pregnancy where they were less able and willing to pursue activities outside the home, and consequently their smoking also tended to increase.

### **Barrier to Staying Quit After Birth - Boredom**

As well as being a significant barrier to quitting, boredom was also a frequently mentioned trigger to relapse after the baby was born. At least three participants who had managed to quit and stay quit throughout their pregnancy attributed their relapse once the baby was born to boredom:

*“The main thing is that my baby sleeps all the time. I have got nothing to do so I go have a cigarette.”* (Quitline caller – relapsed, Pacific, Canterbury)

*“I went back to smoking and now I smoke more than ever. I don’t know why. I guess I get bored. I’m home all the time. I’m not working any more.”* (Quitline caller – relapsed, Maori, Auckland)

## 6.7. Barrier: Fear of Weight Gain

Participants noted that almost all women gain weight during pregnancy, and expressed a concern about additional weight gain as a result of giving up smoking. Younger women expressed concerns about this weight gain causing stretch marks while older women perceived that this weight would be difficult to lose once the baby was born:

*“I had just lost a whole heap of weight [prior to getting pregnant]. I had just lost like 20 kgs and I did worry that I would put it all back on and not be able to get rid of it again. That was my major concern [about quitting].”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

## 6.8. Barrier: Smoking as a Reward

Some participants viewed smoking as a way of rewarding themselves, with the quitting process seen as a denial of self gratification. These participants felt that they had already made sufficient (and significant) sacrifices – not drinking alcohol, not eating certain foods, and in some cases having to stop exercising/playing sport – and felt that it was unfair that they should have to give up smoking as well.

*“I felt like [smoking] was the last pleasure that I had because I wasn’t drinking and I couldn’t do anything, I couldn’t even exercise. I felt I was going to be really depressed because I was going to have absolutely nothing. I’d given up everything else and I just thought ‘If I take [smoking] away, what will I do?’”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

Participants who were relatively heavy drinkers and/or who socialised regularly perceived that drinking alcohol (and in some cases, taking drugs) to be more detrimental to their baby’s health than smoking. Perceiving that they would be unable to give up all negative influences (or, in some cases, feeling that it was unfair for them to be expected to give up ‘everything’), typically nominated to give up alcohol (and drugs) – and often continued smoking as a reward, or as a comfort to deal with the effects of withdrawal from these other influences.

*“With alcohol, it has been drummed into my head the whole ‘baby syndrome’ thing and that it only takes one glass, one sip ...’. So I stopped drinking and I thought ‘I have got to have something’. I said to myself ‘It’s okay if I smoke because at least I am not drinking. There are much worse things that I could be doing than smoking’. Some women take drugs while they are pregnant – I wasn’t doing that, so that would make me think that smoking was okay. That way of thinking went on for a little while.”* (Quitline caller – quit, Maori, Auckland)

## 7. Motivations and Barriers: The Role of Health Professionals in Smoking Cessation

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The section explores the role of health professionals in smoking cessation from the perspective of both the health professionals themselves and the women who have dealt with them. While health professionals ideally would like to be more assertive, and take a more comprehensive approach to encouraging pregnant women to quit smoking, time constraints and the need to find a balance between saying enough to motivate behaviour change without adversely affecting the long-term relationship by being perceived as pushy, domineering or condescending, can be challenging.

### 7.1. Women's Experiences of the Role of Midwives in Smoking Cessation

Most participants who had an independent midwife as their Lead Maternity Carer (LMC) reported that, during their first visit, their midwife had asked whether they smoked and if so, how much. Only one participant, who was using hospital-based midwifery, reported that no-one had talked to her about her smoking or quitting:

*“When I first went, I had to fill out a form and it asked me if I smoked. I handed the form in, but the midwife has never said anything about how much I am smoking. I wonder if they are just sick of asking people about it.”* (Non-Quitline caller – not quit, Pacific, Auckland)

However, the extent to which the issue of smoking – and quitting - was addressed further by the midwife seemed to vary considerably.

Women who were quit at the time of their first visit to their midwife and therefore responded ‘no’ when the midwife asked if they were a smoker, reported that they received little or no information from the midwife with regards to smoking during pregnancy or advice or support to stay quit – or positive reinforcement for having managed to quit since getting pregnant. In most cases, the midwife had not questioned the woman further as to whether she had a smoking history and in particular, how long she had been quit for and what support she was receiving. These women noted that, at the time of their first midwife visit, they had often only been quit for a few days or weeks, typically were not using any form of cessation aids to help quit, and were conscious that they were still very vulnerable to relapse. These women reported that the issue of smoking was not raised on subsequent midwife visits, even though – in some cases – the woman had relapsed:



*“When I first talked to my midwife, I told her I was stopping [smoking] and then at the next appointment I had quit. I told her I had stopped and she has pretty much let it go since then. She is like ‘Okay, cool’ and there has been nothing more about it. But I don’t think I am cured or anything like that. I am not smoking, but it is still in my head.”* (Quitline caller – quit, Maori, Auckland)

In a small number of cases, the issue of smoking was addressed only fleetingly during the first visit, and was not addressed by the midwife on any subsequent visits:

*“[The midwife] noted down how much I smoke and she said ‘At least you don’t smoke a packet a day’ and that’s all she said. She said ‘I’m not telling you to stop. I’m not telling you it’s good to smoke but it’s more or less your choice what you do.’ It was a bit weird actually. I was like ‘Oh, okay’.”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“My midwife, she said to me ‘Smoking is no good for you, try and cut down if you can’. She gave me a bit of a lecture about it then she says ‘I won’t bring it up anymore’ and she never mentioned it again.”* (Quitline caller – relapsed, Maori, Auckland)

*“[My midwife] was like ‘Do you smoke?’ I said ‘Yes’. She’s like ‘Okay, here’s the number for the patch person. Give her a call.’ She never ever mentioned the smoking again. I thought that was quite bad. It was like she was saying ‘I am obliged to tell you this so here you go’ and that was it. She has never ever followed it up, never said to me ‘Oh, so how’s your smoking going?’ No encouragement, no follow up, nothing.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

Most participants had been asked about their smoking status at later visits and, if relevant, if they had followed up on cessation advice. Less common was the experience of midwives being assertive with their women and actually telling them that they needed to stop smoking (this being reported by a small number of New Zealand European women):

*“My midwife, she growls at me. She says ‘You shouldn’t be smoking missy’ and all those kinds of things. She tells me not to smoke. She’s told me all the risks and everything like that.”* (Quitline caller, - not quit, Maori, Auckland)

Most women expressed surprise that their midwife had not made a bigger deal of their smoking and been more assertive and even pushy about getting them to quit smoking – although some were pleasantly relieved, noting that they had ‘heard it all before’ and didn’t feel they needed constant reminders. However, the small number of women whose midwife had emphasised the need for them to stop smoking reported feeling chastised and nagged rather than interpreting it as someone taking an interest in protecting their health and the health of their baby:

*“I thought ‘Oh great, here we go. I just sat there going ‘I know, I know, I’m going to try and quit, I know ...’”* (Non-Quitline caller – not quit, New Zealand European, Auckland)

Both participants and midwives themselves noted that it is important for midwives to find a balance between being too soft and too strict about quitting smoking, and that the appropriate balance for each woman will depend on a range of factors including age, ethnicity, smoking history and openness to quitting:

*“I would have liked her to give me some contact numbers I could make contact with and actually help me stop smoking.”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“I found it good that she didn’t pressurise me, but maybe a gentle reminder about quitting would have been good.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

## 7.2. Midwives’ Perspectives on Their Role in Smoking Cessation

Midwives’ perspective on their role in smoking cessation varied considerably. Some admitted to being desensitised to the issue and therefore not always addressing it with women, while others reported that, if a woman won’t accept the cessation advice and referral to a cessation service offered to them, the midwife will ask them to re-consider their choice of LMC:

*“If a woman says ‘No, I don’t want to [try a cessation programme]’ I suggest that maybe I am not the right midwife for them. That’s how strongly I feel. And if she is not prepared to listen to advice [about quitting smoking] then what else is she not going to do?”* (Independent midwife – Canterbury)

One midwife reported that she tended to spend less time with her women on the issue of smoking as she felt most women already had a good understanding of the health risks of this and were aware of options for quitting. In contrast, she spent more time on promoting breastfeeding as a way to ensure the baby was healthy:

*“I think a lot of women understand the implications of smoking during their pregnancy. To be honest I find the focus to be a bit wrong. Don’t get me wrong, I think it’s really good to stop smoking but I think people seem to know that smoking is bad for them whereas they don’t care if they breastfeed. I see that it’s more important actually to let them know that breastfeeding will make your child healthier. [If I had more time and resources] I’d probably be more inclined to put it into promoting breastfeeding. Most of [the women] consider their child’s health with their smoking whereas they don’t do that with breastfeeding.”* (Community midwife – Canterbury)

All midwives commented that, in dealing with and assisting women who smoke to quit, it can be challenging to find the balance between saying and doing enough to motivate behaviour change but not adversely affecting the longer term relationship by being perceived as pushy, domineering or condescending.

In particular, midwives whose caseload included those from a different cultural and/or socio-economic group to themselves perceived that they needed to be extra cautious in dealing with smoking cessation issues with most admitting that they tended to take a conservative approach:

*“I’m a non-smoker so I tend to give everyone I know who smokes a hard time. But I’ve had to approach my [Bay of Plenty] clients in quite a different way because I’m a white middle-class woman and I am a health professional, and if I walked into their homes and said ‘Put that cigarette out’ then they wouldn’t take up the option of care with me. There’s two reasons why that affects me – one is financially and the other is that I want to get the best for the babies and the families, so I need to approach them quite delicately really.”* (Independent midwife – Bay of Plenty)

*“You get it drummed into you all the way through your training about being sensitive to people’s beliefs and their culture and all kinds of diversity. So it’s hard – it’s a fine line between trying to help them and being inappropriate.”* (Community midwife - Auckland)

*“I say to them at the first meeting ‘Are you interested in becoming smoke-free?’ and they say ‘Oh no, not really’ or ‘Not at the moment’. I say ‘Okay, when you’re interested, come back to me and we’ll talk about it, but I am not going to nag you at the moment because there is no point.’ We don’t want to alienate them. We want them to come back to clinic so we can monitor how they’re doing. They are more at risk if they don’t come to clinic and we don’t know what she’s up to and what the baby is up to. It’s the lesser of two evils.”* (Independent midwife – Auckland)

Because of the difficulty finding a balance between motivating behaviour change whilst maintaining an honest and open relationship with the woman, all midwives stated that they tend to focus – at least during the first visit – on encouraging and assisting the woman to reduce her smoking rather than quitting altogether (unless the woman expressly states that she wants to quit):

*“I go through a checklist of a health questionnaire and it comes up about smoking and I say ‘Oh, are you a smoker?’ I say it like ‘Do you eat yoghurt?’ to take the pressure off the question. If they say they are, that leads in to ‘You obviously know that smoking isn’t too good for baby so how far do you think you can bring this down?’ We talk about bringing it down, reducing it. I don’t know if that’s the right approach really but I do that because it actually gets us into a conversation about it. If I said ‘Right well I want you to stop right now’, they wouldn’t and then they wouldn’t talk to me about their smoking again. It’s about keeping that dialogue open.”* (Independent midwife – Bay of Plenty)

*“I’d like them to stop completely. It would be great but I think, if they are not going to stop, and trying to nag them to stop is going to alienate them, it’s better we work on their terms and try and sneak in through the back door and get them to slow down, rather than getting an ‘up yours’ kind of thing if we tell them to stop completely.”* (Independent midwife – Auckland)

### 7.3. Women's Experiences of the Role of General Practitioners in Smoking Cessation

In most cases, women reported that they had had their pregnancy confirmed by a GP but that typically there had been very little discussion about smoking during pregnancy. Some women visiting a GP who did not know them well expressed surprise that they had not even been asked if they smoked, while most stated that they had not been given any information about the effects of smoking during pregnancy or about smoking cessation services available.

### 7.4. General Practitioners/Practice Nurses' Perspectives on the Role in Smoking Cessation

General practitioners report that they typically have limited contact with pregnant women after the visit where the pregnancy is confirmed – or at the most, after the first 12 weeks of the pregnancy<sup>13</sup>. Consequently, they consider their opportunity to influence pregnant smokers' behaviour to be limited – and therefore see themselves having a lesser role in encouraging smoking cessation than midwives.

General practitioners also point to the short appointment times – typically 10 to 15 minutes – as a barrier to providing smoking cessation education and advice.

*“With the time limitations we have, we can't go into depth with them about the risk factors. If we had more time, we could show them more pamphlets and take our time to explain things, but [with the limited time we have] we have to hope that we have got the message across.”* (General Practitioner – Auckland)

Practice nurses reported that, while they tend to have more time to meet with pregnant smokers to discuss health risks and possible cessation options than GPs, it can be difficult to get women to make an appointment to come back to the clinic for this consultation, particularly if they fear they are going to be chastised for smoking or forced to undertake a cessation programme – or if they perceive they are only going to receive the 'second rate' medical advice of a practice nurse rather than a GP.

Health professionals generally agree that there is limited value in trying to provide smoking cessation advice at the appointment where the pregnancy is confirmed as there tends to be so many other things to be dealt with, even where the pregnancy is wanted and/or expected, women are generally focused on issues other than smoking:

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<sup>13</sup> The New Zealand Report on Maternity: Maternal and Newborn Information (Ministry of Health, 2007) states that approximately 75% of antenatal care is provided by midwives. General practitioners and obstetricians provide around 12% of antenatal care, and for a further 12%, the provider of antenatal care was not reported.

*“In the first visit, sometimes they don’t even know that they are pregnant, and then you have got the blood test to arrange and the ultrasound scan to see how far along they are and how the pregnancy is going, and once they have settled with that, we have the swabs and smear test. We look at their results and see if there is any treatment needed, and we also advise on personal hygiene and how to look after themselves, diet ... there’s a lot to be done in those first couple of visits. We really don’t cover smoking cessation straight away.” (Practice nurse – Auckland)*

Indeed, participants who were given smoking cessation information during the same visit when their pregnancy was confirmed reported that they took very little notice of it.

## 8. Decision to Use the Quitline - Perceptions of Alternative Cessation Aids

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In addition to the Quitline, participants identified four other methods of quitting smoking that they had either seriously considered or actually tried:

- Smokechange (used successfully by n=1 non-Quitline caller; n=3 further participants who had used this method reported having relapsed)
- 'cold turkey' (used successfully by n=2 non-Quitline callers; n=3 participants who had used this method reported having relapsed);
- hypnotherapy; and
- Allen Carr's "Easy Way to Stop Smoking" books.

The appeals and drawbacks of each method are discussed below.

### 8.1. Perceptions on Smokechange

#### *What is Smokechange?*

Smokechange is provided by Education for Change Ltd under contract to the Ministry of Health. Smokechange is free specialist step-by-step support for pregnant women who smoke. Support is offered in the woman's home and via telephone and can extend to her partner and family/whanau. Smokechange places particular emphasis on supporting change where there is heavy addiction and difficult social realities.

A woman either refers herself to Smokechange or, more typically, is referred by her midwife, doctor or health worker. Someone from the Smokechange team makes contact with the woman and a first visit is arranged. Each woman decides the support she needs and this can be a single session or extend to up to six months or more. Subsidised nicotine patches and gum are available<sup>14</sup>. Smokechange programmes are currently offered in Auckland, Christchurch and Invercargill<sup>15</sup>. Of the ten non-Quitline callers interviewed, four had used Smokechange. In addition, one Quitline caller had also used Smokechange (after not receiving any follow-up from the Quitline).

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<sup>14</sup> [http://countiesmanukau.webheath.co.nz/page/countiesmanukau\\_146.php?article=56](http://countiesmanukau.webheath.co.nz/page/countiesmanukau_146.php?article=56)

<sup>15</sup> <http://www.efc.co.nz/infocat.php3?category=2>

## Appeal of Smokechange

The **personal visits** offered as part of the Smokechange programme were considered a key strength of the service among those who had taken up this option. Key benefits included:

- Opportunity to build rapport with the Smokechange staff member, which typically results in the pregnant woman being more open and honest and more receptive to advice and support:

*“I really liked having [Smokechange staff member] come and visit and a friendship developed. [With home visits], you know the person, you get to know them. It becomes more personal because they put in their personal views as well. You can build rapport with them.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“Face-to-face, it’s much harder to lie.”* (Quitline caller – not quit, New Zealand European, Auckland)

*“If it is one-on-one, [the woman] has more chances for asking questions and more chances for giving information. And probably they will feel more confident that somebody is there especially for them.”* (Practice nurse – Auckland)

- Ensures appointments are kept:

*“If you have to go to them, it’s like ‘Do I have to make an effort to go and see them?’ You may think twice about going. I could easily say ‘No, I’m busy.’ But when they come to you, they’re at your door and they’re in your face. You have no way of backing out.”* (Quitline caller – not quit, New Zealand European, Canterbury)

- Provides regular support and frequent reminders of quitting strategies:

*“They don’t leave you hanging here with no support after your first visit. They come every week to support you.”* (Quitline caller – not quit, New Zealand European, Canterbury)

- Offers greater opportunity to include others in the household in quitting;
- Provides company for those who are home alone during the day:

*“It’s company too. I’m not working much and my partner’s out working. He works quite long hours, so it’s nice to have a visitor sometimes.”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“[With a home visit] you can use all your senses. You can use visual material as well as giving them written material, as well as making a personal connection as well as seeing the environment that they live in, as well as meeting their significant other, their children. It’s a much more hands-on service than something that is over the phone.”* (Independent midwife – Canterbury)

The frequency of personal visits varied, from a single visit to weekly visits.

The **initial home visit** is considered **very informative and motivating**. Smokechange staff bring along visual material to inform women about the effects of smoking on their baby (both their own smoking and the effects of passive smoking from others in the household), and also the positive effects that stopping smoking during pregnancy can have. For those women uncertain about the appropriateness of NRT, the first visit is very important in reassuring them that patches and gum can be used:

*“It was that first visit that was the most important. It was the fact that she told me I could use the patches and gum. [I felt] relieved. I knew I could [quit] after she had been and said that.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

A further appealing feature of Smokechange is that women **deal with the same Smokechange staff member** throughout their time on the programme. This allows the woman to build rapport with the staff member (thereby enhancing the openness of the relationship) and the staff member is able to better understand the woman’s motivations and barriers to quitting:

*“That was a good thing [about Smokechange]. We got one person that we were dealing with and she knew us and we knew who she was so it was more friendly. Whereas, if you got a different person every time ... well, everyone has different ideas and different views on things, and you might get conflicting advice as well.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

*“I think continuity is actually very important. I get annoyed if I am in the health system as a patient, having to explain my history over and over again. It is annoying, it’s time consuming and, for some people, it’s embarrassing.”* (Independent midwife – Canterbury)

**Regular telephone follow-ups** are available. One participant reported being contacted weekly by the Smokechange staff member to check on her progress. This participant said, as a result of regular phone calls, the staff member had identified that her patch dosage was too high and had been able to send a lower dose patch. The participant said, had contact been less frequent, she might have just stopped using the patches – and consequently relapsed.

Smokechange is considered **convenient** in that staff provide adequate supplies of free NRT as part of the initial and follow-up visits, rather than just issuing prescriptions/exchange cards which clients have to collect themselves:

*“My husband had tried to give up before with patches, and just the cost of them and the nuisance of having to keep going back to get more ... whereas, with [Smokechange], every time they come around here they say ‘Have you got enough patches?’ and they will drop off more if we need them.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)



**Cessation support is also available to partners** should they wish to quit too. As discussed in Section Four, having a partner that smokes is a significant barrier to quitting for many pregnant women. Having the partner quit reduces the temptation for the pregnant woman to smoke (as there is no smell of cigarettes, or tobacco present in the house), and can also enhance the couple's relationship through having them working together and supporting one another towards a common goal:

*“I had been trying to cut down myself anyway to stop and my husband said that he wanted to give up as well so [with Smokechange] we thought, ‘Well we have the opportunity to do it together.’ I think it is an extra reason to stay [quit] yourself, if you know that it is going to influence someone else.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

**Midwives** see a key strength of Smokechange being that they **make the referral to Smokechange**, rather than leaving it up to the woman. From the midwife's point of view, this provides reassurance that the woman has been referred and doesn't need to be followed up and reminded during subsequent visits. Midwives perceived that, for the woman, this meant one less job they had to do and may also be seen as a positive act on the part of the midwife – someone doing something positive to help and support them. Midwives also report that Smokechange contacts the woman promptly after the referral – generally within 48 hours.

*“I like [the referral process] because it's very fast – you just pick up the phone, leave the information on the voice mail and that is it. I don't have to write a form, I don't have to write referrals, I don't have to fax things through - it's quick, it's easy and it's effective.”* (Independent midwife – Canterbury)

Canterbury-based midwives in particular spoke positively of the **regular feedback** they receive from Smokechange on the quit status of the women they have referred:

*“They send me a report on the women smoking – readiness to change, perception of stress level, all that kind of thing. And I can remember times when they have rung me with concerns about the woman. So they also feed back to me if there is something that they are worried about.”* (Independent midwife – Canterbury)

Canterbury midwives also report that Smokechange occasionally runs **feedback sessions**, where health professionals in the region are invited to morning tea, the Smokechange team presents their quit results, and asks for health professionals' feedback on the programme and any suggestions for improvements they would like to see made.

Finally, for midwives, Smokechange courses/training days are perceived positively as they **receive points** for attendance that count **towards their annual re-certification**.

Other appealing features of Smokechange include:

- provision of extensive written information ('case studies') about the quit experiences of others;
- provision of booklets and pamphlets specific to pregnancy and smoking; and
- one participant reported that Smokechange staff member she dealt with was an ex-smoker herself and was therefore able to offer 'tried and true' quitting strategies. The participant also perceived that the staff member would have had more empathy if she had called to say she had relapsed as the staff member admitted to having relapsed herself when trying to quit.

### **Drawbacks Of Smokechange**

While midwives perceive **referrals made by health professionals** as a key strength of Smokechange, one woman viewed it as a drawback, noting that, at the time Smokechange was discussed, she didn't feel ready to contact a cessation service; she still believed that she could quit on her own:

*"I wasn't ready, and just having someone there nagging at that stage, it wasn't the right time for me."* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

Women who had successfully used Smokechange and stayed quit throughout their pregnancy reported that they had relapsed once the baby was born. The participants attribute this, at least in part, to **insufficient post-natal follow-up**. Smokechange generally provides clients with one post-natal follow-up (generally at around four to six weeks after the birth). Both participants reported that they were still quit at the time of this follow-up and consequently were just congratulated for their efforts then left on their own. In both cases, stressful situations had developed after the last post-natal visit and, without any support, both women had started smoking again:

*"The first six weeks [after the baby is born] is sort of like a grace period. With [daughter], she was wonderful for the first six weeks and then at six weeks, it was like 'Oh my God, she wants to feed all the time, she is not sleeping.' Everything seemed to happen at that time and the midwife had had her last visit. That was when the stress really kicked in."* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

One participant reported that she would have liked more post-natal support as she was uncertain as to how appropriate patches and gum were when breastfeeding. Aware that Smokechange is for pregnant women, the participant was reluctant to call to ask for post-natal advice.

Another participant noted that, while text messages of support and organising interview times by cell phone were applauded, the **mismatch of cell phone providers** meant that the participant could not respond without paying. In this case, the younger participant was on a limited budget and chose not to use her credit this way.

Some health professionals expressed concern about the **potential breach of confidentiality** associated with home visits, particularly if the woman didn't want others in the household – or neighbours - to know that she was either pregnant or a smoker or both:

*“I would say 90% of our clients would not appreciate [home visits]. If [Smokechange staff] come to the house then others in the household will know why they are here, or if they drive up in a car that has got ‘Pregnancy’ or ‘Smoking’ or whatever on the side, then obviously ...”* (Practice nurse – Auckland)

Other drawbacks of Smokechange included a perception that some of the **information** provided is “cheesy” and in some cases, **unrealistic** (particularly with respect to the ‘distraction strategies’).

### ***Perceived Success of Smokechange***

Of the four non-Quitline callers who had used Smokechange, all four had relapsed – two of these whilst still pregnant. In addition, the one Quitline caller had also used Smokechange reported that she was not quit.

However, despite the relative low quit rates among participants, midwives aware of the service are very positive about it:

*“On the whole it is really positive. It is a positive thing so, even if the woman doesn't quit smoking, she will make positive changes, like delaying the first cigarette of the day, change some of her practices around smoking in cars and smoking around children and passive smoking and things like that. It definitely raises awareness [about the risks of smoking during pregnancy] and it gives them information so they are making informed choices.”* (Independent midwife – Canterbury)

## **8.2. Perceptions on Going ‘Cold Turkey’**

### ***Appeal of Going ‘Cold Turkey’***

Among participants who had considered or attempted to quit ‘cold turkey’, the key appeal was the sense of personal achievement they perceived they would feel if they did actually managed to quit:

*“I can say that I did this on my own.”* (Non-Quitline caller – quit, Maori, Auckland)

Other appeals of this method of quitting included:

- perception that it is ‘over and done with’ quickly – that the nicotine withdrawal happens more quickly:
- doesn't involve the use of NRT – which is perceived by some to have health implications for the baby (see Section Eleven); and
- no cost.

### ***Drawbacks of Going ‘Cold Turkey’***

The key drawback of going ‘cold turkey’ is that it **requires considerable self-control**. Smokers often find this very difficult, particularly if they are unable to remove themselves from other smokers:

*“I don’t really have too much self control. I know that, by myself, I could sit at home and say I am not going to smoke, I am not going to smoke, but then, as soon as my friend comes over and lights up, okay, that is the end of that.”* (Quitline caller – quit, Maori, Auckland)

*“The cravings were so bad. I just really wanted a smoke, and when there are smokes around all the time ...If the house was smoke-free, I could probably do it but ...”* (Non-Quitline caller – not quit, Pacific, Auckland)

Participants also reported that the **symptoms of withdrawal experienced via ‘cold turkey’ can be very intense** – and without adequate support and personal willpower, can be very difficult to endure, particularly when coupled with the physical and emotional challenges of pregnancy:

*“The withdrawals are definitely bigger – like headaches, the coughing, all the tar ... it all happens really quick.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

## **8.3. Perceptions Of Hypnotherapy**

### ***Appeals of Hypnotherapy***

Hypnotherapy is perceived to be a very **straightforward and simple** way to quit and therefore is considered an ‘easy way out’. The one participant who reported having seriously considered hypnotherapy also noted that a friend had had **success** using this method.

### ***Drawbacks of Hypnotherapy***

The one participant who had considered hypnotherapy noted that it is a **very expensive** cessation aid, and because there is **no guarantee of success**, had decided not to pursue this intervention.

## **8.4. Perceptions of Allen Carr’s “Easy Way To Stop Smoking”**

### ***Appeals of the Book***

For the one participant who had used this book, the key strength was that it had **actually worked** for her and she had managed to stay quit for some months:

*“I got to the point in the book where he said ‘Now you are going to stop smoking’ and I did. It was like ‘Oh, those cigarettes are disgusting. I didn’t withdraw or anything really. It was really weird. [I quit for] a few months then I started to gain weight. The thing is, I didn’t even want to start again, it was disgusting. I had to force myself to start again. It was weird.”* (Non-Quitline caller – not quit, New Zealand European, Auckland)

Other appeals include the fact that the book **doesn't chastise** the reader for being a smoker, and that it is **well written** and is **enjoyable and easy to read**.

### ***Drawbacks of the Book***

The participant who had used this book to quit prior to their most recent pregnancy perceived that the book **only works once** – because they knew the point in the book where they would be told to stop smoking, when they read the book the second time, they actually stopped reading just before this point.

## 9. Decision to Use the Quitline

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In addition to the appeals and drawbacks of smoking cessation alternatives available, the decision to use the Quitline is dependent on awareness of the service, and the influences of others (either positive or negative). This section addresses these components and also outlines the barriers to the use of the Quitline identified by participants.

### 9.1. Awareness of the Quitline

Awareness of the Quitline service was derived from a range of sources. The most frequently mentioned were (by order of frequency of mention):

- television advertising;
- pictures and advertising on cigarette packets. Quitline callers noted that the pictures of babies were particularly motivating – *“I saw that baby on the smoke packet. I thought ‘Oh, I don’t want my baby to look like that’. I did think about quitting when I saw that.”* (Non-Quitline caller – not quit, Pacific, Auckland)
- family and friends who were registered with the Quitline;
- school (particularly for younger women) – *“We used to have the DARE programme and they used to tell us everything about smoking and alcohol. They said, if you need someone to talk to, there are these helplines. The Quitline was part of that, and we got their number on stickers.”* (Non-Quitline caller – quit, Maori, Auckland);
- LMC;
- Bounty Book (pregnancy resource);
- sexual health clinic;
- sports tournaments; and
- brochures available through Work and Income Service Centres.

Health professionals concur that awareness of the Quitline among pregnant smokers is high, this awareness attributed predominantly to television advertising. However, this high level of (passive) awareness can actually reduce opportunity to promote use of the service. Because women have already heard of the Quitline, health professionals report that they generally ask very few questions about the service – its relevance for pregnant women, how it works, what types of support are offered, the use of NRT etc. Because there is very little dialogue around the issue of quitting and the assistance available through the Quitline, there is little opportunity for the health professional to emphasise the benefits or encourage the woman to call:

*“The women are definitely aware of [the Quitline], yes. When you give them the card, they tend to say ‘Quitline, yes I have heard of that’ and just put the card in their handbag. I get asked very few questions about it.”* (General practitioner, Bay of Plenty)

## 9.2. Influences On The Decision To Call The Quitline

### **Health Professionals**

Most health professionals reported that they advise pregnant women who are smoking of the need for them to quit or cut down. With the exception of those who referred women on to Smokechange and one community midwife who reported difficulties accessing information about smoking cessation services within the hospital environment, most reported that they provided women with information about the Quitline (although, in some cases, this was just a card with the Quitline number).

*“I’d have to be honest and say that most of the time I just give them the number and I leave the rest up to them. I just give them the phone number, I haven’t got any information available.”* (General practitioner, Bay of Plenty)

*“We just give them the phone number and the brochure that comes in, that’s pretty much it.”* (Practice nurse – Auckland)

It should be noted however, that very few health professionals referring clients to the Quitline undertook any follow-up with them to check whether they had actually called or not.

With respect to advocating smoking cessation services, midwives tend to recommend those they know most about. Consequently, in Canterbury, midwives were strong advocates of the Smokechange programme (and by comparison, few recommended the Quitline).

### **Non-Smoking Partners/Family Members**

Quitline callers said that non-smoking partners and other family members were very positive and encouraging about their decision to call the Quitline. They reported that partners/family members who had never smoked themselves often found it difficult to offer non-judgemental, relevant advice and support as they had little empathy with the challenges of quitting smoking. They therefore were pleased that the women were using the service where they would receive appropriate, well-informed support and advice:

*“My partner was like ‘That’s good’ [that you have phoned the Quitline] because he knew that I needed some outside support or somebody that knew what they were talking about. He doesn’t smoke so it was sort of hypocritical of him to be giving me advice.”* (Quitline caller – quit, Maori, Auckland)

However, some Quitline callers reported that they hadn’t told their partner or other family members that they were using the Quitline, fearing that they would be criticised or looked down on for not being able to quit on their own. Some of these women felt ashamed that being pregnant was not a sufficient motivator to encourage them to quit and that they needed external help:

*“I was shy to tell [my partner]. I thought he would judge me, that I can’t do it on my own, that I need someone there to help me, that I can’t do it by myself.”* (Quitline caller – quit, Maori, Auckland)

### **Others Who Have Already Registered**

The success of others who have used the Quitline is a strong influence in the decision to call:

*“[My partner] quit [after] ringing the Quitline. He got the patches and he went for three weeks with no cigarettes, and I thought ‘Wow, I might do that.’”* (Quitline caller – relapsed, Pacific, Canterbury)

*“[A work colleague] told me he had rung the Quitline. I was sitting there with him and he’d have a puff on my smoke but [before calling the Quitline] he was smoking at least a packet and a half a day so he has cut down a hell of a lot. I thought that was really good. I thought ‘Well, if he can do it ...’”* (Quitline caller – relapsed, Maori, Auckland)

Women who had not called the Quitline also suggested that the endorsements of those who had used the cessation service may have encouraged them to call:

*“If someone came and talked to me about it, someone who had experienced it before, someone who had used the Quitline, then maybe I would have been like ‘Oh yeah, I believe that person’ and then maybe I would have tried it too.”* (Non-Quitline caller – quit, Maori, Auckland)

In addition, prior to registering, some Quitline callers reported being uncertain and nervous about making the initial call, being concerned about being asked embarrassing questions or being made to feel guilty by the Quit Advisor, particularly because they were pregnant. Reassurances from family and friends who had already registered with the Quitline as to the ease of answering the questions and the encouraging, non-judgemental manner of the Quit Advisors was important for some:

*“[My partner said the Quitline] are quite encouraging so that was good. After he told me that, I rang up straight away and talked to them.”* (Quitline caller – not quit, New Zealand European, Canterbury)



### 9.3. Barriers To Using The Quitline

Of the ten non-Quitline callers interviewed:

- Three were uncertain as to how relevant the Quitline was for pregnant women, particularly given its perceived emphasis on advocating NRT as a cessation aid;

*“I think they see the Quitline as something outside their pregnancy. It’s something for other people. It’s to do with the advertising – there’s no pregnant women involved in it so it doesn’t apply to them.”* (Independent midwife – Auckland)

*“I don’t think there has been any advertising for pregnant women, you don’t see it on TV, so I just assumed that you can’t [use the programme]. If you go on the Internet and have a look, everyone says never do patches while pregnant, and all the baby books say don’t do patches while you are pregnant as well. So it’s like ‘Okay, if you’re definitely not allowed patches, then why would I call them?’”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

- Two reported that they had tried Quitline in the past, one when pregnant with a previous child. One of these participants, aware of the Quitline’s emphasis on the use of NRT, perceived that the service would not be appropriate for her since she was pregnant, The other was dissatisfied with the lack of pregnancy-specific information and support received previously. Both participants reported preferring to try ‘cold turkey’ instead.

*“[When I was pregnant the last time] I rang up and said ‘I’m pregnant and I want to quit smoking.’ There was an awkward silence on the other end and then she said ‘Oh well, we’ll send you out a pack.’ And that was it - here’s your piece of paper, good luck with that.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

- Two reported being determined to quit ‘cold turkey’, believing that this was the healthiest quit option for their baby. In addition, one of the women wanted the satisfaction of having been able to quit on her own.
- One reported that, while aware of the Quitline, she had not really had the opportunity to consider it as her midwife had referred her to Smokechange instead:

*“I didn’t really consider the Quitline. [Any reason why not?] No reason. I just didn’t think about it. If my midwife had recommended [Quitline] instead of Smokechange, I would have just rung them like I rung Smokechange.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

- One reported that they had been too lazy to call, and, later in the interview, admitted that they were unsure whether they really wanted to quit;

- One reported that, while she was aware of the Quitline, she had very limited knowledge of what the service involved and also expressed concern about being judged by the Quit Advisor. Quitline caller participants and midwives also cited examples of (particularly younger) women they knew who had been reluctant to call the Quitline as they feared that they would be judged by Quit Advisors for being pregnant and smoking. Some participants reported that the quit smoking social marketing campaign had resulted in an increase in societal pressures to 'be quit' and subsequently the development of a societal opinion that to be a smoker is of less value. Further, to also be pregnant and smoking has resulted in some women feeling 'a double whammy' of societal exclusion and negative judgement. As a result, some pregnant women are reluctant to ring the Quitline as they perceive that the Quit Advisors may reflect these societal opinions:

*"Just if they judge you...I think that is why most people are scared because you would ring an absolute stranger and they don't know anything about you."* (Non-Quitline caller - quit, Pacific, Bay of Plenty)

*"They don't want to phone up and get nabbed by some old biddy on the end of the phone going 'You shouldn't be smoking! You're pregnant!' because they know this. I think talking to a stranger on the other end of the phone is quite a barrier for a lot of people. I know for our [South Auckland] ladies it is."* (Independent midwife – Auckland)

Other barriers to the use of Quitline, cited by health professionals, included:

- **lack of recommendation from health professionals**, due to a lack of time, lack of information, greater awareness of alternative services/programmes and/or confusion as to the difference between the Quitline and Smokechange (one midwife in Canterbury thought that the Quitline and Smokechange were the same service):

*"I would recommend Smokechange because Smokechange is fast, it has a home visit component and it's based here in Christchurch. It has a long-standing reputation here and I find it a very good service."* (Independent midwife – Canterbury)

- **a language barrier** – particularly for Pacific, Indian and Asian women.
- **the self-referral process**. Health professionals noted that some women tended to take only limited responsibility for their own health and the health of their baby. These women generally would not make the effort to refer themselves to the Quitline:

*"[Women in central Auckland] would be more open to becoming responsible for their own actions and for their own health and their baby's health. Whereas here [in South Auckland], the attitude is more 'You're the midwife, you sort it out, it's your responsibility to make sure my baby is alright'. That's probably why they don't phone the Quitline – because they have to do it themselves. You have to hold their hand and do everything for them because they have no motivation to do it themselves."* (Independent midwife – Auckland)

*“My feeling is, [after we have spoken to them about quitting], I think when they go out of the door, they forget about the suggestions we have made. They don’t take it that seriously. I believe that they don’t take their smoking [and the implications for their baby] that seriously and that’s why they don’t want to ring Quitline.”* (General Practitioner – Auckland)

- having been **unsuccessful using the Quitline in the past** and feeling guilty or embarrassed about having to admit failure:

*“I’d like to try another way of quitting [in the future] because I lucked out on the Quitline. I don’t want to ring them up and they go ‘Oh, you just tried to give up the other month. You’re a waste of time.’”* (Quitline caller – relapsed, Maori, Auckland)

- lack of a **telephone**. Health professionals working with very low socio-economic clients report that some don’t have a telephone and may be reluctant to make personal/sensitive calls from the home of friends and neighbours;
- lack of awareness of whether the Quitline can be **contacted outside working hours**, particularly for those women who work or study during the day; and
- concerns about **confidentiality** and who will have access to their personal information.

## 10. The Quitline Experience

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This section discusses the experience of those who have used the Quitline.

### 10.1. The Referral Process

Health professionals who were providing clients with information about the Quitline reported that they used a self-referral process – that is, they gave responsibility for calling to the woman herself. Some health professionals stated that this was consistent with their approach to all health issues:

*“That’s my approach all the way through their pregnancy, that they take responsibility for their health.”* (Independent midwife – Bay of Plenty)

Some Quitline callers reported that, while their midwife did not ring Quitline for her, the encouragement received to do so extended beyond the ‘take responsibility for your own health’ approach to a more embracing tone of ‘I care’. This was noted by Maori and Pacific pregnant women in particular to be the difference that counted in assisting women to call the Quitline. Those who had been referred to the Quitline by their health professional felt that they were supportive and encouraging without exerting any forceful opinion.

In contrast however, a small number of health professional reported high levels of loss between the information and phone number been given out and the client actually calling. These participants suggest that a more proactive approach to referrals should be adopted, thereby reducing the opportunities for pregnant women to avoid registering. Suggestions for enhancements to the current referral process are discussed in Section Twelve.

### 10.2. Making The First Call

Prior to making the first call, Quitline callers reported feeling a range of emotions:

- Scared – *“I was scared that they were going to judge me, that they weren’t going to approve of me because I was smoking and because I was pregnant while I was doing it.”* (Quitline caller – quit, Maori, Auckland)
- Hesitant – *“I didn’t know what kind of questions they were going to ask me. I didn’t know how it was going to turn out and I didn’t know if it was going to work.”* (Quitline caller – quit, Maori, Auckland)
- Nervous – *“I thought that maybe [the phone would be answered] by someone who can’t speak English properly. That really annoys me – you call a call centre and then you just get so frustrated trying to talk to these people. I was worried I would be talking to someone who couldn’t understand a word I was saying.”* (Quitline caller – quit, Maori, Auckland)
- Dread – *“I wasn’t ready to quit smoking. I just didn’t feel ready, but I knew I had to do it.”* (Quitline caller – not quit, New Zealand European, Auckland)

- Confident – *“Because I knew I was doing something good for myself.”* (Quitline caller – quit, Maori, Auckland)
- Determination - *“I just thought this time ‘Bugger it, I’m going to give it a go’.”* (Quitline caller - quit, New Zealand European, Bay of Plenty)

The time taken between considering the Quitline as a possible cessation aid and actually making the call varied considerably – from a couple of days to a month. Reasons for delaying the call to the Quitline included:

- Being in denial about the need to quit smoking – *“I was in denial for about a month. I was like ‘Maybe I don’t have to quit. I know I am pregnant but maybe I could keep it on the sly or something.’ I know that is totally stupid but I was in real denial that I needed to quit.”* (Quitline caller – quit, Maori, Auckland)
- The need to get the house (and car etc.) free from cigarettes first;
- A belief that the woman could quit on her own, without needing external support – *“I got down to five [cigarettes] a day and I couldn’t get any lower myself and I just thought ‘Well, I might as well give it a go’.”* (Quitline caller – not quit, New Zealand European, Canterbury);
- Shyness with respect to talking to strangers (particularly for younger women);
- Not mentally prepared to call and therefore not wanting to waste the Quit Advisor’s time; and
- Encountering stressful situations that triggers a smoking response which obscures and interferes with the thought pattern to quit.

### 10.3. Positive Aspects of the Quitline Experience

As Figure 10.1 illustrates, the Quitline experience consists of three interwoven components:

- **Accessibility** – that is, the speed and ease at which the woman can speak to someone who can help;
- **Understanding the caller** - that is, the Quit Advisor’s ability to create sufficient rapport with the caller that they are willing to provide all the information the Advisor needs to understand their situation and identify the most appropriate support; and
- **Providing appropriate, effective support** – that is, the Quit Advisor having the knowledge, skill and tools to provide effective support to the caller.

Quitline callers’ experience of the Quitline are discussed below, classified by each of these components.

**Figure 10.1: Components of the Quitline Experience**



### 1. **Accessibility**

- The service is **accessible via a 0800 number**. Commonly discussed was the ease of being able to contact Quitline through a 0800 number. This released any financial burden from the intending callers. Health professionals in particular consider this advantageous in that it makes the referral process very straightforward – health professionals just need to provide the woman with the phone number, and self-referral is easy (as the number can be accessed for free by everyone, irrespective of where they are).
- **Locating the 0800 number** was easy as it is found on cigarette packets and television advertising.
- The service is **accessible via cellphone**. This is particularly important for those who don't have immediate access to a landline. For those who made their decision to call the Quitline quickly/impulsively, the ability to access the service immediately was important in keeping up their 'quitting' momentum:

*“That you can ring them from a cellphone, that’s a darned good thing. [If you couldn’t ring from a cellphone] it makes it harder because you have got to find a landline if you don’t have one. You’ve got to go over to someone else’s place to find a phone and, by the time you have done that, you’ve already had four smokes so you don’t bother [to make the call].”* (Quitline caller – not quit, New Zealand European, Canterbury)

- Some Quit Advisors it is reported also **offered their extension numbers** so that callers were able to ring back to discuss any issues concerning the desire to relapse, seek information about NRT and have a general chat if feeling isolated. While it is understood that this is not standard practice, the positive responses reported would indicate that pregnant smokers could benefit from such a policy.

*“Just the easy access of being able to just pick up the phone and ring them any time of day.”*  
(Quitline caller – quit, Pacific, Bay of Plenty)

## 2. **Understanding The Caller**

- Perhaps the most reassuring aspect of the Quitline experience for callers is how **non-judgemental** Quit Advisors are. This was applauded, and viewed as critical to the continued use of the Quitline.

*“I was a bit nervous about calling them in case they growled at me because I was pregnant and smoking. But they didn’t. They told me I had taken a step towards quitting by calling them. That surprised me actually.”* (Quitline caller – not quit, New Zealand European, Auckland)

- While most participants agreed that Quit Advisors didn’t deliberately seek to make callers feel guilty, through the questions they asked and the information they provided, some participants reported that they had **felt quite guilty** about their smoking by the end of the registration phone call. These participants all considered this self-imposed guilt to be a strength of the service – and a strong motivator to quitting, or at least seriously considering stopping smoking:

*“I don’t think they are judgemental but they make you feel guilty - but I like that. They talk to you about how [smoking] affects you. They make you feel ‘Gosh, how can I do that to myself?’ I think they should keep doing that.”* (Quitline caller – quit, Maori, Auckland)

- Participants also commented favourably on the **respectful way** they were dealt with by Quit Advisors, with some noting that, in contrast with other call centres, Quit Advisors treated callers as equals.

*“[When I got off the phone I was feeling] really good – like wanting to chop up every cigarette in the world and burn them all.”* (Quitline caller – quit, Maori, Auckland)

- All Quitline callers also commented that Quit Advisors are **very friendly, easy to talk to**, and come across as **open and positive**:

*“[I liked] how nice the person was that I was talking to and how positive he was, how he didn’t sound judgemental on the phone. He was open, bubbly, he sounded happy to help.”* (Quitline caller – quit, Maori, Auckland)

- Quitline callers also noted that Quit Advisors are appropriately **enthusiastic and encouraging**:

*“They were encouraging like ‘You need to do this to help yourself get on track’ but it wasn’t over the top. It was good just to have a little bit of [enthusiasm] in there but because they were strangers, they weren’t over the top.”* (Quitline caller – quit, Maori, Auckland)

- Quitline callers also noted that the Advisors often spoke in **empathetic** ways about the struggles they were encountering which assisted in building rapport. One Pacific woman appreciated the humour used by the Advisor to help her through a relapse period. This strategy of using humour to lighten situations that are viewed to be difficult is often used in Pacific and Maori families and is culturally appropriate.

*“We had a few good laughs on the phone too and, you know he was telling me to stuff a big donut in my mouth and I was like ‘Oh!’ I was going ‘No, I don’t think so’. It really helped.”* (Quitline caller - quit, Pacific, Bay of Plenty)

- Another participant enquired with the Quit Advisor as to whether he had smoked. Upon acknowledging that he had, the participant felt that he would **understand more readily** how and what she was confronting.

- **Assuring** talk and tone was also noted:

*“He assured me at first. He goes ‘Okay, have you got enough time to talk on the phone?’ And I go ‘Yeah yeah’. And I go ‘How much time exactly?’ And then he would laugh...just kind of building that rapport with the customer that rings up.”* (Quitline caller - quit, Pacific, Bay of Plenty)

- Participants with experience using other contact centres viewed the fact that, when they call in for additional support, they are asked for their **name as their identifier, rather than a number**. From a practical perspective participants note that ‘client numbers’ can be difficult to remember. However, being identified by name rather than a number also gave participants a sense of the service being personalised and based around individuals.

### 3. **Providing Appropriate, Effective Support**

- It was a commonly held view that **Quit Advisors are knowledgeable**, with participants noting that they were able to answer all their questions. The confidence with which Quit Advisors deliver information and respond to questions also reinforces perceptions of staff being knowledgeable:

*“With my learning difficulty, I find I ask more questions. And [the Quit Advisors] don’t go ‘Hmm, ah, yeah, I might have to check that.’ They always come back with an answer, a straight answer. They don’t have to go to someone else.”* (Quitline caller – not quit, New Zealand European, Canterbury)



- The availability of **on-going support** is positively received by most Quitline callers, particularly by those living in an environment dominated by smokers. While these participants reported that the positive reinforcement they received if they had managed to stay quit was motivating, they noted that the on-going support was perhaps most valuable when they relapsed. Having someone who could reassure them that they weren't a failure because they had relapsed and being able to re-focus them on their quitting goal after a relapse was seen as very important:

*"[The most important part of the Quitline experience for me has been] just knowing that I can call back whenever I need to, that I have the right to ask for any information that I need. Just knowing that I can call back and ask questions – no matter how ridiculous it might seem, I can still call back and ask. Just knowing that has probably been the best thing." (Quitline caller – quit, Maori, Auckland)*

*"Sometimes you think 'No, I am not going to [stay quit]' but when they ring you up, you think 'Yeah, they are right' and you have second thoughts about having a cigarette." (Quitline caller – relapsed, Pacific, Canterbury)*

*"It's good to know that somebody out there cares that you're trying to quit and they're there to support you through it, no matter what. That's pretty cool." (Non-Quitline caller – quit, Maori, Auckland)*

- The fact that Quit Advisors re-contacted callers was considered an additional motivation to quit and stay quit by some participants:

*"You think 'Oh no, they're going to ring' and you feel guilty. You are probably a bit more motivated if you know somebody is going to ring you and check up on you all the time." (Quitline caller – quit, Maori, Auckland)*

- Participants also note that the fact that Quit Advisors **keep their promises** in actually re-contacting callers is significant in building trust and developing honesty in the relationship:

*"When I heard from them again like they said they would, just knowing that they were truthful and kept to their word, that helped me to believe that the other things that they told me were also truthful. It helped me believe that I could trust what they were telling me." (Quitline caller – quit, Maori, Auckland)*

*"I thought it was quite cool that they rang me to see how I was going. It was like they hadn't forgotten about me after the first call. They encourage you and support you throughout quitting smoking." (Quitline caller – quit, Maori, Auckland)*

- The **cost of the patches and gum are subsidised**. One participant inferred that becoming quit was completely dependent upon subsidised assistance.

- Participants who were quit at the time of the interview commented positively on the '**hints and tips for quitting**' provided by Quit Advisors and as part of the Quit Pack. Participants noted that these were generally practical and effective, and tended to be techniques that the participant had not considered themselves.

## 10.4. Drawbacks of the Quitline Experience

### 1. *Accessibility*

- Participants perceived that Quitline **registrations could only be made via telephone**. While all women participants had telephone access and therefore did not see this as a drawback for them, midwives noted that this would be a significant barrier to those without telephones.

### 2. *Understanding The Caller*

- Participants that were familiar with the Smokechange programme felt that the **lack of an option for face-to-face interaction** with Quit Advisors reduced opportunities to build rapport. Some participants stated that they were less likely to be honest over the phone than when face-to-face with a Quit Advisor.
- One pregnant woman noted that having a **female Quit Advisor** who knew about pregnancy and smoking would have been more beneficial. It was reported that the intricacies of being pregnant, feeling unwell and coping with hormonal changes as well as trying to quit made for an experience that was more complex than when not pregnant. Further, it was noted that there were pregnancy specific questions that were left for her to seek advice from her own health professional because the Quit Advisor either didn't know and/or lacked confidence and clarity.

### 3. *Providing Appropriate, Effective Support*

- Most Quitline callers mentioned the **long registration interview** unprompted. While noting that they were on the phone for longer than they anticipated, some (particularly older) participants were not concerned about this, noting that the questions they were asked seemed relevant, were not embarrassing or difficult to answer, and they assumed that such a thorough interview was needed to ensure that they were provided with most appropriate support, particularly as they were pregnant. However, other (particularly younger) participants were critical of the registration call, noting that parts of it came across as very 'read' rather than conversational, that not all the questions seemed relevant to their situation, and that it was just too long;

*"I was kind of getting annoyed. I just wanted to get off the phone. I was sick of talking. It took about 30 minutes, 40 minutes, something like that and I did feel that it dragged on. While I was on the phone I was like 'Hurry up, hurry up.' After that, I wanted a cigarette!"* (Quitline caller – not quit, New Zealand European, Auckland)

- Three of the eight Quitline callers interviewed expressed dissatisfaction with a **lack of follow-up** from the Quitline. One reported that, despite re-contacting the Quitline two or three times, they still had not received the exchange card for gum that they had been promised (and attributed the fact that they had relapsed to not having received the exchange card). The other two participants were surprised that they had not received the follow-up phone calls they had been promised, and felt that this had contributed to them not having quit. *One of the two had subsequently sought cessation assistance via Smokechange, and was very positive about the three home visits received at the time of the interview. The other had been offered assistance from Smokechange but had declined perceiving it to be similar to the Quitline and therefore unlikely to be successful.*
- Most Quitline callers report that **insufficient information was provided with respect to NRT**, both by Quit Advisors and as part of the Quit Pack. As discussed in Section Eleven, there is considerable confusion as to whether NRT is safe for pregnant and breastfeeding women. In addition, those using the Quitline tend to receive conflicting information, with Quit Advisors reassuring callers that NRT is safer for pregnant women than smoking, but the labelling on the NRT itself informing pregnant women that the product is not safe for them to use. Participants note that, in particular, Quit Advisors should be more proactive about informing women of the labelling on the packaging and further reassuring them that NRT is safe for them to use:

*“I think [Quitline] could have given me a little bit more information about why the gum was still okay. I wanted to know why it says on the box that pregnant women shouldn’t take it. I felt like they should really tell me ‘Well, it says this because of this’. It said on the box that it was bad for pregnant women – I felt like there must have been a reason for that. What is that reason? What chemical is it? How does it affect my body and why is it not recommended? I never managed to get an answer to that one.” (Quitline caller – quit, Maori, Auckland)*

- One participant felt that monthly **follow-up calls were too infrequent**. The participant suggested that, given how difficult it can be to quit, particularly in the early stages, that fortnightly follow-up calls would be more appropriate.
- One participant reported that the **follow-up calls** from the Quitline were made at **inconvenient times**, particularly for those who work during the day. The participant expressed frustration at having missed a number of calls, and expressed a preference to be called in the evening rather than during the day.
- One participant perceived that Quitline callers were only allowed a **maximum of three calls** to the Quitline for additional quitting support and suggested that, over a nine-month pregnancy, only three calls was insufficient.

*“I felt slightly ripped off [when I found out I only had three calls]. I know I have only got three calls so what happens if I have three desperate times, like more desperate than now? I kind of feel I need to save them up, just in case things get even harder.” (Quitline caller – not quit, New Zealand European, Auckland)*

## 10.5. Perceptions of the Quit Pack

Perceptions of the Quit Pack were mixed. Some reported having read all the information provided in the pack and finding it useful from a general quitting perspective (particularly the information about the damage incurred by smoking).

In contrast, younger participants tended to have read little or none of the information in the Quit Pack, with some questioning the need for the Pack at all, stating that they felt that the Quit Advisor had given them all the information they needed:

*“[When I got the Pack] I thought ‘Yeah, I know what I’ve got to do. I don’t need to read anything. I [got] all the information from the Quitline. I know what I am doing. I am going to stop. I don’t need pamphlets to do that.’”* (Quitline caller – not quit, New Zealand European, Canterbury)

However, all Quitline callers who had looked at the Pack were critical of the insufficient amount of pregnancy-specific information. Some were aware of the current pregnancy-specific pamphlet which is included in the Pack but reported that the information provided was too superficial and often covered off what they knew anyway. Participants expressed a desire for more comprehensive information about the effects of smoking on unborn and newborn babies – accompanied by relevant pictures and case studies:

*“There’s only one pamphlet that is all about pregnancy. It needed to be more like a book than a pamphlet. It needed to be a lot more information. Everyone knows that there is a risk of cot death [from smoking], but how? That’s what you want to know.”* (Quitline caller – not quit, New Zealand European, Auckland).

*Note: Further suggestions for the enhancement of the Quit Pack are provided in Section 12.*

# 11. Perceptions of Nicotine Replacement Therapies

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Confusion as to whether Nicotine Replacement Therapies (NRT) can be safely used by pregnant and breastfeeding women has been identified as a strong barrier to quitting, as pregnant women are apprehensive about having to 'go it alone'. This confusion is also a strong barrier to the use of the Quitline, as most participants were aware that the use of NRT is a core component of the service. The main contributor to this confusion appears to be the conflicting information provided by Quit Advisors (that NRT is okay) and what is written on the NRT packaging (that NRT should not be used when pregnant). Women who did use NRT reported mixed experiences.

## 11.1. Women's Perceptions of NRT

There is considerable confusion, both in the general population and among health professionals, around the safe use of NRT by those who are pregnant or breastfeeding. This confusion can be a strong barrier to quitting, with those women who perceived, or were informed by family or friends, that NRT was inappropriate for pregnant women reporting feeling a sense of helplessness at the thought of having to quit without this support:

*"I had an old packet of gum in the cupboard and it said 'Don't use while you are pregnant'. So I thought 'How am I going to do this then? How am I going to quit?'"* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

This confusion has led to a strong feeling of apprehension around the use of NRT among pregnant women, including those who use the Quitline and Smokechange. Some participants reported having done their own research into the appropriateness of NRT during pregnancy (predominantly online) and noted that much of this suggested that NRT was inappropriate in these situations. Consequently participants were often very surprised – and in some cases unconvinced – when the Quit Advisor (or Smokechange staff member) informed them that they could use NRT.

About half the women interviewed (more typically older participants) acknowledged that, while NRT was probably not ideal to use during pregnancy, the small doses of nicotine received were less detrimental than the other harmful chemicals inhaled when smoking tobacco. In contrast however, younger and provincial women were of the view that NRT provided high doses of nicotine at uncontrolled levels in comparison to smoking cigarettes in a controlled way (as they felt that, with smoking, they could limit the amount they smoked and therefore the nicotine intake). These women were of the view that NRT was more risky than smoking.

*“They say ‘You’ve been really heavy smoking’ and they give you the heaviest nicotine patches. And it’s actually more than the amount you have in your system and it can make you chronically sick, because you are putting more nicotine in your body than what you are used to.”* (Non-Quitline caller - quit, New Zealand European, Bay of Plenty)

### **Women’s Perceptions of Patches**

Participants were particularly reticent about the use of patches whilst pregnant, expressing concern about the possible adverse affects of the (perceived) high dosage of nicotine:

*“I’m scared of [using] those patches. I’d rather go cold turkey. They’re a strong dose. I know smoking is worse than having the patches but I’m just scared that it could harm the baby. Something is telling me that I shouldn’t use them.”* (Quitline caller – not quit, New Zealand European, Canterbury)

The majority of participants were of the view that patches provide a high dosage of nicotine and therefore are most appropriate for heavy smokers. Most participants tended to consider themselves light/social or moderate smokers (most stating that they smoked ten cigarettes or less a day prior to falling pregnant) and therefore felt that patches were not appropriate for them.

### **Women’s Perceptions of Gum**

Some pregnant women were of the view that gum was a faster acting method of obtaining nicotine (and therefore reducing cravings) than patches. Most women were more inclined to express a preference for gum over patches due to negative experiences with patches resulting in feeling unwell and/or reports from friends and family about their negative reactions.

### **Motivations for the Use of NRT During Pregnancy**

The fact that NRT obtained through the Quitline is subsidised is viewed positively by pregnant smokers and seen as an opportunity not otherwise available:

*“Then there was a big push on subsidises for patches, and they were free and I thought ‘Yeah, here I go, I’ll use patches, I’ll give up.’”* (Quitline caller - quit, New Zealand European, Bay of Plenty)

NRT is also viewed as a kick start mechanism to quitting, with some women preferring to use NRT for the first two or three days in order to break the habit and then applying the cold turkey method:

*“It was good because what the patches did for me was, it gave me that first few days of sort of getting over it , because you know God that was a killer...”* (Quitline caller - quit, New Zealand European, Bay of Plenty)

### **Barriers to the Use of NRT During Pregnancy**

Other than the Quit Advisor (or Smokechange staff member), the most influential source of information about the appropriateness of NRT for pregnant and breastfeeding women is the NRT packaging, which currently has warnings that patches/gum should not be used by those who are pregnant or breastfeeding. This acts as a very strong deterrent to the trial and use of NRT, even despite reassurances from Quit Advisors:

*“[My Quit Advisor] said ‘Yes [the gum’s] all right because it’s low dosage’, but I have to be sure. They probably know what they are talking about but I would like another opinion.”* (Quitline caller – not quit, New Zealand European, Canterbury)

*“So I rang up Quitline and asked them what was the go with [NRT]. I said I was wondering if I should consult my doctor first before taking it. They told me it wasn’t really something to worry about. I thought it was really weird that they would recommend the gum to me, but on the actual package it says ....”* (Quitline caller - quit, Pacific, Bay of Plenty)

Confusion about the appropriateness of the use of NRT during pregnancy is further compounded by the perceived vagueness of some Quit Advisors’ responses when questioned further about whether NRT can be used or not:

*“[When I rang the Quitline back to ask why the box said I couldn’t use the gum], the lady said ‘Taking it is still better than having a cigarette.’ She didn’t say, she wouldn’t say, that it was okay. She just said that it was better than smoking. Both of them are bad for pregnant women either way apparently.”* (Quitline caller – quit, Maori, Auckland)

In some cases, the conflicting information being received from the Quit Advisor and the packaging can lead to the mistrust of the Quit Advisor and at a broader level, mistrust and a lack of confidence in, the Quitline service.

The above becomes particularly important for Maori and Pacific women whose literacy levels and/or engagement with print may be limited. To this end, reliance upon quality oral information as received from Quit Advisors becomes important.

Experiences using NRT as part of previous quit attempts was also a barrier to using NRT whilst pregnant. All participants who had used patches prior to their most recent pregnancy reported dizziness, nausea, nightmares and a general unwellness as side effects. The previous negative experience of patches contributed strongly to women choosing not to use patches whilst pregnant, the combined side effects of patches coupled with nausea and light-headedness while pregnant was viewed by the women to be too taxing on their baby and pregnancy:

*“Just the headaches, just the big withdrawal symptoms you go through - feeling dizzy, feeling weak. That’s why I wasn’t too keen to go to the patches.”* (Quitline caller - quit, Pacific, Bay of Plenty)

### **Sources of Information About NRT**

Sources of information about NRT include:

- friends and family who have used it themselves. Most often this information tends to focus on the adverse side-effects of NRT (nightmares, stomach aches, wind);
- Quit Advisor (or Smokechange staff member);
- Internet; and
- LMC.

## **11.2. Health Professionals’ Perceptions of NRT**

Midwives generally agreed that there was insufficient information available about the appropriateness of NRT for pregnant and breastfeeding women. Community midwives in particular commented that they would not feel confident giving advice to women as to whether patches or gum were appropriate to use during pregnancy:

*“If a woman said to me ‘Hey, I’ve been wearing this patch, is that okay?’ I wouldn’t be that confident to say either way. It’s not something that there’s been a lot of information given about. I would love more [information] actually.”* (Community midwife, Auckland)

*“For a while I got this feedback that you shouldn’t be recommending patches to pregnant women, then I remember going to a training in early 2000 or 2001 where they were saying patches were a good thing and that we should be looking at them. Then there seemed to be a while there where people were saying ‘Oh no, not patches for pregnant women.’”* (Independent midwife – Bay of Plenty)

One GP also supported this position, discussing the non-conclusive results from research as to the effects of NRT on unborn babies. As a result of the non-conclusive results, and a preference for erring on the side of caution particularly with respect to ante-natal issues, the GP was of the opinion that cold turkey was the best quitting option and recommended this to his patients over smoking cessation services that advocated the use of NRT.

While most health professionals noted that they were not completely comfortable with pregnant and breastfeeding women using NRT, some felt that, provided it was only used for a short period of time – to get the woman over the worst of her cravings – the benefits probably outweighed the drawbacks:



*“If it means they’ll be able to stop smoking or they can reduce then I think it’s quite a good idea myself. As long as it’s not ongoing. If it’s ongoing you might as well have a cigarette. But if it helps them reduce and then they can take the patch off and stop completely, I think they’re a great idea.”* (Community midwife – Canterbury)

For the few health professionals who were prescribing NRT to pregnant women, views were mixed as to whether patches or gum were more appropriate. Some midwives felt that patches were easier for most women as they were slow-release and did not require the wearer to have to worry about them during the day. These participants felt that, with gum, there was too much of a temptation for the woman to use it like chewing gum. In contrast however, others felt that the lower dose gum was likely to fewer adverse effects on the baby.

### 11.3. Women’s Experiences of NRT

As a result of their concerns over the appropriateness of NRT, some of the women who had received NRT exchange cards (Quitline) or the patches or gum themselves (Smokechange) reported that they never actually used them, whilst others delayed their use for some time, hoping that they would be able to quit themselves without needing to resort to the patches or gum:

*“I didn’t end up using the patches. I had given up before during my previous pregnancies without them and I was still concerned that the baby was still getting some harmful nicotine through the patches so I thought ‘If I can give up without them, it’s better than using them’.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury)

#### **Experience of Patches**

Two participants who had used patches considered them to be ineffective, as, while they had minimised the nicotine cravings, they didn’t address the need smokers have to be doing something with their hands.

*“[The Quit Advisor] didn’t say anything about needing your hands to be occupied. And you are constantly sticking things in your mouth because that’s what you are used to doing.”* (Non-Quitline caller - quit, New Zealand European, Bay of Plenty)

One participant who had obtained their patches through Smokechange reported that the dosage had been too high and they had experienced head spins, nausea and headaches. While the Smokechange staff member had promptly provided a lower dose patch, the participant found that these didn’t sufficiently take the ‘edge’ off her cravings and she had started smoking again

#### **Experience of Gum**

The taste of the gum was viewed by most participants who had tried it as unpleasant and subsequently, after the first couple of attempts, they generally stopped using it:

*“I only used [the gum] once. I didn’t want to use it after that because it tasted gross. It tastes like ash. The taste totally put me off.”* (Quitline caller – quit, Maori, Auckland)

One participant reported that the ash-y taste of the gum reminded her of cigarettes and she found that, after she had chewed the gum, she wanted to smoke even more.

One participant who had successfully used gum to quit noted that more information about gum was needed, and in particular, information as to the frequency of gum use. The participant had used gum as a cigarette replacement, chewing it each time she craved for a cigarette. Discussions with the Quit Advisor corrected the practice despite the information being on the gum packet.

## 12. Enhancing Pregnant Women's Access to, and Use of, the Quitline

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The research has found that currently/recently pregnant Quitline callers are generally very positive about the Quitline, particularly with respect to the quality of the service and support provided by Quit Advisors. The research has also identified a number of opportunities to enhance the Quitline, particularly with respect to improving awareness and access, and expanding the support component. These suggested enhancements are discussed in this section.

### 12.1. Enhancing the Motivation to Quit

#### → **Raise Awareness Of The Negative Health Implications of Smoking During Pregnancy**

Accurate information about smoking and the impact upon pregnant women existed only at a very general level for the majority of participants interviewed. While all participants were aware that smoking during pregnancy has negative health implications for the unborn and newborn baby, very few had knowledge as to what these actual health implications are, how severe they can be and what they mean for the long-term development of the child. In addition, there existed a range of views about the positive effects the process of quitting would have for the child. Both health professionals and women participants call for more information/education on the specific health implications of smoking during pregnancy:

*“[If I had had more information about how I was putting my baby at risk], that would have motivated me to quit. The information would have made me sad. I don’t want anything to happen to my baby.”* (Non-Quitline caller – not quit, Pacific, Auckland)

*“I think we need to know more about the effects of smoking on your baby because the low birth weight and premature birth is not going to put people off. I think there should be more information about just how many toxins get through the placenta into the baby and how it affects them, including when they’re toddlers and older kids, what kind of damage it can do, what you leave them with. You need to scare people a bit more into [not smoking].”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

Both midwives and the women interviewed felt that television was the most appropriate medium for conveying this information, particularly for Maori, Pacific and lower socio-economic women – the groups identified as most needing this information (as they tend to have the highest incidence of smoking) and having least access to the information through other channels (due to financial and literacy issues).

Based on the television viewing behaviours of the women participants, for maximum effect, these ‘advertorials’ could be screened on day-time television during talk shows such as Dr Phil and Oprah.

*“There is not really anything directly marketed at pregnant people that I have seen. Show a pregnant woman smoking [on television]. I think it would horrify a lot of people. Some people are that stupid that they need it pointed out to them. It would probably initially cause debate, but public debate encourages people to talk about issues, and if it’s not discussed, how can it be addressed?”* (Non-Quitline caller – quit, New Zealand European, Auckland)

#### *Mixed Views on Graphic Nature of Images Shown*

Some participants, including some midwives, strongly advocated the need for more graphic images showing the detrimental effects of smoking during pregnancy as a way to shock pregnant smokers into quitting:

*“Just give us more disgusting pictures that show people what smoking can do to your body – and how it can happen to anybody. That would make people stop and think.”* (Quitline caller – quit, Maori, Auckland)

*“Show prem. babies maybe, or cutting open half a lung and saying ‘do you think this is what your baby’s lungs look like?’ I think one of the most effective [advertisements] was the aorta with all the crap coming out of it. It’s disgusting, it’s revolting. I think sometimes you have to shock people because a lot of people have a very blasé attitude, that it won’t happen to them.”* (Independent midwife – Auckland)

However, other participants felt that many smokers had developed immunity to such pictures:

*“I found them quite stupid what they are putting on packets these days. I think it is ridiculous because it’s not putting anyone off...to me it’s a waste of time.”* (Non-Quitline caller – relapsed, Maori, Auckland)

Some midwives felt that a more motivating approach would be to appeal to the emotions of the pregnant smoker, which they noted tended to be heightened during pregnancy anyway - for example highlighting the negative impacts of smoking on the woman’s ability to bond with the baby:

*“I think advertisements, like little case studies. For example, a woman who has got a premature baby, showing what it has meant to her to be separated from her family while the baby is in hospital and what it has meant not to be able to hold the baby in her arms and how hard it is to watch them having all the blood tests and having difficulty breathing. I think women respond to that stuff.”* (Independent midwife – Bay of Plenty)

Other participants suggested that the information and images would be more motivating if they were more positive - for example informing pregnant women of the capacity of the body to regenerate after smoking:

*“.. about how fast the body takes to heal itself when you stop smoking...that’s what I think is inspiring to know - that your lung capacity comes back within a shorter time, not years and years, you know that type of stuff...”* (Quitline caller - quit, New Zealand European, Bay of Plenty)

### → **Incorporate Incentives for Quitting**

As discussed in Section Four, because of the mis-information around the negative effects of smoking during pregnancy, minimising the health risks to the baby is not always a significant enough motivator to quit. Midwives suggested that younger women in particular may be motivated by the provision of gifts/incentives/prizes for quitting or even for just contacting a smoking cessation service, particularly if the incentives were baby-related:

*“It would be great if [Quitline] could give out presents, something that would lift the burden on a woman whose making an effort to stop smoking. I know it’s wrong that helping the health of the baby isn’t enough, but for some women, it isn’t. It could be some sort of package where, when she’s quit, there’s a nappy service for six weeks, vouchers for baby gear or vouchers for the supermarket.”* (Independent midwife – Bay of Plenty)

### → **Raise Awareness of the Use of NRT by Pregnant Women**

As discussed in Section Eleven, one of the key barriers to quitting is a fear of having to ‘go it alone’ because the woman believes that it is unsafe to use NRT whilst pregnant and when breastfeeding. Consequently, raising awareness among pregnant women that they can use NRT is important.

It is suggested that, as part of a pregnancy-focused advertisements, (safe) use of NRT could be emphasised:

*“[The Quitline] need to show that it is okay [to use NRT] – have some case studies and things like that – people who have quit using patches or gum, and showing that their babies weren’t deformed or whatever.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

One of the key ways to raise awareness of the use of NRT by pregnant women is through the advocacy of health professionals. All health professionals stated that they would be keen for more information about the use of NRT during pregnancy. Midwives and practice nurses suggested that this could be provided in the form of a study/education day or seminar. Practice nurses also identified clinic visits by Quitline staff/NRT experts as a desirable way to inform them about NRT. In contrast, GPs suggested articles in industry magazines such as ‘GP Weekly’ or ‘Best Practice’ (rather than direct mail – *“because there’s a tendency for stuff that comes in the mail to go straight into the bin.”* – General Practitioner, Bay of Plenty)

## 12.2. Enhancing Awareness of the Quitline

### → Enhance Pregnant Women's Awareness of the Quitline

All participants were aware of the Quitline television advertisements. However, both women and health professionals questioned their relevance and motivating power to pregnant women. The advertisement screening during the field work period (of the man with oral cancer) was considered particularly irrelevant to pregnant smokers.

Women participants suggested more advertisements featuring pregnant women, talking about (and ideally showing) the negative effects smoking has had on their babies. Younger women suggested that showing younger smokers on the advertisements might make them more relevant for them, while midwives working with Maori and Pacific women highlighted the importance of featuring “*brown faces and brown babies*” in the advertisements. Given that one of the most significant barriers to pregnant women's use of the Quitline is a perception that NRT is not appropriate for them, women suggested that the advertisements could also show a pregnant woman using patches or gum to assist with quitting.

However, health professionals working with clients for whom English is a less familiar language reported that advertising on mainstream television may not work well for some client groups. Advertising on ethnic radio stations is recommended as a complement to television, along with print advertising in ethnic newspapers. (The breast screening campaign was cited as an example of a health campaign that employed multi-lingual advertising successfully).

Community midwives working in large hospitals report difficulties sourcing information about the appropriate information to give to women. This, coupled with the fact that community midwives tend to have very limited time to spend with each woman (and therefore to seek out the information), means that, currently, a woman who requests information about the Quitline (or indeed any cessation support) in the hospital environment, may not receive it:

*“I don't think [the information about smoking cessation programmes] would be readily available. I can never find the information on half the things I want in that place [large hospital], it's so disorganised. There are probably pamphlets around but it's the time it takes to dig them out. You haven't really got the time to do the extra stuff like that.”* (Community midwife, Auckland)

Community midwives suggest that smoking cessation information should be more accessible within the hospital (and birthing centre) environment – both to health professionals and to the public. As a minimum, it is suggested that Quitline brochures and cards with the contact number should be on the reception desks of neo-natal wards and birthing units.

Independent midwives in Auckland also suggest that websites and electronic community message boards could be used more effectively to promote the use of the Quitline by pregnant women.

### → **Enhance Health Professionals' Awareness of the Quitline**

All health professionals were aware of the Quitline, but most acknowledged that they did not know enough about how the service actually operates, the exact nature of the services provided, and in particular, the information and support offered to pregnant smokers. This lack of knowledge was a key barrier to health professionals actively promoting the Quitline as a smoking cessation service. In contrast, health professionals commented that they often recommended Smokechange to their patients, not because it was necessarily a better service but because they had a greater understanding of it as a result of attending training days and (for midwives), being lectured on it as part of their midwifery training:

*“We tend to refer people to Smokechange. Smokechange got funded through the College of Midwives, it’s part of the Education for Change, and they actually did huge marketing to midwives. They also go to AUT and teach student midwives about their programme.”*  
(Independent midwife – Auckland)

*“They are really pushing the Smokechange workshops through study days, which is good. You do a full day or a two day workshop which they pay you to attend. That’s always very good! They give you a big booklet on Nicotine Replacement Therapy, how to use it, when you can use it, how long you can use it for, what kinds of questions to ask. That’s really helpful.”* (Independent midwife – Auckland)

It was suggested that the Quitline run a training/study day (or half day/evening session) for health professionals to inform them about the Quitline (with midwives strongly advocating that the training be accredited by the Midwifery Council of New Zealand so that they can gain points as part of their annual Recertification Programme). As well as detailing the background and philosophy behind the service, health professionals recommend that the training session allocate considerable time to the practicalities of the service (to enable them to respond with confidence to women’s questions). Examples include:

- what types of support are actually provided – and how frequently;
- confidentiality issues, particularly who has access to the caller’s information;
- number of inbound and outbound calls allowed;
- information about what happens after eight weeks (that is, after two lots of exchange cards have been sent) if the caller is still not quit – what further support is available?
- whether clients can use the service more than once;
- how long Quit Advisors stay in touch with callers;
- how the service responds to the needs of pregnant women; and
- costs involved in using the service – including costs to call.

### 12.3. Enhancing The Referral Process

Views were mixed as to whether the referral process to the Quitline should remain predominantly one of self-referral or whether health professionals should take a more proactive approach. Most health professionals felt that pregnant women were likely to get very defensive if they perceived that they were being pushed into a smoking cessation service against their will or without being given time to think about it:

*“They would probably be thinking that we are pressuring them to quit, that they are being pressured. Also, because they are in a doctor’s office, they might say ‘yes, yes, I want to quit’ but when they get home they change their mind.”* (General Practitioner – Auckland)

Midwives in particular expressed concern about how this perceived pressure may affect their longer-term relationship with the woman, with one midwife suggesting that some women may decide that they don’t want further ante-natal care.

These participants felt that a more proactive approach to referral would only be relevant after two or three discussions with the woman in regards to her desire to quit. However, midwives noted that these three visits would take three months and felt that this was too much of a delay. The women themselves were similarly resistant to the idea of proactive health professional referrals, some participants noting that, if they knew their LMC was going to automatically refer them on to a cessation service, they may be reluctant to even admit that they smoke.

In contrast however, a small number of midwives and practice nurses expressed a preference for health professionals taking a lead role in referrals. These participants felt that this was particularly important for some Maori, Pacific and lower socio-economic women who tended not to bother following up on services recommended to them (due to lack of time, lack of resources to make contact, fear of the unknown, or laziness). Those who proactively referred women to Smokechange reported that their experience had always been very positive and that the women were often grateful for this assistance and appreciated the interest being shown in them:

*“I think part of it is [the woman] thinking ‘I’m special and somebody’s doing something for me.’ For example, if you refer them to a physio because they have a sore back, that’s not seen as interference, it’s somebody doing something for you. I think this is a similar thing.”* (Independent midwife – Auckland)

*“Some of them would be okay with [a health professional making the referral] because they think ‘that is one thing out of the way’, something has been done for them rather than them doing it because they have got so many other things to do. Clinics should really be ringing for those who really want it.”* (Practice nurse – Auckland)



To assist in making referrals, it was recommended that the Quitline provide health professionals with a brief referral form or letter that can be completed and faxed through to notify the Quitline of the referral. Some health professionals preferred a fax referral over contact by telephone noting that a fax could be co-signed by the client to show their consent to be referred and to participate in the service.

## 12.4. Tailoring the Quitline to Pregnant Women

As discussed in Section Four, there is a range of myths and misconceptions to be debunked about smoking and pregnancy and there is a wide range of questions that pregnant smokers seek answers to. Pregnant women reported that having access to quality information about the health risks associated with smoking during pregnancy is important. However, some felt that the current Quitline service is more generally focused:

*“[Quit Advisors] need to explain the issues a bit more and say ‘this is what it’s doing to your baby’ because I know that would have helped me a lot with quitting. [At the moment] they are really nice about it, maybe too nice. They need to say ‘look, if you keep smoking, this could happen, this can happen’ – lots of specific things.”* (Quitline caller – not quit, New Zealand European, Auckland)

These participants report that the development of a specific pregnant women’s Quitline service would be beneficial (and midwives note that this may appeal to some women as something *“special, just for them.”*). Such a service would include:

### → **Specialist ‘Maternity’ Quit Advisors.**

These Quit Advisors would be specially trained to provide information and offer support and advice to pregnant smokers. Suggested skills and qualities of these specialists include:

- female;
- friendly, approachable;
- non-judgemental;
- good knowledge of smoking colloquialisms e.g. rollies, taylies
- previous history of being a smoker and having quit – *“More experience of trying to give up, whereas a person who hasn’t smoked doesn’t have any experience, wouldn’t know what the [craving] feels like.”* (Quitline caller – quit, Maori, Auckland)

*“I certainly think they quite like the idea of knowing that other people struggle with quitting as well and how they managed. They like someone they can share their stories with.”* (Community midwife – Canterbury)

- some level of medical knowledge in relation to pregnancy – ideally a midwife;
- has children themselves - *“Just so they know how hard it is to have kids and how stressful it can get.”* (Non-Quitline caller – relapsed, New Zealand European, Canterbury); and
- understanding/empathy with the emotional turmoil experienced by some pregnant women of dealing with pregnancy and the need to quit.

Participants generally agreed that an ideal cessation service targeted at pregnant women would include the option of home visits by a Quit Advisor. In addition, clients of the service would be able to nominate how regularly they wanted the visits to be, based on the level of support they required.

### → **Inclusion of the Woman's Social Circle**

As discussed in Section Five, one of the main barriers to quitting and staying quit is regular/constant exposure to others in the woman's social circle who continue to smoke. Similar to Smokechange, the ideal pregnancy-specific Quitline service would also include the provision of quitting support to the woman's social circle – particularly partners, but also parents, flatmates, friends and/or work colleagues as appropriate.

### → **Post-Natal Support**

The birth of the baby is a key trigger for relapse, with the desire to minimise the health risks to the baby becoming less of a motivator, alcohol often being consumed again, and increased boredom and stress enticing the woman to smoke. Having relevant support available in the first three to six months after the child's birth is essential to minimising relapse:

*"I knew lots of people who had started again [after their baby was born] but I just thought 'Nah, I will be fine'. But then, just the stress of things pushed me off the edge. It would have been nice to have had someone to call or something at that stage after I had that one cigarette that I could say 'Help, I have had one cigarette and I feel like more'." (Non-Quitline caller – relapsed, New Zealand European, Canterbury)*

Suggestions for this support include:

- the provision of information (pamphlet, poster etc) about the effects of smoking on a newborn baby, accompanied by 'tips and hints' to stay quit, particularly those which address the issues of boredom and stress;
- more frequent phone calls, and reminding woman that they can call the Quitline for support;
- the option of a home visit after the baby is born (perhaps with a small relevant gift for the baby such as a bib stating that the mother is smoke-free); and
- follow-ups to ensure the woman has sufficient NRT and, acknowledging that the woman may be confined to the home, sending the patch/gum themselves rather than an exchange card.

### → **Enhancing The Quit Pack**

Suggestions for improvements to the Quit Pack relate predominantly to further tailoring it to the needs of pregnant smokers in particular.

Suggestions include:

- more information (and pictures) about the negative effects of smoking on unborn and newborn babies – accompanied by more positive information about the body's ability to regenerate after smoking stops. This point in particular may motivate those whose attitude tends to be *"I might as well keep smoking because nothing I do will change the consequences"*.
- the inclusion of success stories of other pregnant smokers, showing what techniques they used to quit, how they dealt with stressful situations, how they dealt with relapse and so on. Younger participants suggested that this information would be best presented as a DVD rather than as written information;
- wallet card containing quick responses women can use when asked by those in their social circle why they are not smoking:

*"Like five quick little answers that they could give. I think the younger people in particular, they often feel quite embarrassed when people pull them up about it. If they just had a line that rolled off their tongue – like 'I want my baby to be as healthy as possible', that would really help them."* (Independent midwife – Bay of Plenty)

- wallet-sized fold-out card, showing the range of negative impacts smoking can have on a baby:

*"If you had a fold-out credit card-sized card which showed all the reasons why smoking is bad for [the mother] and the baby. Let them have it as something they can stick in their pocket and, when they feel like having a cigarette, they can take it out and go 'oh, that's disgusting' and put it back again."* (Independent midwife – Auckland)

- posters showing the negative effects of smoking on unborn and newborn babies and/or the positive benefits of stopping smoking during pregnancy (participants comment that they would be useful reminders not only for themselves, but also for other smokers in the household);
- information about the importance of staying quit after the birth – particularly the impact of smoking on breast milk/breastfeeding - and tips and advice on how to stay quit;
- the inclusion of vouchers for baby clothing, equipment, toys, nappies etc (as an incentive for women to call and register with the Quitline);
- bibs, baby cups etc that advertise to others the fact that the mother is smoke-free:

*"They could put in little bibs that say 'my mummy is a non-smoker', something to make the mother feel proud of what she has done – or guilty if she has started [smoking] again!"* (Non-Quitline caller – quit, Maori, Auckland)

Participants suggest that the Quit Pack should be made more readily available – for example, through health professionals. It is noted that currently only those motivated to quit are able to access the Packs whereas it is often those who are reluctant quitters, or embarrassed about their smoking, who need easy access to this information.

## 12.5. Enhancing the Range of Quitline Touch Points

The current Quitline service is based predominantly on telephone support. Health professionals note that, particularly for younger women, the telephone is not always a preferred access channel as mobile phones can be expensive to run, and some women lack confidence talking on the phone, particularly with strangers or where English is a less familiar language. Midwives note that, over the last few years, they have had to make adjustments to the way they communicate with their clients, and suggest that the Quitline may need to do the same thing:

*“You phone people and they don’t answer, so you leave a message and you know it’s not going to be picked up. So you text them and they text back within five minutes. The phone’s there, but if they don’t recognise the number, they’re not going to pick up, whereas if you text them, they go ‘okay, sweet’. It is all about finding out what works for them, what they respond to.”* (Independent midwife – Auckland )

Participants identify chat rooms/community message boards, texting and a multi-lingual telephone-based service as possible complementary access channels to the existing telephone-based service.

### → **Chat Room/Community Message Boards**

The younger participants in particular tended to be very computer literate and often used the Internet. One younger provincial woman reported that she had developed a quit smoking coping mechanism of talking in online chat rooms when she felt tempted to smoke:

*“There is a web site that I go to that’s got a chat room in it that I know through a friend of mine. And also I go into Trademe message boards and I just read there, and just release it some other way.”* (Non-Quitline caller - quit, New Zealand European, Bay of Plenty)

The development of a chat room for pregnant smokers where stories are shared and stress is released would particularly assist those who find themselves isolated from their social circles due to their decision to quit (or who have chosen to isolate themselves), to establish friendships and a support system with others encountering similar experiences:

*“It’s getting you in contact with people who are going through the same thing. And because they can’t see you, they really don’t know who you are, you can be more honest. You’re all going through the same thing so you get that support group-type thing happening.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

Participants suggest that the ‘chat room’ could include a range of spaces, including:

- clinical/medical space – relevant information and advice from health professionals;
- ‘tips and hints’ from Quitline Advisors and other women;
- case studies/personal stories of other pregnant smokers; and
- free chat space.

### → **Text Messaging**

Text messaging as a form of contact was viewed as helpful and supportive as an extra or complementary form of communication to the telephone:

*“Texting tips for quitting would be quite good, ideas and tips. A bit of a motivational start for the day, that sort of thing.”* (Non-Quitline caller – relapsed, New Zealand European, Auckland)

However, it was not perceived as important as face to face and phone contact. Participants noted the importance of hearing a voice of encouragement as being more powerful than a text message (which could be ignored or deleted). In addition, one woman who had participated in Smokechange noted that text message systems relied on the client and the organisation using the same mobile company (the client was unable to send a return text as her phone did not have credit).

### → **Multi-lingual Service**

Health professionals dealing with women for whom English is a less familiar language report that the provision of bi-lingual Quit Advisors would both encourage these women to call, and would also ensure that they were getting all the information and support they needed. Work and Income’s Multi-Lingual Contact Centre is cited as ‘best practice’ in this area:

*“More and more people are using Work and Income’s [Multi-Lingual] contact centre because the caller can solve the problems themselves rather than getting an agent or somebody to interpret for them, rather than having to give all their personal information to somebody else to call for them. If there was a Hindi speaker [at the Quitline, callers] would be able to get so much more information.”* (General Practitioner – Auckland)

Note: The Quitline currently provide te reo, Samoan, and Tongan speakers and speakers of other Pacific language among their Quit Advisors. However, the comments made by health professionals suggest that none were aware that this multi-lingual support is available for women for whom English is a less familiar language. More could be done to promote this service to both health professionals and the bi-lingual women themselves. One health professional working with Indian clients noted that the availability of a Hindi-speaking Quit Advisor would be a key draw for Indian smokers looking to quit.

## **12.6. Enhancing Links with Health Professionals**

While noting that time can be a significant constraint on how much support they are able to offer pregnant smokers, all health professionals reported that they would like to do as much as they could to help pregnant women quit smoking.

Health professionals suggest that some form of regular (possibly monthly) feedback from the Quitline on the quit status of their pregnant patients would be useful, both to provide them with accurate information about the woman's quit status at any point in time (which the woman may be reluctant to disclose) and also to allow the health professional to reinforce information and advice being given by the Quitline during appointments. GPs in particular note that receiving progress reports on the status of those referred to the service (particularly if the outcomes are positive, but also if the comprehensiveness of the support is illustrated) may encourage them to refer more patients in the future:

*“I would love some communication around what has happened [with my patients who have been using the Quitline]. After you refer someone to Quitline, they just disappear. It would be good to have some sort of feedback on what's actually happened.”* (General practitioner, Bay of Plenty)

*“[The Quitline and I] probably should be working together. Maybe I should get in touch with them and find out exactly what they have done and what I can do to help continue to reinforce the message.”* (Independent midwife – Auckland)

*“It would be nice to get a letter to say that we have enrolled this person on our programme and we will be providing her with support and NRT patches or whatever. Otherwise we just rely on the feedback of the woman – which I know is not always 100% accurate.”* (Independent midwife – Canterbury)

## 12.7. Additional Support - Local Level Initiatives

### → **Establish Local Support Groups/Quitline-Sponsored Ante-Natal Classes**

Establishing physical social circles of support for pregnant women is viewed by health professionals as being critical in attempting to – and staying - quit. This is particularly important for a pregnant woman whose social support system smokes and as a result of choosing not to smoke, finds herself isolated.

Participants suggest that physical support groups could incorporate:

- presentations by health professionals, both with respect to smoking-related issues, but also general pregnancy issues (including health and fitness during pregnancy);
- motivational speakers – for example, other women who had managed to quit whilst pregnant;
- presentations on helping partners and others in the social circle to quit;
- presentations on ways for the women to keep busy/change their daily routine, such as crafts, part-time study options, sports and fitness, etc.
- opportunities for informal discussion – sharing of experiences, “hints and tips” etc;
- opportunities for one-on-one counselling after the group meeting;
- opportunities for the formation of ‘coffee groups’ so that women can meet and support one another informally. These coffee groups were also seen as an opportunity for women to establish new non-smoking social circles and to provide opportunities for socialising in a smoke-free environment, as well as offering much-needed post-natal support; and
- the sharing of food (important culturally).

As well as addressing the two key barriers to quitting smoking during pregnancy – lack of awareness of the health risks of smoking on the baby and lack of support from one’s social circle - other perceived benefits of local support groups include:

- reducing boredom (one of the key barriers to quitting) by providing women with something to do during the day; and
- providing networking opportunities. Midwives report that younger, partner-less women and women from lower socio-economic backgrounds (who tend to be over-represented among smokers) tend not to attend ante-natal classes due to access difficulties and stigma associated with not having a partner to attend with. Consequently, they tend not to participate in coffee groups after the baby is born. ‘Quit’ support groups are considered to provide an excellent opportunity for these women to establish friendship and support networks.

Pacific participants noted that the success of these support groups for Pacific women would be maximised by:

- offering bi-lingual support groups – so the information given and materials provided, as well as informal discussion during the session, was also available in the attendees’ home country language; and
- linking the support groups in with local churches. While it is acknowledged that not all Pacific women attend church, for those who do, providing a comfortable familiar location for the group (church hall etc), having church elders as advocates for the groups, and having other members of the congregation available as support people/sponsors may provide reassurance to those who are reluctant or embarrassed about attending.

### ➔ **Establish Local Quitline Office**

Health professionals working in South Auckland and provincial areas in particular suggested the establishment of a local Quitline office:

*“I think that would work really well for [South Auckland]. Somewhere that’s local, within the community, that’s visible to the community where they can just wander up with their 15 kids in tow and [the kids] can play in the playroom while she talks to the smoking lady.”* (Independent midwife – Auckland)

Possible services offered by a local Quitline office could include:

- on-site Quit Advisors available to offer regular support (via an appointment system) as well as offering advice and support to those at risk of relapse;
- on-site Quit Advisor available to offer information and advice to health professionals working with pre-natal maternal smokers:

*“I will be saying ‘I have done so and so to this patient and I think the message is still not getting through, is there anything more we can do to help them?’ They may be able to give you back up or offer better suggestions.”* (General Practitioner – Auckland)

- on-site Quit Advisors available to take those interested in quitting through the registration interview face-to-face (particularly important for those who dislike using the telephone, those with language issues and those for whom face-to-face contact is culturally more appropriate – particularly Maori);
- extensive library of information about the impacts of smoking, and tips and advice on how to quit (DVDs, CDs, brochures, booklets, posters, fridge magnets, wallet cards etc);
- provision of NRT (including the provision of additional NRT for those who have run out, rather than having to phone the Quitline to request another exchange card);
- 'drop in' service, providing opportunities for current smokers and those who have quit to network with one another and share ideas and advice informally (ideally with refreshments made available);

*“You might have a Quit counsellor visiting, with the open-door sort of stuff so people walking past might think ‘Maybe I’ll go and talk to them’ because sometimes people don’t take any action on pieces of paper, but seeing something can motivate them. It’s like ‘Oh, there’s that Quit person. I’ve always wanted to cut back. Maybe I should go and talk to them.’”* (Independent midwife – Bay of Plenty)

Staffing the service with people demographically similar to those of the local community will assist in building rapport and trust:

*“The value of [a local Quitline office] is it’s a face-to-face thing, face-to-face with somebody that looks like they understand what these women are going through. Around [South Auckland] that means brown faces. I think that would get more response than white faces sitting there going ‘You shouldn’t be smoking!’”* (Independent midwife – Auckland)

It is suggested that a local Quitline office could be operated either alongside, or within, the local Plunket rooms. Advantages of this arrangement include:

- Plunket rooms are generally easily accessed;
- They are a non-threatening environment (as opposed to health clinics for example); and
- The arrangement offers synergies for both services – Plunket can refer smoking parents onto the Quitline office; the Quitline office can advise pregnant women about the benefits of Plunket.

Based on the success of other similar health campaigns (for example, Plunket, breast screening), health professionals also suggest that a mobile service (such as a Quitline caravan) might be both cost effective and sufficiently novel to encourage interest.



## 12.8. Enhancing the Role of Health Professionals in Smoking Cessation Support

### → *Enhance the Role of Midwives*

As noted earlier, all health professionals reported that, within time constraints, they would like to do as much as they can to help pregnant women quit smoking. It is noted that midwives are in a unique position to provide quitting support in a similar (potentially complementary) way to a Quit Advisor as they:

- have face-to-face contact with the woman on a regular basis;
- have generally established a relationship of trust with the woman, and their advice is respected;
- have a good understanding of the woman's physical and emotional state to offer appropriate advice; and
- are perceived as knowledgeable:

*“As a midwife I actually have a little bit of weight behind me with them. They have invited me into their lives to help them when they have their baby and they do listen to me. “[Midwives are] a familiar and constant visitor. I’ve gained their trust and have been allowed into their lives and I know intimate things about them. I think midwives are in a position where we can assert a bit more influence.”* (Independent midwife – Bay of Plenty)

Midwives identified the following support that would be useful for them in helping pregnant women to quit and stay quit:

- DVD resource depicting the negative impacts of smoking during pregnancy that midwives could show to women prior to discussing possible cessation with them. Midwives suggested the DVD could depict a ‘coffee group’ situation with each woman talking about her smoking history and the different negative effects on her baby. Midwives felt that, to have greatest impact, at least some of the women featured on the DVD should be of Maori and/or Pacific Island descent;
- A designated Quit Advisor that health professionals could call for advice about a particular cessation issue or for support and advice on dealing with clients who are struggling to quit. Midwives also noted that this would allow them to use their time with clients more efficiently – that they could phone and get an answer to a client’s question immediately rather than searching through booklets etc. One GP cited the telephone-based support available to health professionals as part of the immunisation programme as a ‘best practice’ example:

*“It would be good to have someone you could ring to talk over an issue. We tend to talk to our colleagues – you might meet for coffee sometimes and you might say ‘I’ve got this woman and she smokes like a train but I don’t know what to do.’ It would be quite good to talk to someone more qualified about it, get some ideas.”* (Independent midwife – Bay of Plenty)

*“If the patient comes in and [asks a question about immunisation], there are books [we can refer to] but sometimes we can’t go through the books, flipping through 300 or 400 pages to get the information we need. Sometimes it is easier just to ring them up because they are full of knowledge. For things that come up just once in a while or a mother who asks a question we haven’t had before, it’s easier to ring. It’s a one minute job.”* (General Practitioner – Auckland)

- More smoking cessation training – and for those working in provincial areas, financial assistance to get to the training courses (see Section 12.2).

### → **Enhance the Role of GPs and Practice Nurses**

Midwives felt that GPs have a role in encouraging smoking cessation and promoting the Quitline as they are often the woman’s first point of contact with a health professional in pregnancy (in contrast to midwives who typically don’t see the woman until the end of her first trimester). Midwives also note that, at least initially, GPs may have more rapport with the woman than they do, particularly if the GP is the woman’s family doctor, and therefore may be in a better position to motivate her to quit:

*“They’re their family doctor and they know their history probably better than we do. They may well know that their mother died of cancer from smoking and things like that that they can use [to motivate change]. People say ‘Oh it won’t happen to me’ so if the GP knows things – knows that she’s got high blood pressure and is at high risk of diabetes and all the rest of it and it’s going to get worse when they’re pregnant if they keep smoking, he can raise this with them.”* (Independent midwife – Auckland)

GPs and practice nurses identified a lack of time as the main barrier to providing more information and advice to pregnant smokers and providing some form of follow-up. These health professionals reported that having more time would allow them to:

- talk through the health implications of smoking during pregnancy with the woman in more detail, ideally with the support of resources such as pamphlets and DVDs;
- explain the smoking cessation services/programmes available in more detail (benefits and drawbacks, what happens during the first call etc); and
- telephone the woman to check on her progress/follow up on referral advice given/check whether she needs any other support.

Practice nurses reported that, ideally, they would re-contact the woman in the week following her initial visit, then move to fortnightly or monthly follow-ups.

The research has found that the first two to three months after the birth of the baby is a key point of relapse. GPs suggest that they could have a role in providing continued quitting support and relapse advice and support during this period, particularly as most women will visit their GP for the baby’s six-week health check.

However, they note that it is likely to be more difficult to encourage women to quit smoking after the birth (due to the desire to minimise the health risks to baby becoming less of a motivator) and therefore call for more support from the Quitline – in the form of pamphlets, information sheets etc that can be referred to during the appointment and also given to the women to read.

### **12.9. Improving the Sharing of Information Between GPs/Practice Nurses and Midwives**

The GPs and practice nurses participating in the research noted that there is currently no formal transitioning process for moving a pregnant woman from GP care to the care of a midwife. GPs note that, ideally, there should be a procedure in place whereby midwives are informed by the GP of the woman's smoking history (this being particularly relevant for women who quit smoking whilst under the care of the GP and therefore are identified as a non-smoker by the midwife). Ideally, the GP would also inform the midwife of the smoking cessation interventions discussed and pursued and the success to date, thereby allowing the midwife to continue reinforcing efforts already made.

## 13. Conclusions and Recommendations

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The following conclusions can be drawn from the research:

1. While a desire to minimise the health risks of the unborn baby is the key motivator to quitting among pre-natal maternal smokers, the actual risks to the baby are poorly understood. In some cases, this has resulted in smokers playing down the risks to justify their decision not to quit or, more concerningly, has led to some risks being mistakenly regarded as benefits. The reasons why quitting during pregnancy is beneficial need to be clearly established. This could be achieved through:

- television advertising/'advertorials' featuring pregnancy case studies;
- more resources (booklets, posters, DVDs, wallet cards) to support health professionals; and
- more pregnancy-specific resources included in Quit Packs.

2. There is a very poor understanding of the appropriateness of the use of NRT during pregnancy and when breastfeeding among both pre-natal maternal smokers and health professionals. Furthermore, because the use of NRT is perceived as a core component of the Quitline there is a perception that the service is not appropriate for pregnant women. This suggests a need to provide more information about the safe use of NRT. This could be achieved through:

- more information made available to health professionals (through training days for midwives and practice nurses, and in GPs' industry magazines);
- Quit Advisors being more confident when informing pregnant women about use of NRT and having sufficient knowledge to address their concerns; and
- Reconciling the conflict between the information Quit Advisors provide to callers (that NRT is okay to use when pregnant) and the warnings on the NRT packaging (that NRT should not be used when pregnant).

3. A strong attitude exists among pregnant smokers, their social circle and health professionals that pregnant women 'should be able to do it alone', that the fact that a woman is pregnant should be sufficient motivation alone. The lack of cessation support women receive from their social circle – particularly their partner – results in them either choosing to isolate themselves from their social context and quitting, or fearing this isolation, continuing to smoke. A pregnant woman who may already be feeling isolated, risks exacerbating these circumstances by quitting and/or feels weak and lonely because she can't quit.

These findings point to the need for health risk education and cessation support to the smoking partner, family and friends of the pregnant smoker.

A programme of social marketing which emphasised the ways in which people around pregnant women could and should support their decision to quit would be valuable, providing positive reinforcement of a non-smoking environment for women and their babies. Such a programme should emphasise that the responsibility for quitting is a shared one and help women to accept that it is okay both to get and to expect help.

4. There is not a strong culture of encouraging quitting in health circles. This can be complicated, especially in circumstances where there may be other perceived threats to the woman and her baby which are seen as more significant than smoking. Nevertheless, health professionals working with ante-natal and post-natal smokers need more support, resources and guidance about when to give smoking cessation advice and support, and how this can be most successfully achieved. The research suggests that there is much more potential in the role of all health professionals – GPs ('planting the seeds of quitting' by notifying of the health risks of smoking and referring those who express an early interest in quitting, then following up on quit status and offering further support at the baby's six-week health check), practice nurses (further explaining the health risks of smoking ideally through the use of culturally and age-specific resources, making referrals and following up on progress one or two weeks after visit) and midwives (recommending referrals to cessation services/programmes, monitoring of quit status at each visit, offering advice and support to deal with barriers to quitting such as stress and boredom and ensuring the home and car remain smoke-free as a minimum).

5. The fact that pregnant smokers' key motivation for quitting is unique, and that many of the barriers to quitting smoking are heightened due to the physical, emotional and lifestyle changes associated with pregnancy, suggests the need for pregnant smokers to be treated as a special client group by the Quitline. Examples of how this might be achieved include:

- offering specialist 'maternity' Quit Advisors;
- an option for Quit Advisors to make home visits (ideally) or at least be in the community;
- an option for cessation support to be offered to others in the woman's social circle, particularly those living in the same household;
- offering comprehensive post-natal support; and
- tailoring the Quit Pack to the needs and circumstances of pregnant smokers, including more information about the negative effects of smoking on unborn and newborn babies, the relative benefits and/or lower level risks of NRT and the inclusion of 'success' stories of other pregnant smokers.

In summary, enhancing pregnant women's awareness and use of the Quitline through a social marketing campaign should consist of three key strands:

1. **Environment and context for the women** – using social marketing to improve support for pregnant women to quit and to make it clearly a shared responsibility, paired with increased support and education to health professionals.

2. **Awareness of appropriateness of Quitline** – while awareness of the Quitline itself is high, there is a need to promote the service’s appropriateness for pregnant women, including addressing the appropriateness of NRT or at least its merits relative to smoking; and
3. **Service delivery** - developing specific treatments and resources for pregnant women such as support groups, specialist Quit Advisors and pregnancy-specific Quit Packs.

The first two strands should be targetted at pregnant women, the pregnant women’s social circle and at health professionals. The third strand is predominantly internal, but also should consider the three target groups independently.

# **APPENDIX**

## ***Topic Guides***

# Appendix One: Topic Guides

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## 1. QUITLINE CALLERS

### 1.0 INTRODUCTION

- Introduce Gravitas as independent market research company – not from the Quitline
- Explain purpose and nature of research:

*“The Quit Group, who manage the Quitline, want to understand how the Quitline could better work with pregnant callers and attract more pregnant women to use the service for support and advice”*

- Explain interviewer and participant roles
- Explain that there are no right or wrong answers – that we are just interested in their experiences, thoughts and opinions
- Discuss issues of confidentiality – re-iterate that participation and comments have no bearing on relationship with Quitline or with Quit Advisor. No comments made will be reported back to Quit Advisor.
- Explain and gain consent on use of tape recorder.
- Before we start, can you tell me a little bit about yourself. *Probe:*
  - *living situation/number of children/other smokers in the household*
  - *employment status*
  - *pregnancy status (including health issues, type of LMC, attendance at antenatal classes etc)*
- And tell me about your smoking since you contacted the Quitline.
  - Stopped smoking? *If so*, when? For how long?
  - Stopped smoking but started again? *If so*, when did you stop? For how long?
  - Haven't stopped?
  - Have cut down? *If so*, how much are you smoking now?

### 2.0 SMOKING HISTORY

- I would also like to find out a little about your smoking history.
  - When did you start?
  - Why did you start?
  - Around the time that you contacted the Quitline, what did you smoke? When did you smoke? How much did you smoke?



- Prior to getting pregnant, had you tried quitting smoking before? *If no*, why not?

*If yes:*

- What had motivated you to try to quit on these previous occasions?
- How many times had you tried?
- What method(s) had you used to quit?
- How successful were you? How long did you stay quit on each occasion?
- Why did you start smoking again on each occasion?

*If participant has more than one child:*

- Did you try to quit smoking when you were pregnant with your other child(ren)? *If no*, why not? Why did you want to quit during this pregnancy?

*If yes:*

- What motivated you to try to quit?
- What method(s) did you use to quit?
- How successful were you? How long did you stay quit?
- Why did you start smoking again?

### **3.0 MOTIVATIONS AND BARRIERS TO QUITTING**

- Once you found out you were pregnant, did you want to quit smoking? *If no*: Why not?

*If yes:*

- Why did you want to quit smoking when you found out you were pregnant? *Compare and contrast with motivations for previous quit attempts.*
- Would you say you were more or less motivated to quit when you found out you were pregnant than on previous occasions when you had tried to quit? Why?
- Did you want to quit completely or just cut down? Why?
- What concerns did you have about quitting once you found out you were pregnant?
- What people influenced your decision to try to quit smoking once you were pregnant? *For each person*: How did this person influence you (may be positively or negatively)?

*If not mentioned:*

- To what extent has your LMC influenced your decision to quit smoking? How?
- Have other health professionals influenced your decision? How?
- How have you found quitting smoking since you found out you were pregnant?
- What things have helped you quit – and stay quit (*if relevant*)
- What things have made it hard for you to quit – and stay quit.
- Have the things that have made it hard to stay quit changed over the course of your pregnancy?
- *If relevant*: Tell me about a time when it was really hard not to have a cigarette. *Compare and contrast with barriers from previous quit attempts.*

*For those who have had their baby:*

- Once you had your baby, did you still want to quit/stay quit? Why/why not?
- What people influenced your decision to quit/stay quit once your baby was born? *For each person:* How did this person influence you (may be positively or negatively)?
- How have you found quitting/staying quit since your baby was born?
- What things have helped you quit/stay quit
- What things have made it difficult for you to quit/stay quit since your baby was born

#### **4.0 CHOICE OF QUITLINE AS CESSATION AID**

*Why the Quitline was used as a cessation aid.*

- Before we talk about the Quitline, I want to ask you about other ways of quitting smoking that you may have considered, and other ways you may have used. What other ways of quitting smoking did you consider when you found out you were pregnant? *For each cessation aid – including going “cold turkey”, ask:*
  - How did you find out about this method?
  - What appealed about this method?
  - What didn't appeal?
  - Do you think this method would have been successful for you? Why/why not?
  - Did you try this method? *If yes:* Tell me about your experience. How successful was this method? Why/why not?
  - Based on your experience, would you recommend this method/service/programme to a pregnant family member or friend wanting to quit smoking? Why/why not?

- How did you find out about the Quitline? *Probe role of advertising, friend/family, health professionals*

- Did your LMC/health professional tell you about Quitline?

*If yes:*

- What did they tell you about it?
- Is there anything that, in hindsight, they should have told you but didn't?
- Did they actively encourage you to contact the Quitline? Why/why not? What assistance did you give you to register?
- What other information/assistance do you think your LMC/health professional could have offered in relation to the Quitline? What difference would this have made?

- I want to understand more about how you made the decision to use the Quitline to help you quit smoking. I have five different-coloured hats here. Each hat represents different things that you may have thought about. The first hat I am going to put down is:

***Rotate order of hats***

Yellow Hat

The yellow hat represents the positive features of the Quitline that motivated you to join. What were the features of the Quitline that appealed to you? *Probe positive features compared with alternative cessation aids if relevant*

Black Hat

The black hat represents the drawbacks of the Quitline, the things that discouraged you from joining. What features of the Quitline did not appeal to you or you did you not like? *Probe drawbacks compared with alternative cessation aids if relevant*

Red Hat

The red hat represents your emotions – your feelings, fears and concerns. What feelings (positive and negative), fears or concerns did you have about the Quitline before you registered?

Blue Hat

The blue hat represents the practical aspects of joining the Quitline. What things made it easy for you to register with the Quitline? What things made it difficult? *Probe: time, access to telephone, ability to find contact details for Quitline*

Green Hat

The green hat represents the social aspects influencing your decision to join the Quitline. What role did family members, friends, work colleagues and health professionals have in your decision to register with the Quitline?

- What (or who) motivated you to make the first call to the Quitline?
- How long did it take you to call the Quitline following your initial thought to join? Why this length of time? *If it took a long time: What could have helped you to make that first call sooner than you did?*

**5.0 THE QUITLINE EXPERIENCE**

*Expectations and experiences of the level of service that was sought and received, and thoughts on resources sent. Also, support received to stay quit after birth, and perceived usefulness of this.*

- Talk me through what happened when you registered with the Quitline. Tell me about that first call. *Probe: perceived appropriateness of questions asked/information sought, level of support, friendliness/politeness, empathy/understanding of issues associated with pregnancy, feelings of being judged etc.*
- And tell me about your contact with the Quitline since you registered with them. *Probe: frequency of contact, type of support received, relationship with Quit Advisor, appropriateness of advice/support to pregnant women*
- What words would you use to describe your experience of dealing with the Quitline?

- I have some words and phrases here that other people we have spoken to have used to describe the Quitline. I would like to show them to you *[write on cards]* and you can tell me if you agree or not.
  - Easy to talk to
  - Supportive
  - Enthusiastic and encouraging
  - Know what they are talking about
  - Sensitive - understand what it's like to be a pregnant smoker and the challenges pregnant smokers face
  - Judgemental/made to feel guilty
  - Pushy
  - Treat me like a number – no individual service
  - Difficult to access/get hold of
  - Waste of time

***Rotate strengths and weaknesses:***

- What have been the good things about the Quitline for you? *Probe positive features in relation to pregnancy in particular.*
- What have been the things about the Quitline that have not been so good? *Probe weaknesses in relation to pregnancy in particular*
- Is there anything that has surprised you about the Quitline? *May be positive or negative.* If you had known about this earlier, what difference would it have made to you?
- What aspects of the Quitline have been most helpful in *(as appropriate to participant)*:
  - getting you to start thinking about quitting
  - getting you to quit
  - helping you stay quit
  - getting you to quit again after you have relapsed
- What aspects of the Quitline have not been helpful in *(as appropriate to participant)*:
  - getting you to start thinking about quitting
  - getting you to quit
  - helping you stay quit
  - getting you to quit again after you have relapsed
- Is there any aspect of the Quitline that has discouraged you from quitting smoking? What? Why?

***If not mentioned:***

- Did you receive a Quit Pack (**show if necessary**)

***If yes:***

- What did you like about the Quit Pack? *Probe: readability, usefulness, quantity of resources, cultural appropriateness, pregnancy appropriateness, presentation etc.*
- What did you not like so much about the Quit Pack? *Probe: readability, usefulness, quantity of resources, cultural appropriateness, pregnancy appropriateness, presentation etc.*
- How did you use the Quit Pack (*e.g. read everything when it arrived then kept for future reference, only read things of interest, not read at all*)
- How helpful was the Quit Pack in (*as appropriate*):
  - getting you to start thinking about quitting
  - getting you to quit
  - helping you stay quit
  - getting you to quit again after you have relapsed
- What additional information/things do you think should be included in the Quit Pack, particularly in relation to assisting pregnant women quit smoking?

***For those who have had their baby:***

- What aspects of the Quitline have been most helpful in helping you stay quit/getting you to quit again after you have relapsed now that you have had your baby?
- What aspects of the Quitline have not been helpful in helping you stay quit/getting you to quit again after you have relapsed now that you have had your baby?

**6.0 NICOTINE REPLACEMENT THERAPIES**

*Perceptions of NRT use during pregnancy and extent to which this influences use/engagement with the Quitline and other quit methods.*

- What did you know about NRT prior to making contact with the Quit Line? *Probe: perceived strengths and weaknesses/concerns, perception of side effects, understanding of use, perceived success*
- Where did you get this information?
- Had you used NRT before? *If yes:* Tell me about your experience. *Probe type of NRT used, side effects, success*
- Before calling the Quitline, what did you know about pregnant women's use of NRT? Where did you get this information?
- Before you contacted the Quitline, had you considered using NRT while you were pregnant? Why/Why not?
- Did your Quit Advisor recommend using NRT to assist you with quitting? *If no:* Why not? How did you feel about this?

***If Quit Advisor recommended use of NRT:***

- Were you recommended patches, gum or both?
- How did you feel when your Quit Advisor recommended you use NRT to assist you with quitting? What concerns did you have? What questions did you ask? Did you talk to your LMC about the NRT recommended? What information did they give you?
- Did you use the NRT? *If no*: why not?

***If used NRT:***

- Tell me about your experience of using NRT whilst pregnant. *Probe: likes, dislikes/side-effects, effectiveness*
- If you had a family member or friend who was pregnant and wanting to quit smoking, would you recommend NRT to them? Why/why not?

**7.0 SUMMING UP/RECOMMENDATIONS FOR IMPROVEMENT**

*Recommendations for service improvements.*

- Thinking about your experience with the Quitline, how successful would you say the service has been in (*as relevant*):
  - getting you to start thinking about quitting
  - getting you to quit
  - helping you stay quit
  - getting you to quit again after you have relapsed
- If you had a pregnant friend or family member who was a smoker, would you recommend the Quitline to help them quit smoking? Why/why not? *If no*: What would you recommend instead? Why?

Finally, I would like you to pretend that you have been given the job of the pregnant women's advisor to the Quitline. Your new job is to make the Quitline more appropriate, supportive and successful for pregnant smokers and those who have recently given birth.

- What changes would you make to the current Quitline service? What would you do differently? *If needed*: For this exercise, pretend that you have unlimited budget and unlimited resources.
- What new things would you add to the Quitline?
- What things about the current service would you do away with?
- What things about the current service would you definitely keep?

**Probe:**

- *The initial/registration call*
- *The qualities of the Quit Advisor*
- *Tailoring of the service specifically to pregnant smokers*
- *The Quit Pack*
- *Additional access channels to receive support*
- *Involvement of other health professionals*
- *Follow-up support calls, including support calls post-birth*
- *Additional conversations*
- *Preferred time period over which support would be offered*

**For those who have had their baby:**

- What other support to quit/stay quit should be available to women after they have had their baby?

## Participant- generated comments

Thank you for taking the time to talk to me today. Just before we finish, one of the aims of the research is to compare and contrast the quitting experiences of pregnant women who used the Quitline with women who didn't. I was wondering whether you have any family members, friends or work colleagues who are pregnant or who have recently given birth who currently smoke, or who quit smoking just prior to, or during, their pregnancy. We may be interested in talking to them. If we do interview them as part of this research, they would receive a \$50 voucher, and to thank you for the recommendation, you would receive a \$30 voucher. *Collect contact details of potential participant, or provide Gravitas contact details so potential participant can call in.*

Thank and close

## 2. NON QUITLINE CALLERS

### 1.0 INTRODUCTION

- Introduce Gravitas as independent market research company – not from the Quitline
- Explain purpose and nature of research:

*“The Quit Group, who manage the Quitline, want to understand how the Quitline could attract more pregnant women to use the service for support and advice”*

- Explain interviewer and participant roles
- Explain that there are no right or wrong answers – that we are just interested in their experiences, thoughts and opinions
- Discuss issues of confidentiality
- Explain and gain consent on use of tape recorder.
- Before we start, can you tell me a little bit about yourself. *Probe:*
  - *living situation/number of children/other smokers in the household*
  - *employment status*
  - *pregnancy status (including health issues, type of LMC, attendance at antenatal classes etc)*
- And tell me about your smoking since you got pregnant – have you:
  - Stopped smoking? *If so*, when? For how long?
  - Stopped smoking but started again? *If so*, when did you stop? For how long?
  - Haven't stopped?
  - Have cut down? *If so*, how much are you smoking now?

### 2.0 SMOKING HISTORY

- I would like to start off by finding out a little about your smoking history.
  - When did you start?
  - Why did you start?
  - Around the time that you got pregnant, what did you smoke? When did you smoke? How much did you smoke?

- Prior to getting pregnant, had you tried quitting smoking before? *If no*, why not?

*If yes:*

- What had motivated you to try to quit on these previous occasions?
- How many times had you tried?
- What method(s) had you used to quit?
- How successful were you? How long did you stay quit on each occasion?
- Why did you start smoking again on each occasion?



*If participant has more than one child:*

- Did you try to quit smoking when you were pregnant with your other child(ren)? *If no*, why not?

*If yes:*

- What motivated you to try to quit?
- What method(s) did you used to quit?
- How successful were you? How long did you stay quit?
- Why did you start smoking again?

### **3.0 MOTIVATIONS AND BARRIERS TO QUITTING**

- Once you found out you were pregnant, did you want to quit smoking? *If no*: Why not?

*If yes:*

- Why did you want to quit smoking when you found out you were pregnant? *Compare and contrast with motivations for previous quit attempts.*
- Would you say you were more or less motivated to quit when you found out you were pregnant than on previous occasions when you had tried to quit? Why?
- Did you want to quit completely or just cut down? Why?
- What concerns did you have about quitting once you found out you were pregnant?
- What people influenced your decision to try to quit smoking once you were pregnant? *For each person*: How did this person influence you (may be positively or negatively)?

*If not mentioned:*

- To what extent has your LMC influenced your decision to quit smoking? How?
- Have other health professionals influenced your decision? How?
- How have you found quitting smoking since you found out you were pregnant?
- What things have helped you quit – and stay quit (*if relevant*)
- What things have made it hard for you to quit – and stay quit.
- Have the things that have made it hard to stay quit changed over the course of your pregnancy?
- ***If relevant***: Tell me about a time when it was really hard not to have a cigarette. *Compare and contrast with barriers from previous quit attempts.*

*For those who have had their baby:*

- Once you had your baby, did you still want to quit/stay quit? Why/why not?
- Which people influenced your decision to quit/stay quit once your baby was born? *For each person*: How did this person influence you (may be positively or negatively)?
- How have you found quitting/staying quit since your baby was born?
- What things have helped you quit/stay quit?
- What things have made it difficult for you to quit/stay quit since your baby was born

#### 4.0 CESSATION AIDS

- What ways of quitting smoking did you consider when you found out you were pregnant?

*For each cessation aid – including going “cold turkey” - considered, ask:*

- How did you find out about this method?
- What appealed about this method?
- What didn't appeal?
- Did you think this method would be successful for you? Why/why not?
- Did you try this method? *If no:* Why not?

*If yes:* Tell me about your experience using this method:

- What have been the good things about this method for you? *Probe positive features in relation to pregnancy in particular.*
- What have been the things about this method that have not been so good? *Probe weaknesses in relation to pregnancy in particular*
- Is there anything that has surprised you about this method? *May be positive or negative.* If you had known about this earlier, what difference would it have made to you?
- What aspects of this method have been most helpful in *(as appropriate to participant)*:
  - getting you to start thinking about quitting
  - getting you to quit
  - helping you stay quit
  - getting you to quit again after you have relapsed
- Based on your experience, would you recommend this method/service/programme to a pregnant family member or friend wanting to quit smoking? Why/why not?

*For those who have had their baby:*

- What aspects of this method have been most helpful in helping you stay quit/getting you to quit again after you have relapsed now that you have had your baby?
- What aspects of this method have not been helpful in helping you stay quit/getting you to quit again after you have relapsed now that you have had your baby?

#### 5.0 AWARENESS AND PERCEPTIONS OF THE QUITLINE

- Had you heard of Quitline before today?

*If yes:*

- What is involved?
- Who is entitled to use it?
- Knowledge of components of service - telephone support, subsidised NRT, Quit Pack
- Perceived relevance/appropriateness to pregnant/breastfeeding women?

I want to understand more about what you think of the Quitline. *If needed:* It doesn't matter that you haven't actually used the Quitline. I am just interested in your perceptions of the Quitline, what you think it is like. I have five different-coloured hats here. Each hat represents different things that you may think about. The first hat I am going to put down is:

***Rotate order of hats***

Yellow Hat

The yellow hat represents the positive features of the Quitline. Given what you know about the Quitline, what are the features of the Quitline that appeal to you? ***Probe positive features compared with alternative cessation aids if relevant***

Black Hat

The black hat represents the drawbacks of the Quitline, the things that discouraged you from joining. Given what you know about the Quitline, what features of the Quitline do not appeal to you or you do not like? ***Probe drawbacks compared with alternative cessation aids if relevant***

Red Hat

The red hat represents your emotions – your feelings, fears and concerns. What feelings (positive and negative), fears or concerns do you have about the Quitline?

Blue Hat

The blue hat represents the practical aspects of joining the Quitline. What things seem easy about using the Quitline? What things seem difficult? What things are stopping you from using the Quitline? ***Probe:*** time, access to telephone, ability to find contact details for Quitline

Green Hat

The green hat represents the social aspects influencing your decision to join the Quitline. What role did family members, friends, work colleagues and health professionals have in your decision not to register with the Quitline?

- What aspects of the Quitline are you unsure about? What questions do you have about the Quitline? What other information about the service would be useful to know?
- Do you think that you would be successful in quitting smoking if you used the Quitline? Why/why not?
- How did you learn about the Quitline?

***If not mentioned:***

- Did your LMC/health professional tell you about Quitline?

***If yes:***

- What did they tell you about it?
- Did they actively encourage you to contact the Quitline? Why/why not?
- What other information/assistance do you think your LMC/health professional could have offered in relation to the Quitline?

- Why did you decide not to call the Quitline?
- Did anyone in particular influence your decision not to call? *If so*, who? What did they say to you?

## **6.0 NICOTINE REPLACEMENT THERAPIES**

*Perceptions of NRT use during pregnancy and extent to which this influences use/engagement with the Quitline and other quit methods.*

- What do you know about NRT? *If needed*: By NRT, I am referring to nicotine patches and gum that help with quitting smoking.
- What do you know about pregnant women's use of NRT? *Probe: perceived strengths and weaknesses/concerns, perception of side effects, understanding of use, perceived success*
- Where did you get this information?
- Had you used NRT prior to getting pregnant? *If yes*: Tell me about your experience. *Probe type of NRT used, side effects, success*
- When you found out you were pregnant, did you consider using NRT while you were pregnant? Why/Why not?

*If considered, ask:*

- What concerns/questions did you have about using NRT?
- Where did you get information about using NRT whilst pregnant?
- Have you used NRT since getting pregnant? *If no*: Why not?

*If yes:*

- Did you use patches, gum or both?
- Tell me about your experience of using NRT whilst pregnant. *Probe: likes, dislikes/side-effects, effectiveness*
- If you had a family member or friend who was pregnant and wanting to quit smoking, would you recommend NRT to them? Why/why not?

## **7.0 SUMMING UP/RECOMMENDATIONS FOR IMPROVEMENT**

*Recommendations for service improvements.*

The Quitline is looking for ways to encourage more pregnant women who smoke to use their service and support to help them quit. I would like you to pretend that you have been given the job of the pregnant women's advisor to the Quitline. Your new job is to make the Quitline appealing and successful for pregnant smokers and those who have recently given birth.

- What would the Quitline be like if it was perfect for pregnant women? *If needed*: For this exercise, pretend that you have unlimited budget and unlimited resources.
- What components of other methods of quitting smoking that you have tried (that you know about) should be included in the Quitline?

*If participant has sufficient awareness of the Quitline, ask:*

- What new things would you add to the Quitline?
- What things about the current service would you do away with?
- What things about the current service would you definitely keep?

*For those who have had their baby:*

- What other support to quit/stay quit should be available to women after they have had their baby?

Participant- generated comments

Thank you for taking the time to talk to me today. Just before we finish, one of the aims of the research is to compare and contrast the quitting experiences of pregnant women who used the Quitline with women who didn't. I was wondering whether you have any family members, friends or work colleagues who are pregnant or who have recently given birth who currently smoke, or who quit smoking just prior to, or during, their pregnancy. We may be interested in talking to them. If we do interview them as part of this research, they would receive a \$50 voucher, and to thank you for the recommendation, you would receive a \$30 voucher. *Collect contact details of potential participant, or provide Gravitas contact details so potential participant can call in.*

Thank and close

### 3. HEALTH PROFESSIONALS

#### 1.0 INTRODUCTION

- Introduce Gravitas as independent market research company – not from the Quitline
- Explain purpose and nature of research:

*“The Quit Group, who manage the Quitline, want to understand how the Quitline could better work with pregnant callers and attract more pregnant women to use the service for support and advice. As part of this, they are keen to understand the role of health professionals in referring pregnant smokers on to cessation services.”*

- Explain interviewer and participant roles
- Explain that there are no right or wrong answers – that we are just interested in their experiences, thoughts and opinions
- Discuss issues of confidentiality.
- Explain and gain consent on use of tape recorder.
- Before we start, can you tell me a little bit about yourself. **Probe:**
  - Current position and role
  - Length of time working in current role/in health sector
- And I am also interested in the extent of your contact with pregnant women who smoke. **Probe:**
  - How many in the last year (*or as appropriate*)?
  - Ethnicity
  - Age
  - SES status
  - Additional social, cultural, economic, or familial stress factors these women also face

#### 2.0 ATTITUDES TO SMOKING DURING PREGNANCY

- **If appropriate:** What is the organisation’s/clinic’s perspective on pregnant women who smoke? What is the organisation’s/clinic’s view on how these women should be dealt with? Why?
- What do you see your role as being in terms of dealing with the smoking issues of the pregnant women you see? **Probe:**
  - No role? Why not? Whose role should it be?
  - Provider of information only? Information and advice? Information, advice and active support?
  - Encourage stopping completely or encouraging cutting down?

- Ideally would you like to take a greater role in dealing with the smoking issues of pregnant women?

*If yes:*

- What more would you like to do?
- What is stopping you doing this at the moment?
- What do you need to help you take more of a role?

### **3.0 PERSPECTIVES OF WHAT QUITLINE PROVIDES**

- Tell me about what you know about the Quitline. *Probe:*
  - What is involved?
  - Who is entitled to use it?
  - Perceived relevance/appropriateness to pregnant/breastfeeding women?
  - Knowledge of components of service - telephone support, subsidised NRT, Quit Pack
- What aspects of the Quitline are you unsure about? What questions do you have about the Quitline? What other information about the service would you like to have?
- How did you learn about the Quitline?

### **4.0 PERCEPTIONS OF THE QUITLINE AND OTHER CESSATION OPTIONS**

I want to understand what you see the strengths and weaknesses of the Quitline as being, particularly in relation to supporting pregnant smokers to quit.

*If time available/participant conducive:* I have some hats here. Each represents a different aspect of the Quitline. *Rotate order of hats*

*Interviewer: Participant may say that they don't refer anyone to Quitline. They should still answer this section, based on their perceptions of the service (as this will give insights into why they don't refer).*

*Note: If insufficient time/participant not conducive, just ask about perceived strengths and weaknesses of the Quitline*

#### Yellow Hat

The yellow hat represents the positive features of the Quitline. What are the positive features of the Quitline, particularly in relation to pregnant women?

#### Black Hat

The black hat represents the drawbacks of the Quitline. What are the negative features of the Quitline, particularly in relation to pregnant women?

#### Red Hat

The red hat represents emotions – feelings, fears and concerns. What feelings (positive or negative), fears or concerns do you have in relation to the Quitline, particularly with respect to pregnant women?

Blue Hat

The blue hat represents the practical aspects of joining and staying with the Quitline. What things make it easy for you to inform patients about the Quitline and to refer them on? What things made it difficult?

*Probe:* time, information available,

Green Hat

The green hat represents the social/cultural aspects influencing your decision to refer to the Quitline. What role do other social, familial, cultural and financial factors have in your decision to refer to the Quitline?

- Do you believe that the Quitline achieves successful outcomes for pregnant smokers? Why/why not? *Probe to identify what “successful outcomes” are considered to be.*
- *If relevant:* Which pregnant smokers have the most positive outcomes through the Quitline? Which have the least positive? Why?

**5.0 (NON) USE OF QUITLINE**

**1. Informing Process**

- Do you (or does your organisation/clinic) inform pregnant/breastfeeding smokers about the Quitline? *If not:* Why not? Whose role do you think this should be? Why?  
*Now go to Section 6*

*If yes:*

- Which pregnant/breastfeeding smokers are you likely to inform about the service? Why? Which are you least likely to inform? Why? *Probe:*
  - age
  - ethnicity
  - SES
  - level of education
  - living situation – including other smokers in the household
  - residential location
  - number of pregnancies
  - smoking history - length of time smoking, amount smoked, previous quit history
  - possible health complications during pregnancy
  - other social/cultural issues in the household e.g. alcoholism, domestic violence, drug use etc
- How do you inform pregnant smokers about the Quitline?
  - What methods do you use?
  - How do these methods vary across the different women you inform?
  - Who does the informing? Why this person?



- How would you describe the information you have available for informing pregnant smokers about the Quitline? *Probe:*
  - amount/accessibility
  - appeal
  - appropriateness (for pregnant women, culturally, socially etc)
  - comprehensiveness
  - format
- What improvements could be made to the material available (both quantity and quality) to make the informing process easier for you – and more successful in encouraging uptake of the service among women?

## **2. Referral Process**

- Do you think you (your organisation/clinic) should have a role in actually assisting with referring pregnant/breastfeeding smokers on to the Quitline? Why/why not?
- Do you (or does your organisation/clinic) actually assist with referring pregnant/breastfeeding smokers on to the Quitline? E.g. providing a telephone to make the call. Why/Why not? *If yes:*
  - What does this referral process involve?
  - Who in the organisation/clinic actually does the referrals?
  - What additional resources would be useful in this referral process?
  - What do you see the benefits of the referral process as being?

### *If don't currently assist with referrals:*

- Would you be interested in setting up a referral process? *If yes, probe:*
  - How would this work?
  - Ideally, what level of involvement would you (the organisation/clinic) have eg giving patients something to take away, actually sending a referral through as part of a visit etc
  - What resources would you need to help with this referral process?
  - What do you see the benefits of this as being?

## **6.0 ALTERNATIVE CESSATION PROGRAMMES/SERVICE PROVIDERS**

- What other cessation programmes or service providers do you inform pregnant smokers about, or refer them on to?

### *For each, ask:*

- What are the positive features of this programme/provider, particularly in relation to pregnant women?
- What are the negative features?
- What feelings, fears or concerns do you have about this programme/provider?

- Which pregnant smokers do you think this programme/provider is most relevant for? *Probe:*
  - age
  - ethnicity
  - SES
  - level of education
  - living situation – including other smokers in the household
  - residential location
  - number of pregnancies
  - smoking history - length of time smoking, amount smoked, previous quit history
  - possible health complications during pregnancy
  - other social/cultural issues in the household e.g. alcoholism, domestic violence, drug use etc
  
- What are the strengths of this programme over the Quitline, particularly in relation to pregnant women?
- What are the weaknesses of this programme over the Quitline, particularly in relation to pregnant women?
- Does the programme work? What have the outcomes been? How are the outcomes from this programme different to those of the Quitline?

**7.0 PERCEPTIONS OF NICOTINE REPLACEMENT THERAPY USE DURING PREGNANCY**

- Do you think NRT is appropriate for pregnant women? Why/Why not? In which circumstances is it more/less appropriate? *Probe any differences in appropriateness between gum and patches*
- Do you think NRT is appropriate for breastfeeding women? Why/why not? In which circumstances is it more/less appropriate? *Probe any differences in appropriateness between gum and patches*
- Where did you get this information?

**8.0 SUMMING UP/RECOMMENDATIONS FOR IMPROVEMENT**

- What does the Quitline need to be like to encourage you to inform more pregnant women about the service?
  - What existing components should be kept/adjusted?
  - What existing components should be dropped?
  - What new features/services/resources are needed?

*(Also probe changes that may need to be made at an organisation/clinic level)*
  
- What does Quitline need to do to increase its success rate, particularly among pregnant smokers?
  - What existing components should be kept/adjusted
  - What existing components should be dropped?
  - What new features/services/resources are needed

*(Also probe changes that may need to be made at an organisation/clinic level)*

- Are there any additional services that could be introduced to support/complement the work that the Quitline does? *Probe particularly at a local level. If yes:* How would these work?

Thank you for taking the time to talk to me today. Just before we finish, we are keen to speak to a range of health professionals who deal with pregnant women who smoke. I was wondering whether you have any work colleagues who might be interested in taking part in our study. If we do interview them as part of this research, they would receive a \$50 voucher, and to thank you for the recommendation, you would receive a \$30 voucher. *Collect contact details of potential participant, or provide Gravitas contact details so potential participant can call in.*

Thank and close