2008 New Zealand Tobacco Use Survey

Quitting Results

Please note: Care must be taken when comparing quitting rates, as rates may vary depending on survey type, age range of respondents, definition used for quitting (for example, 24 hours or one week without smoking) and statistical adjustments (for example, age standardisation).

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Foreword

Tobacco smoking is a major health problem in New Zealand, responsible for almost 5000 deaths each year. In addition to premature deaths, smoking causes significant morbidity, and contributes to health inequalities in New Zealand.

The Ministry of Health is continually striving to ensure New Zealand's tobacco control activities are compatible with international best practice and based on the best evidence and information available.

The New Zealand Tobacco Use Survey (NZTUS) provides valuable information to understand tobacco use and the impact of tobacco control interventions upon New Zealanders. The NZTUS has been undertaken in 2006, 2008 and 2009. The results for this report relate to the 2008 survey.

The results outlined in this report will help us to better understand New Zealand smokers and their thoughts about quitting. Importantly, the report confirms the findings from the previous survey that the vast majority of smokers would not smoke if they had their time again and that many smokers want to quit and are actively trying to do so. The report also outlines clearly the differences between sub-population groups, for example, young people and Māori. It also provides updated information about the impact of tobacco control interventions such as graphic warnings.

This report provides important information for the implementation of the revised Smoking Cessation Guidelines (Ministry of Health 2007) in the health sector. All of this contributes to the Government's priority of *Better help for smokers to quit*.

The Ministry looks forward to continuing to work with the tobacco control sector to ensure New Zealanders who smoke get the best possible support to quit, so that as a nation we are able to reduce the unnecessary harm caused by tobacco use.

Dr Ashley Bloomfield
Acting Deputy Director General
Sector Capability and Innovation

Acknowledgements

Thank you to the New Zealanders who gave their time to participate in the New Zealand Tobacco Use Surveys.

The author is very grateful for comments received from the external peer reviewer, Dr Chris Bullen, and for those of internal Ministry of Health peer reviewers Dr Anthea Hewitt, Dr Niki Stefanogiannis, Robert Templeton, Karen Evison and Dr Hayden McRobbie.

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Key Points

Introduction

This report presents the quitting results of 15–64-year-olds from the 2008 New Zealand Tobacco Use Survey (NZTUS), including, where possible, comparisons with the 2006 NZTUS.

Quitting attempts

- In 2008 an estimated19,600 New Zealanders had quit smoking in the previous 6–12 months.
- Three out of five current smokers had tried to quit smoking in the past five years, a third of smokers had quit for at least 24 hours in the past 12 months and a fifth had successfully quit for a week before starting to smoke again.
- Four out of five current smokers said that they would not smoke if they had their life over again.
- Three-quarters of smokers who had tried to quit in the past 12 months said one of the reasons was for their own health, while a third had tried to quit because of the cost of smoking.

Quitting services and programmes

- Among current smokers, three-quarters had been asked their smoking status by a health care worker in the past 12 months.
- Māori and Pacific people and those from areas of high deprivation were more likely than the total New Zealand population aged 15–64 years and those from the least deprived areas respectively to have been asked their smoking status by a health care worker over the past 12 months.
- Over a quarter (27.6%) of 15–64-year-old current smokers had been given advice or information, referred to quitting programmes or given quitting aids by a health care worker in the past 12 months.
- Māori current smokers were two-fifths more likely than all current smokers aged 15–64, and current smokers living in the most deprived areas were twice as likely as those in the least deprived areas to have been provided with advice or information, referred to quitting programmes or given quitting aids by a health care worker in the past 12 months.
- A third of people who had tried to quit smoking in the past 12 months (‘recent quit attempters’) had used quitting products or advice in their most recent quit attempt. The most common product used was nicotine replacement therapy (NRT) (19.5%). Quitline was used by one in eight, and general practitioners were used by 6% of recent quit attempters.

Knowledge and awareness of anti-smoking messages

- Nearly all (97.3%) current smokers reported having seen or heard anti-smoking messages in the past six months: the most common place for them to see these messages was on television.
- Two-fifths of recent quit attempters agreed that cigarette and tobacco displays in dairies, petrol stations, supermarkets and convenience stores make it more difficult for smokers to quit smoking or stay quit.
- Less than a third of current smokers understood that NRT is less harmful than smoking cigarettes, and over half were uncertain about it.
- Significantly fewer current smokers than ex-smokers or non-smokers thought that tobacco contributed a large extent to lung cancer.
- One in ten people thought that tobacco did not contribute to stroke, or were unsure whether it did or not.

Conclusion

Information from this report can be used to evaluate and inform tobacco control programmes and policies. Although quitting smoking is clearly very difficult for the majority of smokers, data from this report illustrate that most smokers show regret at becoming a smoker, and realise some of the impact on their health: many of them have tried to quit.

NRT is a safe and effective treatment for quitting smoking. However, despite one in five recent quit attempters having used NRT, there is still a lot of uncertainty among smokers about its safety.

Population groups with high levels of smokers appear to be the ones more likely to be receiving guidance and referral to cessation services from health care workers. More progress is needed to ensure this support is provided for all smokers.

Introduction

The New Zealand Tobacco Use Survey (NZTUS) is part of the New Zealand Health Monitor (Ministry of Health 2005), an integrated programme of household surveys and cohort studies managed by Health and Disability Intelligence (HDI) of the Ministry of Health.

Objectives of the NZTUS include collecting valid and reliable data on quitting and relapse and knowledge, attitudes and beliefs about tobacco smoking and control, as well as monitoring changes in these over time. This report will be of interest to anyone involved in tobacco control research or policy, or the provision of quitting products or services.

The NZTUS 2008 was the second comprehensive national tobacco use survey to be conducted in New Zealand. The first NZTUS was carried out in 2006. Smoking prevalence for 2007 was measured from the 2006/07 New Zealand Health Survey. The third NZTUS was carried out in early 2009, and the results of this are yet to be analysed. All New Zealanders aged 15–64 years who were usually resident in permanent, private dwellings at the time of the survey were eligible for selection in the NZTUS 2008.

This report presents data from five components of the NZTUS 2008: quitting behaviour, quitting programmes, quitting services, health services and health professionals. These components included questions directly related to smokers' history of quitting smoking; their reasons for quitting; the products, services and advice they had used; their regret; and their experience with health professionals in regards to quitting. Two other components of the NZTUS 2008, pictorial warnings and awareness of media campaigns, and knowledge and attitudes, included questions regarding people's awareness and knowledge of tobacco control campaigns, as well as their awareness and knowledge of the different health effects of nicotine and tobacco.

Baseline data for the *New Zealand Smoking Cessation Guidelines*, are presented in this report. These data also provide baseline information about one of the six health targets, *Better help for smokers to quit*, that came into effect on 1 July 2009.

This report, focusing on the quitting behaviour of current smokers, is the second report based on the NZTUS 2008 data. The first report, *Tobacco Trends 2008: A brief update of tobacco use in New Zealand* was released in June 2009 (Ministry of Health 2009a).

Brief Methodological Notes

Survey design and analysis

The target population for the NZTUS 2008 was the usually resident population aged 15–64 years living in permanent private dwellings in New Zealand: approximately 2.7 million people.

A multi-stage, stratified, probability-proportional-to-size sampling design was used. The design included a Pacific stratum, as well as sampling by District Health Board area and a screen sample to boost the proportions of Māori, Pacific people and those aged 15–24 years.

The survey was carried out using a face-to-face computer-assisted personal interview system from February to June 2008.

The survey was weighted to represent the total New Zealand population aged 15–64 years. The overall weighted response rate for the survey was 74%. The sample size was 5132 respondents, which included 933 Māori, 528 Pacific people, 556 Asian people and 3670 European/Other people.[1]

The methodology report available from http://www.moh.govt.nz/moh.nsf/indexmh/methodology-report-08-nz-tobacco-use-survey contains more information on the sample design and analysis.

Total response ethnicity

Total response ethnicity measures the distribution of the population by ethnic group categories. Because individuals may count themselves in one or more of the four ethnic groups (European/Other, Māori, Pacific, Asian), the sum of the ethnic populations exceeds the total New Zealand population.

For more information, refer to Statistics New Zealand's classification for ethnicity output (http://www.stats.govt.nz/reports/analytical-reports/review-measurement-of-ethnicity.aspx), or see *Presenting Ethnicity: Comparing prioritised and total response ethnicity in descriptive analyses of New Zealand Health Monitor surveys* (Ministry of Health 2008).

[1] Note that these sample sizes add to more than 5132, because total response ethnic groups have been used.

Neighbourhood socioeconomic deprivation: The New Zealand Index of Socioeconomic Deprivation 2006

The New Zealand Index of Socioeconomic Deprivation 2006 (NZDep2006) is used in this report as a measure of neighbourhood socioeconomic deprivation and as a proxy for individual socioeconomic position. The NZDep2006 is created from Census 2006 data, and describes deprivation using nine census variables.[2] In this report NZDep2006 scores have been aggregated into five even groups (quintiles) to compare neighbourhoods with the least deprivation (quintile 1) with neighbourhoods with the most deprivation (quintile 5).

Significant differences

There are two reasons prevalence estimates in this report may be described as 'significantly different':

- The 95% confidence intervals do not overlap.
- An independent samples t-test has been used to check if the prevalence estimates are different and the p-value for this is less than 0.05 (5%).

A significant effect of a descriptive variable has been described when a distinct pattern was evident in a bar graph, but the confidence intervals were overlapping. This was tested using a logistic regression model.

For the logistic regression models, the outcome variable was the probability of the relevant event occurring, with the explanatory variables being categorical age group, NZDep2006 quintile, gender and prioritised ethnic group. Backwards selection was used, with a significance level of 5%. The survey design was controlled for.

Comparisons with NZTUS 2006

Compared to those which were analysed and presented in this publication, there are differences in specific populations analysed and presented in the *New Zealand Tobacco Use Survey 2006* report, as well as some differences in definitions (Ministry of Health 2007a). Some differences include the following.

- The NZTUS 2006 questionnaire comprised two sections, one for those aged 15–19 years and the other for those aged 20–64 years. Not all the questions were the same in these two sections; hence many comparisons between the NZTUS 2008 and the NZTUS 2006 have been made for 20–64-year-olds only.
- Total response ethnicity (see above) has been used in this report,[3] whereas prioritised ethnicity was used in the 2006 report.

[2] Receiving a means-tested benefit, having a low household income, not owning the home a person lives in, being part of a single-parent family, unemployment, lacking school qualifications, living in an overcrowded household, lacking access to a telephone and lacking access to a car.

[3] When the odds ratios of total response and prioritised ethnic groups were compared there was little difference. Therefore, following the principle of model parsimony, prioritised ethnic groups were used in the logistic regression modelling.

- This report has used identifiable population groups (for example, current smokers), rather than limiting the analysis to just those who answered a particular question (for example, in analysing sources of quitting advice or products, this report has analysed information pertaining to all people who had tried to quit smoking in the past 12 months, rather than only those who had received quitting advice or products).
- A current smoker was defined in the previous report as someone who smoked at least weekly. In this report a current smoker has been defined as someone who has smoked more than 100 cigarettes in their lifetime and is currently smoking at least once a month (this has had a very minor effect on the results, with the difference in the current smoker prevalence for 2006 increasing from 23.5% to 23.8%).
- There were some differences in question order and a few questions between the two surveys (a specific example of the latter is the inclusion of questions regarding 24-hour quitting in the 2008 questionnaire, which appear to have filtered out those who tried to quit but were not able to stay quit for a week; the dramatic changes in prevalence figures between 2006 and 2008 (see page 10) are likely to be due, for the most part, to this questionnaire change).

Comparisons of quitting data between the two surveys should only be taken from those that are presented in this report and in the online data tables available at: http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report-appendix1

How to interpret graphs in this report

Bar graphs

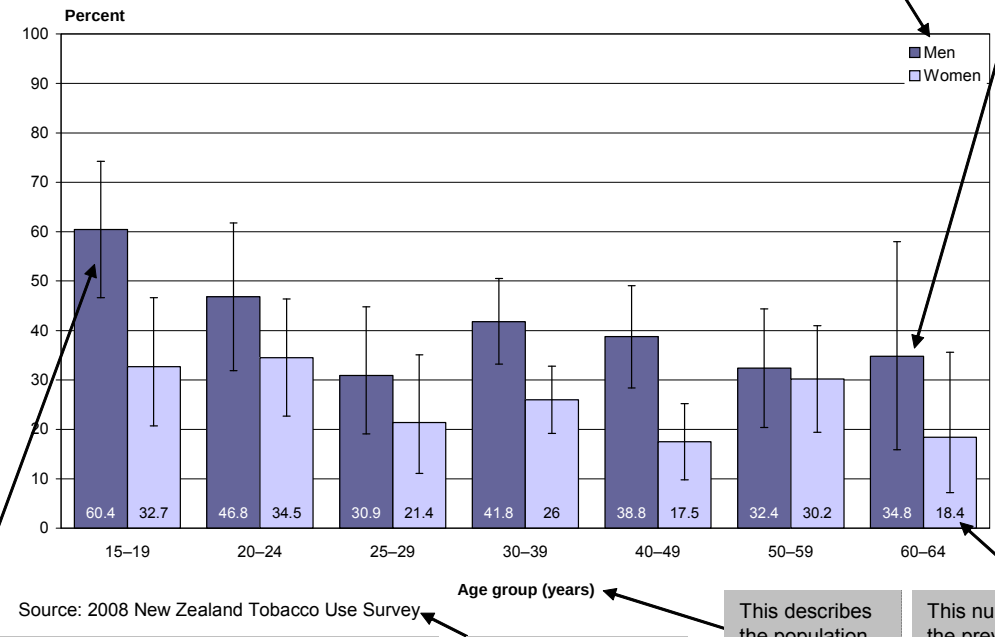
The bar graphs in this report show the proportions (or percentage) of people in different groups who demonstrated a particular smoking-related behaviour. The following diagram shows how to interpret the bar graphs presented in this report. For further information, please see the glossary on page 52.

The title gives information about what the graph is about, and notes whether the data are age-standardised

The legend shows who or what is represented by the different colours in the graph

The bar indicates the prevalence for each population group

Figure X: Agree smokers should be able to quit without the help of programmes and products, current smokers by age group and gender (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

The line indicates the 95% confidence interval for the prevalence estimate. If two confidence intervals do not overlap, the difference between the two prevalence estimates is statistically significant. However, in some cases, two prevalences can be statistically significant even if the confidence intervals overlap. In these cases, the difference was tested for statistical significance using a t-test.

When the confidence intervals overlapped in a bar graph of age or deprivation but it looked like there might be a significant effect, this was tested using logistic regression, controlling for gender, age group, ethnic group and neighbourhood deprivation, where relevant. In the text this was referred to as 'a significant effect after adjusting for ...'.

The notes provide essential information about the graph

This describes the population group or groups that the results relate to

This number gives the prevalence value (%) for each bar

Rate ratio graphs

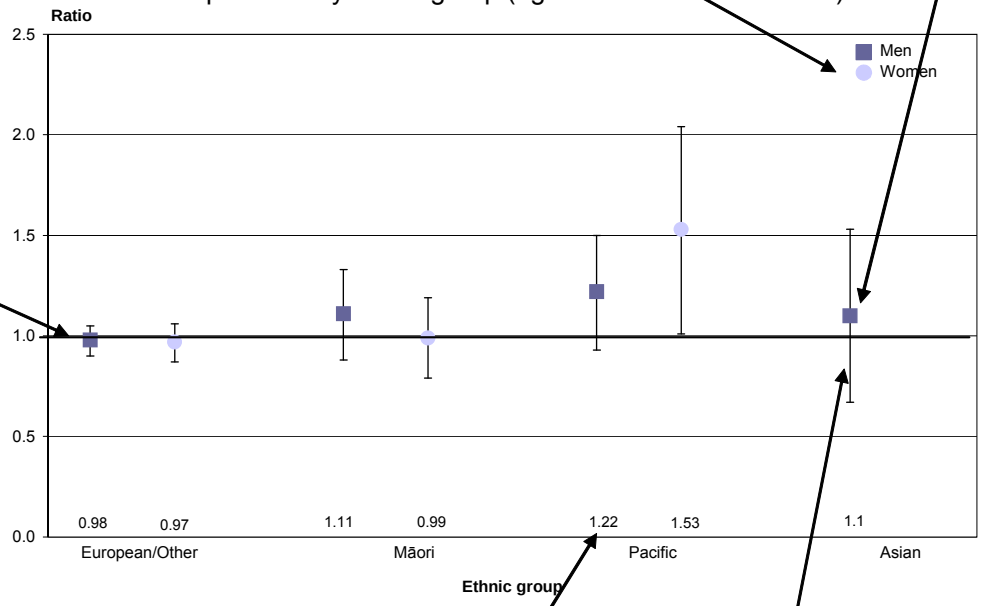
The rate ratio graphs in this report show how the percentages in the different ethnic groups compare to that of a reference population (usually all current smokers aged 15–64). The following diagram shows how to interpret the rate ratio graphs presented in this report. For further information, please see the glossary on page 52.

The title provides information about what the graph is about, and notes whether the data are age-standardised

The legend shows who or what is represented by the different shapes and colours on the graph

This point indicates where the data point lies, compared with the whole population relevant to that data point: in this case, all current smoking men aged 15–64 years

Figure X: Agree smokers should be able to quit without the help of programmes and products by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey
Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the current smoking male or female population aged 15–64 years. Total response standard output for ethnic groups has been used. The value for Asian women cannot be provided due to small numbers.

The reference group is represented with a line at rate ratio = 1

The notes provide essential information about the graph

This number is the value for the standardised rate ratio for each data point. A value *less* than one means that the population group is *less* likely to have the outcome than the reference group, while a value *greater* than 1 means the population group is *more* likely to have the outcome.

This line is the 95% confidence interval. If this line does not cross the bold line at 1.0, there is a statistically significant difference between the rate for this group and the rate for all males or females in the total population

1 Quitting Attempts

Introduction

This section presents information about the quit attempts of smokers, their reasons for quitting and their attitudes towards quitting.

Based on the World Health Organization definition, a current smoker is someone who has smoked more than 100 cigarettes in their lifetime and is currently smoking at least once a month (World Health Organization 1998).

The term 'recent quit attempter' is used in this report to refer to people who have made a quit attempt in the past 12 months. A quit attempt is defined as a deliberate attempt to stop smoking and succeeding for at least 24 hours. This definition includes current smokers who have quit for more than 24 hours in the past 12 months, as well as people who have successfully quit smoking in the past 12 months and remained abstinent.

All results presented here, together with some additional results, are available in Excel format at http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report-appendix1

Successful quitting

This section focuses on New Zealanders aged 15–64 who quit smoking 6–12 months ago and have remained abstinent since then. This measure is a proxy for successful quitters: approximately 70–80% of smokers who quit for 6–12 months become lifelong ex-smokers (Stapleton 1998).

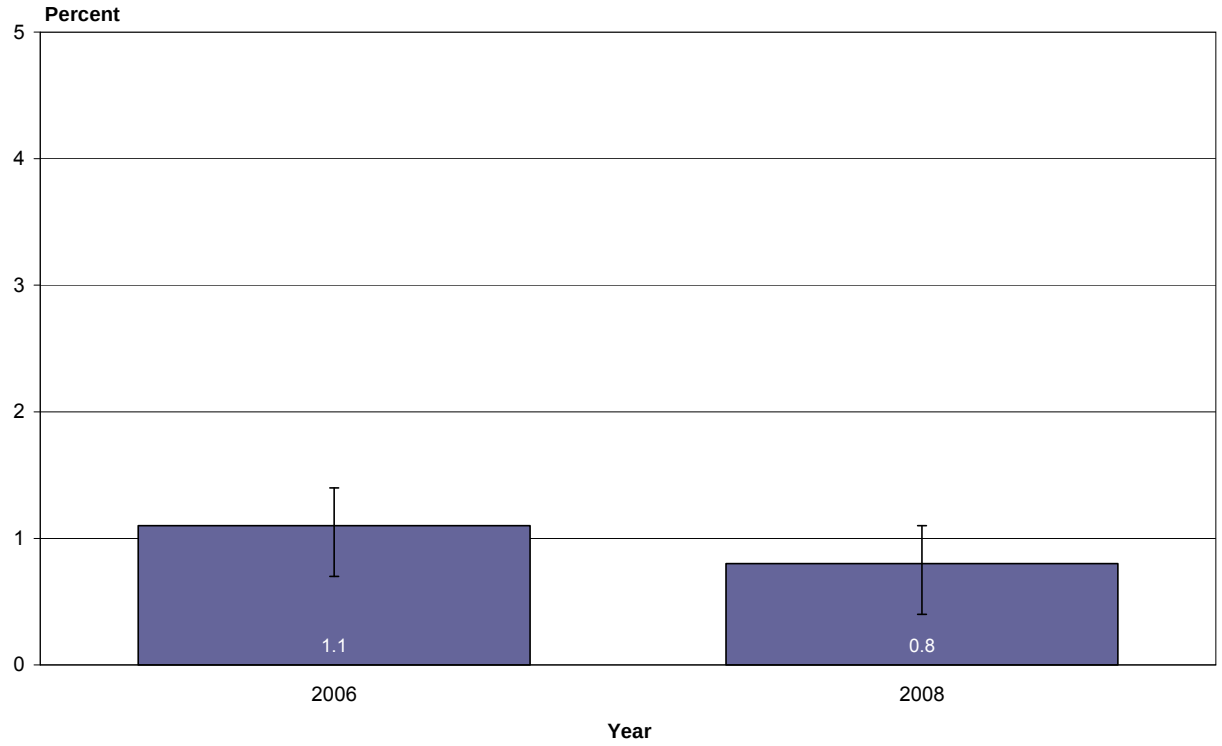
At the time of the survey approximately 19,600 (0.7%, 0.5–1.0) New Zealanders aged 15–64 years had quit smoking in the past 6–12 months.

There were no significant differences in the proportions who had successfully quit by gender, age, ethnic group or deprivation.

Quit smoking in past 12 months, comparison with 2006

There was no significant change between 2006 and 2008 in the proportion of New Zealanders aged 20–64 years who had quit smoking in the past 6–12 months (Figure 1).

Figure 1: Quit smoking in the past 6–12 months, 20–64-year-old smokers, 2006 and 2008 (age-standardised prevalence)



Source: 2006 and 2008 New Zealand Tobacco Use Surveys

Note: Due to changes in definitions, data from 2006 have been reanalysed to allow for comparability: see page 3 for further information.

Quit attempts

Introduction

In the NZTUS 2008, adult participants aged 15–64 years were asked a series of questions about whether they had considered quitting smoking, whether they had tried to quit smoking and, if they had, how long they had quit for.

Three out of five (59.0%, 95% confidence interval: 55.4–62.5) current smokers had tried to quit smoking in the past five years.

Quit smoking for at least 24 hours in the past 12 months

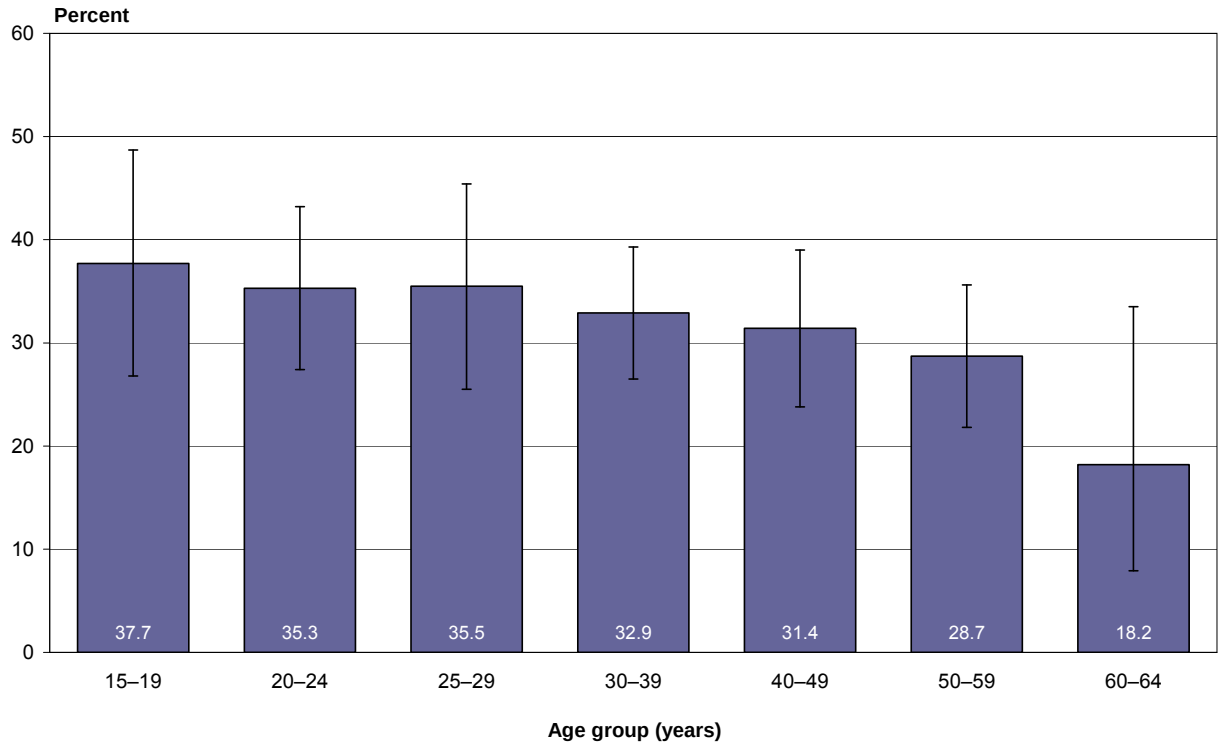
Approximately one-third (32.5%, 28.9–36.1) of current and previous smokers had quit for more than 24 hours in the past 12 months. There were no significant differences by gender or neighbourhood deprivation.

The average number of times a current smoker had quit for more than 24 hours in the past 12 months was twice (median = 2).

Quit for at least 24 hours in the past 12 months, by age group

A significantly higher proportion of people in the 15–39-year age groups had quit for at least 24 hours in the past 12 months than those in the 60–64-year age group (Figure 2).

Figure 2: Quit smoking for at least 24 hours in the past 6–12 months by age group



Source: 2008 New Zealand Tobacco Use Survey

Quit for at least 24 hours in the past 12 months, by ethnic group

Table 1 gives an indication of the proportion of 15–64-year-old current and previous smokers of different ethnic groups who tried to quit smoking in the past 12 months.

Table 1: Tried to quit smoking in the past 12 months, current smokers by ethnic group (unadjusted)

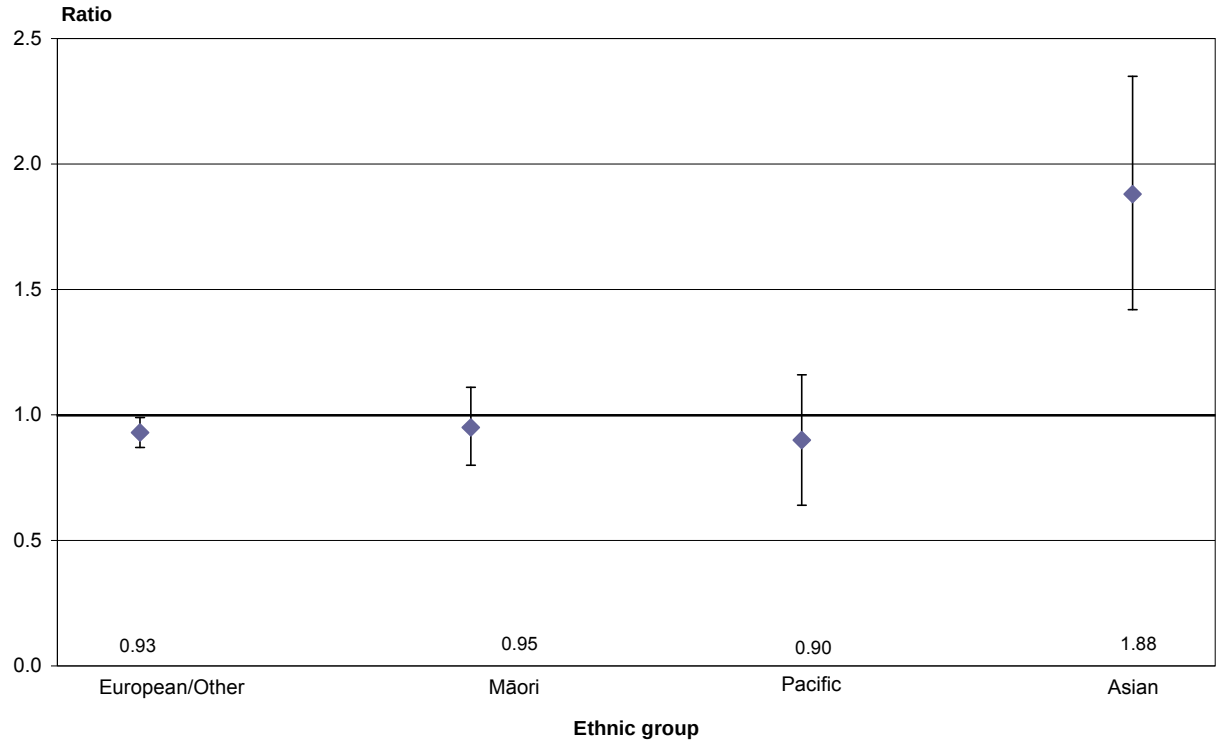
Ethnic group	Prevalence for all current smokers aged 15–64 years (95% CI)	Number of current smokers aged 15–64
European/Other	29.8 (25.7–33.9)	135,200
Māori	32.2 (26.9–37.5)	50,200
Pacific	31.1 (22.4–39.8)	15,900
Asian	60.4 (44.4–76.4)	24,200

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Asian people were nearly twice as likely to have quit for at least 24 hours in the past 12 months as people in the total population aged 15–64 years (Figure 3). European/Other people were significantly less likely to have quit for at least 24 hours in the past 12 months than people in the total population.

Figure 3: Quit smoking for at least 24 hours in the past 12 months, 15–64-year-old current and previous smokers by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the 15–64-year-old current and previous smoker population. Total response standard output for ethnic groups has been used.

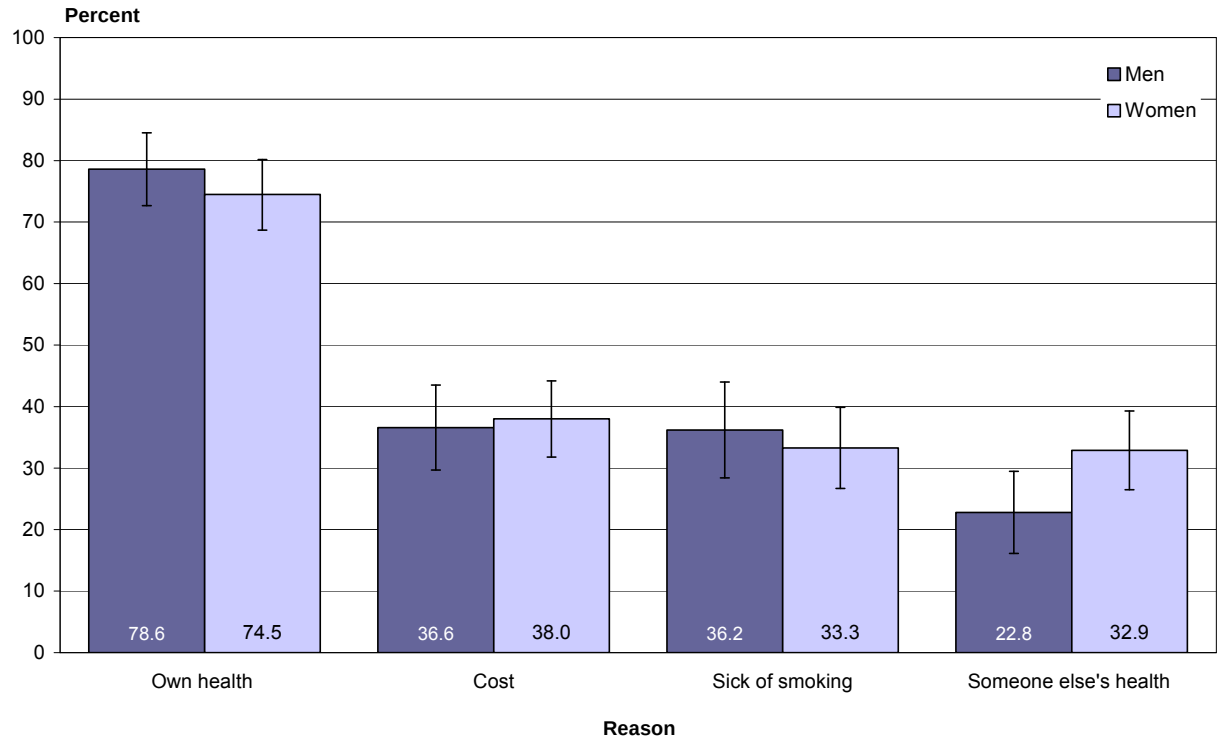
Quit smoking for at least a week in the past 12 months

One in five current and previous smokers (20.6%, 17.7–23.5) had quit for at least a week in the past 12 months. There were no significant differences by gender, age or neighbourhood deprivation.

Reasons for quitting

The most common reason recent quit attempters gave for their most recent quit attempt was their own health (Figure 4).

Figure 4: Reasons for most recent quit attempt, recent quit attempters by gender (age-standardised prevalence)



Source: 2008 New Zealand Tobacco Use Survey

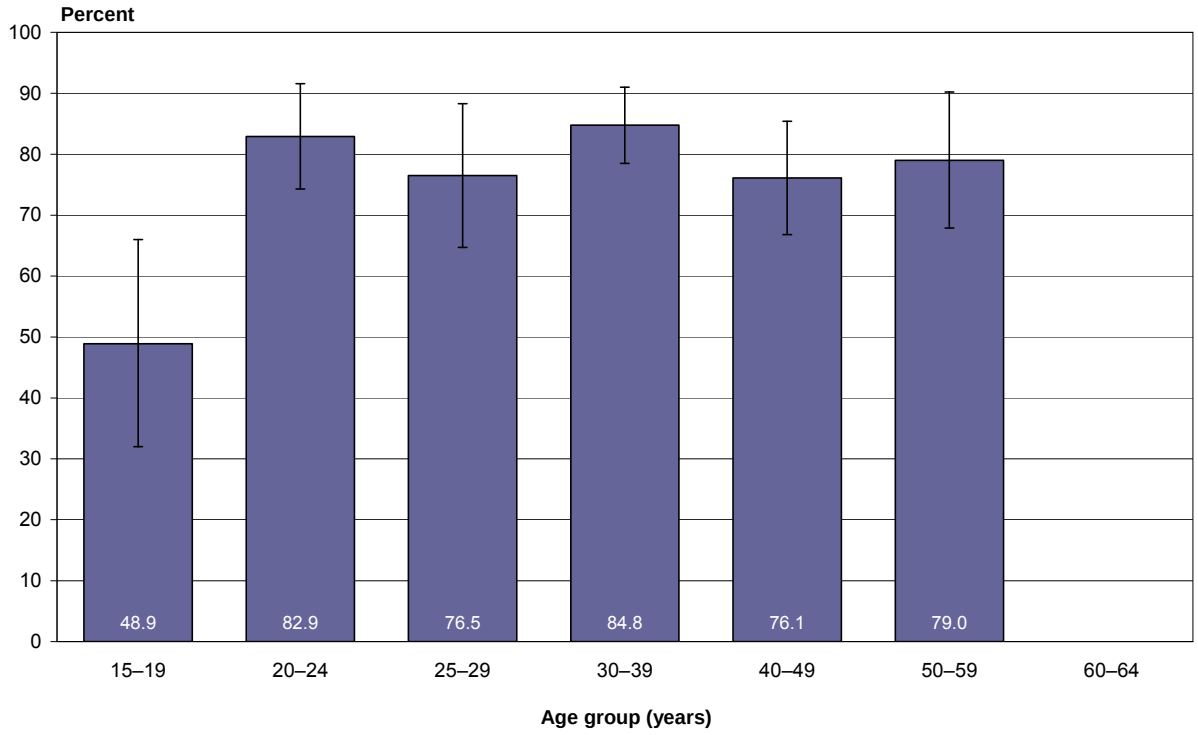
Reason for most recent quit attempt: own health

Three-quarters of recent quit attempters cited their own health as a reason for their most recent quit attempt (76.5%, 72.7–80.3). There were no significant differences between males and females.

Tried to quit for own health, by age group

Significantly fewer 15–19-year-olds (48.9%, 32.0–66.0) cited their own health as a reason for their most recent quit attempt than the 20–59-year-old age groups (Figure 5).

Figure 5: Tried to quit for own health, recent quit attempters by age group (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey
Note: The value for 60–64-year-olds cannot be provided due to small numbers.

Tried to quit for own health, by ethnic group

Table 2 gives an indication of the proportion of 15–64-year-old recent quit attempters of different ethnic groups who tried to quit smoking in the past 12 months.

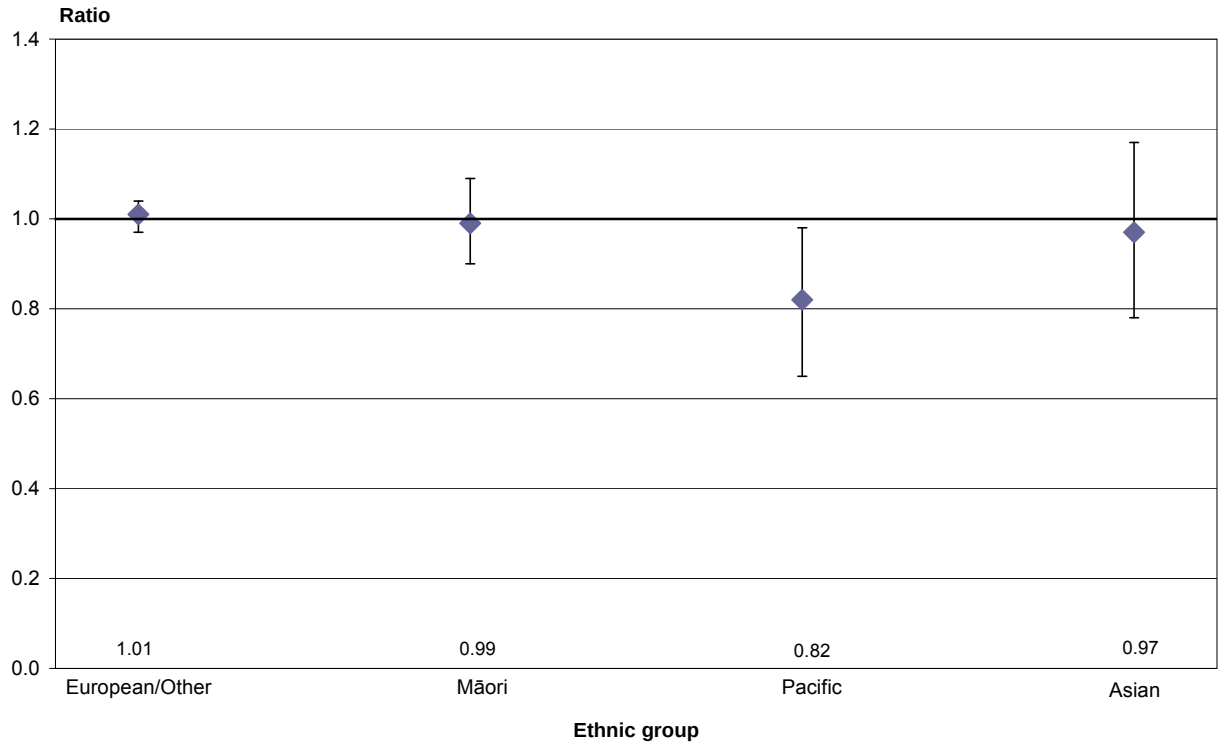
Table 2: Tried to quit for own health, recent quit attempters by ethnic group (unadjusted)

Ethnic group	Prevalence for all recent quit attempters aged 15–64 years (95% CI)	Number of recent quit attempters aged 15–64
European/Other	77.7 (73.4–82.0)	144,500
Māori	76.1 (68.0–84.1)	47,300
Pacific	63.2 (50.8–75.7)	11,900
Asian	74.4 (54.6–88.8)	23,100

Source: 2008 New Zealand Tobacco Use Survey
Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Pacific people were almost a fifth less likely to have quit for their own health than all 15–64-year-old recent quit attempters (Figure 6).

Figure 6: Tried to quit for own health, 15–64-year-old recent quit attempters by ethnic group (age-standardised rate ratio)



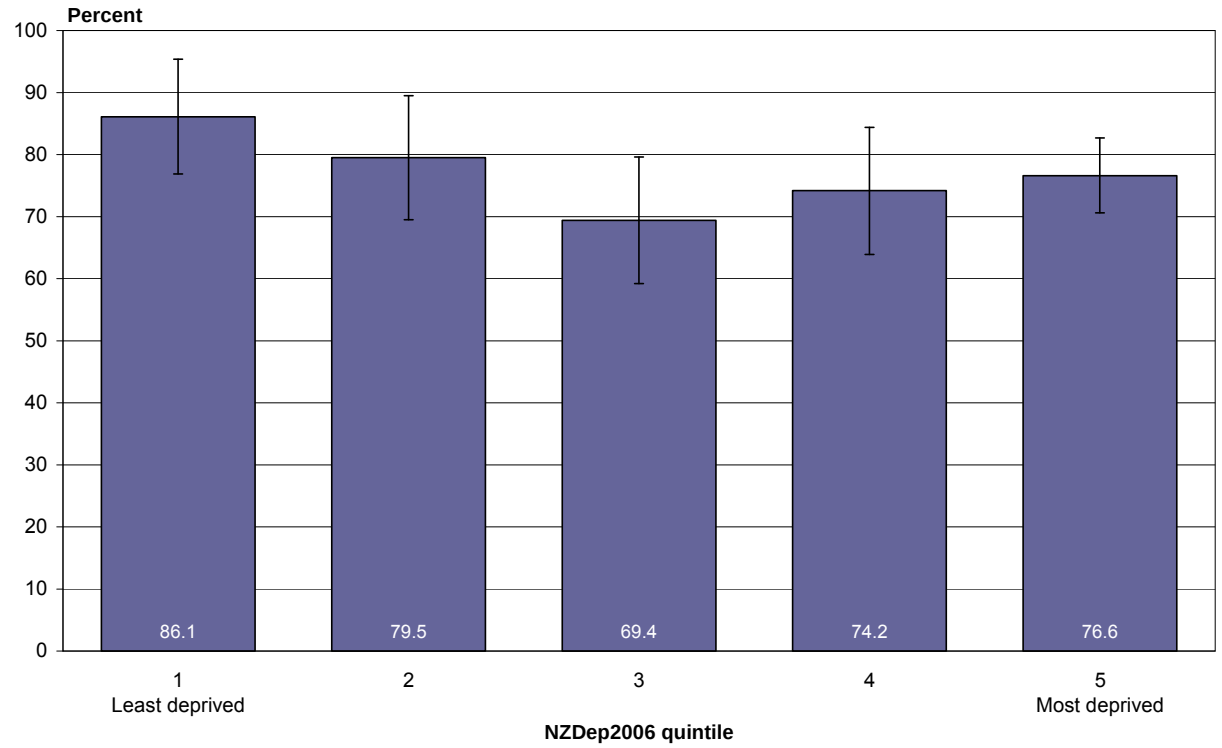
Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the recent quit attempter population aged 15–64 years. Total response standard output for ethnic groups has been used.

Tried to quit for own health, by neighbourhood deprivation

There was little difference by neighbourhood deprivation in the proportions of recent quit attempters who cited a reason for their most recent quit attempt as their own health (Figure 7).

Figure 7: Tried to quit for own health, 15–64-year-old recent quit attempters by NZDep2006 quintile (age-standardised prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Reason for most recent quit attempt: cost

Over a third (37.0%, 32.2–41.8) of recent quit attempters cited the cost of smoking as a reason for their most recent quit attempt. There were no significant differences by gender, age group or neighbourhood deprivation.

Tried to quit because of cost, by ethnic group

Table 3 gives an indication of the proportion of 15–64-year-old recent quit attempters of different ethnic groups who cited the cost of smoking as a reason for their most recent quit attempt.

Table 3: Tried to quit smoking because of cost, recent quit attempters by ethnic group (unadjusted)

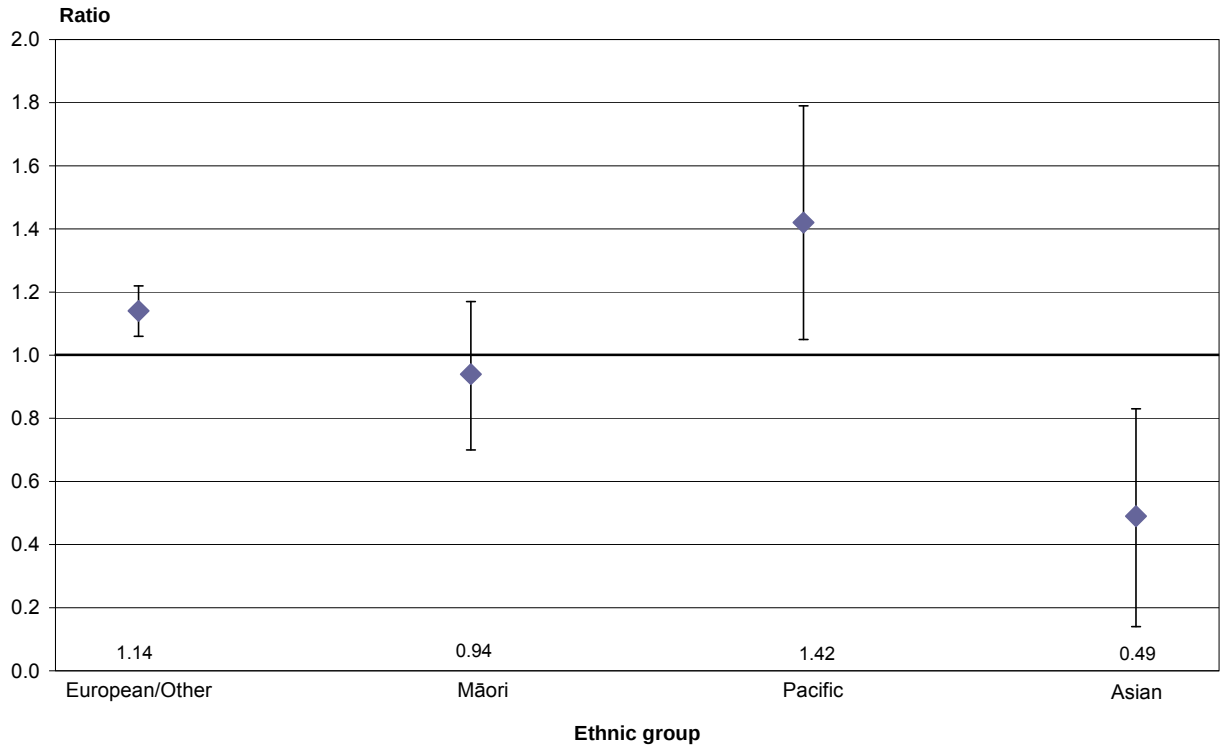
Ethnic group	Prevalence for all recent quit attempters aged 15–64 years (95% CI)	Number of recent quit attempters aged 15–64 years
European/Other	41.6 (35.5–47.7)	77,400
Māori	34.4 (26.4–42.4)	21,400
Pacific	51.9 (37.8–66.0)	9,700
Asian	16.7 (7.1–31.2)	5,200

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

Pacific people who were recent quit attempters were 42% more likely to cite cost as a reason for their most recent quit attempt than all 15–64-year-old recent quit attempters, when adjusted for age. European/Other people were 14% more likely and Asian people approximately half as likely as people in the total population to cite cost as a reason for their most recent quit attempt (Figure 8).

Figure 8: Tried to quit because of cost, 15–64-year-old recent quit attempters by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the recent quit attempter population aged 15–64 years. Total response standard output for ethnic groups has been used.

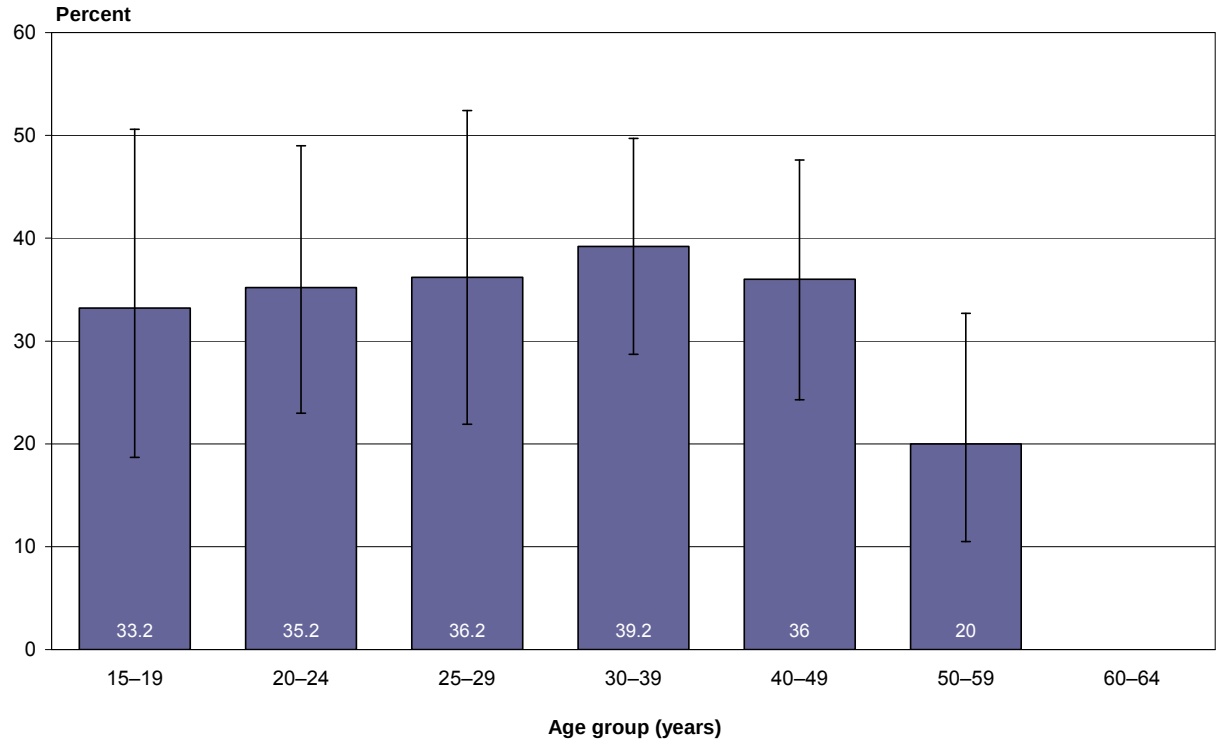
Reason for most recent quit attempt: sick of smoking

Over a third (34.6%, 29.1–40.1) of recent quit attempters cited being sick of smoking as a reason for their most recent quit attempt. There were no significant differences by gender or neighbourhood deprivation.

Tried to quit because sick of smoking, by age group

Significantly fewer 50–59-year-olds (20.0%, 10.5–32.7) cited being sick of smoking as a reason for their most recent quit attempt than those in the 30–49-year-old age groups (Figure 9).

Figure 9: Tried to quit because sick of smoking, recent quit attempters by age group (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Note: The value for 60–64-year-olds cannot be provided due to small numbers.

Tried to quit because sick of smoking, by ethnic group

Table 4 gives an indication of the proportion of 15–64-year-old recent quit attempters of different ethnic groups who cited being sick of smoking as a reason for their most recent quit attempt.

Table 4: Tried to quit because sick of smoking, recent quit attempters by ethnic group (unadjusted)

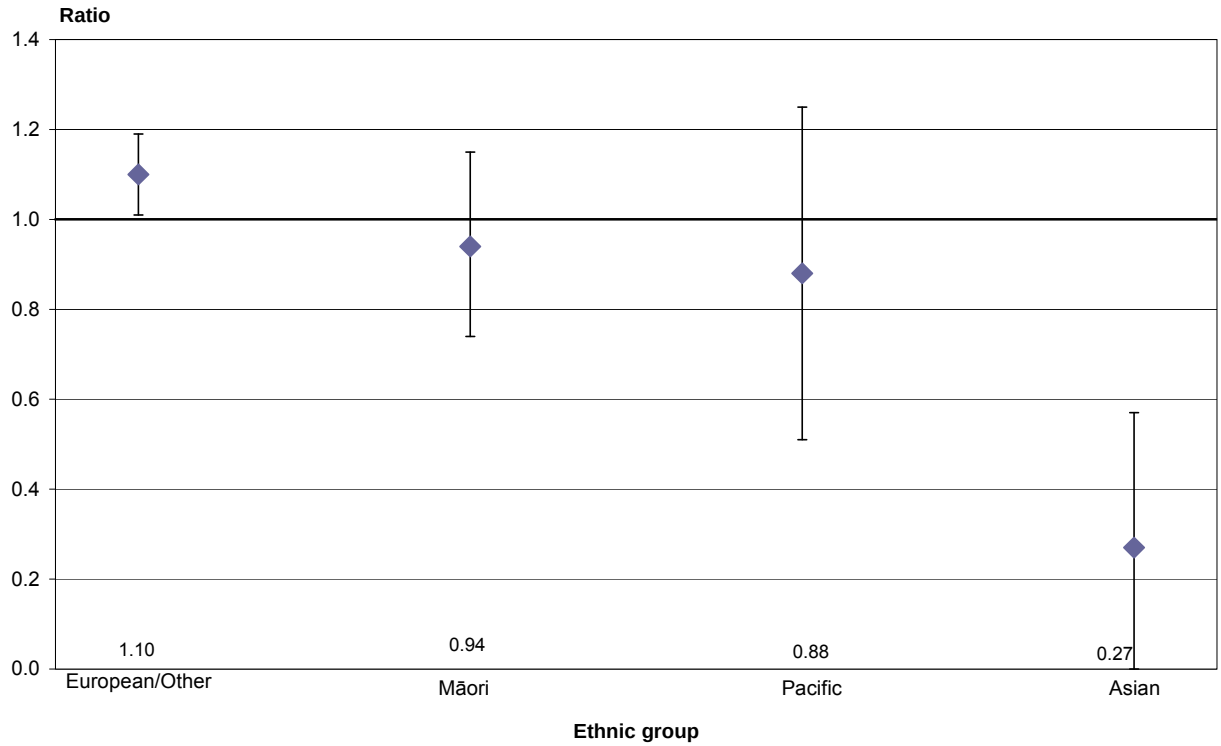
Ethnic group	Prevalence for all recent quit attempters aged 15–64 years (95% CI)	Number of recent quit attempters aged 15–64 years
European/Other	37.9 (31.2–44.6)	70,400
Māori	33.9 (25.8–42.0)	21,000
Pacific	31.5 (18.9–46.4)	5,900
Asian	11.7 (2.4–30.9)	3,600

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, European/Others were significantly more likely than people in the total recent quit attempter population to cite being sick of smoking as a reason for their most recent quit attempt (Figure 10). Asian people were a quarter as likely as 15–64-year-olds in the total population who were recent quit attempters to cite being sick of smoking as a reason for their most recent quit attempt.

Figure 10: Tried to quit because sick of smoking, 15–64-year-old recent quit attempters by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the recent quit attempter population aged 15–64 years. Total response standard output for ethnic groups has been used.

Reason for most recent quit attempt: someone else's health

Just over a quarter (26.6%, 22.4–30.7) of recent quit attempters cited someone else's health as a reason for their most recent quit attempt.

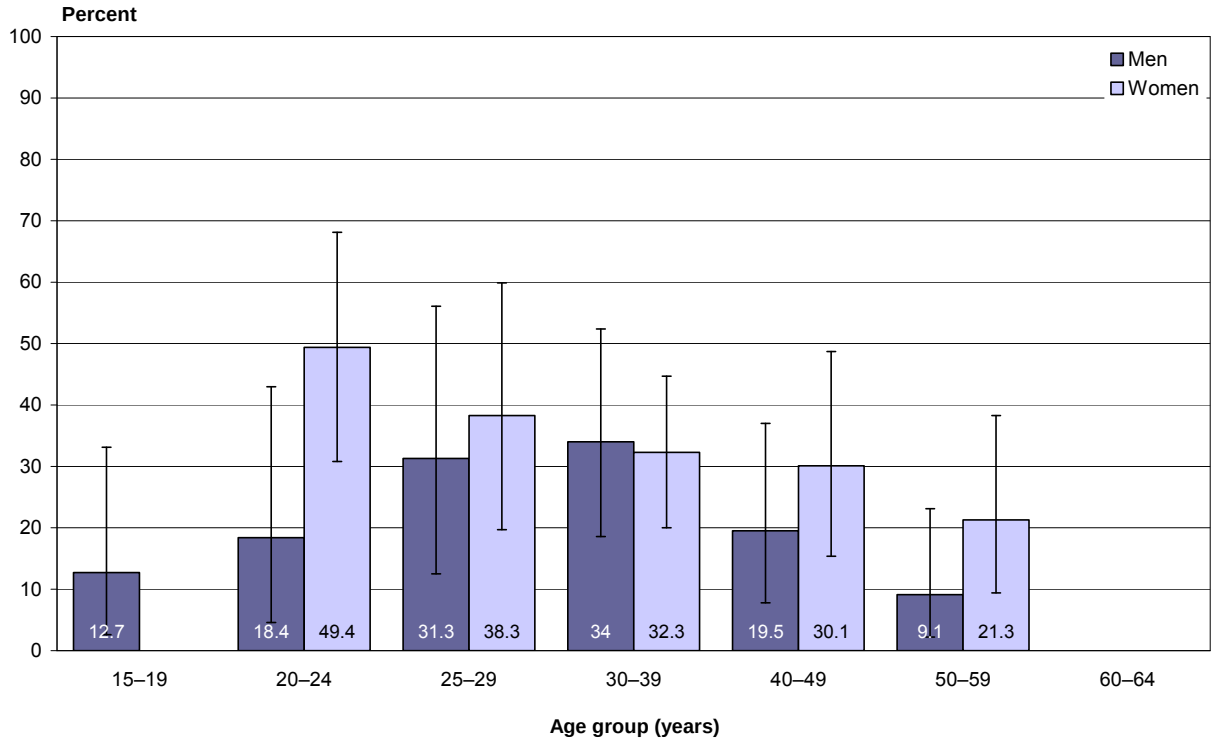
Women were significantly more likely (32.9%, 26.6–39.2) than men (22.8%, 16.1–29.5) to cite someone else's health as the reason for their most recent quit attempt, when adjusted for age.

There were no significant differences by ethnic group or neighbourhood deprivation.

Tried to quit because of someone else's health, by age group

Half of women recent quit attempters aged 20–24 (49.4%, 30.8–68.1) cited someone else's health as a reason for their most recent quit attempt: this was significantly higher than the one in five women recent quit attempters aged 50–59 (21.3%, 9.4–38.3) who cited the same reason (Figure 11). A third of men who were recent quit attempters aged 30–39 (34.0%, 18.6–52.4) cited someone else's health as a reason for their most recent quit attempt: this was significantly higher than the one in ten men who were recent quit attempters aged 50–59 years (9.1%, 2.2–23.1) and the one in eight aged 15–19 years (12.7%, 2.6–33.1) who cited the same reason (Figure 11).

Figure 11: Tried to quit because of someone else's health, recent quit attempters by age group and gender (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Note: The values for 15–19-year-old women and 60–64-year-old men and women cannot be provided due to small numbers.

Attitudes to quitting

Smokers who fail to quit do not really want to quit

Respondents were asked whether or not they agreed with the following statement: *Smokers who fail to quit, do not really want to quit*.

Respondents could select one of five answers to this question: strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

In this section, the 'strongly agree' and 'agree' responses and the 'strongly disagree' and 'disagree' responses have been combined. The proportions of people who agreed with this statement by smoking status are shown in Figure 14 on page 22).

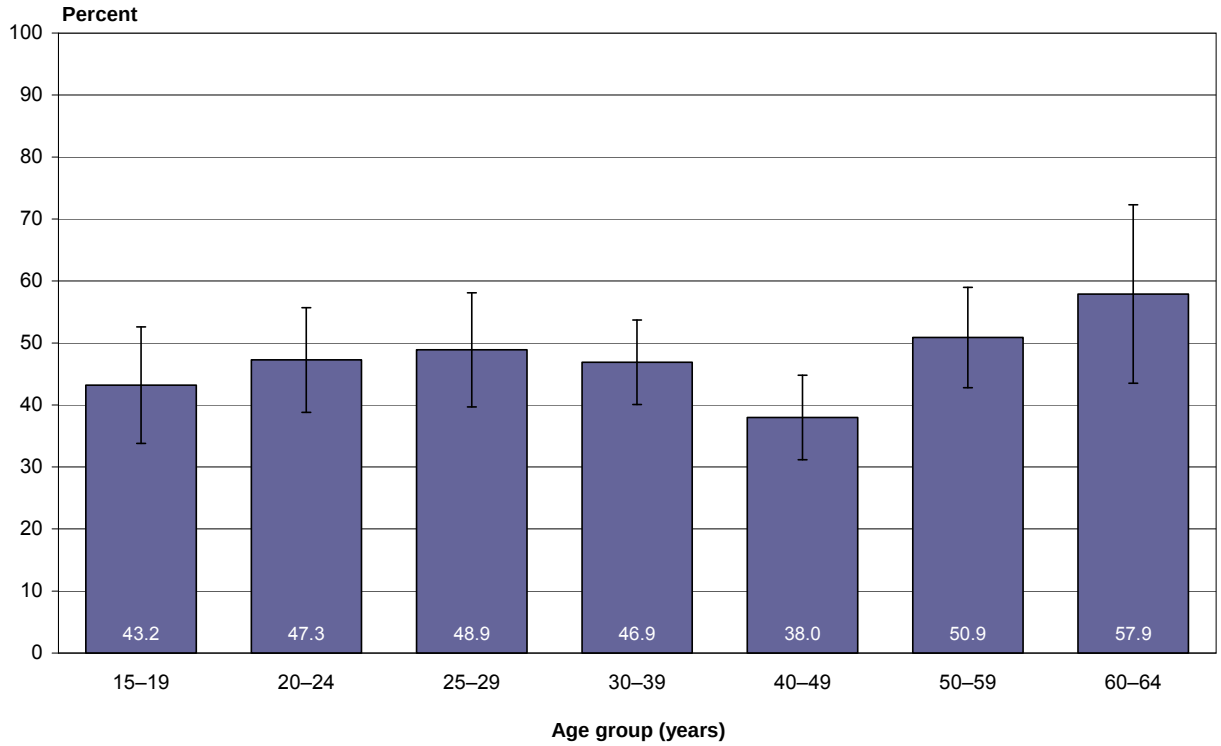
Further analyses of this question, including by smoking status, are available in Excel format at http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report#appendix1

Significantly more current smokers (46.0%, 42.7–49.3) agreed than disagreed (40.4%, 37.2–43.6) that smokers who fail to quit do not really want to quit. There were no significant differences between the proportions of men and women current smokers who agreed or disagreed that smokers who fail to quit do not really want to quit.

Smokers who fail to quit do not really want to quit, by age group

Nearly three out of five 60–64-year-old current smokers (57.9%, 43.5–72.3) agreed that smokers who fail to quit do not really want to quit: this was significantly higher than the proportion of those in the 40–49-year-old age group who agreed: just under two out of five (38.0%, 31.2–44.8) (Figure 12).

Figure 12: Agree that smokers who fail to quit do not really want to quit, current smokers by age group (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Smokers who fail to quit do not really want to quit, by ethnic group

Table 5 gives an indication of the proportion of 15–64-year-old current smokers of different ethnic groups who agreed that smokers who fail to quit do not really want to quit.

Table 5: Agree that smokers who fail to quit do not really want to quit, current smokers by ethnic group (unadjusted)

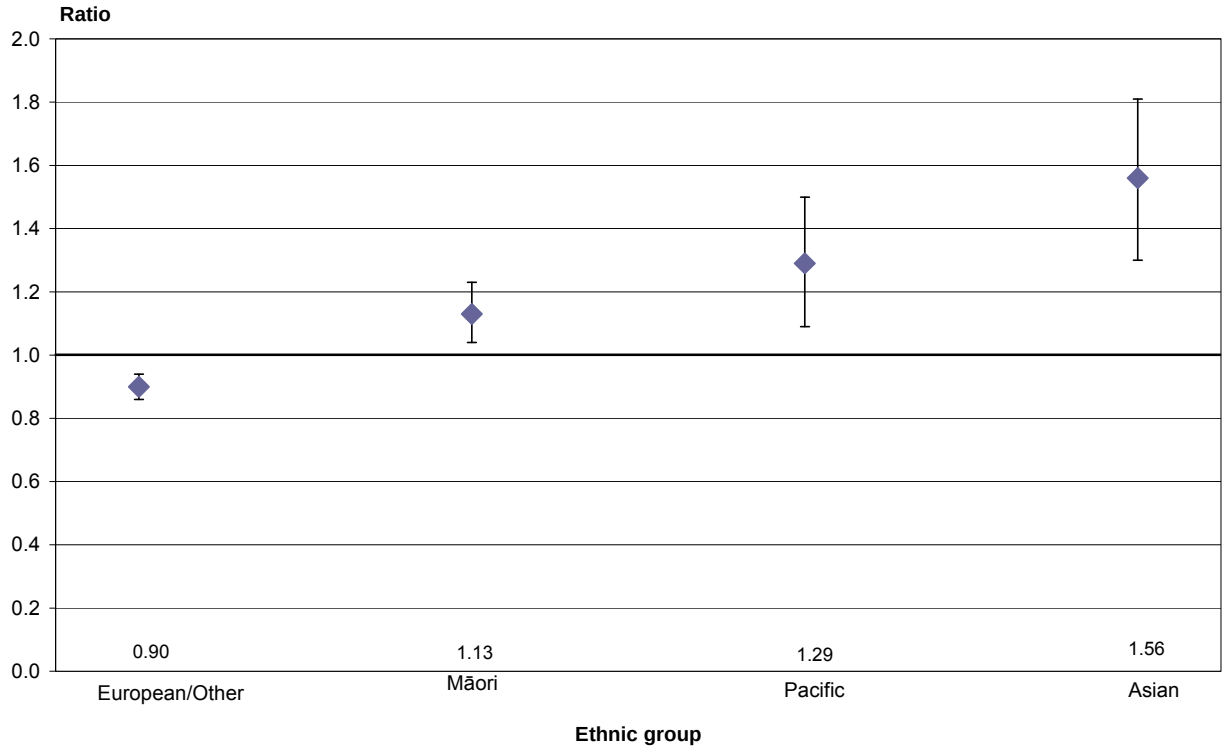
Ethnic group	Prevalence for current smokers aged 15–64 years (95% CI)	Number of current smokers aged 15–64 years
European/Other	41.8 (38.3–45.3)	186,000
Māori	52.2 (47.3–57.0)	80,700
Pacific	57.3 (48.4–66.3)	28,700
Asian	66.9 (52.3–81.4)	26,500

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Māori, Pacific and Asian current smokers were all significantly more likely than all 15–64-year-old current smokers to agree that smokers who fail to quit do not really want to quit. European/Other current smokers were significantly less likely to agree with this statement (Figure 13).

Figure 13: Agree that smokers who fail to quit do not really want to quit, current smokers by ethnic group (age-standardised rate ratio)



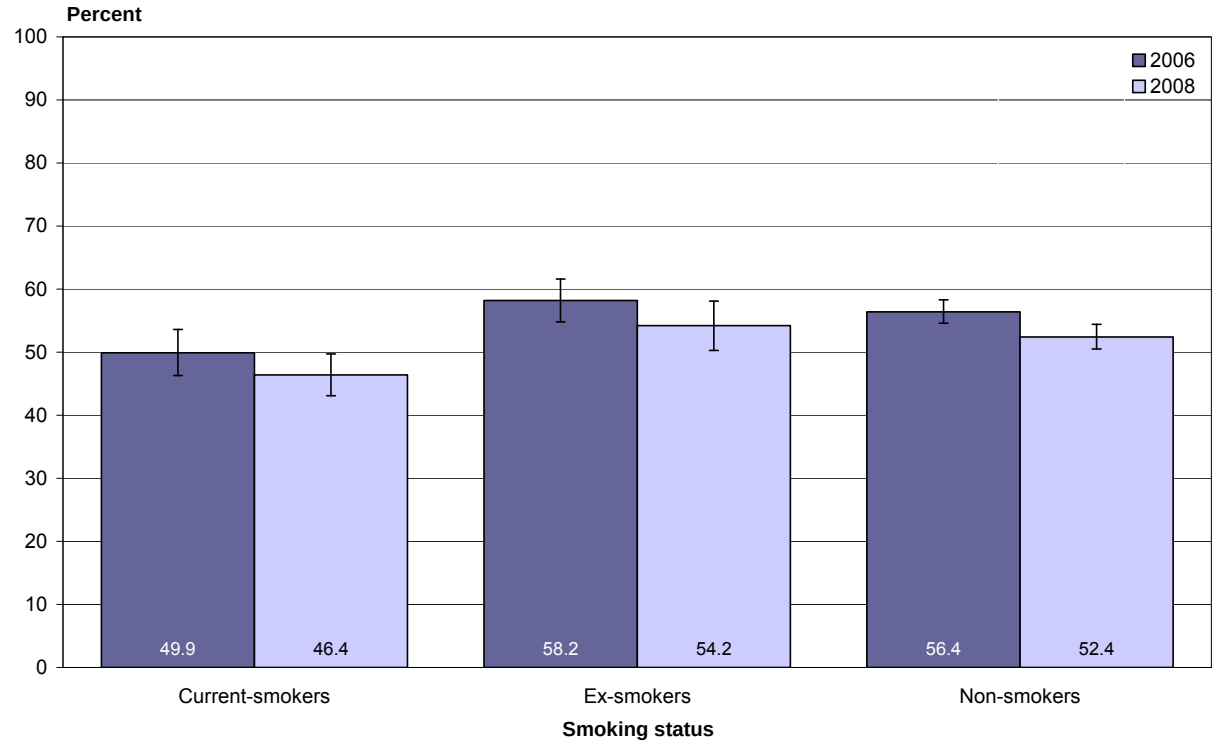
Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the current smoking New Zealand population aged 15–64 years. Total response standard output for ethnic groups has been used.

Agree with the statement smokers who fail to quit do not really want to quit, comparison with 2006

Comparing the proportions of people aged 20–64 between 2006 and 2008 who agreed that smokers who fail to quit do not really want to quit, there was a significant decrease in the proportion of non-smokers aged 20–64 agreeing with this statement, and slight (but not significant) decreases for current and ex-smokers (Figure 14).

Figure 14: Agree that smokers who fail to quit do not really want to quit, 20–64-year-olds by smoking status, 2006 and 2008 (age-standardised prevalence)



Source: 2006 and 2008 New Zealand Tobacco Use Surveys

Note: Due to changes in definitions, data from 2006 have been reanalysed to allow for comparability: see page 3 for further information.

Would not smoke if had life over again

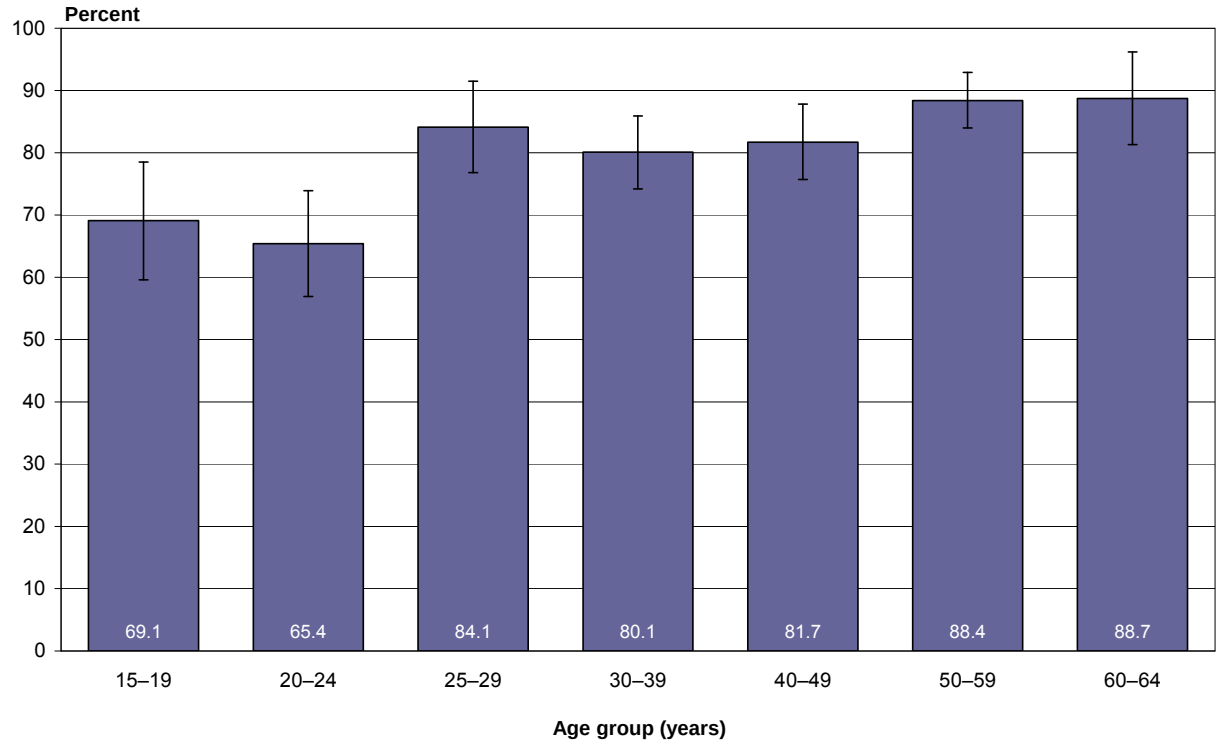
Four out of five current smokers (78.5%, 75.5–81.5) said that they would not smoke if they had their life over again. There were no significant differences by gender or ethnic group.

Would not smoke if had life over again, by age group

Significantly fewer 20–24-year-old current smokers (65.4%, 56.9–73.9) said that they would not smoke if they had their life over again than all of the older age groups (Figure 15).

The proportion of 15–19-year-old current smokers in 2008 who said they would not smoke if they had their life over again (69.1%, 59.6–78.5) was the same as it was in 2006 (69.3%, (61.0–77.6).

Figure 15: Would not smoke if had life over again, current smokers by age group (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

2 Quitting Services and Programmes

Introduction

Objective 2 of *Clearing the Smoke: A five-year plan for tobacco control in New Zealand (2004–2009)* is to promote quitting smoking (Ministry of Health 2004). This objective includes the provision of quit smoking services.

All results presented here, and some additional results, are available in Excel format at www.moh.govt.nz/moh.nsf/indexmh/portrait-of-health

Support from health professionals – ABC

The *New Zealand Smoking Cessation Guidelines* provide updated guidance for health care workers in their contacts with smokers (Ministry of Health 2007b).

The guidelines are structured around the ABC approach for quitting smoking: health care workers should **Ask** about smoking status, give **Brief** advice to stop smoking to all smokers and provide evidence-based **Cessation** (quitting) support for those who wish to stop smoking (Ministry of Health 2009b).

Using this approach, health workers will work towards achieving one of the six health targets, *Better help for smokers to quit,* that came into effect on 1 July 2009 (Ministry of Health 2009c).

This section provides some baseline information on the proportion of people experiencing parts of the ABC approach for quitting smoking before this approach was implemented in late 2008 and early 2009.

Asked smoking status

More than half (53.6%, 51.7–55.6) of all 15–64-year-olds and approximately three-quarters of current smokers (74.4%, 71.2–77.6) reported that, at some time in the past 12 months, a health care worker had asked if they had ever been or currently were a smoker. For the total 15–64-year-old population, there was no significant difference by gender.

Further analyses of this question among ex-smokers are available in Excel format at http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report-appendix1

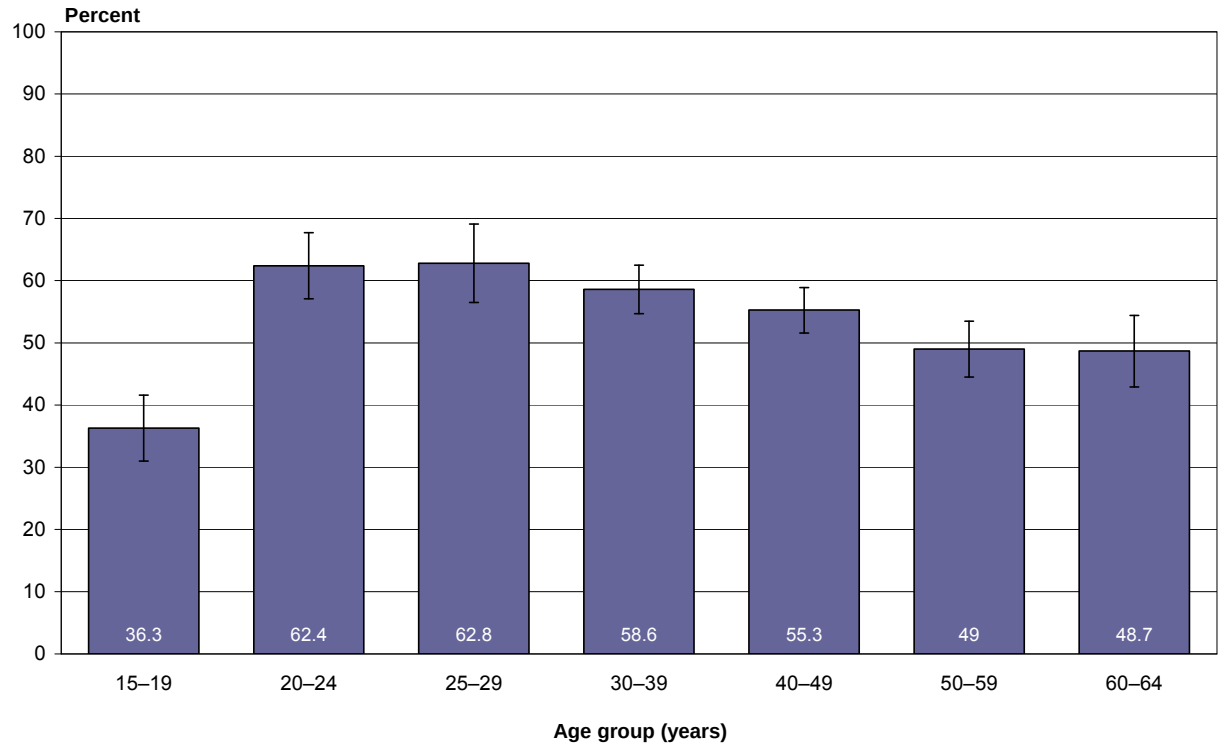
Asked smoking status, 15–64-year-old current smokers, by gender

Women current smokers (78.2%, 74.7–81.6) were significantly more likely than men (70.1%, 65.1–75.2) to report that they had been asked if they ever had been or currently were a smoker by a health care worker in the past 12 months, after adjusting for age.

Asked smoking status, 15–64-year-old total population, by age group

Significantly fewer 15–19-year-olds (36.3%, 31.0–41.6) were asked if they had ever been or currently were a smoker by a health care worker in the past 12 months than all of the older age groups (Figure 16).

Figure 16: Asked smoking status by a health care worker in the past 12 months, 15–64-year-old total population by age group (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Asked smoking status, 15–64-year-old total population, by ethnic group

Table 6 gives an indication of the proportion of 15–64-year-olds of different ethnic groups who were asked if they had ever been or currently were a smoker by a health care worker in the past 12 months.

Table 6: Asked smoking status by a health care worker in the past 12 months, 15–64-year-old total population by ethnic group (unadjusted)

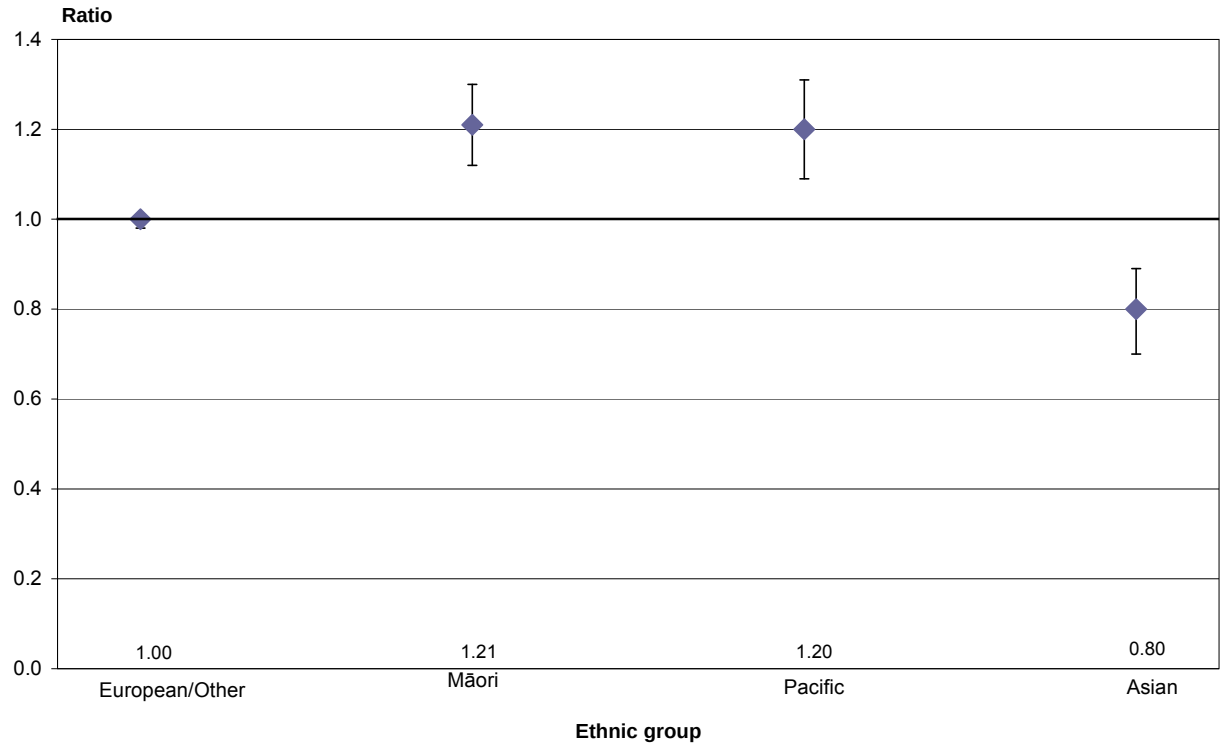
Ethnic group	Prevalence for current smokers aged 15–64 years (95% CI)	Number of current smokers aged 15–64 years
European/Other	53.4 (51.3–55.4)	970,800
Māori	64.9 (60.1–69.7)	175,100
Pacific	64.1 (58.6–69.7)	75,600
Asian	43.3 (37.8–48.7)	106,800

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Māori and Pacific people were significantly more likely than all 15–64-year-olds to report that they had been asked if they had ever been or currently were a smoker by a health care worker in the past 12 months (Figure 17). Asian people were significantly less likely to have been asked their smoking status by a health care worker in the past 12 months than the total 15–64-year-old population.

Figure 17: Asked smoking status by a health care worker in the past 12 months, 15–64-year-old total population by ethnic group (age-standardised rate ratio)



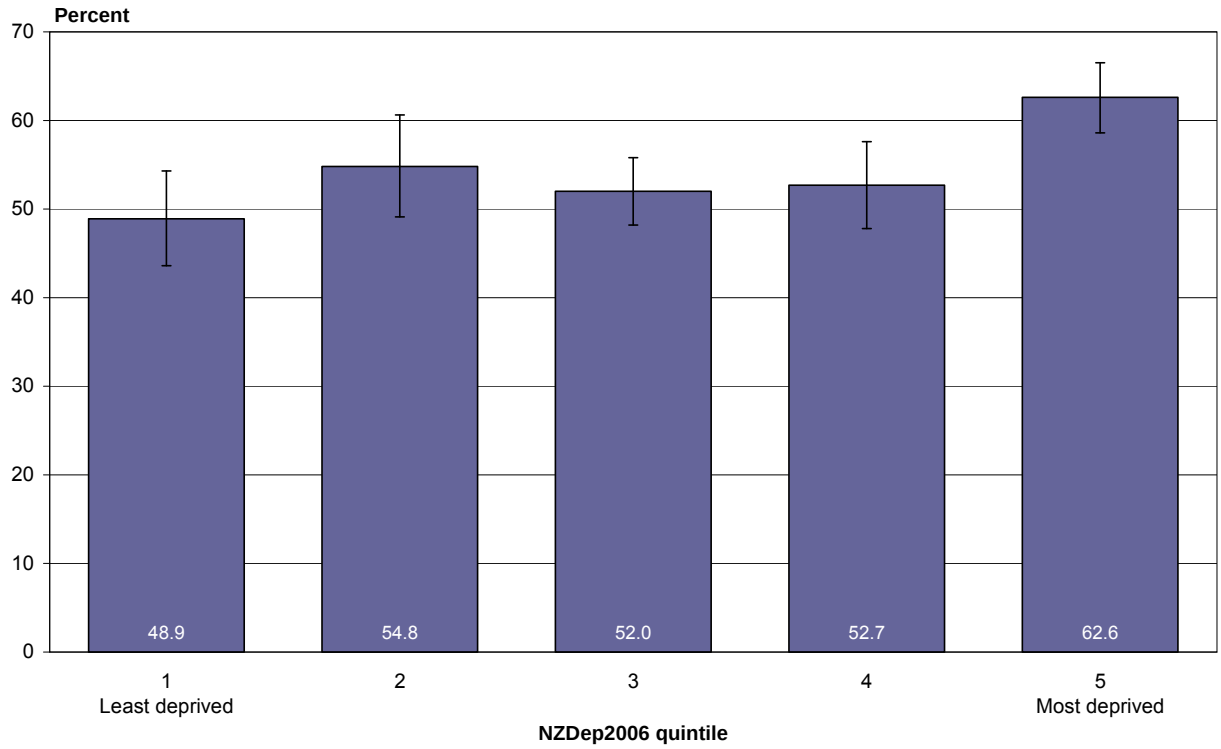
Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the New Zealand population aged 15–64 years. Total response standard output for ethnic groups has been used.

Asked smoking status, 15–64-year-old total population, by neighbourhood deprivation

Almost two-thirds of 15–64-year-olds (62.6%, 58.6–66.5) in the most deprived areas (NZDep 2006 quintile 5) had been asked if they had ever been or currently were a smoker by a health care worker in the past 12 months (Figure 18). This prevalence was significantly higher than the proportion of 15–64-year-olds (48.9%, 43.6–54.3) in the least deprived areas (quintile 1) who were asked their smoking status in the past 12 months.

Figure 18: Asked smoking status, 15–64-year-old total population by NZDep2006 quintile (age-standardised prevalence)



Source: 2008 New Zealand Tobacco Use Survey

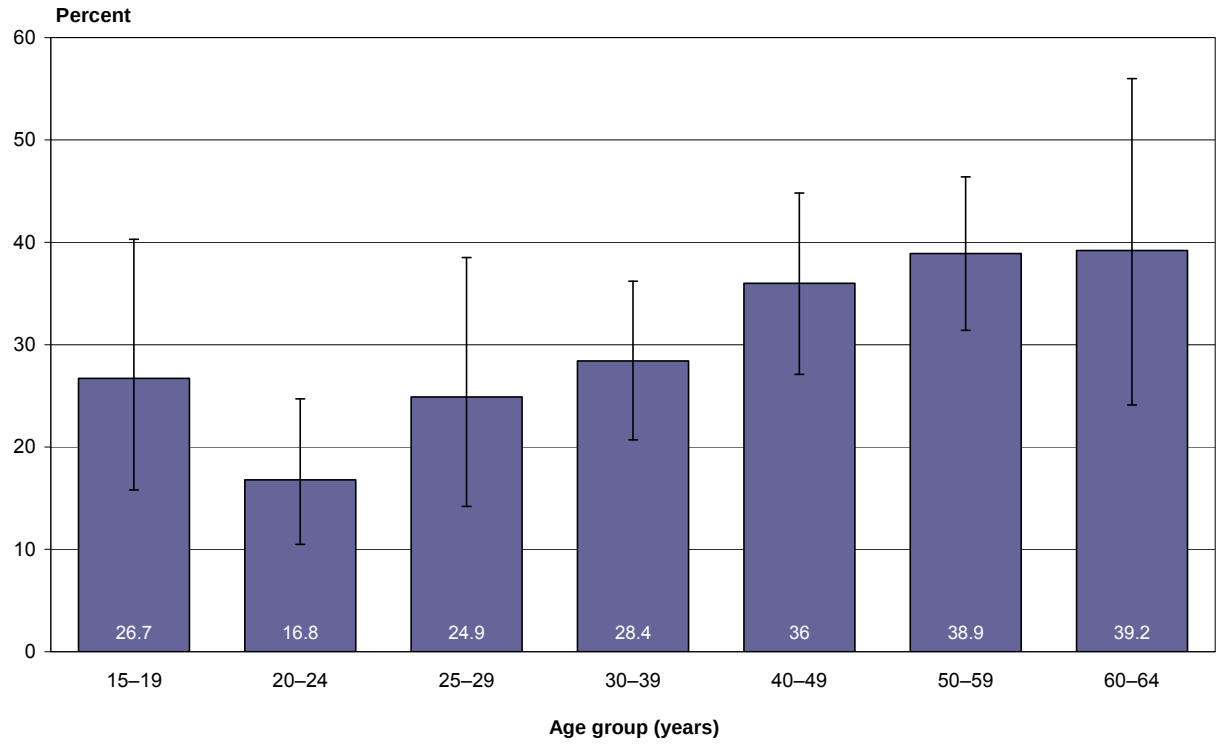
Quitting advice or referral from a health care worker

Almost 30% (29.9%, 26.2–33.7) of 15–64-year-old current smokers who had seen a health care worker were provided advice or information, referred to quitting programmes or given quitting products by a health care worker in the past 12 months. There was no significant difference by gender.

Quitting advice or referral from a health care worker, current smokers, by age group

The proportion of current smokers provided with advice or information, referred to quitting programmes or given quitting products by a health care worker in the past 12 months increased with smokers' increasing age (Figure 19). The proportion of 20–24-year-old current smokers who had received this help was significantly lower than the proportions among the 30–64 year age groups. This effect for age group remained after adjusting for gender, ethnic group and neighbourhood deprivation.

Figure 19: Provided advice or referral by a health care worker in the past 12 months, 15–64-year-old current smokers by age group (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Quitting advice or referral from a health care worker, current smokers, by ethnic group

Table 7 gives an indication of the proportion of 15–64-year-old current smokers provided with advice or information, referred to quitting programmes or given quitting products by a health care worker in the past 12 months.

Table 7: Quitting advice or referral from a health care worker in the past 12 months, current smokers by ethnic group (unadjusted)

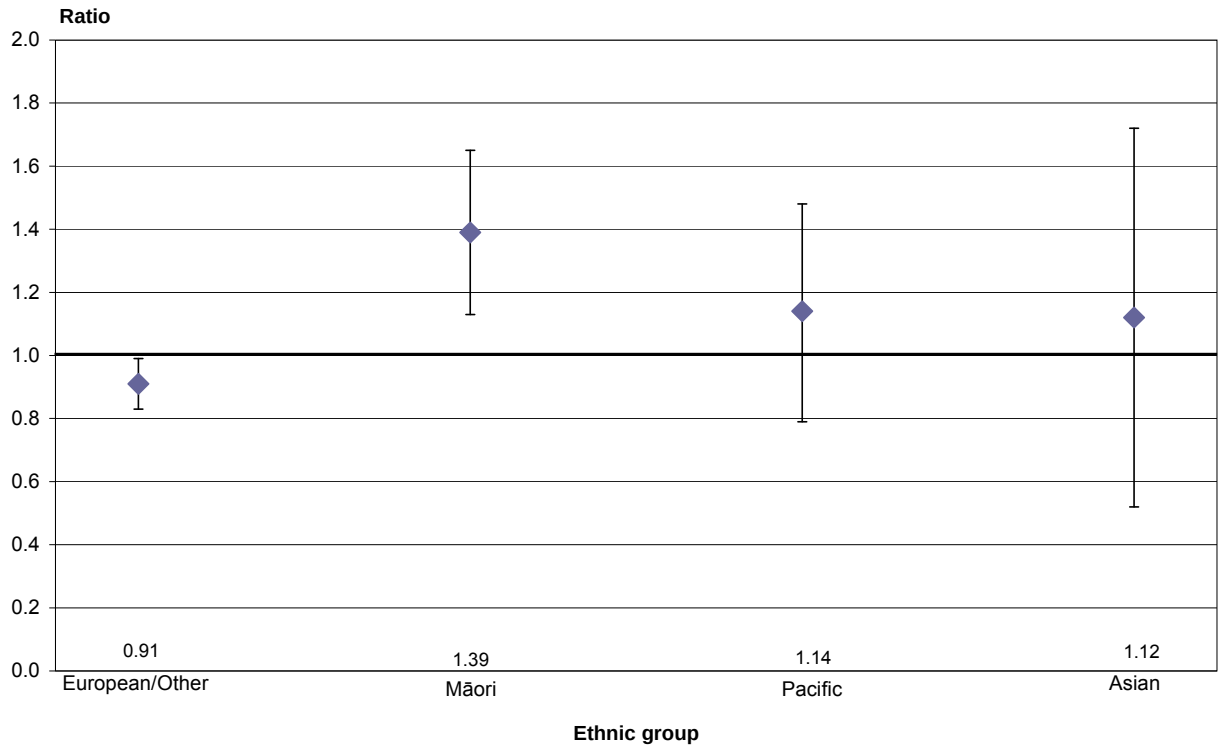
Ethnic group	Prevalence for total adults (95% CI)	Number of adults
European/Other	27.2 (22.7–31.7)	94,100
Māori	39.6 (32.6–46.6)	39,900
Pacific	33.5 (23.6–43.4)	10,500
Asian	33.9 (15.4–56.9)	8,300

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Māori current smokers were two-fifths more likely than all 15–64-year-old current smokers to report being provided with advice or information, referred to quitting programmes or given quitting products by a health care worker in the past 12 months (Figure 20). European/Other current smokers were significantly less likely to report being provided with this help than all 15–64-year-old current smokers.

Figure 20: Quitting advice or referral from a health care worker, 15–64-year-old current smokers by ethnic group (age-standardised rate ratio)



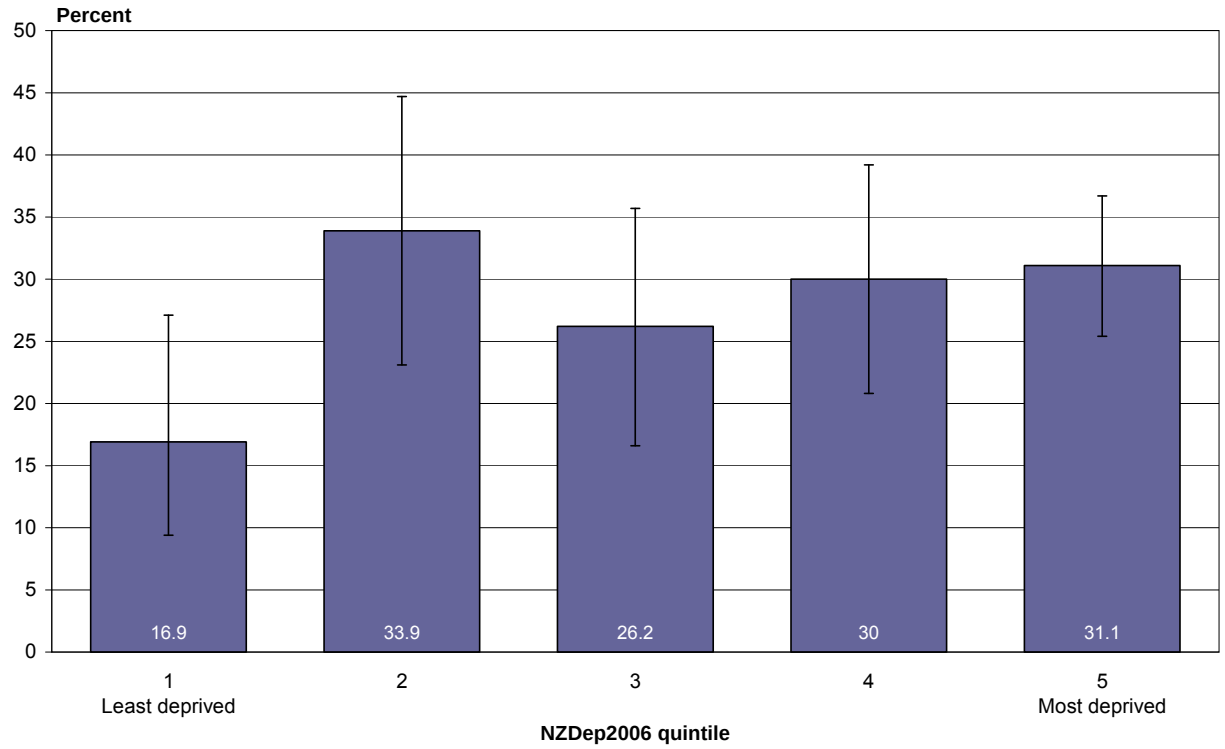
Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the current smoking population aged 15–64 years who have seen a health care worker in the past 12 months. Total response standard output for ethnic groups has been used.

Quitting advice or referral from a health care worker, current smokers, by neighbourhood deprivation

Current smokers aged 15–64 in the most deprived areas (NZDep2006 quintile 5) who had seen a health care worker in the past 12 months were nearly twice as likely (31.1%, 25.4–36.7) as those in the least deprived areas (quintile 1) (16.9%, 9.4–27.1) to have been provided with advice or information, referred to quitting programmes or given quitting products by a health care worker in the past 12 months, after adjusting for age (Figure 21).

Figure 21: Provided advice and referral by a health care worker, 15–64-year-old current smokers by NZDep2006 quintile (age-standardised prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Received quitting advice or products

Respondents were asked to identify any help, advice, programmes or products they used to help them quit during their most recent quit attempt from the following list:

- Quitline
- another stop smoking programme
- a doctor from a hospital
- a GP
- a dentist
- a nurse
- a pharmacist
- a midwife

- a Māori community health worker
- a friend or family member
- a school counsellor
- some other advisor you haven't mentioned
- nicotine patches
- nicotine gum
- microtab
- lozenges
- nicotine inhalers
- Zyban
- Champix
- the internet
- a texting service
- a self-help book
- some other product you haven't mentioned.

Quitline (call: 0800 778 778) is a national free quit smoking telephone helpline. Callers can:

- request a quit pack, which contains practical quit smoking advice and information
- register with the Quitline programme for advice and support
- get exchange cards for subsidised nicotine patches or gum where suitable ($3 for eight weeks' supply of patches, lozenges or gum).

Nicotine replacement therapy (NRT) includes patches, gum and lozenges. These products work by reducing the intensity of nicotine withdrawal symptoms through replacing some of the nicotine a smoker usually gets from cigarettes. It is a safe and effective treatment that doubles the chances of long-term quitting success. NRT has not been shown to cause cancer or heart disease, and is much safer than smoking (The Quit Group 2009).

Used quitting products or advice in most recent quit attempt

A third (34.3%, 29.6–38.9) of recent quit attempters used quitting products or advice in their most recent quit attempt. There were no significant differences by gender, age group, ethnic group or neighbourhood deprivation.

Used quitting products or advice in most recent quit attempt, comparison with 2006

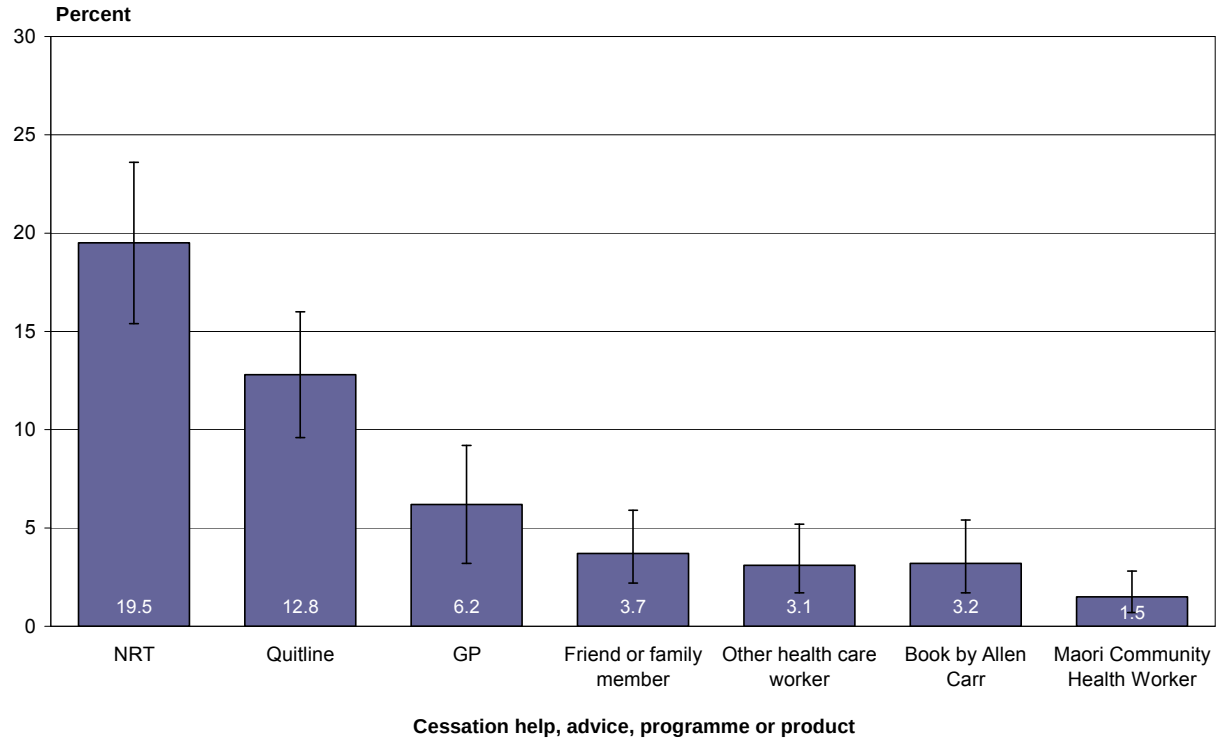
Caution is needed when comparing the NZTUS 2006 and 2008 results for the proportions of recent quit attempters who used quitting products or advice in their most recent quit attempt. In this comparison recent quit attempters were limited to those who had quit for at least a week in the past 12 months. This is probably more accurate for 2008 than for 2006, because in 2008 questions asking about 24-hour quit attempts

effectively filtered out quitters whose attempts were less serious (see page 10). The significant increase (adjusted for age) in product or advice users aged 20–64 years in 2008 compared with 2006 (38.7%, 31.2–46.2 compared with 24.0%, 19.0–29.0) may well be due to these methodological differences: the real increase is likely to be much less.

Services used in most recent quit attempt

The most common quitting product recent quit attempters used in their most recent quit attempt was NRT (19.5%, 15.4–23.6). Quitline was used by one in eight (12.8%, 9.6–16.0) recent quit attempters, while 6.2% (3.2–9.2) received help from their general practitioner (GP) (Figure 22).

Figure 22: Help, advice, programmes and products used in most recent quit attempt, 15–64-year-old recent quit attempters (age-standardised prevalence)



Source: 2008 New Zealand Tobacco Use Survey

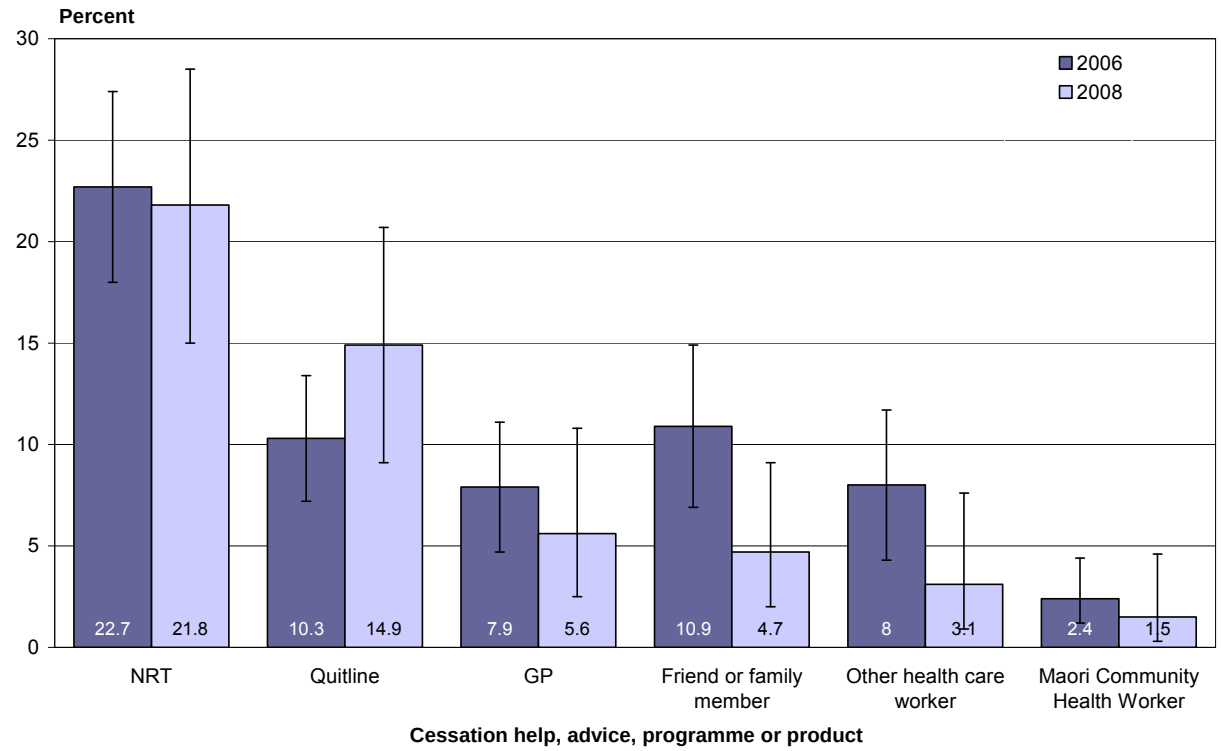
Help, advice, programmes and products used in most recent quit attempt, comparison with 2006

As mentioned above, caution is advised when comparing results for this question between those who had attempted to quit for at least a week aged 20–64 years in 2006 and those who did so in 2008 (see page 10). However, the only service here for which responses follow the same dramatic increase seen in overall use is Quitline, and this is not statistically significant (Figure 23). It should be noted that the Quit Group has not reported any substantial increase in new callers (the Quit Group 2009), and estimates from the two surveys of the numbers of those who reported having quit for at least a

week and used Quitline to do so for their most recent quit attempt are fairly similar (20,000 in 2006 compared with 18,100 in 2008).

Notably there was a significant decrease in the proportion of 20–64-year-olds who used friends or family members for advice and support to quit between 2006 (10.9%, 6.9–14.9) and 2008 (4.7%, 2.0–9.1).

Figure 23: Help, advice, programmes and products used in most recent quit attempt, recent quit attempters 20–64 years, 2006 and 2008 (age-standardised prevalence)



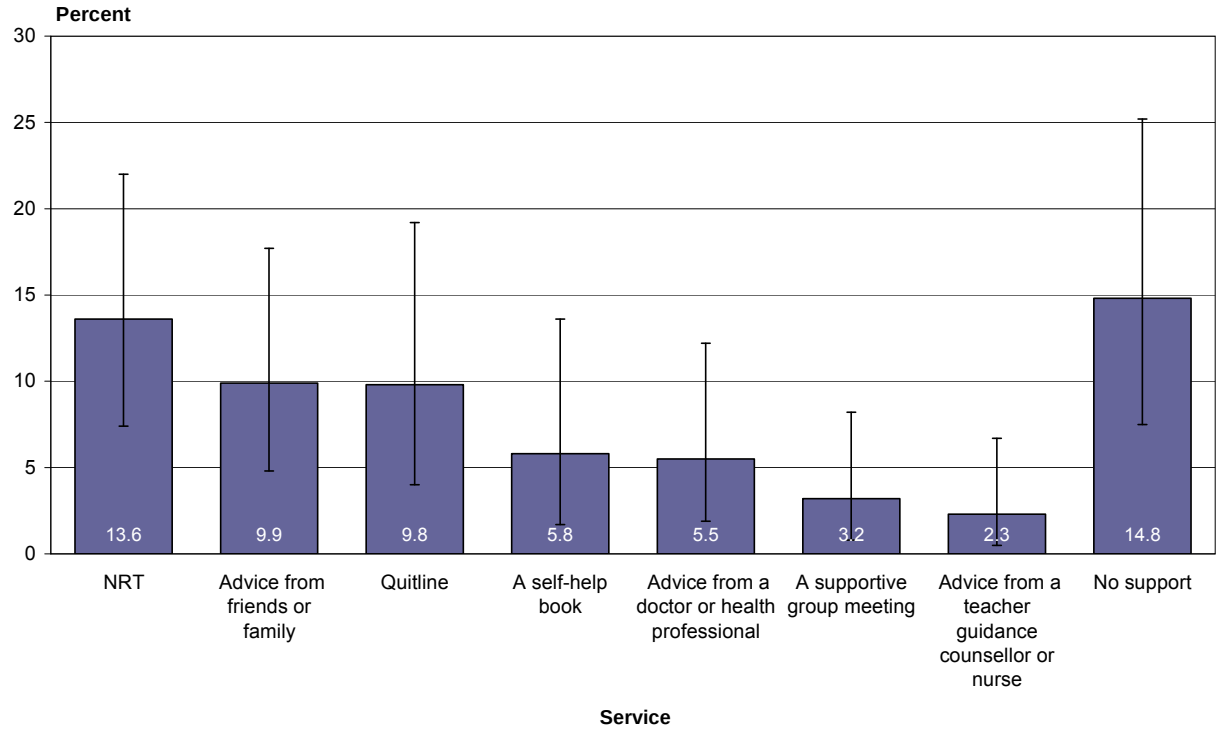
Source: 2006 and 2008 New Zealand Tobacco Use Surveys

Note: Due to changes in definitions, data from 2006 have been reanalysed to allow for comparability; however, caution is still advised: see pages 3 and 31–32 for further information.

Choice of service among youth aged 15–19 years

Current smokers aged 15–19 years were asked what services they would consider using to help them quit if they were thinking about quitting. One in seven (14.8%, 7.5–25.2) felt that if they were thinking of quitting, they would do it without support. Quitline (9.8%, 4.0–19.2) and NRT (13.6%, 7.4–22.0) were more popular choices than most other options (Figure 24), as they were for the total population of 15–64-year-old recent quitters (see p 32, 'Services used in most recent quit attempt'). One choice that stood out for this group was that of advice from family and friends, with one in ten (9.9%, 4.8–17.7) 15–19-year-old current smokers selecting this as something they would consider using to help them quit.

Figure 24: Youth choice of service, 15–19-year-old current smokers (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

NRT

There were no significant differences in use of NRT by gender, ethnic group or neighbourhood deprivation.

Subsidy of NRT

Quitcards are vouchers given by trained health workers, or sent in the mail by Quitline, to smokers who wish to quit. The smoker can take the Quitcard to a community pharmacy and receive NRT patches, gum or lozenges for a small fee ($3 for eight weeks' supply). Without a Quitcard, smokers wanting to quit can purchase some NRT products over the counter at full price in supermarkets and pharmacies.

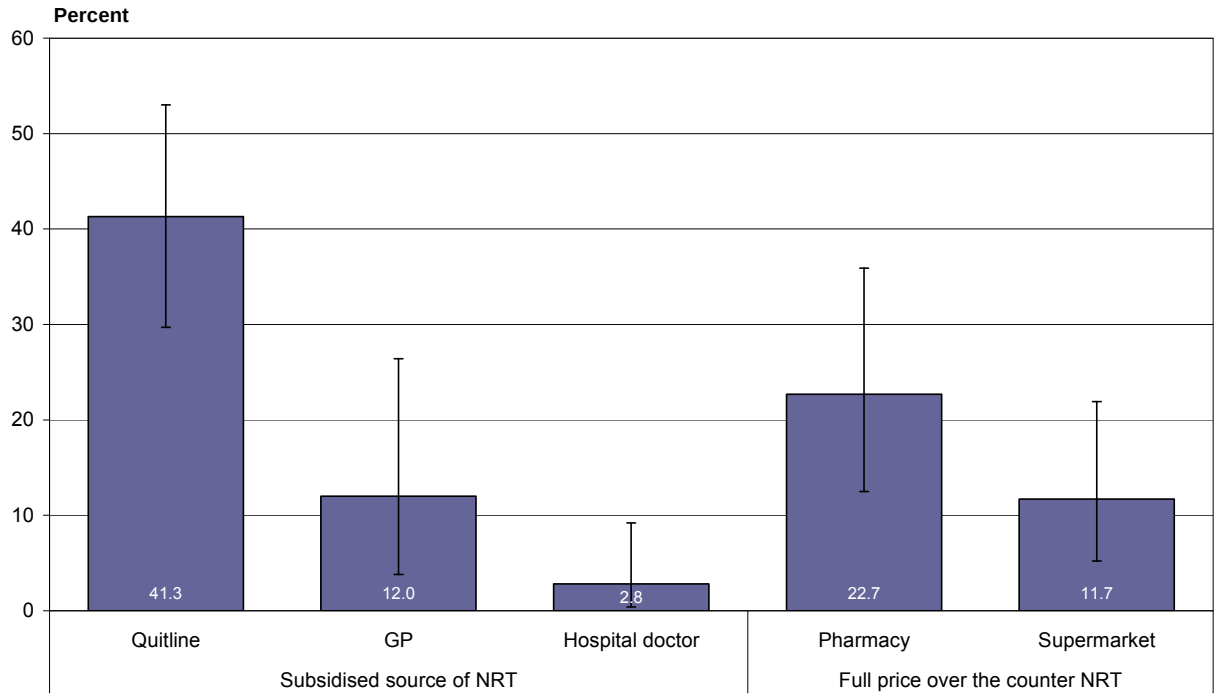
Respondents were asked where they got their NRT from and whether it was subsidised or not.

Of those people who had used NRT in their most recent quit attempt, almost two-thirds (62.7%, 49.9–75.5) received subsidised NRT, while just over a third (37.3%, 24.5–50.1) bought it full price over the counter.

Two out of five (41.0%, 29.7–53.0) of those who had used NRT received it from Quitline (Figure 25), while one in eight (12.0%, 3.8–26.4) got their prescription or Quitcard from their GP.

Over a fifth (22.7%, 12.5–35.9) of recent quit attempters who used NRT in their most recent quit attempt had bought their NRT for full price at a pharmacy, while half this proportion (11.7%, 5.2–21.9) had bought their NRT for full price from a supermarket.

Figure 25: Source of NRT, 15–64-year-old recent quit attempters who used NRT (age-standardised prevalence)

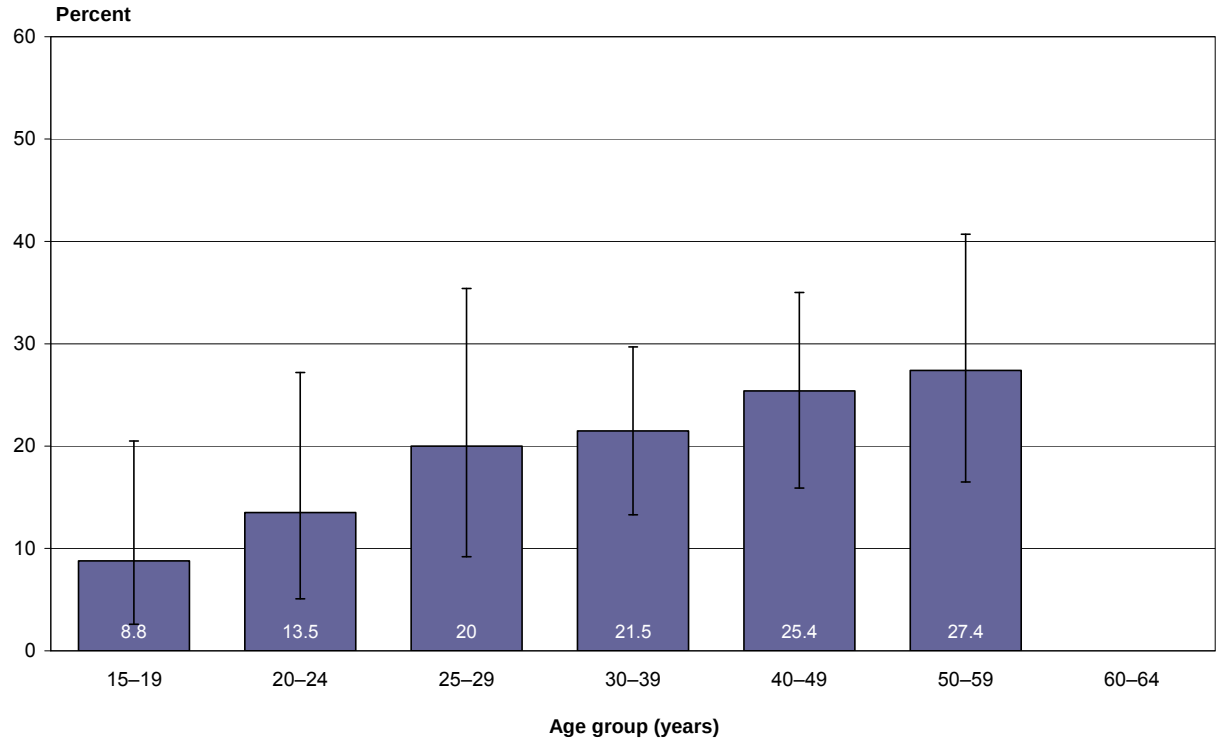


Source: 2008 New Zealand Tobacco Use Survey

NRT use, by age group

The proportion of recent quit attempters who used NRT in their most recent quit attempt increased with increasing age (Figure 26). The proportion of 15–19-year-olds who used NRT (9.2%, 2.7–21.5) was significantly lower than that of recent quit attempters in the 40–59 year age groups. There was a significant effect for age group after adjusting for gender, ethnic group and neighbourhood deprivation.

Figure 26: Used NRT during most recent quit attempt, 15–64-year-old recent quit attempters by age group (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Note: The value for 60–64-year-olds cannot be provided due to small numbers.

Beliefs about NRT

Respondents were asked whether they agreed or disagreed with statements about NRT. These statements included the following.

Nicotine replacement medications are more harmful than smoking cigarettes.

Nicotine replacement medications improve a smoker's chances of quitting successfully.

Respondents could select from the following options: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree or don't know.

In this section, the 'strongly agree' and 'agree' responses and the 'strongly disagree' and 'disagree' responses have been combined. Further analyses of this question, including by smoking status, are available in Excel format at http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report#appendix1

Nicotine replacement medications are more harmful than smoking cigarettes

Almost one third of current smokers disagreed that NRT is more harmful than smoking cigarettes (28.9%, 26.2–31.6). Over half of current smokers neither agreed nor disagreed (39.0%, 35.3–42.7) or didn't know (16.5%, 13.7–19.2) whether NRT is more harmful than smoking cigarettes, and one in six current smokers (15.6%, 13.4–17.8) agreed with the statement.

Of current smokers who agreed that NRT is more harmful than smoking cigarettes, there were no significant differences by gender, age group or neighbourhood deprivation.

Nicotine replacement medications are more harmful than smoking cigarettes, by ethnic group

Table 8 gives an indication of the proportion of 15–64-year-old current smokers who agreed that NRT is more harmful than smoking cigarettes.

Table 8: Agree nicotine replacement medications are more harmful than smoking cigarettes, current smokers by ethnic group (unadjusted)

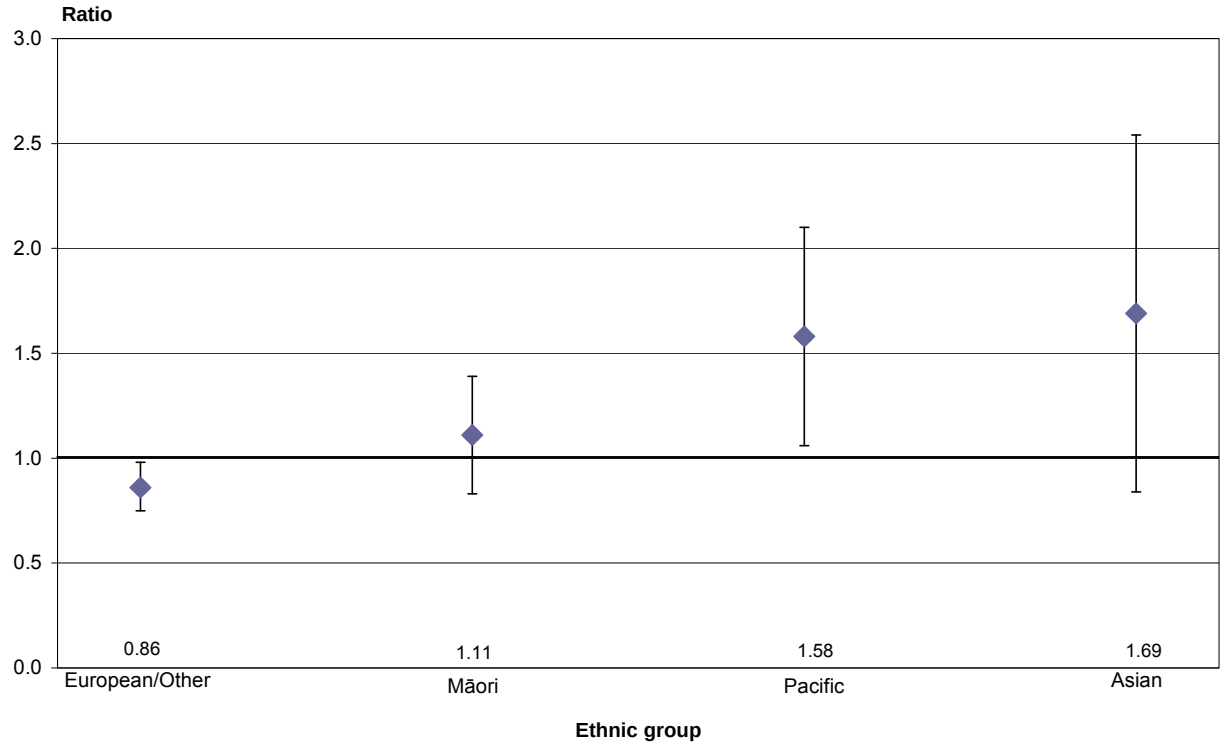
Ethnic group	Prevalence for all current smokers aged 15–64 years (95% CI)	Number of current smokers aged 15–64 years
European/Other	13.4 (10.6–16.2)	62,500
Māori	17.3 (12.5–22.1)	26,900
Pacific	24.6 (16.9–32.3)	12,300
Asian	26.3 (13.6–42.7)	11,000

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Pacific current smokers were 58% more likely than all 15–64-year-old current smokers to agree that NRT is more harmful than smoking cigarettes (Figure 27). European/Other current smokers were 14% less likely to agree with this statement.

Figure 27: Agree nicotine replacement medications are more harmful than smoking cigarettes, 15–64-year-old current smokers by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the current smoking population aged 15–64 years. Total response standard output for ethnic groups has been used.

Nicotine replacement medications improve a smoker's chances of quitting successfully

Nearly half of current smokers (45.6%, 42.3–48.8) agreed that NRT improves a smoker's chances of quitting successfully. However one in seven (14.6%, 12.4–16.7) current smokers disagreed with this statement, and two-fifths neither agreed nor disagreed (30.9%, 27.5–34.3) or didn't know (8.9%, 6.8–11.0).

Significantly fewer current smoking men (11.3%, 8.5–14.2) than women (17.9%, 14.4–21.4) disagreed that NRT improves a smoker's chances of quitting successfully, after adjusting for age.

Of the current smokers who agreed that NRT improves a smoker's chances of quitting successfully, there were no significant differences by age group or neighbourhood deprivation.

Nicotine replacement medications improve a smoker's chances of quitting successfully, by ethnic group

Table 9 gives an indication of the proportion of 15–64-year-old current smokers who disagreed that NRT improves a smoker's chances of quitting successfully.

Table 9: Disagree nicotine replacement medications improve a smoker's chances of quitting successfully, current smokers by ethnic group (unadjusted)

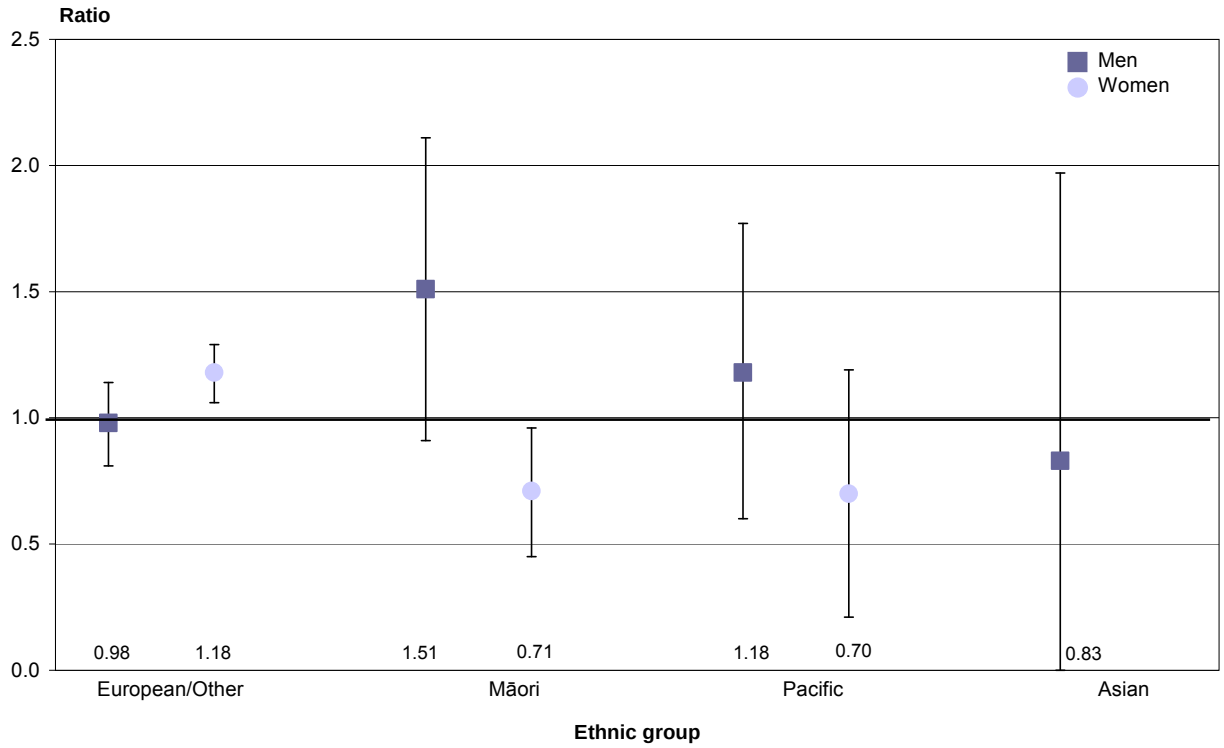
Ethnic group	Prevalence for all current smokers aged 15–64 years (95% CI)	Number of current smokers aged 15–64 years
European/Other	15.9 (13.2–18.6)	74,000
Māori	14.5 (10.3–18.8)	22,500
Pacific	12.9 (7.7–19.9)	6,500
Asian	12.2 (3.0–30.2)	5,100

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Māori current smoking women were significantly less likely than all 15–64-year-old current smoking women to disagree that NRT improves a smoker's chances of quitting successfully (Figure 28). European/Other current smoking women were significantly more likely to disagree with this statement.

Figure 28: Disagree nicotine replacement medications improve a smoker's chances of quitting successfully by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the current smoking male or female population aged 15–64 years. Total response standard output for ethnic groups has been used. The value for Asian women cannot be provided due to small numbers.

Quitline

One in eight (13.1%, 9.9–16.4) recent quit attempters used Quitline in their most recent quit attempt. There were no significant differences by gender, age group, ethnic group or neighbourhood deprivation.

Beliefs about quitting programmes and products

Respondents were asked whether they agreed or disagreed with the statement:

People should be able to quit without the help of programmes or products.

Respondents could select from the following options: strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

In this section, the 'strongly agree' and 'agree' responses and the 'strongly disagree' and 'disagree' responses have been combined. Further analyses of this question are available in Excel format at http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report#appendix1

A third (33.3%, 30.3–36.3) of 15–64-year-old current smokers agreed that smokers should be able to quit without the help of programmes and products. Half (49.3%, 46.2–52.3) of 15–64-year-old current smokers disagreed with this statement.

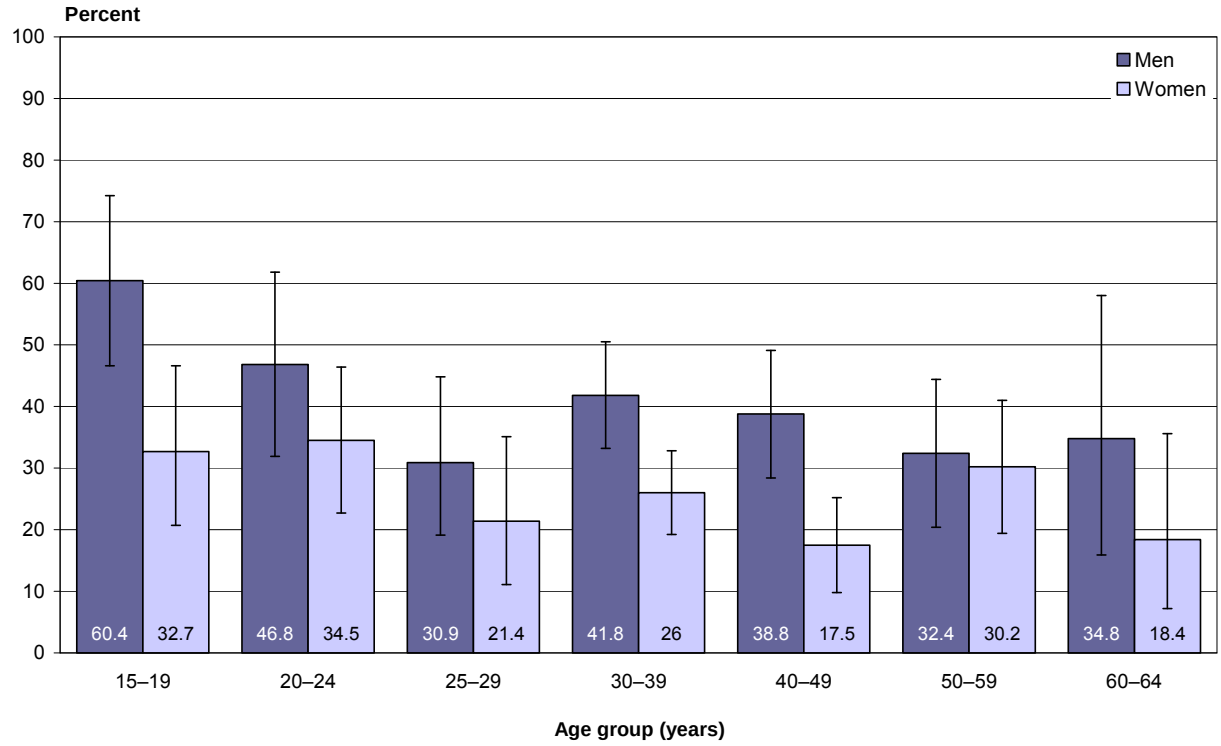
A significantly higher proportion of men (40.5%, 36.1–44.9) than women (26.6%, 22.5–30.7) agreed with the statement that smokers should be able to quit without the help of programmes and products, after adjusting for age. A higher proportion of women (55.8%, 51.3–60.2) than men (41.9%, 37.1–46.7) disagreed with this statement.

There were no significant differences among current smokers who agreed with this statement by neighbourhood deprivation, nor were any evident when comparing the figures by gender from 2006 with those from 2008.

Beliefs about quitting programmes and products, by age group

Three-fifths of current smoking men in the 15–19-year-old age group agreed that smokers should be able to quit without the help of programmes and products (60.4%, 46.6–74.2); this was significantly higher than the proportion who agreed with this statement in the 25–64 year age group (Figure 29).

Figure 29: Agree smokers should be able to quit without the help of programmes and products, current smokers by age group and gender (unadjusted prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Beliefs about quitting programmes and products, by ethnic group

Table 10 gives an indication of the proportion of 15–64-year-old current smokers who disagreed that quitting programmes and products improve a smoker's chances of quitting successfully.

Table 10: Agree smokers should be able to quit without the help of programmes and products, current smokers by ethnic group (unadjusted)

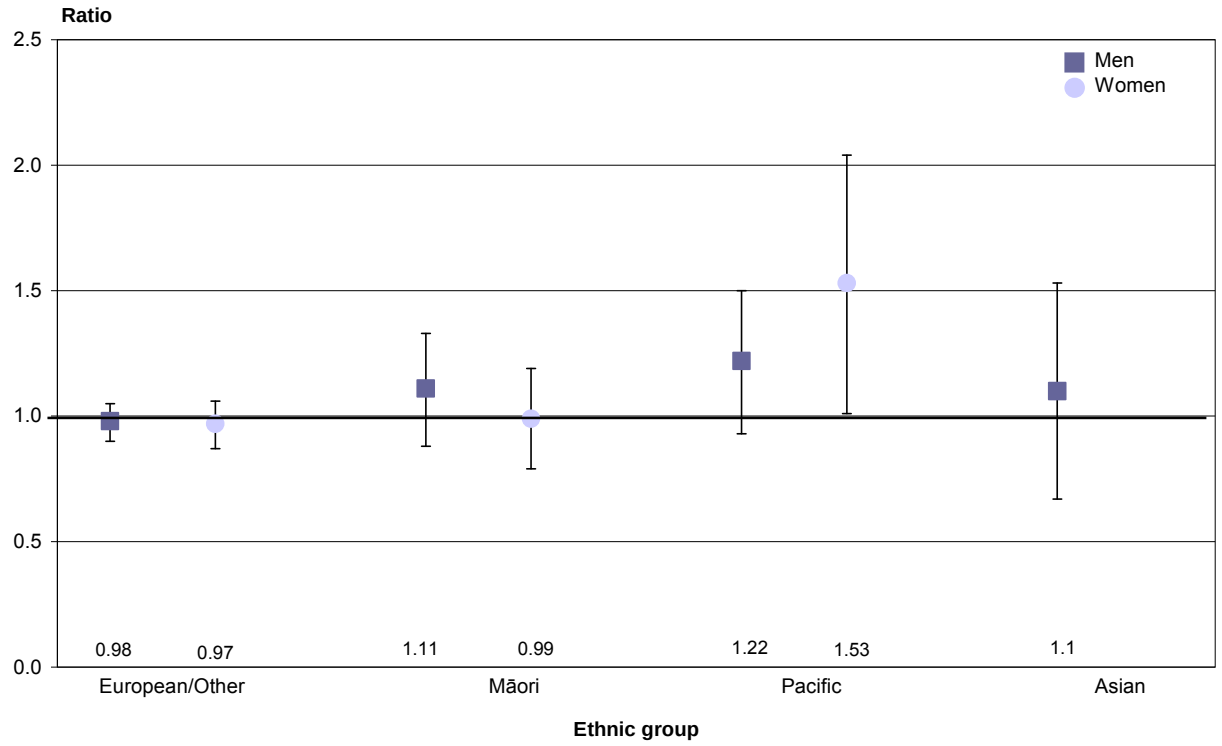
Ethnic group	Prevalence for all current smokers aged 15–64 years (95% CI)	Number of current smokers aged 15–64 years
European/Other	32.8 (29.2–36.4)	152,500
Māori	34.1 (28.8–39.4)	53,000
Pacific	45.1 (36.6–53.6)	22,500
Asian	41.9 (26.1–59.1)	17,500

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Pacific current smoking women were 53% more likely than all 15–64-year-old current smoking women to agree that smokers should be able to quit without the help of programmes and products (Figure 30).

Figure 30: Agree smokers should be able to quit without the help of programmes and products by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the current smoking male or female population aged 15–64 years. Total response standard output for ethnic groups has been used. The value for Asian women cannot be provided due to small numbers.

3 Knowledge and Awareness of Anti-smoking Messages

This section provides some information about the level of knowledge or uncertainty people have about the potential harm tobacco and nicotine can cause.

New Zealand has had text warnings on cigarette packets since 1974 to warn and educate smokers about potential harm from smoking. From February 2008 graphic warnings were introduced on cigarette packets and loose tobacco packets. The NZTUS 2008 data were collected at the time when the graphic warnings were starting to be introduced.

Knowledge of harm from smoking

Respondents were asked how much they thought tobacco in cigarettes contributed to specific health conditions, including high blood pressure, stroke, lung cancer, asthma, coronary heart disease, oral cancer, wrinkling of the skin, diabetes and emphysema. Respondents were then asked how much nicotine in cigarettes contributed to each of these health conditions.

Respondents could select one of five answers to these questions: to a large extent, to some extent, to a small extent, to no extent or don't know.

Further breakdowns of these questions are available in Excel format at http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report-appendix1

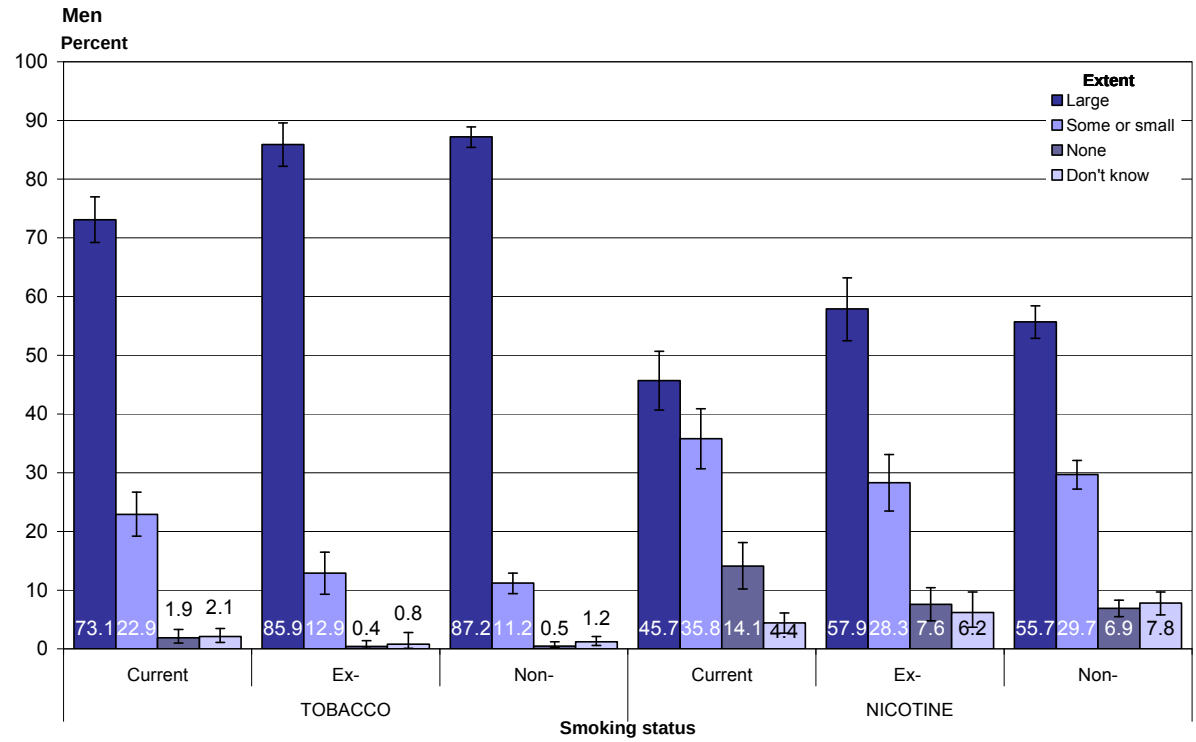
Over 80% of lung cancers are caused by smoking

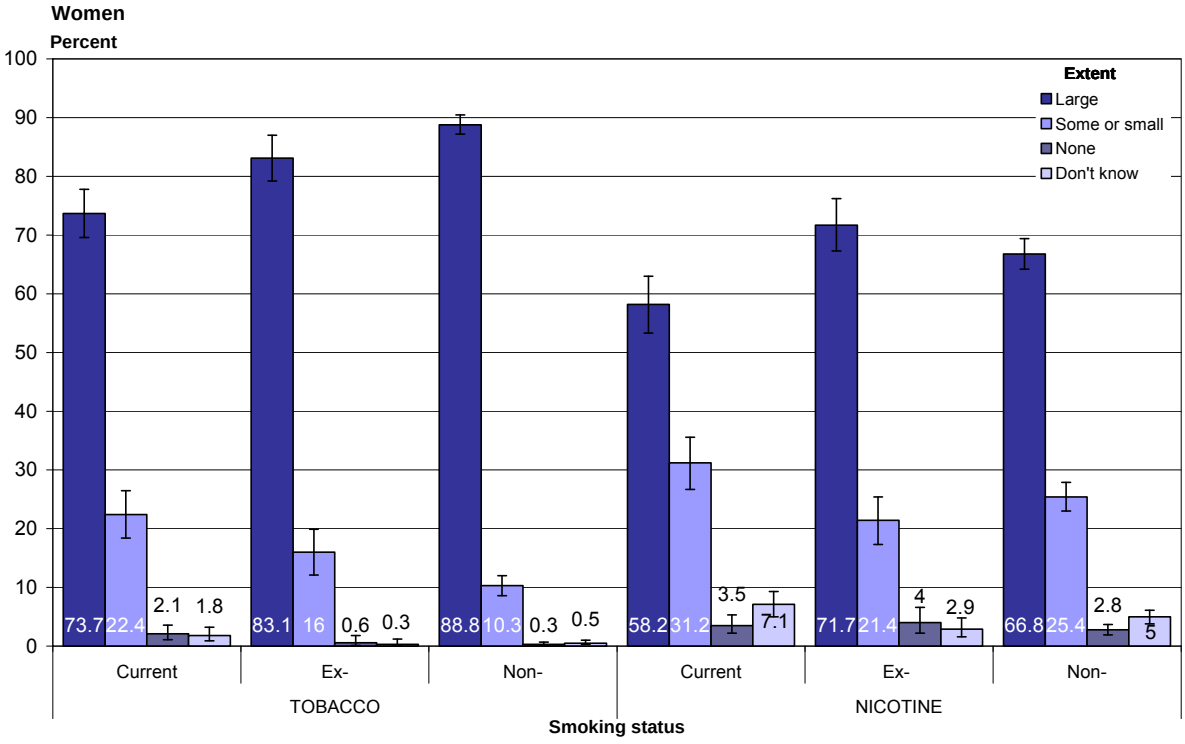
Nearly everyone thought that tobacco contributed to lung cancer, while significantly fewer current smokers (73.4%, 70.6–76.2) than ex-smokers (84.5%, 81.7–87.4) or non-smokers (88.1%, 86.7–89.4) thought that it contributed a large extent to lung cancer (Figure 31).

Although fewer people thought nicotine contributed to lung cancer, the same pattern of results existed, with significantly fewer current smokers (51.6%, 48.0–55.3) thinking that nicotine contributed a large extent to lung cancer than ex-smokers (64.6%, 60.8–68.3) or non-smokers (61.6%, 59.8–63.4).

Significantly more women (64.9%, 62.5–67.2) than men (52.8%, 50.3–55.2) thought that nicotine contributed a large extent to lung cancer, when adjusted for age.

Figure 31: Perception of contribution of tobacco and nicotine to lung cancer, 15–64-year-olds by smoking status and gender (age-standardised)





Smoking more than doubles your risk of stroke

One in ten people thought tobacco did not contribute to stroke (3.9%, 3.2–4.5), or were unsure about whether it did or not (6.9%, 6.0–7.9) (Figure 32).

Significantly more women (32.0%, 29.9–34.2) than men (24.5%, 22.4–26.5) thought that nicotine contributed a large extent to stroke, after adjusting for age.

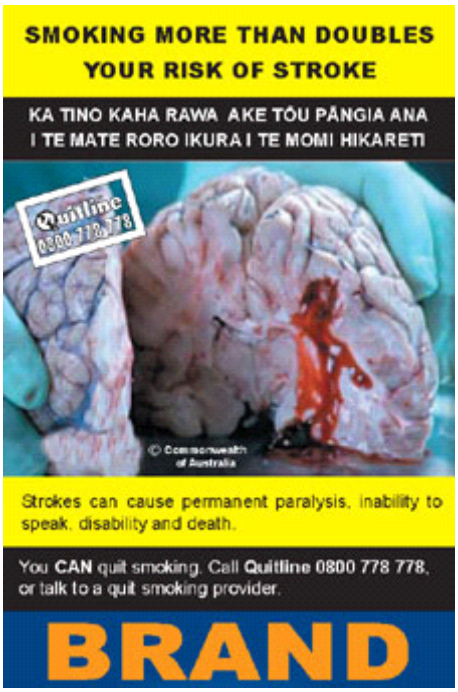
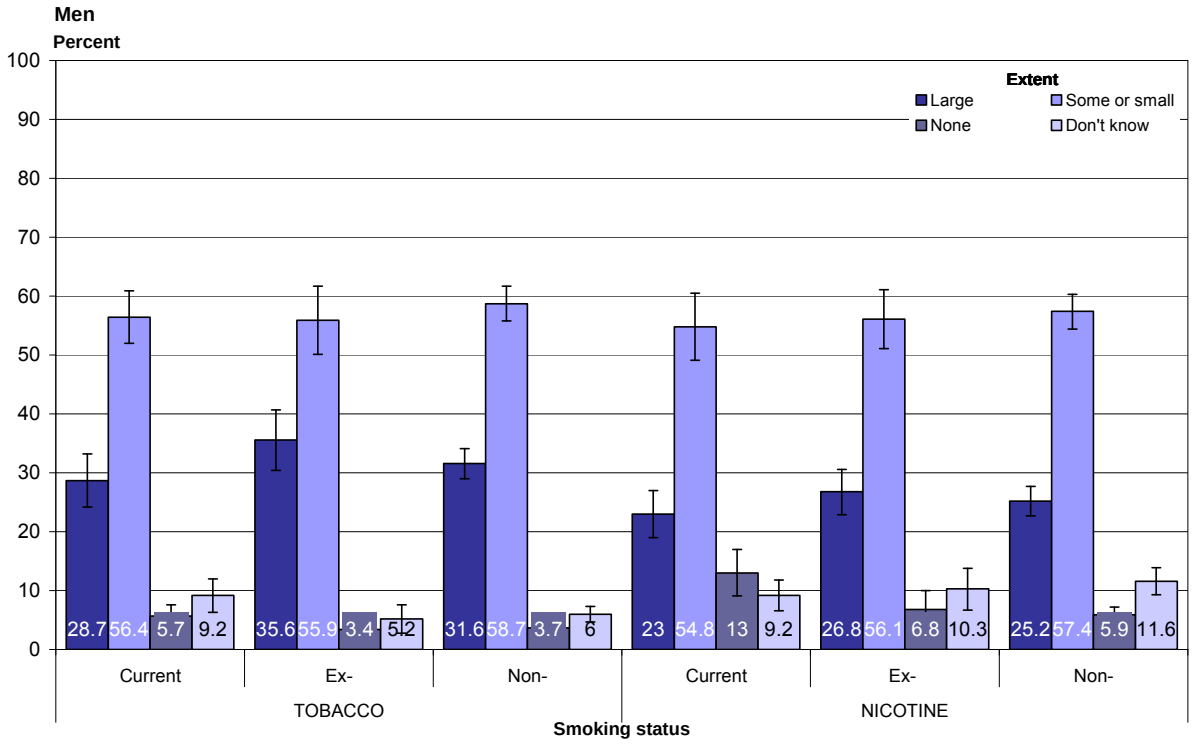
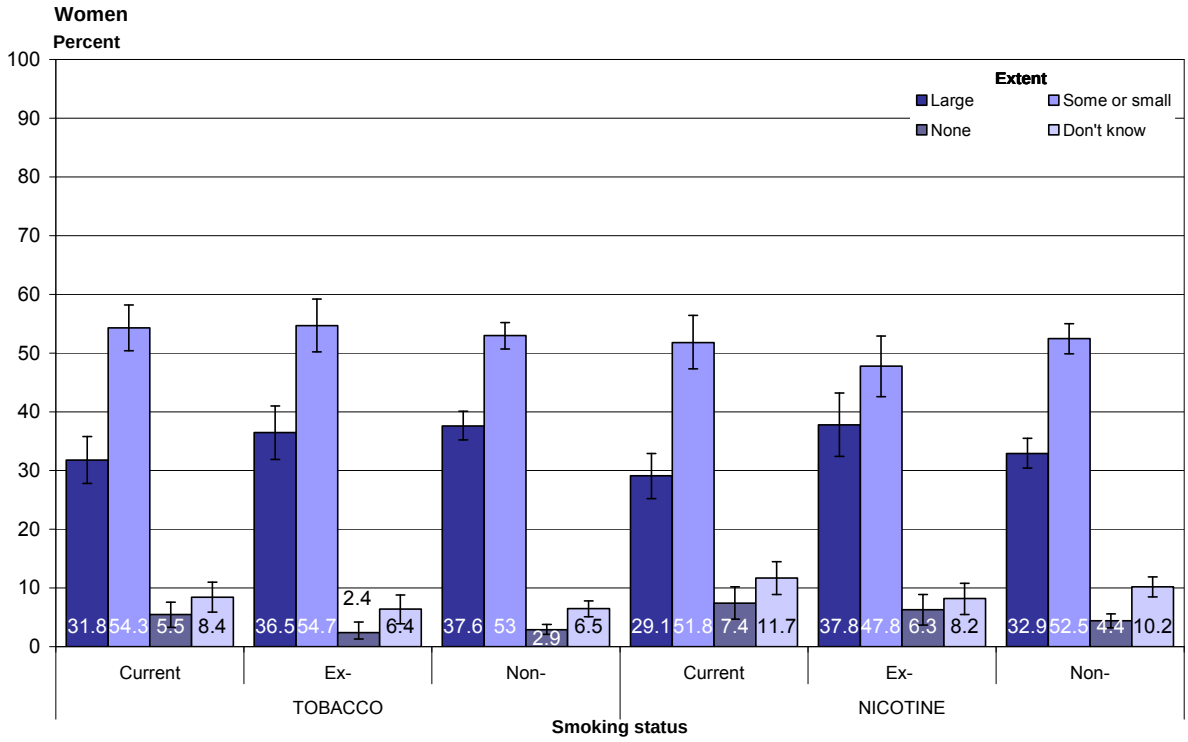


Figure 32: Perception of contribution of tobacco and nicotine to stroke, 15–64-year-olds by smoking status and gender (age-standardised)





Smoking causes serious lung diseases

Current smokers (5.4%, 3.9–6.8) were twice as likely as non-smokers (2.6%, 1.9–3.2) to think tobacco doesn't contribute to asthma (Figure 33).

After adjusting for age, current smoking men (35.4%, 31.2–39.5) were less likely to think that tobacco contributed a large extent to asthma than current smoking women (49.2%, 44.5–54.0).

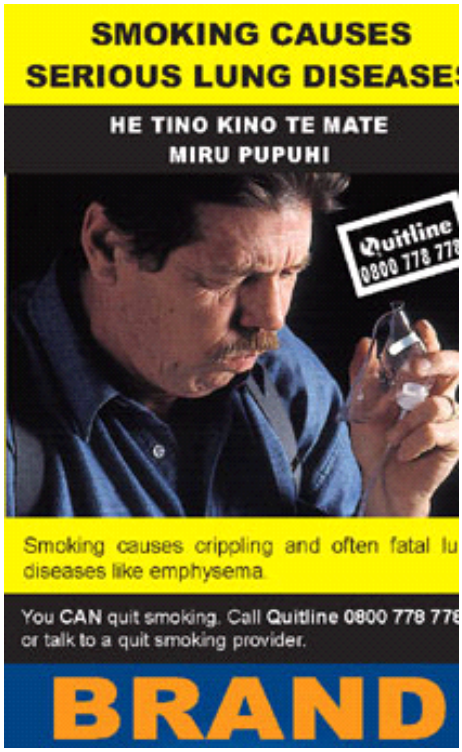
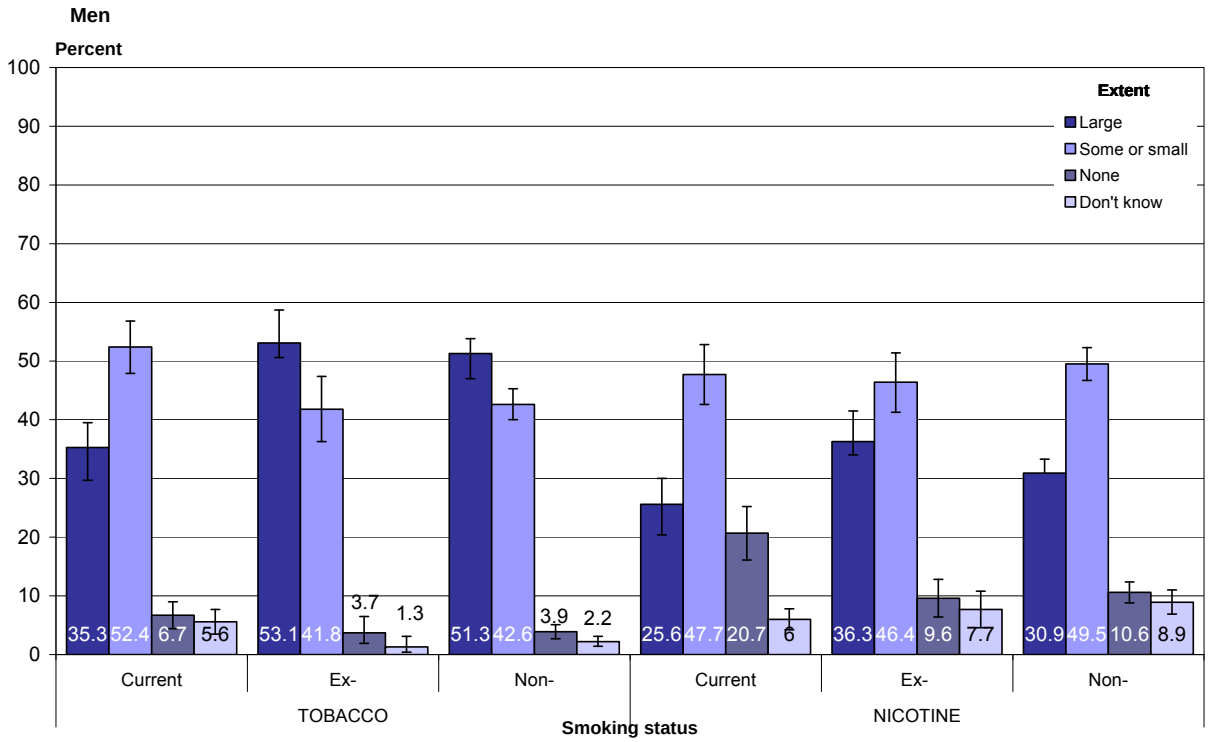
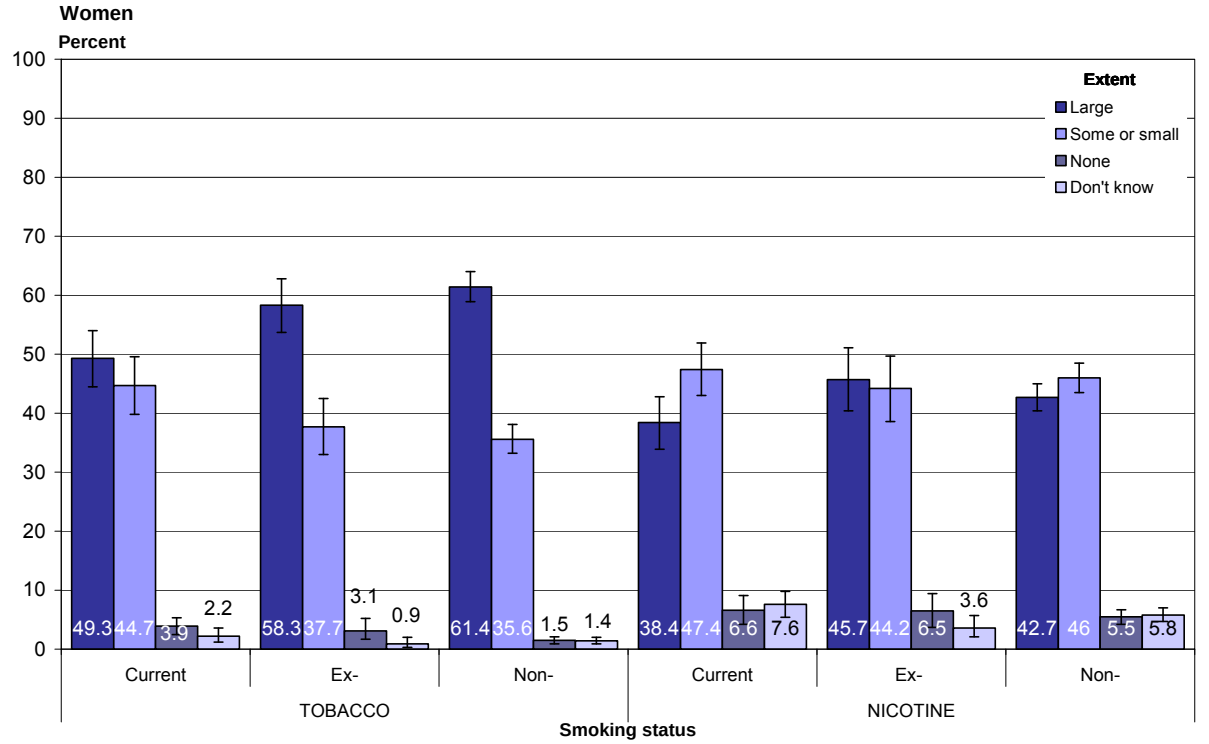


Figure 33: Perception of contribution of tobacco and nicotine to asthma, 15–64-year-olds by smoking status and gender (age-standardised)





Attitudes to tobacco displays

In New Zealand the Smoke-free Environments Amendment Act 2003 includes restrictions on how tobacco products may be displayed in retail premises such as dairies, supermarkets and service stations (Ministry of Health 2007c).

These restrictions include the following.

- At each point of sale, the tobacco display is limited to a maximum of 100 cigarette packets and 40 cartons.
- Each tobacco display may include a maximum of two packets of the same variant (no block displays).
- Tobacco products may not be displayed within one metre of 'children's products' such as confectionery and ice cream, soft drinks and products that are marketed primarily for children.
- Tobacco products may not be displayed on a counter top or similar surface, whether at a point of sale or not.
- If tobacco products are displayed within two metres of a point of sale, a sign stating 'SMOKING KILLS' must be displayed in clear view of the customer at the point of sale (the Ministry of Health supplies free signage).

Respondents were asked whether they agreed or disagreed with these statements:

> *Cigarette and tobacco displays in dairies, petrol stations, supermarkets and convenience stores make it more difficult for smokers to quit smoking or stay quit.*
>
> *Banning cigarette and tobacco displays in dairies, petrol stations, supermarkets and convenience stores would make it easier for smokers to quit smoking or stay quit.*

Respondents could select from the following five options: strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

In this section, the 'strongly agree' and 'agree' responses and the 'strongly disagree' and 'disagree' responses have been combined. Further analyses of these questions are available in Excel format at http://www.moh.govt.nz/moh.nsf/indexmh/quitting-report-appendix1

Two-fifths of recent quit attempters (39.7%, 34.5–45.0) agree that cigarette and tobacco displays in dairies, petrol stations, supermarkets and convenience stores make it more difficult for smokers to quit smoking or stay quit. As well as this, more than two-fifths of recent quit attempters (42.4%, 37.6–47.1) agree that banning cigarette and tobacco displays in dairies, petrol stations, supermarkets and convenience stores would make it easier for smokers to quit smoking or stay quit. There were no significant differences by gender, age group or neighbourhood deprivation.

Attitudes to tobacco displays, by ethnic group

Table 11 gives an indication of the proportion of 15–64-year-old recent quit attempters from different ethnic groups who agreed that cigarette and tobacco displays in dairies, petrol stations, supermarkets and convenience stores make it more difficult for smokers to quit smoking or stay quit.

Table 11: Agree tobacco displays make it more difficult to quit smoking, recent quit attempters by ethnic group (unadjusted)

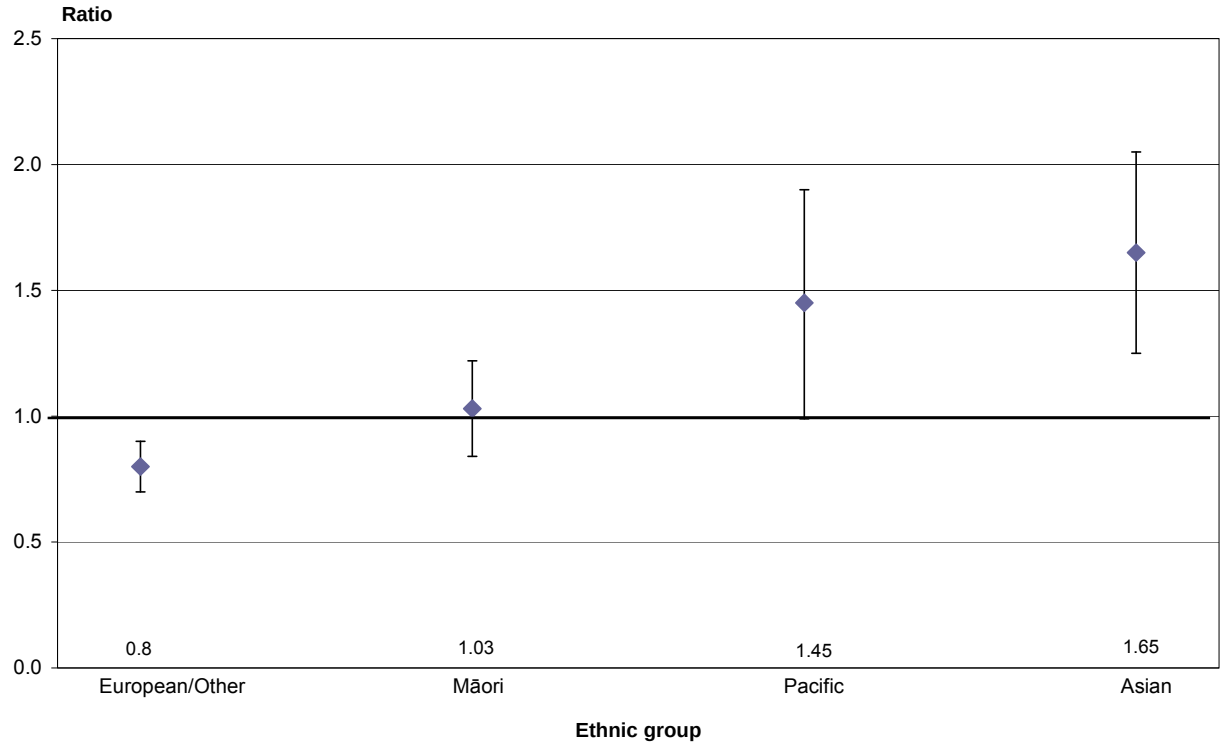
Ethnic group	Prevalence for recent quit attempters aged 15–64 years (95% CI)	Number of recent quit attempters aged 15–64 years
European/Other	32.1 (25.7–38.4)	63,300
Māori	41.4 (33.0–49.9)	25,400
Pacific	58.1 (41.1–75.1)	10,500
Asian	66.2 (46.8–82.4)	22,200

Source: 2008 New Zealand Tobacco Use Survey

Note: Total response standard output for ethnic groups has been used.

After adjusting for age, 15–64-year-old Asian recent quit attempters were two-thirds more likely than all recent quit attempters aged 15–64 years to agree that cigarette and tobacco displays in dairies, petrol stations, supermarkets and convenience stores make it more difficult for smokers to quit smoking or stay quit (Figure 34). European/Other recent quit attempters were significantly less likely to agree with this statement.

Figure 34: Agree tobacco displays make it more difficult to quit smoking, 15–64-year-old recent quit attempters by ethnic group (age-standardised rate ratio)



Source: 2008 New Zealand Tobacco Use Survey

Notes: Age has been standardised to the WHO world population. The reference group, with a rate ratio of 1.0 (indicated by the bold line), is the recent quit attempter population aged 15–64 years. Total response standard output for ethnic groups has been used.

Anti-smoking messages and campaigns

A number of stop-smoking campaigns have been promoted through different media. Some examples can be seen here: http://www.quit.org.nz/page/media/campaigns/campaigns.php.

This section includes information about the proportion of people who saw or heard some of these campaigns. Respondents were asked to identify anywhere they had seen or heard any anti-smoking messages over the past six months (this timeframe included the second half of 2007 and early 2008).

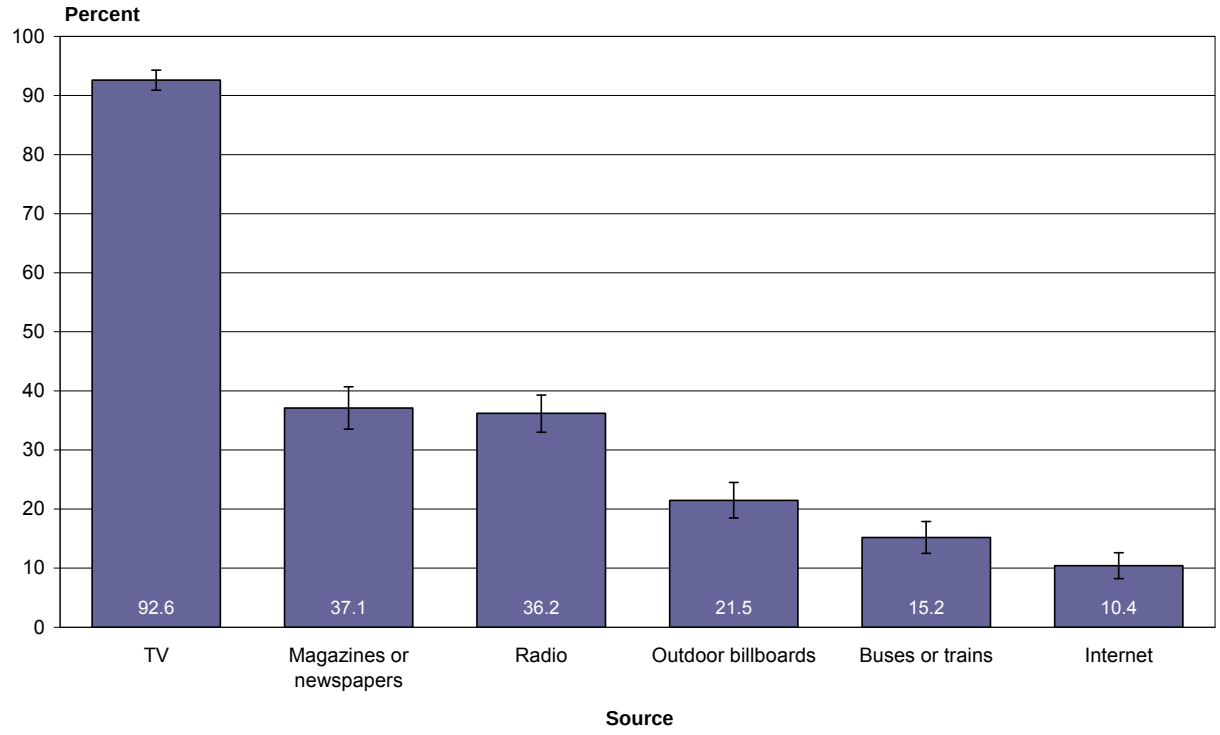
Over 90% (93.7%, 92.8–94.5) of 15–64-year-olds reported seeing or hearing anti-smoking messages over the past six months. There was no significant difference by gender.

Nearly all (97.3%, 96.4–98.3) current smokers reported seeing or hearing anti-smoking messages in the past six months, after adjusting for age, this was significantly higher than for ex-smokers (94.2%, 92.7–95.8) and non-smokers (93.1%, 92.1–94.2).

Sources of anti-smoking messages

After adjusting for age, the most common source from which current smokers had seen or heard anti-smoking messages in the past six months was the television (92.6%, 90.9–94.3), while over a third had heard them on the radio (36.2%, 33.0–39.3) or seen them in magazines or newspapers (37.1%, 33.5–40.7) (Figure 35).

Figure 35: Sources of anti-smoking messages, 15–64-year-old current smokers (age-standardised prevalence)



Source: 2008 New Zealand Tobacco Use Survey

Glossary

Age standardisation

A procedure for adjusting prevalence rates to minimise the effects of differences in age composition when comparing rates for different populations (Last 1988).

Current smoker

Someone who has smoked more than 100 cigarettes in their lifetime and at the time of the survey was smoking at least once a month (World Health Organization 1998).

Ex-smoker

Someone who has smoked more than 100 cigarettes in their lifetime and at the time of the survey had not smoked for at least a month.

Logistic regression

A statistical model of an individual's risk (for example, of being provided advice by a health care worker) as a function of a risk factor (for example, age) (Last 1988).

The survey design was controlled for by including the cluster and strata variables. The outcome variable was the probability of the relevant event occurring, with the explanatory variables being categorical age group, NZDep2006 quintile, gender and prioritised ethnic group. Backwards selection was used, with a significance level of 5%.

95% confidence interval

A range of values for a prevalence rate, which has a 95% probability of including the true value of the prevalence (Last 1988).

Non-smoker

Someone who at the time of the survey did not smoke at all. Non-smokers include:

- ex-smokers (people who were formerly current smokers but at the time of the survey did not smoke at all)
- people who have not smoked more than 100 cigarettes in their lifetime
- people who have never smoked.

P-value

A statement of probability that the difference observed could have occurred by chance (Last 1988).

In this report if a p-value is less than 0.05 (5%), the difference between two prevalence values is said to be statistically significant.

Prevalence

The proportion or percentage of the specified population at a given time (for the NZTUS 2008, this is 2008) demonstrating a particular health behaviour (for example, smoking).

Recent quit attempter

Someone who has attempted to quit smoking in the past 12 months. This includes current smokers who have quit for more than 24 hours in the past 12 months, as well as people who have quit smoking in the past 12 months (that is, ex-smokers).

Significant effect

An effect caused by a variable that has been tested as having a significant explanatory factor in a logistic regression model.

Smoking

The active smoking of tobacco products such as manufactured or roll-your-own cigarettes, cigars or pipes. Smoking does not include:

- the smoking of any other substances (for example, herbal cigarettes or marijuana)
- the consumption of tobacco products by other means, such as chewing.

Standardised rate ratios

The ratio of the prevalence of one group compared with the prevalence of another group. In this report, rate ratios are used to compare the four ethnic groups with the total New Zealand population, and have been age standardised.

Statistically significant

An outcome of the measurement of the probability of an observed association between variables being due to chance (Last 1988).

In this report differences between estimates are said to be statistically significant when the confidence intervals for each prevalence value do not overlap. Sometimes, however, even when there are overlapping confidence intervals the difference between the groups can be statistically significant. In this report, any differences between two variables where the confidence intervals overlapped were tested using a t-test. The significance of a t-test is represented by a p-value. If a p-value is below 0.05, then we are 95% confident the difference between the two estimates is statistically significant. Unless otherwise stated, all differences noted in the text in this publication are statistically significant.

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