

ETS AND CHILDREN PROJECT TASKFORCE

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EVALUATION OF NSW
CAMPAIGN REGARDING
YOUNG CHILDREN'S EXPOSURE
TO ETS IN HOMES AND CARS:
2005

Table of contents

Executive summary	1
Research context	8
2.1 Background	8
2.2 Research objectives	11
Research design	13
3.1 Rationale for methodology	13
3.2 Conduct of quantitative research	13
3.3 Sample details	15
3.4 Approach to analysis	20
Research findings	23
4.1 Behaviour	23
4.2 Attitudes	26
4.3 Knowledge	32
4.4 Practical barriers to smoking outdoors	40
4.5 Campaign awareness	42
Conclusions	58
Appendix A – Questionnaire	60
Appendix B	73
Summary of statistically significant changes in knowledge and attitude statements	73

Executive summary

Background and objectives NSW Health has funded a program to develop and implement a campaign that aims to reduce the exposure of infants and children up to 6 years of age to environmental tobacco smoke (ETS) in the home and car. Prior to the launch of the campaign in September 2002, baseline measures of parents' behaviours, attitudes and knowledge relating to children's exposure to ETS in the home and car were established. At the conclusion of the first burst of mass media activity, research was conducted to monitor changes against the baseline data.

The campaign is scheduled to conclude on 1 December 2005, with the final block of mass media running in February and March 2005. To evaluate the effectiveness of the campaign, the ETS and Children Project Taskforce commissioned research to be conducted both just prior to, as well as after the final burst of mass media. Research conducted just prior to the final burst of mass media would provide an indication of whether the behavioural and attitudinal changes that had been obtained early in the campaign had been maintained, or whether relevant attitudes, knowledge and behaviours had reverted to pre-campaign levels. The final wave of research then allowed the impact of the final mass media burst to be evaluated, in addition to providing measures against which those obtained in the baseline research could be compared.

This is a report of the research conducted during March 2005, during the final weeks and also immediately after the conclusion of the final block of mass media.

Methodology As in the previous two waves of research, the methodology used in the baseline research was replicated for this study, with a sample size of 600. This involved a telephone survey with adults living in households in NSW with at least one child aged 0-6 years and where at least one person in the household is a smoker. Targeted sampling was used in order to reconcile a very low incidence population with the need to collect a sufficiently large sample to achieve the desired level of statistical accuracy. This involved

sampling from areas of the state with a relatively high incidence of young children and low income earners. A sample of 600 adults from households with both at least one smoker and at least one child aged 6 or under was obtained in this way.

Behaviours In the final campaign evaluation, nearly three-quarters of those surveyed (73.0%) reported that smoking had not occurred in the home in the last month, compared to 46.9% in the baseline survey. This represents a **55.7% increase in the number of smoke free homes** within the primary target audience since the implementation of the campaign. The final campaign results also show a significant increase in the number of smoke free homes compared with the pre-2005 media results (62.2%).

Around three-fifths of those surveyed (60.7%) reported that all cars that children had travelled in during the last month were smoke free, compared with a baseline measure of 42.8%. This represents a **41.8% increase in the number surveyed reporting that all cars in which children had travelled during the last month were smoke free.**

An analysis of the behavioural effects among different language and cultural groups showed no significant differences. It can therefore be concluded that the campaign has been equally effective among members of the target audience from non-English speaking households and Aboriginal and Torres Strait Islanders, in bringing about behavioural change in the home and in the car.

Attitudes **Perceived importance of minimising exposure to tobacco smoke.**

From a list of factors that may influence children's health, minimising exposure to tobacco smoke was nominated by the second largest proportion of respondents (26.8%). This has not changed significantly from previous results. Diet and nutrition has continued to be perceived as the factor likely to make the biggest difference to children's health.

Linking ETS with harm. The proportion disagreeing that smoking in the **home** is unlikely to affect the children's health was 84.3%. Therefore, the previous increase in the proportion disagreeing with this statement has been maintained (76.3% in February/March 2002 compared to 82.9% in November/December 2002).

Similarly, the previous increase in the proportion disagreeing that smoking in the **car** is unlikely to affect children's health (77.4% in February/March 2002 compared to 86.0% in

November/December 2002) was also maintained, with 88.2% disagreeing with this statement in the final campaign evaluation.

Further, there has been a significant increase in the proportion who disagree that “Most healthy children would be unlikely to be harmed by exposure to passive smoking” (78.3% in February/March 2002 vs 82.2% in March 2005), also suggesting that the campaign has helped to strengthen the perceived link between exposure to ETS and potential harm.

Recognition that children have no choice. The vast majority of participants (92.8%) agreed with the statement “Because children don’t have a choice, it’s up to adults to think about whether there is tobacco smoke around the children”. This represents a significant increase since the baseline survey (86.7% in February/March 2002).

Preparedness to adopt smoking bans. Over two thirds (67.7%) of those who still permitted indoor smoking reported that they could foresee a time when their household would ban smoking in the home.

Nearly three-quarters (71.5%) of those who still permit smoking in cars in which children travel agreed with the statement, “Sometime in the future, I think our household will ban smoking inside the car / in any car in which children sometimes travel”.

These findings suggest that there is still much mileage in a campaign of this kind.

Knowledge **Perceived safety of inadequate strategies.** Compared with pre-campaign measures, there were significant improvements in the following measures of knowledge:

- It was found that 83.0% disagreed that “If no-one blows smoke in their direction, the children will probably be fine”, which is significantly more compared with the proportion disagreeing with this statement in February/March 2002 (79.1%).
- There was a significant increase in the proportion that disagreed that “If the children are in a separate room, it’s safe to smoke in the home”, increasing from 75.3% in February/March 2002, to 88.2% in March 2005. The final campaign results also showed a significant increase in the proportion disagreeing with this statement when compared with pre-media 2005 results (84.3%).

- The proportion who disagreed that “If the windows are wound down, it’s safe to smoke with children in the car.” increased from 85.3% in February/March 2002 to 91.7% in March 2005.

Nature of passive smoking. Although there was no significant change in the proportion who failed to disagree that “Tobacco smoke you can no longer see stays in the air for hours”, the research does provide some evidence that there has been improvements in knowledge of when passive smoking can occur. Four-fifths of participants (80.0%) in March 2005 disagreed that “Passive smoking can only happen when you can see cigarette smoke in the air”, representing a significant increase from the baseline measure (73.6%).

Understanding of risks of passive smoking. In addition to a significant increase in the proportion disagreeing that most healthy children would be unlikely to be harmed by exposure to passive smoking (mentioned above), there has been a small, yet significant increase in the proportion who disagree that “Only children who have asthma or a breathing problem can be harmed by passive smoking” (82.5% in February/March 2002 vs 89.3% in March 2005).

However, there remain some gaps in participants’ understanding of the risks of passive smoking. More than a fifth of participants (22.0%) fail to disagree with the statement “There is no hard evidence that passive smoking is harmful to children”, showing no significant change from previous surveys.

Awareness that children may experience asthma (72%) or other breathing/lung problems as a result of exposure to tobacco smoke continues to be high. The proportion that was either unable to name any illnesses associated with children’s exposure to environmental tobacco smoke or indicated that there were no illnesses or health problems related to such exposure dropped from 12% in February/March 2002 to 7% in March 2005. However, in general, unprompted knowledge of the specific illnesses children are likely to experience as a result of exposure to environmental tobacco smoke was poor.

Practical barriers to smoking outdoors The biggest practical barriers to smoking outdoors were a lack of suitable places to smoke outside (30.1% agreement), and having to sometimes leave the children unsupervised (30.1% agreement). The proportion reporting supervision of children to be an issue has not changed significantly over time, which is to be expected with a largely factual statement. However, the proportion reporting a lack of

suitable places outdoors did change significantly during the life of the campaign, with 38.5% in February/March 2002 agreeing that this was the case compared with 30.1% in the final survey. Similarly, there was a significant change in the proportion reporting that they smoke too often to be going outdoors every time they wish to smoke, decreasing from 28.4% in February/March 2002 to 16.2% in March 2005. These shifts in the perceived barriers to smoking outside suggests that smoking in home has become less socially acceptable, and the target audience has accordingly become less inclined to use these reasons as excuses for smoking in the home.

Campaign awareness

TVC. After the first mass media burst in November/December 2002, around a third (33.0%¹) reported that they had seen the campaign TVC (after being read a description of the advertisement) in the last month. In the final campaign evaluation, the corresponding figure was 40.9%. These results suggest that awareness of the campaign TVC has improved from previous media rounds, although there is still scope to increase its reach.

Despite limited reach, there was acceptable frequency among those who had seen the campaign TVC, with the average number of times respondents reported having seen the TVC being 7.2. Of those who recall the advertisement, about a fifth recall (unaided) the slogan “Car and home, smoke free zone”. Recall of the organisations behind this advertisement was poor.

Perceived messages. Most respondents (84.3%) believed that the commercial recommended that, if you do have a smoke, to do so outside. Only a little over a fifth (21.5%) perceived that the television advertisement was advocating cessation, suggesting that the key campaign message has been understood by the target audience.

In the final campaign evaluation, over half (54.3%) believed that the main message of the television advertisement was “Do not smoke in the home or car when children are nearby”, while 42.0% believed it was “Do not smoke in your home or car, even when children are not present”. It is therefore unclear the extent to which a “gold standard” message has been communicated by the campaign, although changes in behaviours and knowledge suggest that the target audience has perceived a strong message about smoking outside, rather than merely avoiding smoking around children.

¹ This figure has been corrected, taking into account the level of false recall obtained in the baseline data.

The vast majority (91.8%) correctly interpreted the rationale behind this message as being to protect children from the harmful effects of passive smoke, rather than incorrectly perceiving the rationale as being to prevent children from becoming smokers later in life.

Radio advertisements and collateral materials. There was limited recall of radio advertising, with 15.8%² of respondents indicating that they had heard any radio advertisements on the subject of passive smoking and children during the last month.

Awareness of collateral materials used to support the campaign messages was somewhat limited, although a quarter of respondents recalled stickers, fridge magnets or key rings with the slogan “Car and home, smoke free zone.” There was a significant increase in awareness of posters or brochures, from 20% in December 2004 to 25% in March 2005.

Visits to campaign website. Only 16% of those with Internet access report having ever visited www.smokefreezone.org.au

Health professionals. Participants were asked which health professionals and other professionals who work with children they had seen during the last three months. The most commonly visited was the GP (57%). Nearly three quarters (72%) indicated that they had seen at least one of the nominated professionals during the last three months.

Participants were most likely to nominate feeling comfortable talking to their GP about the health effects of passive smoking on their children (82%), while around two-fifths of participants indicated that they felt comfortable discussing this issue with the other professionals about which they were asked. Most (92%) indicated that they would feel comfortable talking to at least one of the nominated professionals about this issue.

The GP was nominated by the largest proportion (79%) to provide accurate, factual information about the effects of passive smoking on their children, compared with figures ranging between 41% and 53% for the other professionals. Again, most (93%) indicate at least one health or other nominated professional whom they believe would provide accurate, factual advice on this subject.

² This has not been corrected, because there was no baseline measure of awareness of radio advertising.

Of those who had seen at least one of these professionals, only 10.9% indicated that they had spoken to them about the effects of passive smoking on their children. This was not significantly different from the proportion in December 2004 (13.2%).

Conclusions The campaign has achieved significant and sizeable behavioural changes, with a:

- 55.7% increase in the number of smoke free homes and a
- 41.8% increase in the number reporting that all cars in which children have travelled during the last month were smoke free

Since only those households where a smoker lives qualified for survey, these measures of the impact of campaign on smoking behaviour in the home and car may be underestimates. Among those who are yet to ban smoking in home and car, more than two-thirds appear open to implementing bans in the future.

Despite no change in knowledge of specific illnesses associated with children's exposure to ETS, the target audience is more likely to link ETS with harm compared to before the implementation of the campaign. In addition, there is now almost universal acknowledgement that a child's lack of choice means adults must take responsibility for children's exposure to ETS. The observed changes in perceived barriers to smoking outside the home suggest that smoking in homes in which children live is becoming less socially acceptable. Overall, desired attitudes are now held by vast majority of the target audience.

The research also shows that there are also greater proportions of people rejecting inadequate protection strategies (such as smoking in a separate room). This suggests some improvements in understanding of when children can be at risk of exposure to passive smoke. There is also some evidence that the campaign has helped to dispel the myth that only visible smoke is potentially harmful.

The results suggest that reach of the campaign has been reasonably limited, although among those who have seen the campaign TVC, understanding of key campaign messages has been strong. Likewise, the results show that there is significant scope for increases in health professional intervention.

Research context

This section outlines the background to the project, and specifies the research objectives.

2.1 Background

Health effects of ETS on children The health effects of passive smoking are well documented. Children are at greater risk of damage than adults, due to their smaller body size, higher ventilation rates and less developed respiratory and immune systems. The National Health and Medical Research Council (NH&MRC), in a review of the evidence, concluded that:

- roughly 8% of childhood asthma (46,500 Australian children) is attributable to passive smoking
- the risk of lower respiratory illnesses (such as croup, bronchitis, bronchiolitis and pneumonia) is about 60% higher in children exposed to ETS during the first eighteen months of life than in unexposed children
- passive smoking contributes significantly to the risk of sudden infant death syndrome³

There is also evidence that children who are exposed to ETS in the home are at greater risk of reduced lung function, slower lung growth and more frequent ear, nose and throat (ENT) infections.

The campaign and its objectives The most significant sources of children's exposure to ETS are in the family home and in the car. Accordingly, NSW Health has funded a

³ National Health and Medical Research Council. (1997). *The Health Effects of Passive Smoking: a Scientific Information Paper*. Commonwealth Department of Health and Family Services: Canberra, p.3.

program to develop and implement a campaign that aims to reduce exposure of infants and children up to 6 years of age to ETS in the home and car. Specifically, the campaign objectives are to:

- Increase awareness among parents and carers of the health effects associated with exposing children and infants to ETS
- Increase knowledge of strategies for reducing children's and infants' exposure to ETS in homes and cars
- Increase the number of smoke free homes and cars
- Increase the number of health professionals routinely identifying infants and children 0-6 at risk of exposure, and providing information and advice to the parents and/or carers

The program is being conducted under the auspices of the ETS and Children Project Taskforce: The Cancer Council NSW, the National Heart Foundation, Asthma NSW, SIDS and Kids NSW, and NSW Health. The campaign includes:

1. Media campaign using TV, local radio and billboard advertising, as well as coverage in the local and national press
2. Information and resource dissemination (stickers, magnets, key-rings, A1/A3 posters, brochures), advice and referral through selected health professional networks (primarily Child Health Nurses)

The project has also included a community grants scheme and health professional training, as well as the development of a website - <http://www.smokefreezone.org> - containing reference and educational information. A colouring-in competition is also being used to help promote the campaign messages.

The campaign was launched in September 2002, and is expected to conclude on 1 December 2005, with the final block of mass media running in February and March 2005.

Campaign target audience Parents of low socio-economic background have been identified as a significant group likely to benefit from the information and resources

disseminated through this campaign, and thus form a key target audience.

In general, the target audience for this campaign is parents and carers of children aged 0-6 years, especially those living in households where at least one person smokes.

Secondary target audiences for this campaign include:

- Health Professionals
- Early Childhood Education Professionals
- Policy Makers
- General Public
- Young children

Aboriginal and Torres Strait Islander (ATSI) communities are a priority audience for this campaign, given the smoking rates among these communities are significantly higher than those of the general population. Similarly, some other culturally and linguistically diverse communities (in particular Vietnamese, Chinese and Arabic groups) have higher smoking rates. Consequently, it is assumed that rates of exposure for infants and children to environmental tobacco smoke are also higher among these population groups. Therefore, the results of specific research conducted with these communities (exploring relevant cultural, knowledge, attitude and behavioural factors) have contributed to the formation of the campaign strategy.

Evaluation of the campaign Prior to the launch of the campaign, baseline measures of parents' behaviours, attitudes and knowledge relating to children's exposure to ETS in the home and car were established (*Young children's exposure to ETS in homes and cars: Baseline survey, Eureka Strategic Research*). After the first burst of mass media, a second survey was conducted to ascertain whether there had been any changes in the target audience's behaviours, attitudes or knowledge relative to the baseline data. This research found significant behavioural changes since the implementation of this campaign, as well as significant improvements in some of the key attitudes that link children's exposure to ETS in the home and car to harm. The findings from this research were reported in a subsequent report: *NSW*

campaign regarding young children's exposure to ETS in homes and cars: Evaluation survey (wave 1), Eureka Strategic Research.

In addition to conducting a final campaign evaluation at the conclusion of the campaign in 2005, the ETS and Children Project Taskforce decided to conduct a survey **prior** to the final burst of mass media to allow the campaign to be more thoroughly evaluated. Research conducted just prior to the final burst of mass media would provide an indication of whether the behavioural and attitudinal changes that had been obtained early in the campaign had been maintained, or whether relevant attitudes, knowledge and behaviours had reverted to pre-campaign levels.

The final campaign evaluation was then conducted during March 2005, the results of which are reported in this document. This research highlights any changes relative to the previous survey results, enabling the ETS and Children Project Taskforce to evaluate the impact and reach of the campaign.

The research objectives are outlined in the following sub-section.

2.2 Research objectives

The overall aim of this research was to measure relevant behaviours, attitudes and knowledge of the target audience prior to the campaign's final burst of mass media, thus allowing any changes in these variables to be monitored over time.

Among the target audience, the research measured the following:

- smoking behaviours, including
 - the prevalence of smoking bans in homes and cars
 - the prevalence of other strategies implemented to protect children from exposure to ETS in homes
- attitudes towards children's exposure to ETS
- knowledge of the nature of passive smoking
- knowledge of the health effects of exposure to ETS on children aged 0-6 years

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION

- perceived barriers to protecting children from exposure to ETS in the home and car
- awareness and recall of the campaign designed to reduce exposure of young children to ETS

The research methodology used for obtaining these measurements is detailed in the following section.

Research design

A telephone survey was conducted among adults living in households in NSW with at least one child aged 0-6 years and where at least one person in the household is a smoker. Targeted sampling was used to obtain a sample of 600.

The rationale for the research approach and the stages involved in the quantitative research are provided in the sections below.

3.1 Rationale for methodology

In order to reconcile a very low incidence population with the need to collect a sufficiently large sample to achieve the desired level of statistical accuracy, a targeted sampling approach was employed.

What is targeted sampling? In targeted sampling, one draws a sample from areas where the incidence of the population of interest is known or believed to be higher relative to other areas. So, rather than randomly calling households across all of NSW, calls were made to areas where there are known concentrations of young children, and of low-income households.

3.2 Conduct of quantitative research

Drawing a sample Eureka sourced the following information from the Australian Bureau of Statistics on all Census Collection Districts (CCDs) in NSW, based on the 2001 Census data:

- the total number of households in the CCD
- the total number of households in the CCD with a child aged 0-6 years

- the total number of households in the CCD with a weekly income of less than \$300 per week⁴
- Section of State Indicator (i.e. location type)

This information was used to select CCDs with a relatively high incidence of the target population, ensuring a balance of metropolitan and rural areas that reflected the distribution of the population of interest. Households were interviewed at random within the selected areas.

An index was developed which allowed us to identify CCDs that were more likely to have a higher incidence of the population of interest. The index was equal to the proportion of households with at least one child aged 0-6 years squared, multiplied by the proportion of households with a weekly household income <\$300. Thus, CCDs were selected in which the proportion of low-income earners and, especially, young children, were known to be high.

Survey questionnaire

The survey questionnaire was exactly the same as that used in the December 2004 research. The questionnaire used in the December 2004 research was largely the same as that used in the previous two rounds of research, although it contained some additional items that were relevant to the evaluation of the campaign. Care was taken to ensure that any additional items were unlikely to affect responses to the questions for which baseline measures had been established. The survey questionnaire is located at Appendix A.

The questionnaire was designed to minimise false reporting with respect to current behaviours, which is particularly important when researching a sensitive issue. In addition, the way in which the questionnaire topic was introduced was structured so as to minimise bias:

- in terms of the type of respondents who were more likely to agree to participate in the interview
- in terms of respondents' responses to questionnaire items

The average interview length for the March 2005 research was 12 minutes.

⁴ It should be noted that information about smoking status is not collected in the Census. However, since smokers are more likely to be from lower socio-economic backgrounds, and since a key audience for the campaign is those from lower

Telephone survey The research was conducted using Computer Assisted Telephone Interviewing (CATI) technology. The fieldwork was conducted between 28/02/05 and 29/03/05.

The consent rate⁵ for the final campaign evaluation research was 50.0%, which was comparable with previous research waves (e.g. the consent rate in November / December 2002 was 54.7%). The consent rate in the December 2004 research was 37.8%, which is likely to be because the research was completed closer to Christmas.

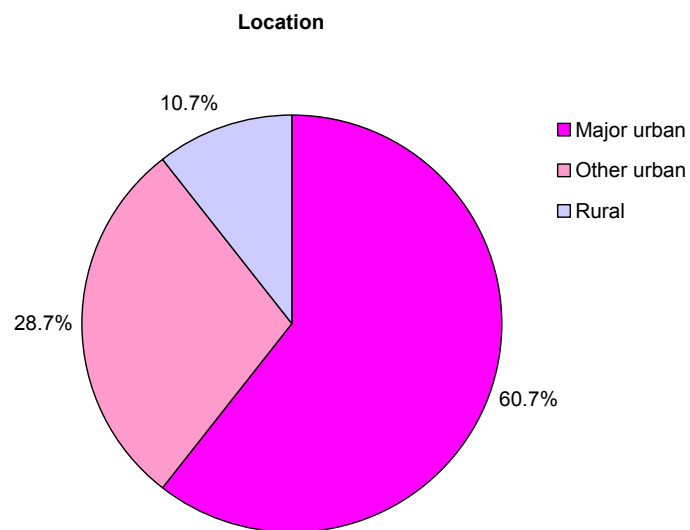
3.3 Sample details

The total sample for this research was 600. As in previous waves of research, the sample was stratified by location but not by age and gender. This sub-section provides demographic details of the obtained sample.

Location Quotas were imposed to ensure the sample was geographically representative of the distribution of the target audience across NSW. The geographic breakdown of the sample is shown in the following chart.

socio-economic backgrounds, information regarding the proportion of households with a weekly income of less than \$300 per week was incorporated in the selection of CCDs from which the sample was drawn.

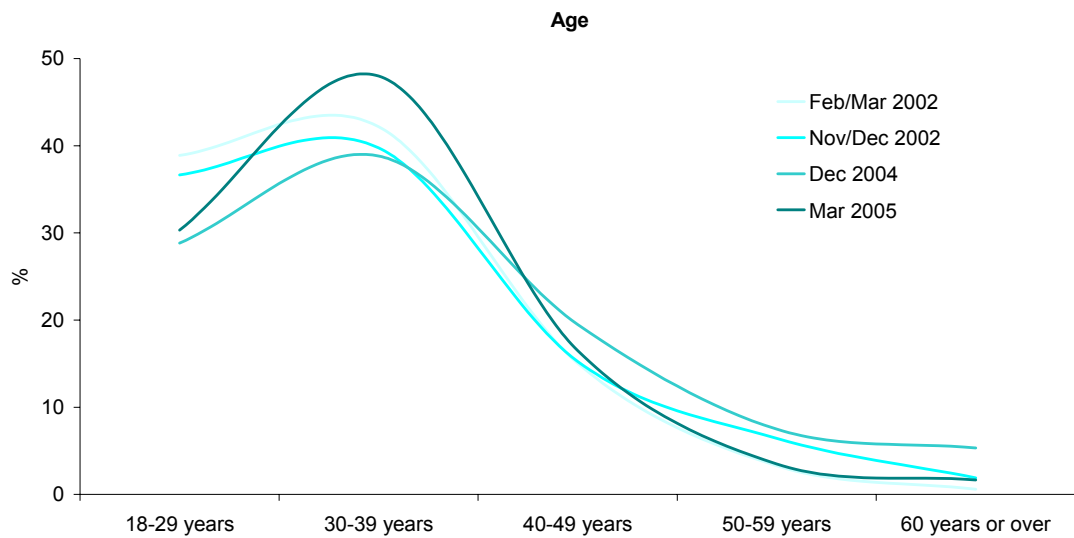
⁵ Calculated as the proportion of those both eligible and willing to participate in the research.



The majority of the respondents lived in areas defined as ‘Major urban’ (urban areas with a population of 100,000 and over). Over a quarter (28.7%) of the sample was from ‘Other urban’ areas, which is defined as urban areas with a population of 1,000 to 99,999. ‘Rural’ refers to the remainder of the State, from which 10.7% of the sample was drawn.

Age and gender The proportion of female respondents in the sample was 71.3%. No weights have been applied in the analysis of the data to adjust for this skew towards females, as the skew is likely to reflect the population of greatest interest. That is, females are more likely to be the primary caregiver of children aged 0-6 years.

The age profile of the sample is shown in the following graph, which shows the age profile obtained in each of the waves of research.



As seen above, the sample is skewed towards younger respondents, as would be expected with a sample of adults living with children aged 0-6 years.

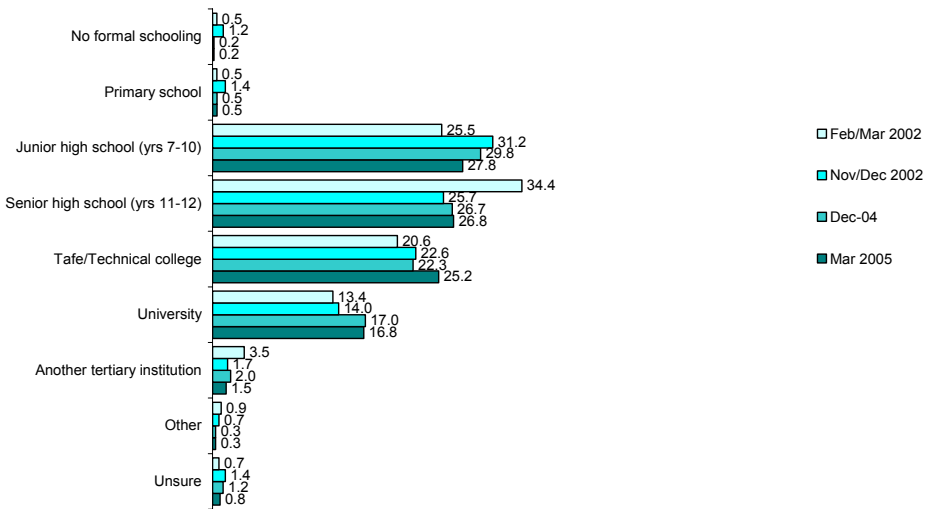
The age profile of the sample is broadly the same as previous surveys, but has changed fractionally over time. Specifically, the proportion of the target audience aged 18-29 years has gone down slightly, while the proportion aged in their thirties has gone up. While this is likely to be a result of random variation in the samples, it is probable that it also reflects underlying demographic trends within the target audience. That is, the data may also reflect a general trend in society towards delaying having children.

Education

Respondents were asked to report the highest level of education they had ever attempted. The results are shown in the following graph.

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION

Highest level of education ever attempted (%)

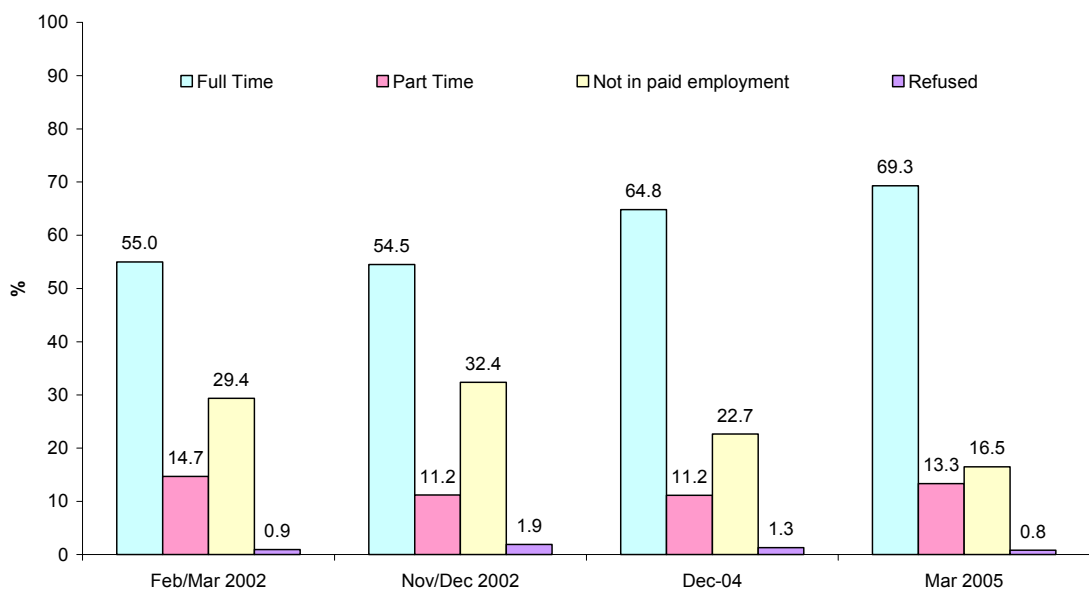


Nearly one in three (28.5%) of those interviewed had not continued beyond Year 10 at high school. Less than half (43.5%) had ever attempted a post-secondary qualification. Overall, the last three waves of research have been similar in terms of level of education.

Employment status of main income earner

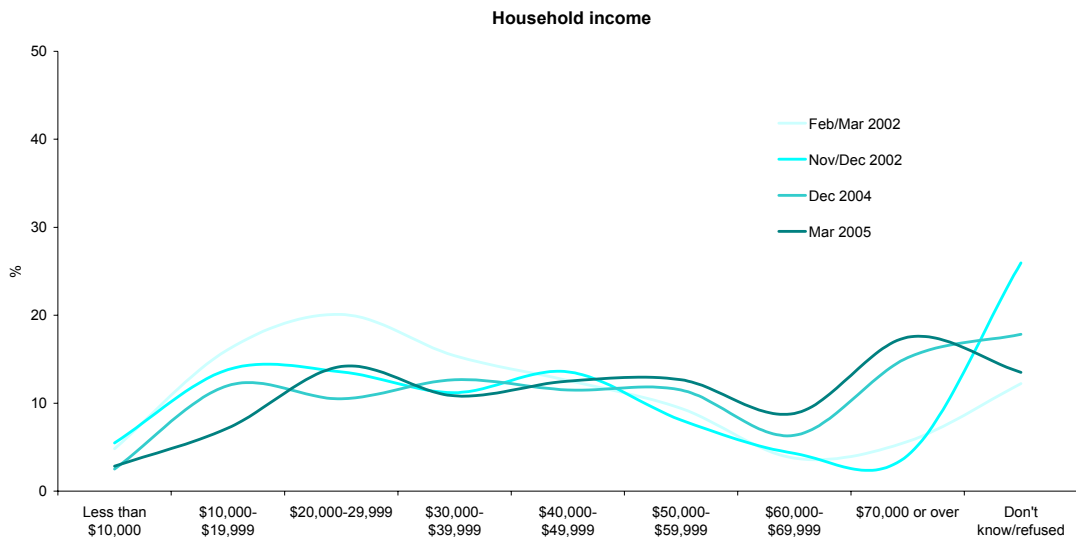
Respondents were asked whether the main income earner worked full-time, part-time or was not currently in paid employment. The results are shown in the following graph.

Employment status



Household income

The sample's reported household income is shown in the following graph. This appears to have gone up over time, consistent with a slightly older sample and wages growth (and reductions in unemployment) over the intervening years.



Culturally and linguistically diverse groups

Respondents were asked what was the main language spoken in their home, with 89.7% indicating that it was English. Analysing the languages other than English, the most common of these was Arabic (24 respondents, representing 4.0% of the total sample), followed by Chinese/Mandarin/Cantonese (1.2%), Indian languages (1.0%) and Vietnamese (1.0%).

In the final campaign evaluation, 41 people (6.8%) identified as Aboriginals and Torres Strait Islanders. Although there has been some variation across the samples in the proportion that identifies as Aboriginal or Torres Strait Islander, it has consistently been higher than the population average (which is approximately 1.6% of the population in NSW⁶)

Smoking status

As mentioned above, the sample for this research was defined as adults living in a household with children aged 0-6 years where at least one person is a smoker. Towards the end of the questionnaire, respondents were asked whether

⁶ New South Wales Adult Health Survey, 2003. Sourced from http://www.health.nsw.gov.au/public-health/survey/hs03/prodout/r_dem2/r_dem2_barresp.htm on 25th May, 2004.

they themselves were a smoker. The proportion of smokers in the sample was 63.7%, a similar proportion to that found in previous waves.

Parental status At the outset of the questionnaire, respondents were asked how many children aged 0-6 years live in their household (with the mean being 1.5 children 0-6 years). Towards the end of the questionnaire, respondents were asked whether they themselves were the parent or carer of any of the children aged 0-6 years, with 95.3% indicating that they were.

3.4 Approach to analysis

Frequencies were calculated for all questions. In addition, appropriate statistical tests were conducted on the data from each question to determine whether there were any significant changes relative to the baseline data. All analysis was carried out against the **desired campaign outcome**. For example, smoking bans in the home/cars that children have travelled in during the last month where smoking is not permitted (given that the campaign advocates a gold standard of not smoking in such homes/cars at any time), agreement with desired attitudinal or knowledge statements, and disagreement with non-desired attitudinal or knowledge statements. Fisher's Exact Test was used for all categorical data using 1-sided tests for this wave of research, given that the hypotheses are directional (i.e. it was anticipated that the campaign would have a positive effect).

All statistical tests were conducted on the basis of a critical p-value of 0.05. In other words, a result was accepted as statistically significant if the probability that it was due to chance alone was estimated to be less than 5%.

Reporting changes in behaviour As has been discussed with the ETS and Children Project Taskforce, the most accurate and simple way to state the findings that relate to behaviour is in terms of percentage reductions in the number of households and cars in which young children are exposed to ETS. Such statements do not rely on any understanding of the surveyed population. They stand on their own as statements about the NSW population. Eureka's first evaluation research report adopted this approach.

If one wishes to refer to **increases** in smoking bans, this requires conveying information about the nature of the sample for the findings to make sense. This is because many households and

cars in NSW have smoking bans, but were not included in the survey (because they did not have young children and a smoker living in them). This, therefore, means that the true level of increase in smoking bans across all households in NSW is, first, likely to be very small in percentage terms and, second, not determinable from this research.

Given that the ETS and Children Project Taskforce has tended to report the findings in terms of increases in smoking bans **within the sample**, we have adopted this approach in this report.

Examining NESB and ATSI sub-samples Those who identify as Aboriginal or Torres Strait Islander and those from certain non-English speaking backgrounds were audiences of specific interest for this campaign, given the high smoking prevalence among these communities. The design of the campaign had taken into account the diversity of the target audience with a view to being relevant to both the mainstream population as well as these specific culturally and linguistically diverse groups.

The researchers tested the null hypotheses that the campaign effects were the same among ATSI and non-ATSI, and among NESBs and those from English-speaking households. A multivariate general linear model was used to analyse the full sample with:

- main language spoken at home or whether the participant identified as Aboriginal or Torres Strait Islander as a fixed factor
- time in months since the launch of the campaign included as a fixed factor⁷
- smoke free homes and smoke free cars in which children ever travel as dependent variables

This allowed us to either accept the null hypothesis (i.e. the campaign was equally effective with ATSI populations / NESB populations), or reject the null hypothesis and conclude that the campaign had had a different impact on different groups. The results are reported in section 4.1.

⁷ Time in months since the implementation of the campaign was used, rather than just “research wave”, which is an ordinal variable. Time in months (a interval variable) allows us to conduct a more appropriate and powerful statistical test.

**Correcting for
false campaign
recall**

In calculating awareness of the campaign's television advertising, figures have been corrected to take into account the known level of false recall established in the baseline research.

The research findings are detailed in the following sections.

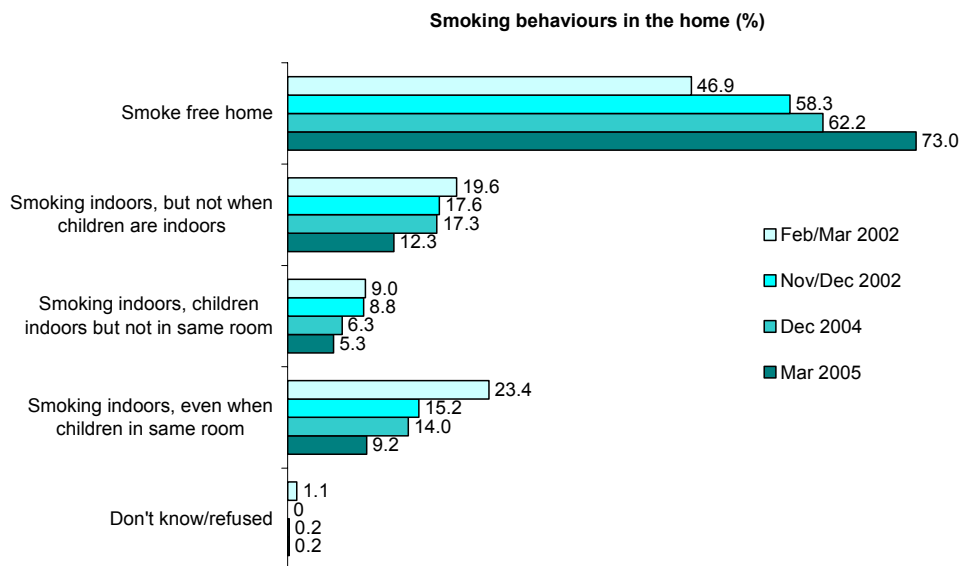
Research findings

This section reports the findings from the final campaign evaluation research, conducted in March 2005, and how these results compare with the earlier surveys. It details the behaviours, attitudes and knowledge of the target audience, as well as recall of the media campaign and resource materials designed to reduce exposure of children to ETS.

4.1 Behaviour

The results for behaviours in the home and car are reported below.

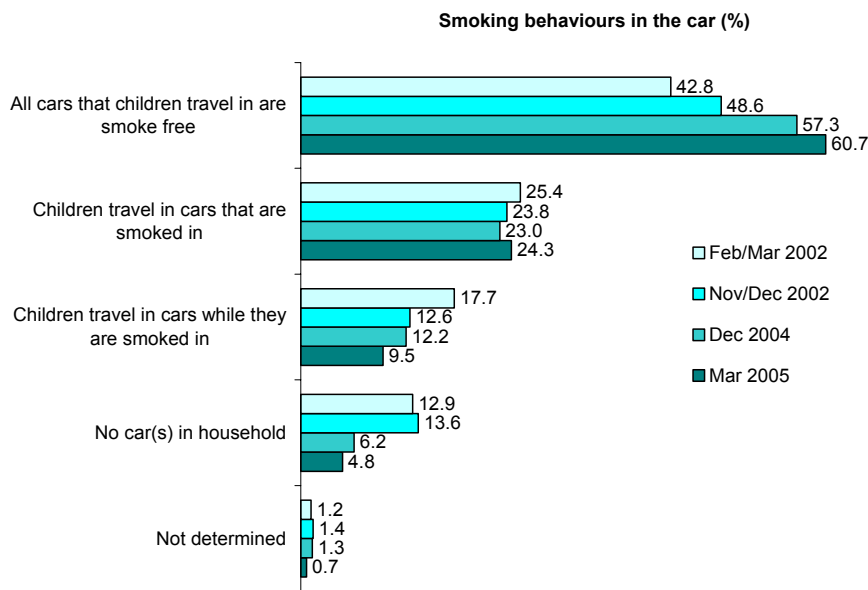
Home Nearly three-quarters of respondents (73.0%) indicated that their home was smoke-free. This represents a 55.7% increase in the proportion of smoke-free homes since the implementation of the campaign. Compared to the pre-2005 media survey results, it represents a 17.4% increase in the number of smoke-free homes. These results are shown in the following graph.



Statistical analyses were undertaken to examine the impact of the campaign on smoking behaviours in the home among NESB and ATSI participants, each compared with the rest of the sample. Details of statistical tests undertaken are provided in Section 3. The results show that the campaign has been just as effective in increasing the number of smoke free homes among ATSI communities as the remainder of the sample, and likewise for those from non-English speaking households.

Car

The questionnaire included questions about the number of cars in the household, the number of cars that are smoked in, the number of cars that children travel in, and (where necessary) whether smoking occurred in the cars that children travel in. Respondents who indicated that smoking occurred in cars that children travel in were then asked whether smoking ever occurs while the children are travelling in the car. Like the questions regarding smoking in the home, this sequence of questions was designed to minimise the transparency of the purpose of the questions. An analysis of the results, for the baseline and evaluation surveys, is shown in the following chart.



As can be seen, 60.7% reported that smoking had not occurred in any car in which children travel during the last month, compared with a baseline measure of 42.8%. Although this does not represent a significant increase since the December 2004 research (57.3%), this represents a 41.8% increase since the launch of the campaign in the proportion reporting that all cars that children travel in are smoke free.

There remains scope for further gains in this area, with a total of 33.8% reporting that smoking occurred in cars in which children travel, and just under a tenth (9.5%) indicating that smoking occurs while children are in the car. Even so, the behavioural changes that have been achieved have been impressively large.

The research results suggest that the campaign has made a greater impact on smoking behaviours in the home than in the car. It is possible that prohibiting smoking in the car is actually more difficult than implementing smoking bans inside the home. For example, given that the smell of tobacco smoke in cars is very difficult to remove, it is possible that people postpone banning smoking in the car until they change or upgrade their car. Another possible interpretation is that the car is more of a personal space than the home (even though children may still travel in the cars in the household), and so implementing a ban in the car may be more of a personal decision and not influenced so much by the views of other members of the household.

Statistical analyses were undertaken to examine the impact of the campaign on smoking behaviours in the car among NESB and ATSI participants. These tests were the same as those used to investigate behavioural change in the home. Again, the results show that the campaign has been just as effective in increasing the number of homes where all cars in which children travel are smoke free among ATSI communities as the remainder of the sample, and likewise for those from non-English speaking households.

The analysis also showed that, on average, **not** having smoke free cars in which children travel was more common among the ATSI sub-sample than the remainder of the sample (across all surveys, average proportion in ATSI sub-sample reporting all cars that children travel in are smoke free cars was 36.4%, compared to 52.9% for the remainder of the sample.) Conversely, those from non-English speaking households were **more** likely than English speaking households to report that all cars in which children travel were smoke free (across all surveys, average proportion in NESB sub-sample reporting all cars that children travel in are smoke free cars was 62.9%, compared to 49.9% in English speaking households.) Given the higher rates of smoking among some non-English speaking communities, it is interesting to note that smoke free cars (i.e. all cars in which children travel are smoke free) are actually more common among non-English speaking households on average, compared with English speaking households. A possible reason for this finding may be that women often take a greater role in the parenting of infants and young children, while the higher incidence of smoking in some language groups (such as Vietnamese and Arabic speakers) relates only to males.

So, these findings suggest that, despite differences in absolute proportions, the campaign has been equally effective in increasing the number of smoke free cars across the NSW population, including culturally and linguistically diverse groups.

4.2 Attitudes

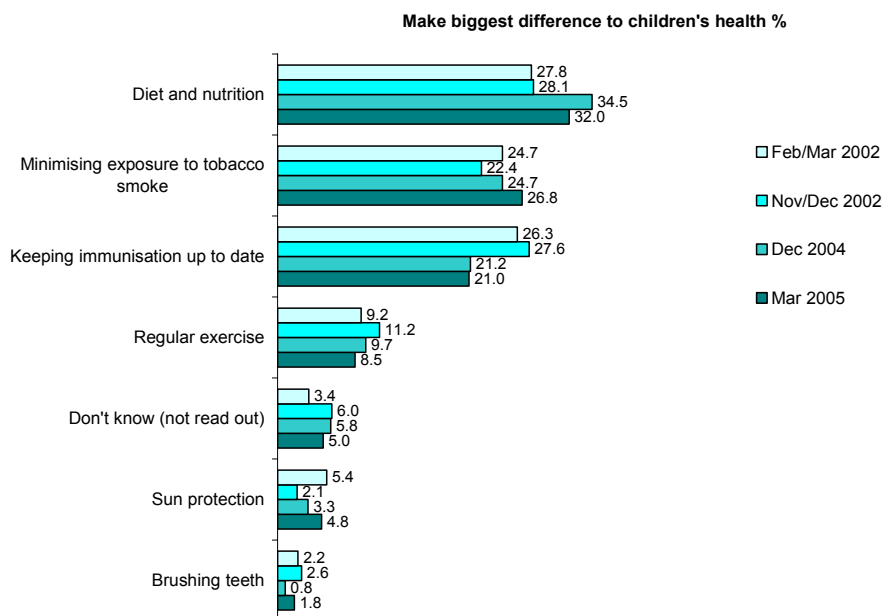
Perceived importance of minimising exposure to tobacco smoke

The questionnaire included an item to gauge perceptions of the importance of minimising children's exposure to environmental tobacco smoke relative to other factors that may influence children's health. As shown in the following graph, out of 'sun protection', 'brushing teeth', 'minimising exposure to tobacco smoke', 'diet and nutrition', 'keeping immunisation up to date', and 'regular exercise', more than a quarter (26.8%) nominated

‘minimising children’s exposure to tobacco smoke’. This proportion has not changed significantly since the launch of the campaign.

The most common response (32.0%) was again that diet and nutrition would make the biggest difference to children’s health. The proportion who nominated “diet and nutrition” as being the most likely to make the biggest difference to children’s health increased significantly between February/March 2002 (27.8%) and November/December 2004 (34.5%).

While diet and nutrition has increased in perceived importance, immunisation is now seen as less of an issue, dropping from 26.3% in February/March 2002 to 21.0% in March 2005. These results are shown in the following graph.

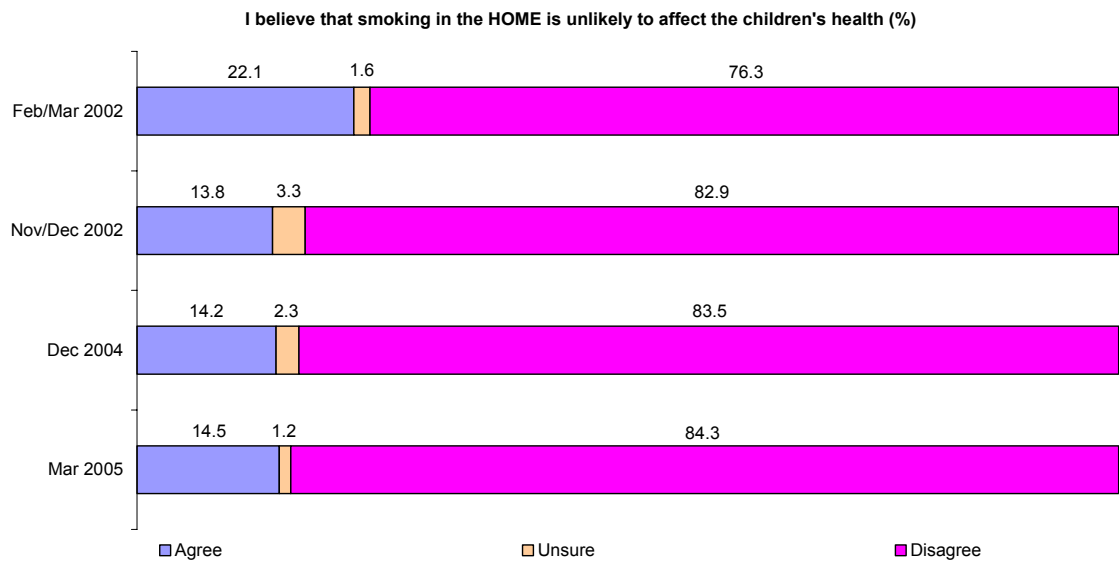


Linking ETS with harm

The developmental research found that one of the barriers to parents’ adopting adequate protective behaviours was a failure, or a refusal, to link exposure to ETS with harm. Hence, the qualitative research concluded that the communications needed to strengthen the link between ETS and harm.

Survey respondents were asked about the likelihood that smoking in the home or car would affect children’s health. The results relating to the home are shown in the following graph.

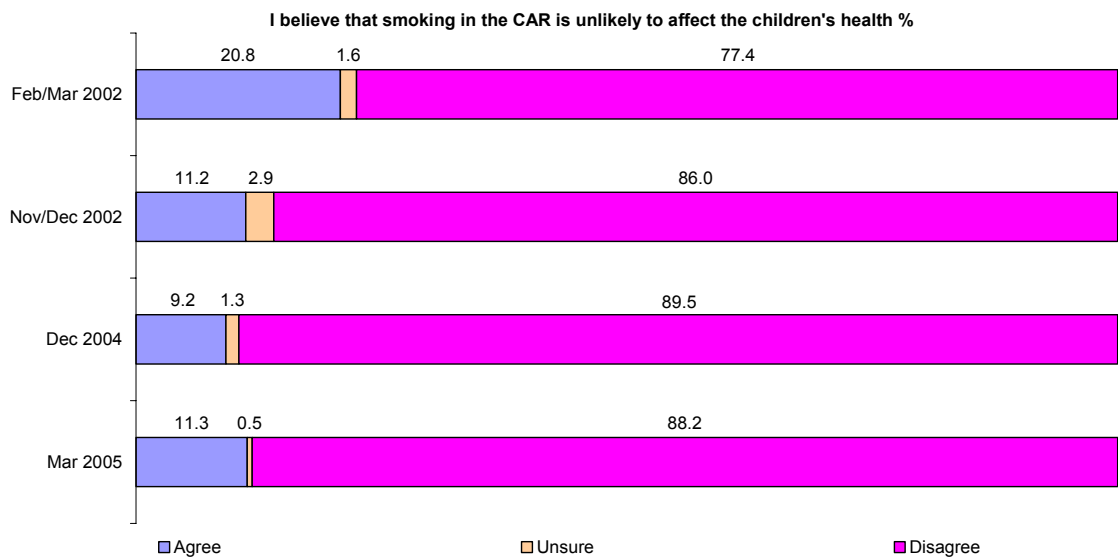
THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



After the launch of the campaign, there was an increase in the proportion of respondents disagreeing that smoking in the **home** is unlikely to affect children’s health (76.3% in February/March 2002 to 82.9% in November/December 2002, $p < 0.05$). This increase has been maintained, with 84.3% disagreeing with this statement in March 2005.

Likewise, the proportion of respondents who disagreed that smoking in the **car** is unlikely to affect children’s health increased from 77.4% in February/March 2002, to 86.0% in November/December 2002 ($p < 0.05$). Again, the increase in the proportion disagreeing with this statement has been maintained (88.2% disagree), as shown in the following chart.

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION

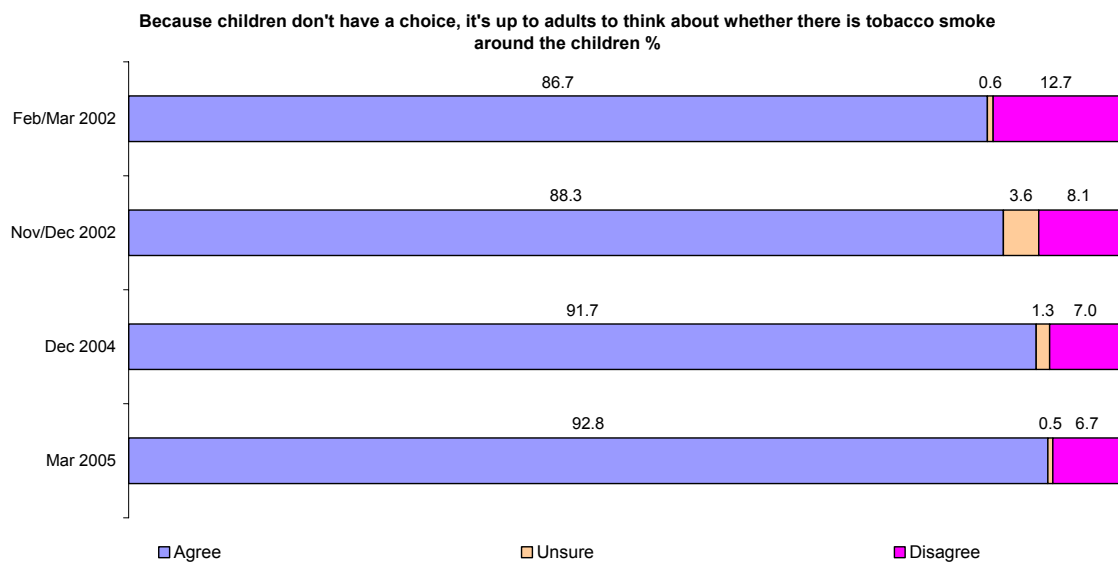


Recognition that child has no choice

Previous qualitative research (conducted to assist in the development of the campaign) identified that a strong motivator for adopting precautions was recognition of the fact that the child had no choice about his/her exposure to tobacco smoke in the home and car. The campaign TVC aims to leverage this motivator.

As shown in the following chart, 92.8% agreed with the statement, 'Because children don't have a choice, its up to adults to think about whether there is tobacco smoke around the children?'. This represents a significant increase from the proportion that agreed with this statement in the baseline survey (86.7%).

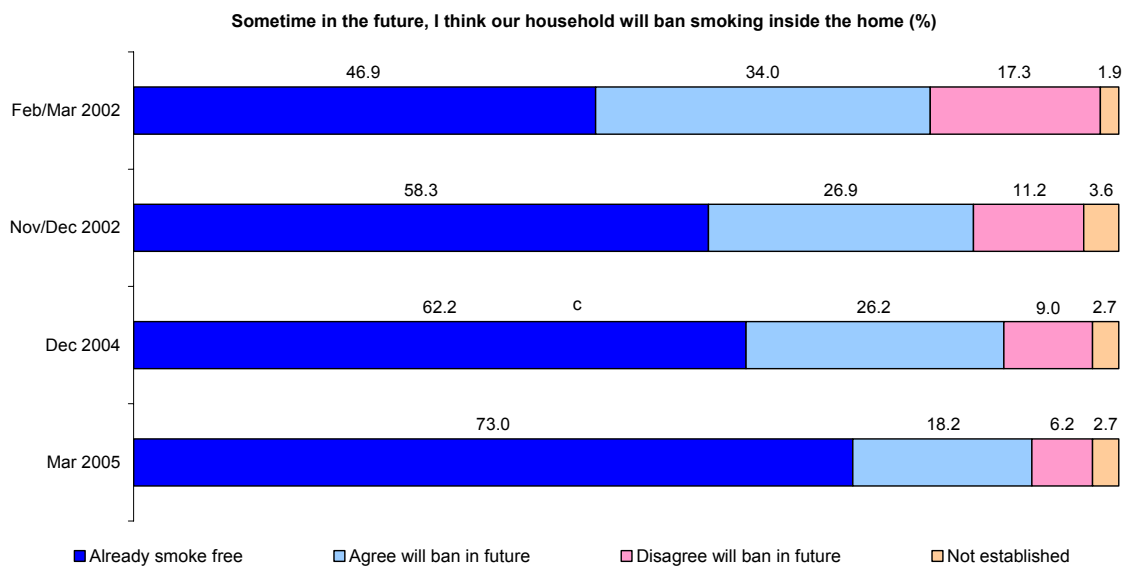
THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



Preparedness to adopt smoking bans

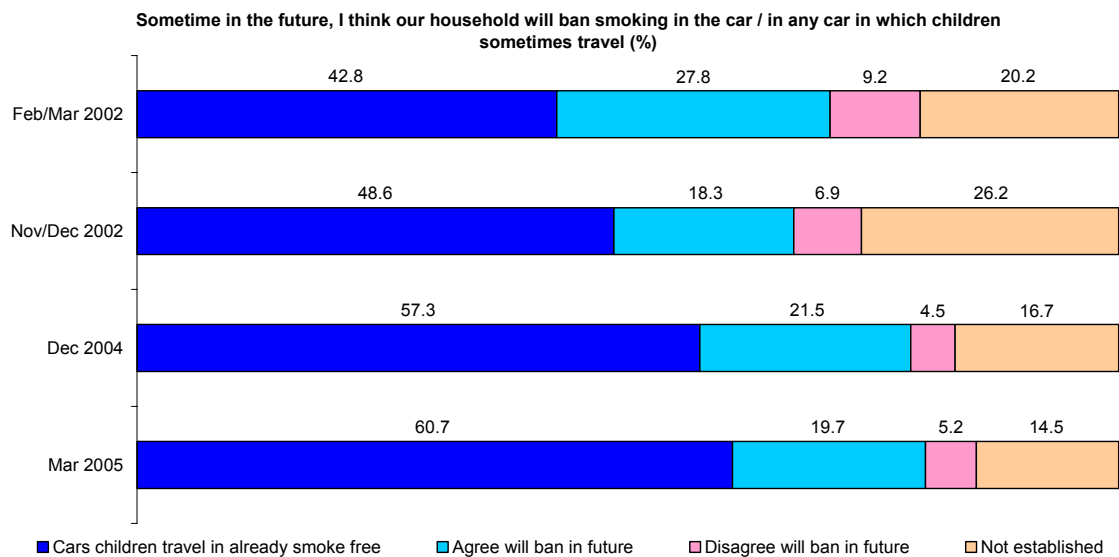
To gauge preparedness to adopt smoking bans in the **home**, those who indicated that smoking was permitted in their home were asked whether they agreed or disagreed that sometime in the future, their household would ban smoking inside the home. The majority (67.7%) indicated that they could foresee a time when their home would be smoke-free.

The following chart shows the combined data from the question relating to whether or not smoking has occurred in the home during the last month, as well as, among those who still permitted smoking inside the home, whether their household was likely to ban smoking inside the home at some time in the future.



The results show that the attitudes are consistent with the previous surveys and that, among those who are yet to ban smoking inside the home, there is a general willingness to consider banning smoking inside the home at some stage in the future. Each time the survey has been conducted, roughly two-thirds of those yet to ban smoking in the home have indicated that they can foresee a time in the future when their household will ban smoking inside the home. It appears that behavioural intentions have translated into action, with the number of smoke-free homes having increased significantly over the life of the campaign, while new people join the ranks of those considering a ban.

Similarly, those who indicated that smoking was ever permitted in the **car(s)** in which children ever travelled were asked whether they believed that their household would ban smoking in these cars in the future. The results of this question, combined with the proportion of households where smoking had not occurred in cars in which children ever travelled, are shown in the following chart.



The majority (71.5%) of those who still permit smoking in cars in which children travel agreed with this statement, suggesting that there is still mileage in a campaign of this type.

4.3 Knowledge

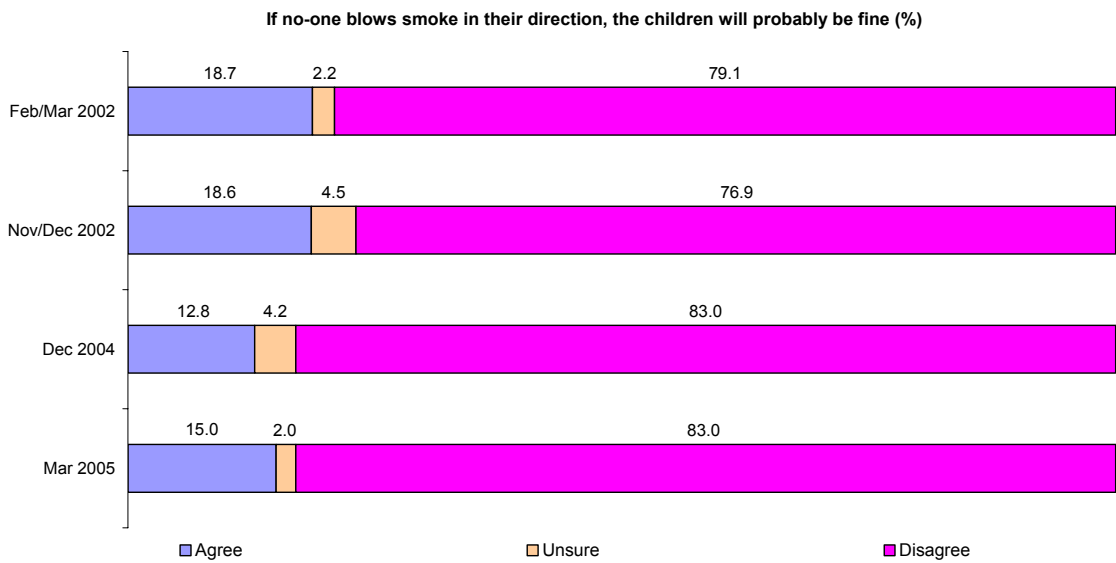
Perceived safety of inadequate strategies

The qualitative developmental research found that some parents simply avoid blowing smoke in the child’s face, or open windows in the house or car, believing that these strategies would be sufficient to protect their children from any dangers of passive smoking. To gauge the extent to which this campaign changed such beliefs, a number of measurements were included in the research. Significant changes have been observed in all of these measures compared with pre-campaign levels.

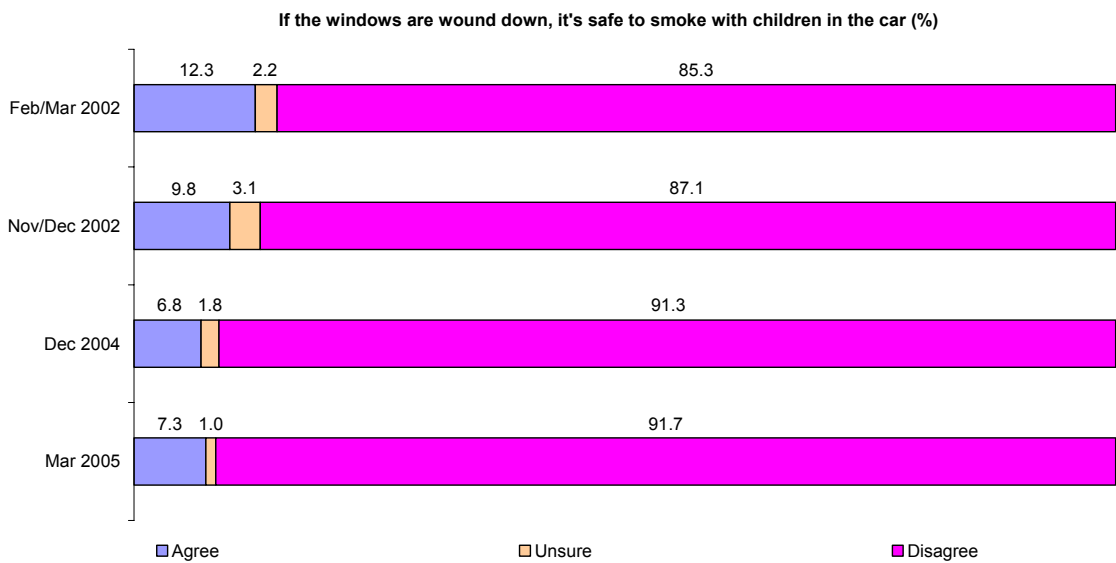
As shown in the following graph, 83.0% disagreed that “If no-one blows smoke in their direction, the children will probably be fine”. This is significantly more than the proportion that disagreed with this statement in February/March 2002, when 79.1% disagreed with this statement.⁸

⁸ It is worth noting that a non-significant change between the baseline and the December 2004 research was reported in the pre-2005 media report. This may seem strange, given the proportion disagreeing is consistent between the last two surveys (i.e. both are 83.0%) and yet a significant change from the baseline research is being reported here. This is because a 2-sided, non-directional test was used in the pre-2005 media report (because there was no *a priori* hypothesis about whether attitudes would have remained consistent, improved or deteriorated in the absence of media campaign activity), whereas a 1-sided or directional test has been used in the final campaign evaluation because it is reasonable to hypothesise that the campaign has made a change in the desired direction.

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



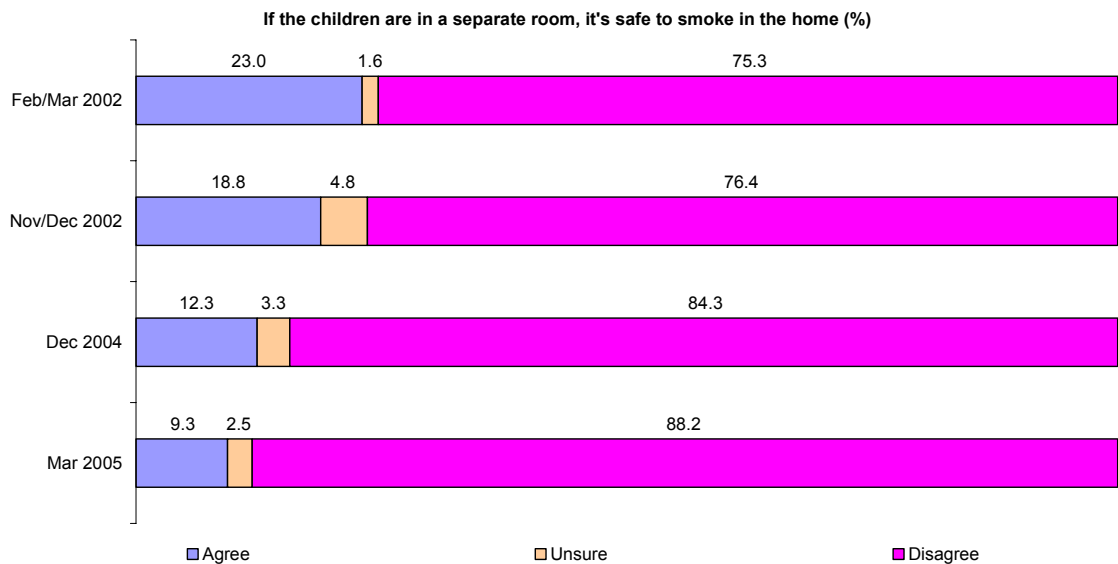
With respect to smoking in the car, the proportion agreeing with the statement “If the windows are wound down, it’s safe to smoke with children in the car” is shown in the following chart.



There has been a significant increase in the proportion of respondents who disagree with this statement, from 85.3% in February/March 2002 to 91.7% in March 2005. Only a total of 8.3% now fail to disagree with this statement, compared with 14.7% in the baseline survey.

The proportion agreeing that “If the children are in a separate room, it’s safe to smoke in the home” is shown in the following chart. There have been significant increases in the proportion

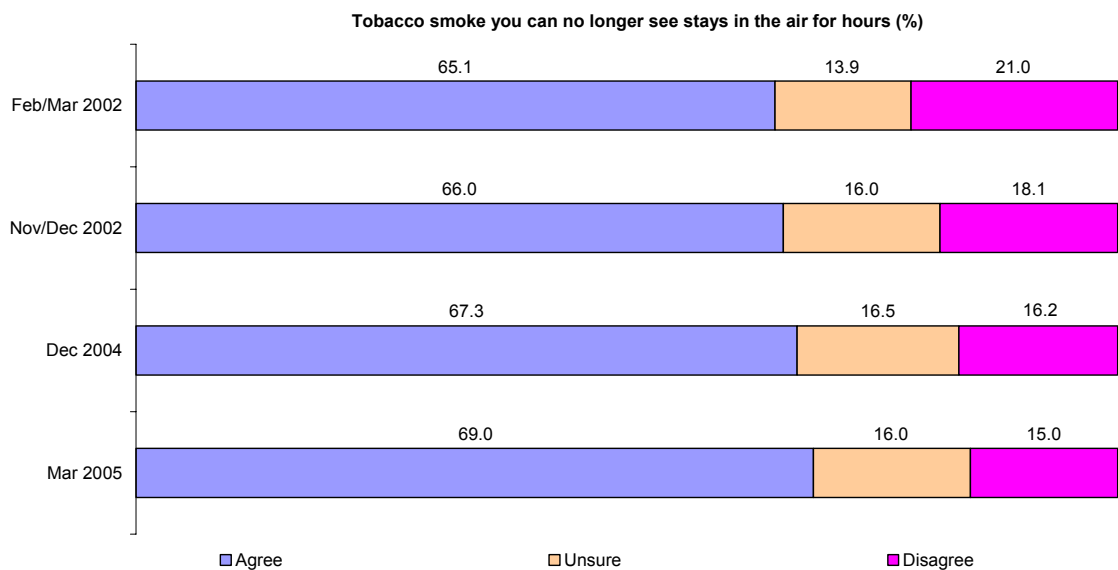
disagreeing with this statement: the final campaign result (88.2%) is significantly higher than the proportion disagreeing with this in the baseline survey (75.3%) and the pre-2005 media survey (84.3%). The proportion that failed to disagree with this statement was 11.8% in March 2005, compared with around a quarter (24.7%) in the baseline study.



Nature of passive smoking The developmental research found that a lack of knowledge about the nature of passive smoking appeared to act as a barrier to adopting adequate precautions. Hence, the research contained a number of items to measure respondents’ understanding of what constitutes passive smoking.

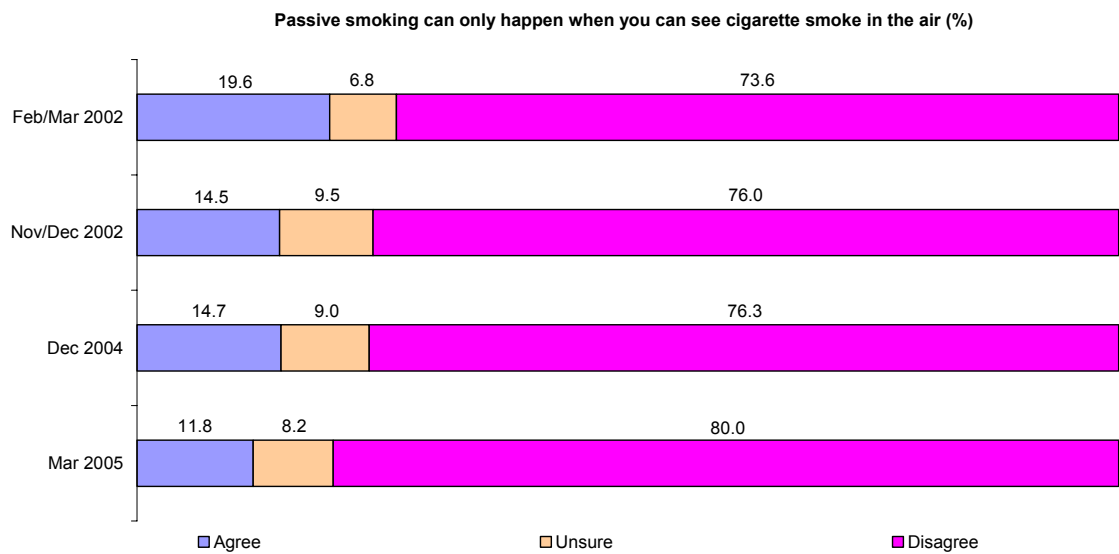
One of these statements related to residual tobacco smoke. Respondents were asked whether they agreed or disagreed with the statement, “Tobacco smoke you can no longer see stays in the air for hours”. The results from the baseline and evaluation surveys are shown in the following graph.

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



Although there has been a significant decrease in the proportion of respondents who disagree with this statement (21.0% in February/March 2002 vs 15.0% in March 2005, there has been no significant change in the proportion that agree with this statement over the life of the campaign. Nearly a third (31.0%) fail to agree in the final campaign evaluation.

Pleasingly, there has been a significant increase in the proportion of respondents that disagree with the statement, “Passive smoking can only happen when you can see cigarette smoke in the air”, increasing from 73.6% in the baseline survey to 80.0% in March 2005. This suggests that the campaign has helped to dispel the myth that only visible smoke is potentially harmful.

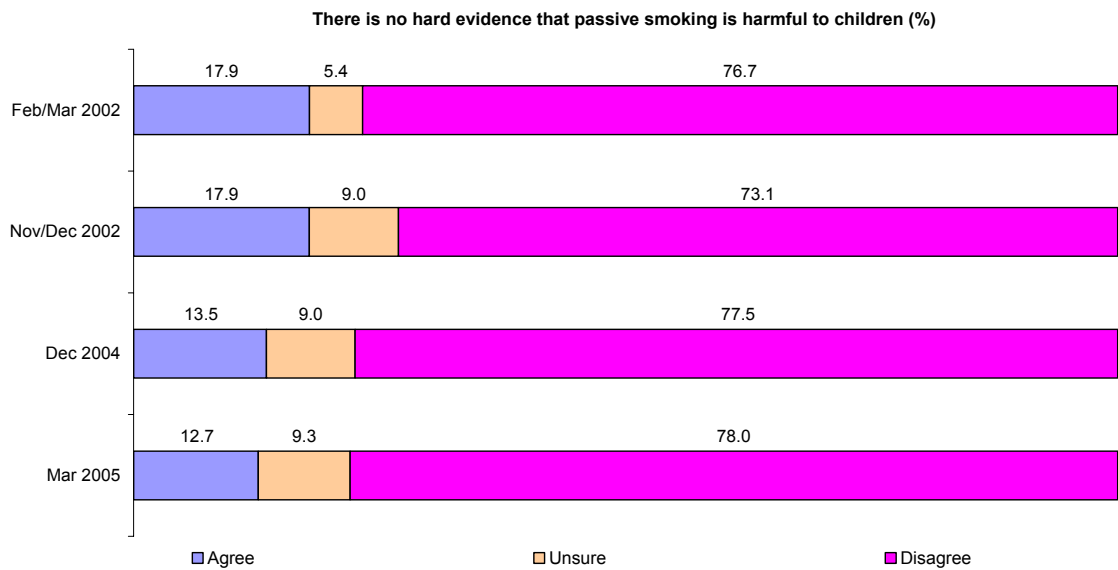


Understanding of risks of passive smoking

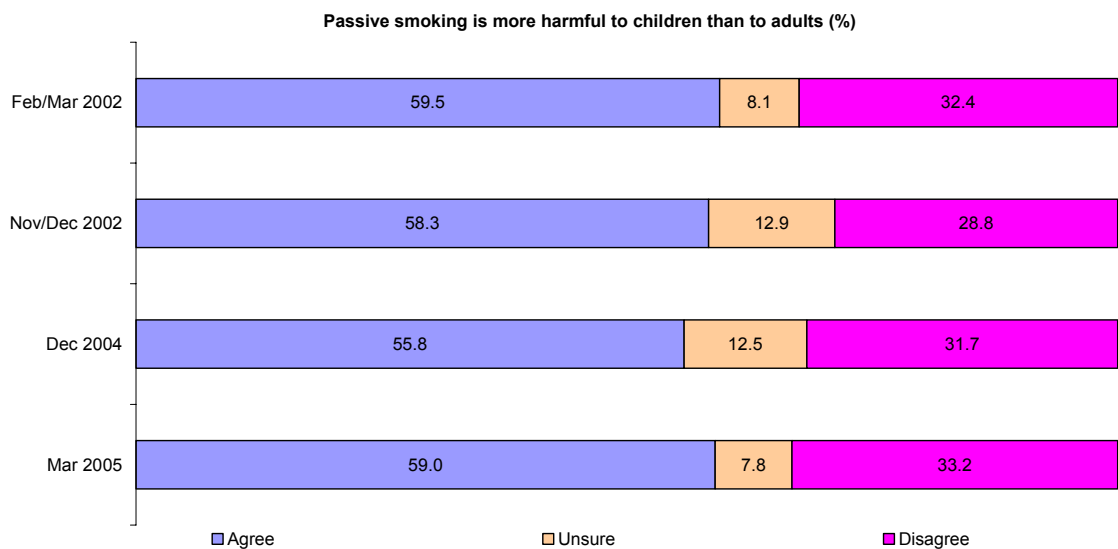
Respondents were asked whether they agreed or disagreed with a series of statements about the risks of passive smoking in relation to children.

The proportion that disagreed that “There is no hard evidence that passive smoking is harmful to children” was 76.7% in February/March 2002. Although there has been a significant reduction in the proportion that agree with this statement (17.9% in February/March 2002 vs 12.7% in March 2005), the final campaign evaluation results show no significant change in the proportion that disagreed with this statement (78.0% in March 2005). As shown on the following chart, the proportion agreeing with this statement was 12.7%, and 9.3% indicate that they are unsure whether there is any hard evidence that passive smoking is harmful to children.

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



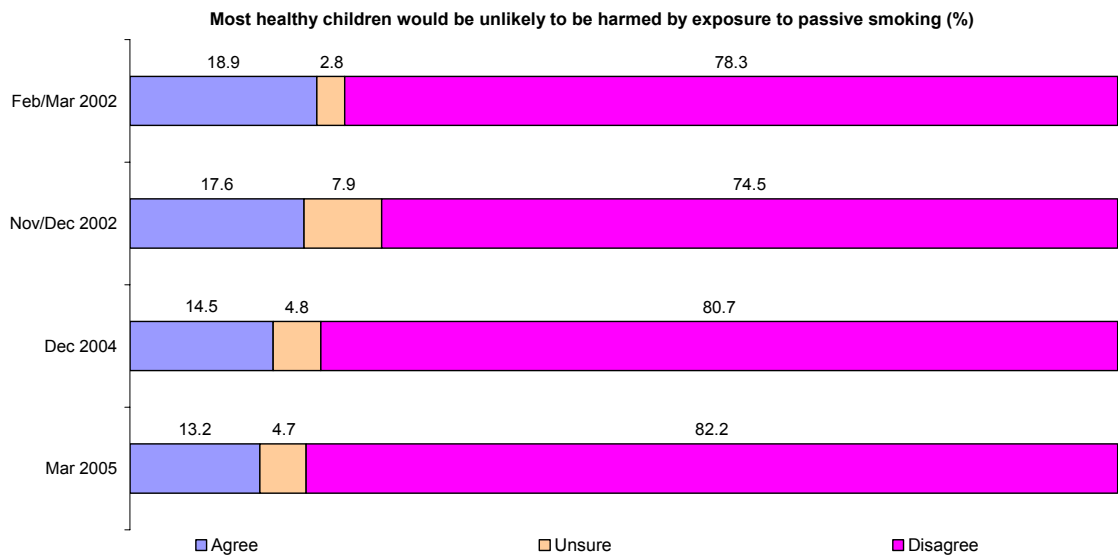
With respect to the possible harm caused to children by passive smoking relative to adults, there was no significant change from previous measures, with more than half (59.0%) agreeing that “Passive smoking is more harmful to children than to adults”.



Although the developmental qualitative research found that, for some parents, awareness that children were at increased risk of harm associated with ETS acted as a motivator to protect their children from exposure to ETS, it is unlikely that such an understanding would always be essential for adopting protective behaviours. If parents believe that the risks associated with

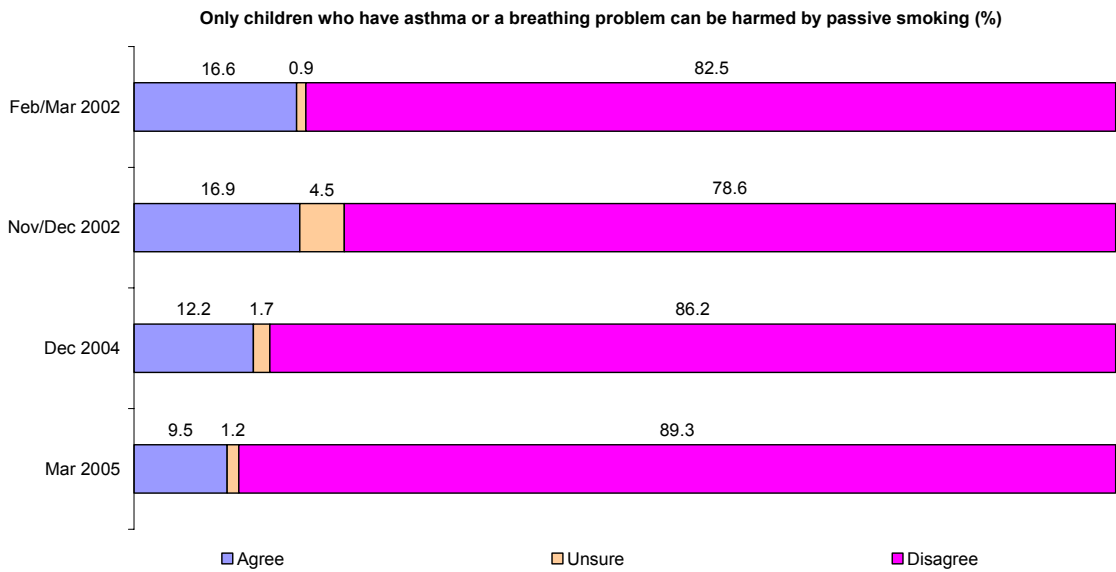
exposure to ETS are significant, then an understanding of the increased risk may not be necessary. That said, awareness of the increased risk is likely to act as a motivator to minimise children’s exposure to ETS in some cases, and there remains scope to address this knowledge deficit among the target audience.

The developmental research found that the apparent healthiness of the child can act as a barrier to perceiving a link between exposure to environmental tobacco smoke and harm. In December 2004, more than four-fifths (82.2%) disagreed that “Most healthy children would be unlikely to be harmed by exposure to passive smoking”. This represents a significant increase compared to the pre-campaign measure, where 78.3% disagreed with this statement.

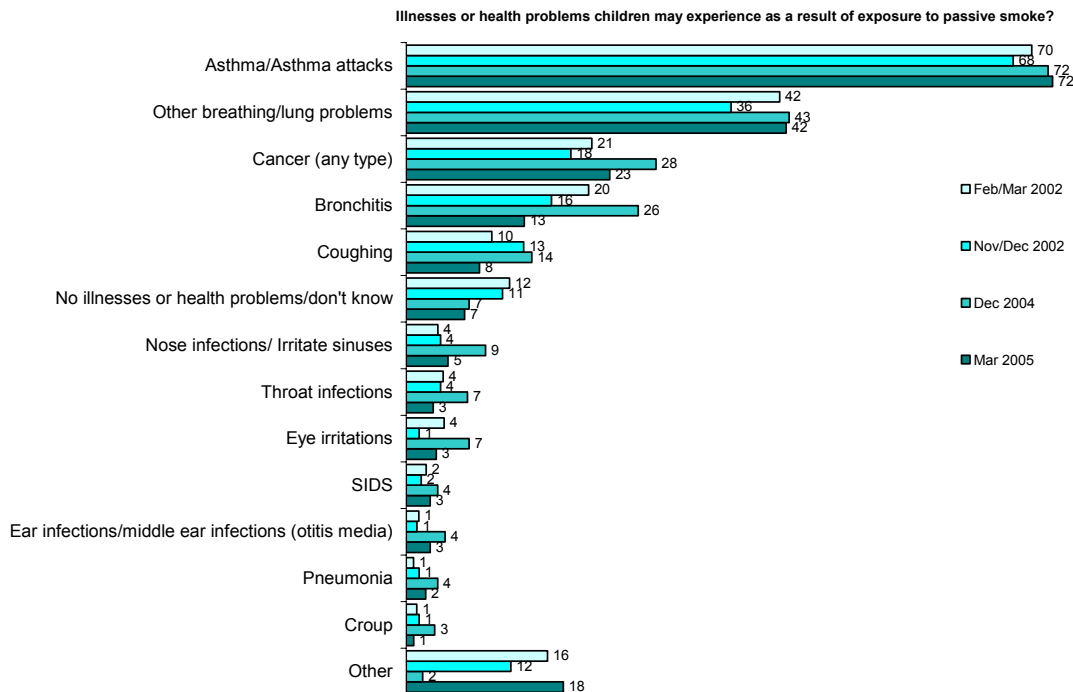


Respondents were also asked whether or not they agreed that “Only children who have asthma or a breathing problem can be harmed by passive smoking”. There has been a significant change in the desired direction comparing the final campaign evaluation results with the baseline survey results (82.5% disagreed in February/March 2002 compared to 89.3% in March 2005). The results are shown in the following graph.

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



Respondents were asked “Which illnesses or health problems, if any, do you think children may experience as a result of exposure to passive smoke?”. The responses were coded by interviewers (using a response frame that was developed in advance) and are shown in the following chart.



Consistent with the findings from previous surveys, illnesses relating to children’s breathing were commonly mentioned. The proportion that knew that children may experience asthma or

asthma attacks as a result of exposure to passive smoke was 72%. Nearly half (42%) mentioned other breathing or lung problems.

There were few significant gains in knowledge of illnesses observed over the life of the campaign. However, the proportion that did not know any illnesses or health problems associated with children's exposure to passive smoke, or who said there were no such illnesses or health problems, declined from 12% in the baseline research to 7% in the final campaign evaluation. There was also a small increase in the proportion mentioning pneumonia (0.8% in February/March 2002 to 2.2% in March 2005).

"Other" illnesses that were mentioned by respondents included "stunted growth", "reduced immune system", "generally unhealthy", "allergies", "heart disease", "circulatory problems", "emphysema", "colds / flu", and "addicted when older".

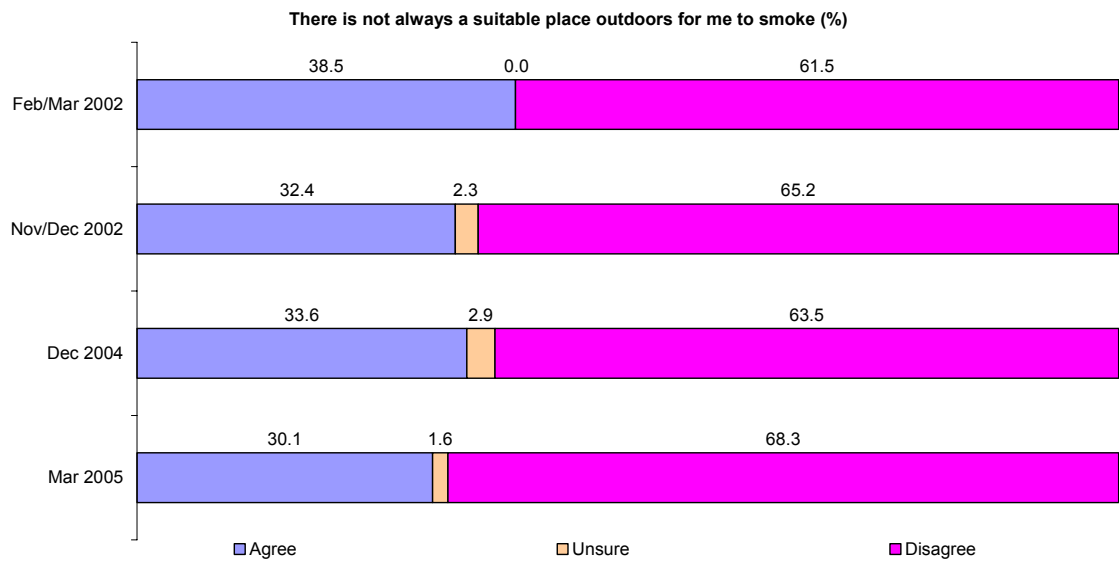
It should be noted that unprompted awareness of illnesses or health problems is a conservative measure of knowledge, because it is confounded with salience. It is likely that prompted awareness of some of these illnesses (like SIDS) is higher than unprompted awareness. Further, care should be taken in interpreting the results of coded open-ended questions, where classification of responses can depend to some extent on the subjective interpretation of the interviewer. However, it is clear that the salience of the link between some of these illnesses and exposure to ETS remains poor.

4.4 Practical barriers to smoking outdoors

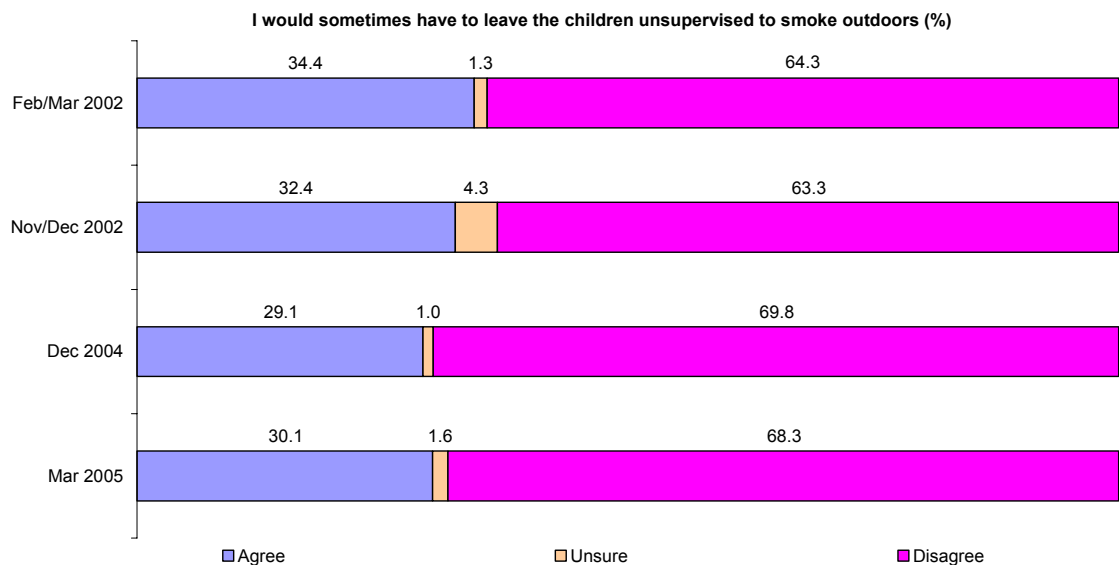
The proportion of smokers in the sample was 63.7% (n=382). These respondents were asked three statements relating to more practical barriers to implementing smoking bans in the home and car.

A lack of suitable places to smoke outside represented a barrier for 30.1% of respondents who smoked. This is a significantly lower proportion than that found in the baseline survey (38.5%). One would not expect large changes from a statement that is largely factual, although the reduction in the proportion of respondents agreeing with this statement suggests that smoking inside the home where children live is becoming more socially unacceptable among the target audience and using a lack of suitable outdoor places to smoke as a reason for not smoking outside is accordingly becoming less common.

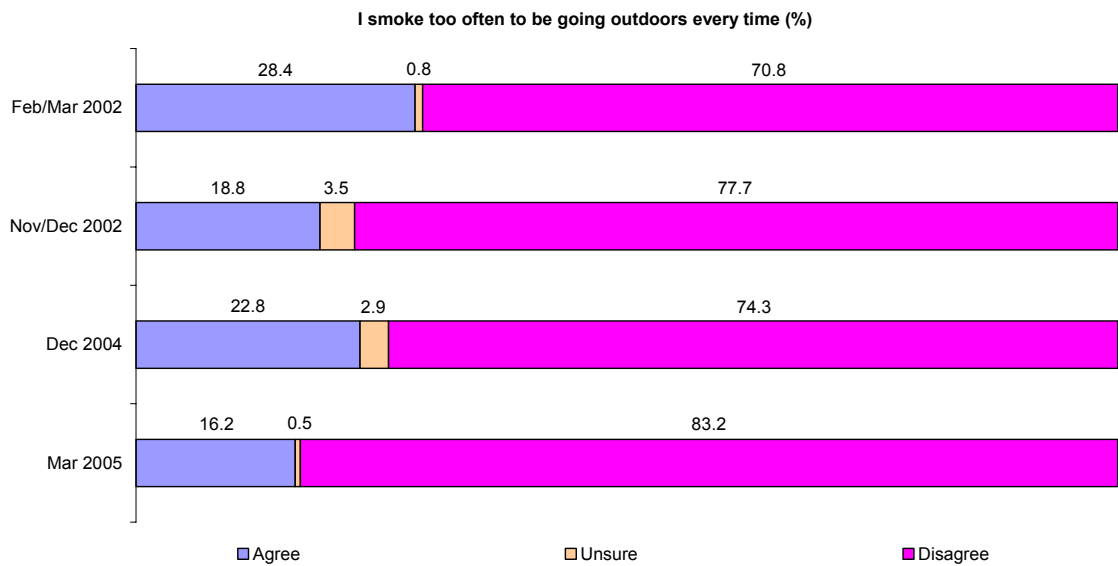
THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



Around a third (30.1%) indicated that having to leave the children unsupervised was a problem. There has been no significant change in this finding over time.



Respondents were asked whether they agreed that “I smoke too often to be going outdoors every time”. The results are shown in the following chart.



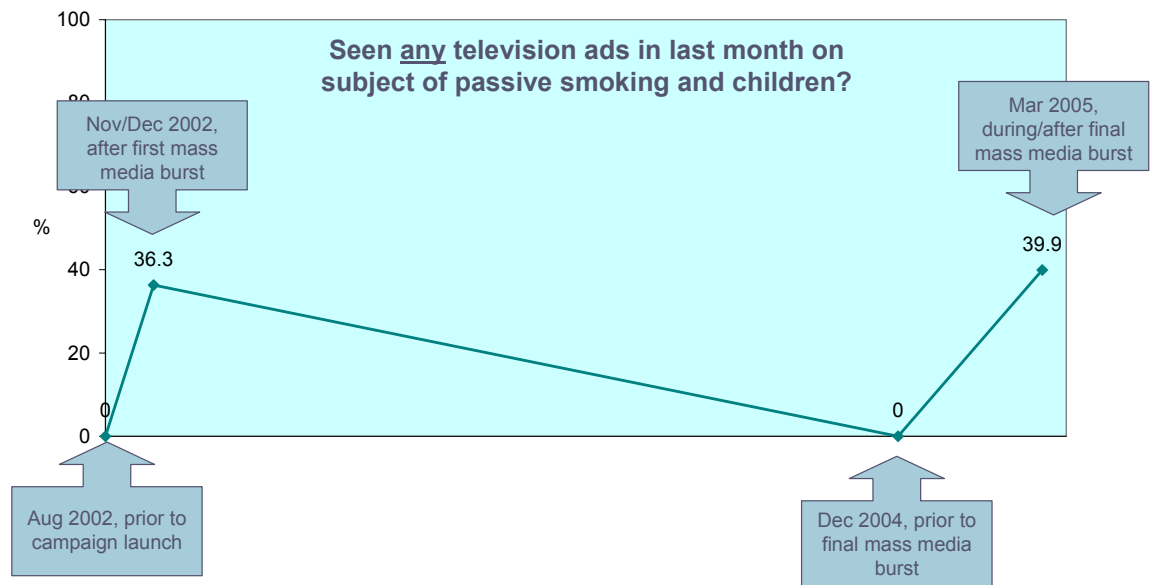
There was a significant increase in the proportion rejecting this statement (83.2%), both when comparing the final campaign evaluation results with the pre-2005 media results (74.3%) and when comparing the final campaign evaluation results with the baseline results (70.8%).

4.5 Campaign awareness

Respondents were asked a number of questions regarding their awareness of communications on the subject of passive smoking and children. The results are reported under the following headings.

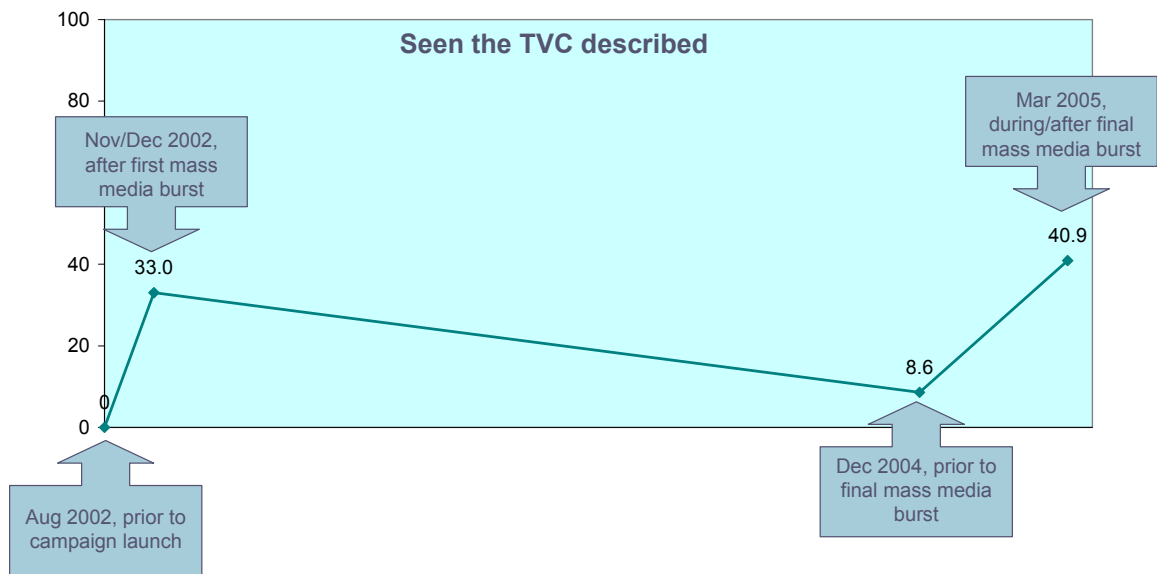
TVC First, respondents were asked whether they had seen any television advertisements in the last month on the subject of passive smoking and children. As shown in the following chart, the proportion in the March 2005 research that indicated that they had was 39.9%.⁹

⁹ This has been corrected to take into account the level of false recall established in the baseline research.



Respondents were then read a brief description of the television advertisement (see Appendix A). As shown in the following chart, prior to the final mass media burst in 2005, the proportion that recalled the TVC was 8.6%¹⁰. Of course, these respondents were not accurately recalling the timeframe in which they saw the advertisement. However, the results suggest that some recall of the advertisement had remained from previous media waves. In the final campaign evaluation research, it was found that two-fifths (40.9%) reported having seen this particular advertisement in the last month. Although awareness of the campaign TVC has improved compared to previous media rounds (33.0%), there is still scope to increase the reach of the campaign.

¹⁰ Campaign TVC recall figures have been corrected to take account of the level of false reporting which was established in the baseline survey.

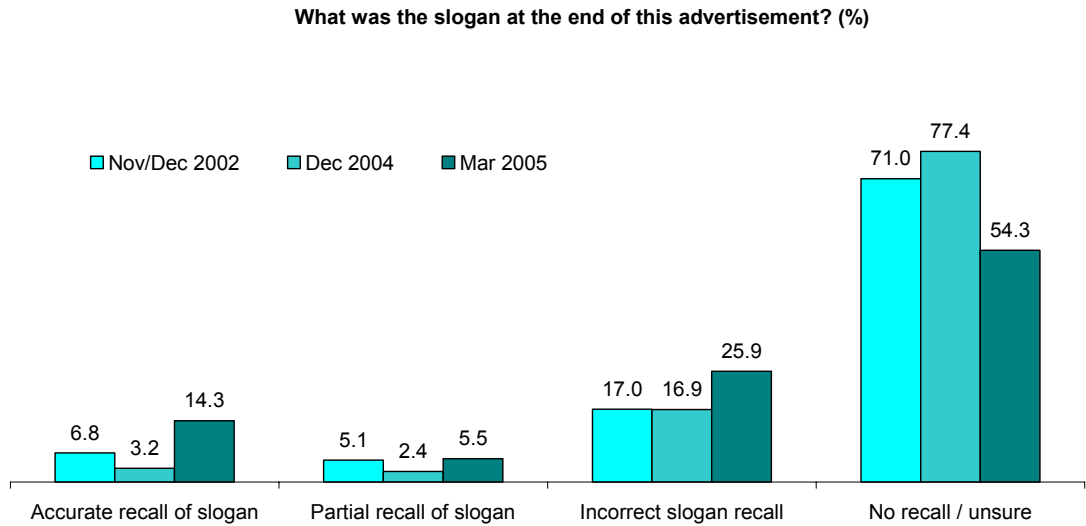


Of those who recall seeing the campaign TVC, the average number of times respondents claimed to have seen this advertisement was 7.2, and the median was 5. This is comparable with the previous post-media result, where the average was 7.7 times and the median was 5. Expressed another way, 58.9% of those respondents interviewed in the final campaign evaluation indicated that they had seen the campaign TVC five or more times. So, the research suggests that there has been acceptable frequency among those who recall seeing the campaign TVC.

Respondents who recalled having seen the campaign TVC were asked what was the slogan at the end of the advertisement. The verbatim responses were coded into the following categories:

- Accurate recall of slogan (including responses such as “Car and home, smoke free zone”, “Make car and home smoke free zone”, “House and car smoke free zone”);
- Partial recall of slogan (including responses such as “Smoke free zone”, “Don’t smoke in the car or home”, “Smoke free in the home and in the car”, “House and home, smoke free zone”);
- Incorrect slogan recall, and
- No recall / unsure.

As shown in the following chart, the final campaign evaluation survey found that about a fifth of those who have seen the TVC recall the slogan ““Car and home, smoke free zone”¹¹ (either accurately or partially). This represents a significant increase from previous evaluations.

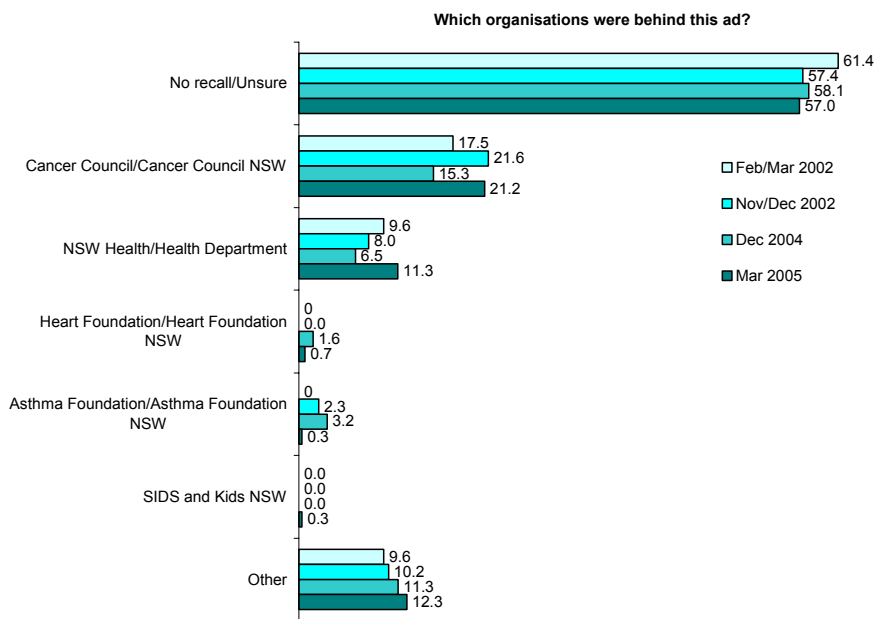


Base: Those who recall seeing the described TVC.

Those who indicated that they had seen the advertisement were also asked which organisation or organisations were behind the advertisement. The responses were coded, and are presented in the following chart.

¹¹ Of the full sample, this equates to 9.7% slogan recall.

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



Base: Those who recall seeing the described TVC.

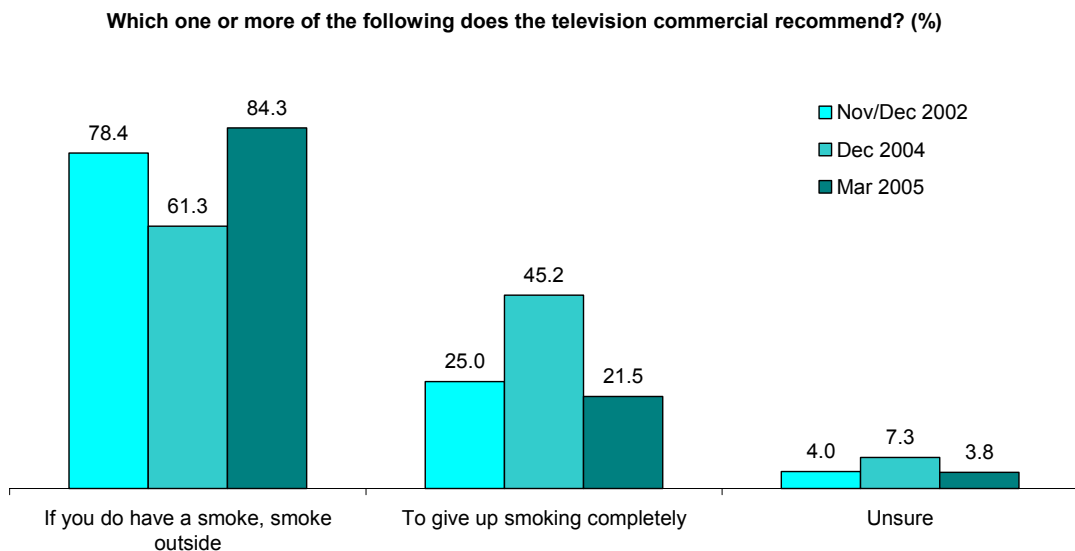
The results from the December 2004 research showed that correct recall of the organisations behind the advertisement had declined over time, which could be expected given the length of time since the advertisements had been aired.

The final campaign evaluation results show that the majority (57.0%) was unable to provide the name of any organisation behind the advertisement. The most commonly mentioned organisation was the “Cancer Council” (21.2%). It is known from the baseline study that even people who have not seen the TVC have a tendency to associate such communication with the Cancer Council, presumably because it is the most salient authority on smoking-related communication. “Other” responses included “Government” (including “Federal government”), which accounted for 2.0% of responses and “Quit” or “Quit program” (5.1% of responses).

During the developmental qualitative research, research participants were provided with some resource materials on children and passive smoking, to gauge their reactions to these communications. A number of participants in this qualitative research immediately assumed that the materials were cessation messages. Several of these participants vehemently expressed their negative views on anti-smoking materials and, since they assumed the testing materials were merely cessation messages, rejected them outright. Hence, a question was included in the

evaluation research to ascertain to what extent the TVC was perceived as advocating cessation.¹² As can be seen in the following chart, the December 2004 research showed that 61.3% believed that the television advertisement recommended that “If you do have a smoke, smoke outside”, compared with 78.4% in November/December 2002. This pattern of findings is to be expected, with the recall of key messages having become less precise as the length of time since the target audience has seen the TVC increased.

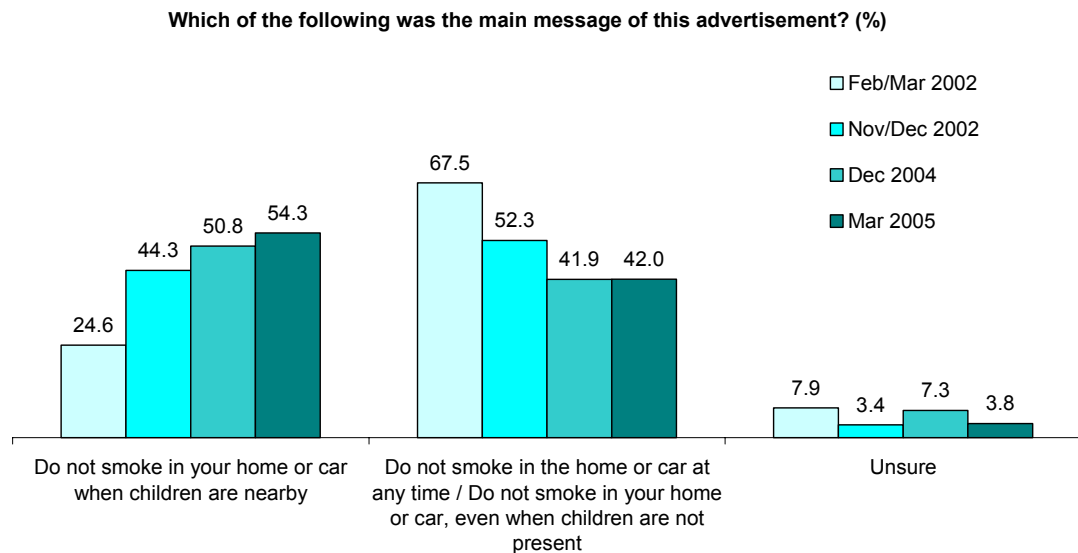
The final campaign evaluation results found that most (84.3% of respondents) believed the commercial was recommending only smoking outdoors, compared with 21.5% believing that the commercial was advocating cessation. Only 5.8% indicated that they believed the commercial was recommending giving up smoking completely and did not **also** say that they believed the commercial was recommending only smoking outside. This suggests that nearly all participants do not see cessation as the primary or sole message, even though several may agree that quitting smoking may be one of the messages within the advertisement.



Base: Those who recall seeing the described TVC.

¹² It should be noted that this question was not included in the baseline survey.

Respondents who indicated having seen the advertisement were then asked, out of two possibilities, what was the main message of the advertisement. The results are shown in the following chart.



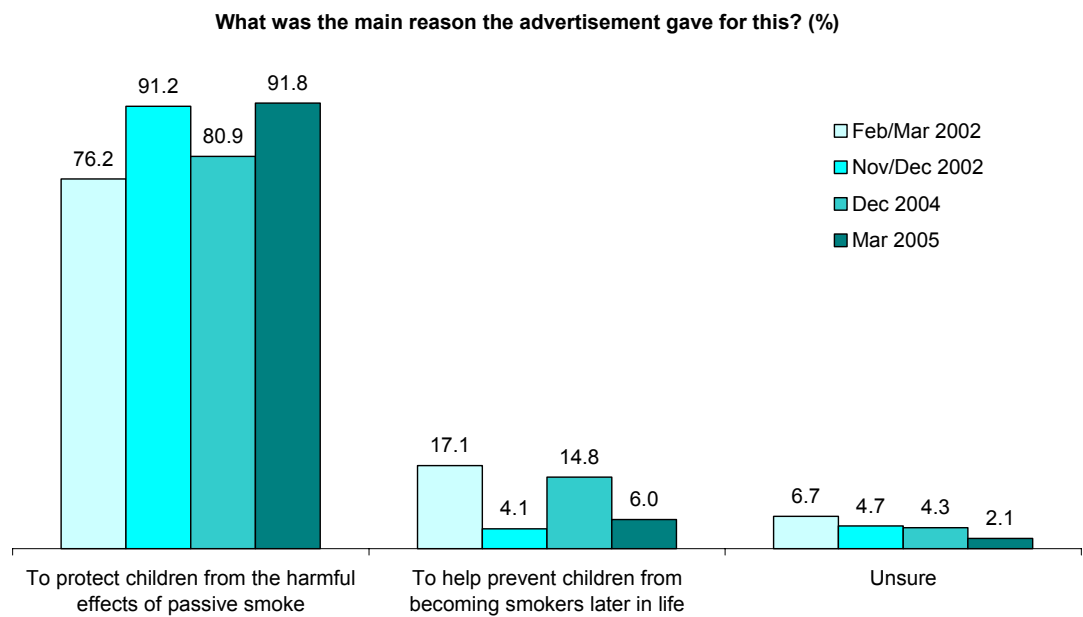
Base: Those who recall seeing the described TVC.

The intention of this question was to establish whether or not the campaign was effectively communicating a “gold standard”, a focussed and unambiguous message. That is, was the target audience perceiving the intended message of the campaign (i.e. that smoking should only occur outside any house and car that kids ever occupy), or was the campaign communicating a message that was open to misinterpretation and could risk reinforcing inadequate strategies for protecting children from exposure to ETS (such as “Don’t smoke around the children”)? In light of the research results after the first wave of evaluation (November/December 2002), it is clear that the wording of this question needed to be improved. The baseline data revealed that 24.6% of respondents assumed that, having been read a description of the TVC, the main message of the advertisement was “Do not smoke in the home or car when children are nearby.” With this proportion increasing to 44.3% in the first evaluation survey, it appeared that the effect of the campaign had been to strengthen the association of the message with children. Hence, in the December 2004 research, a new wording of this question was adopted.

“Do not smoke in the home or car when children are nearby, or
 Do not smoke in your home or car, even when children are not present”

This was done in an attempt to clarify whether or not the campaign is conveying its intended message. In the March 2005 survey, just over half (54.3%) indicated that they believed that the main message was “Do no smoke in your home or car when children are nearby”, while 42.0% believed that it was “Do not smoke in your home or car, even when children are not present.” This finding would suggest that the campaign has been only moderately successful in conveying a “gold standard” message, rather than simply suggesting that smoking around children should be avoided. It is possible that this finding may have been partly driven by part of the wording of the TVC (which mentions “Please don’t smoke **around** children in the house or in the car”). However, the changes in behaviour that have been observed and the increases in the proportion of respondents rejecting inadequate protection strategies (such as smoking in another room) suggest that the campaign has in fact communicated a “gold standard” message. However, the extent to which it has unambiguously done so is difficult to determine.

Following the question regarding the intended message of the advertisement, respondents were then asked “What was the main reason the advertisement gave for this?”, and asked to choose from two possible options. Similar to the result from the evaluation research conducted after the first burst of mass media (November/December 2002), most respondents (91.8%) felt that the main reason was “To protect children from the harmful effects of passive smoke”. This suggests that the campaign has communicated a clear message about the harms of passive smoking and has successfully avoided conveying a message relating to role modelling.



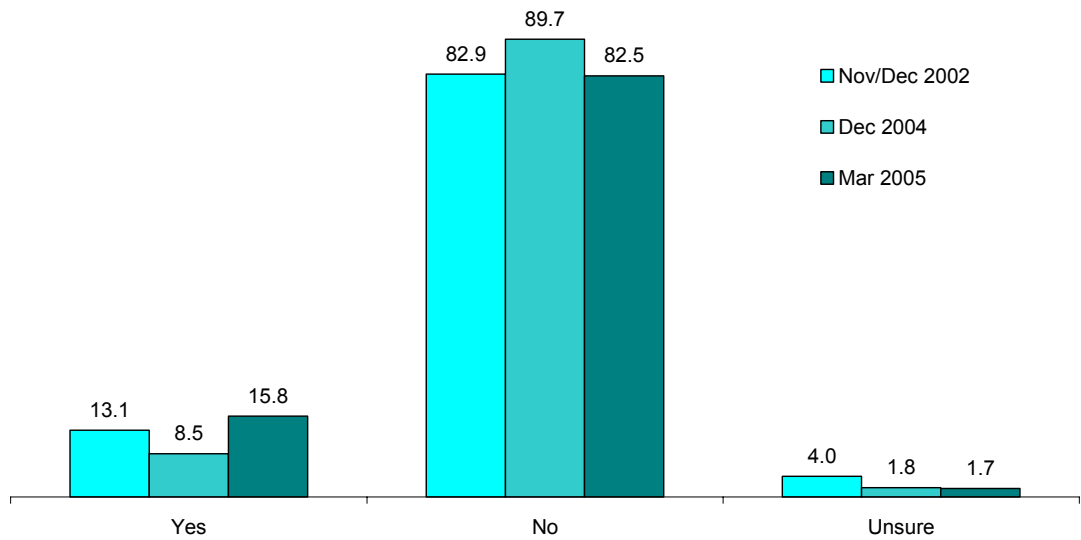
Base: Those who recall seeing the described TVC.

Radio advertisements and collateral materials

All respondents were asked whether they had heard any radio advertisements in the last month on the subject of passive smoking and children.¹³ As can be seen in the following chart, most respondents (82.5%) said they had not heard any such radio ads, suggesting limited recall of radio advertising.

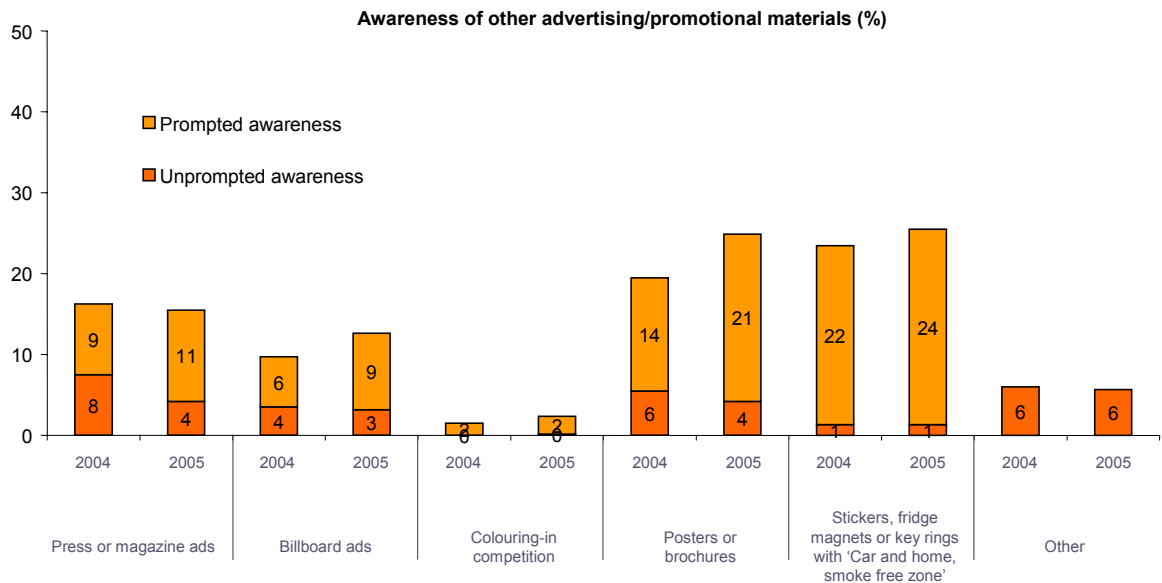
¹³ This question was not asked in the baseline survey, hence these figures have not been corrected for false recall.

Heard any radio ads in last month on subject of children and passive smoking? (%)



The ETS and Children Project Taskforce was interested in exploring any geographic differences in awareness of radio advertising, given the structure of the media buy. Analysing the awareness of radio advertising by location showed no significant difference. However, this may be because of imperfect overlap between the location variable which was captured in the research (i.e. Section of State Indicator, as per the ABS Census data) and the pattern of radio advertising across the state.

Respondents were then asked whether they had seen any other advertising or promotional material about passive smoking and children. After unprompted responses were captured, prompted awareness of a range of materials was obtained. The results from the December 2004 and March 2005 results are shown in the following chart.

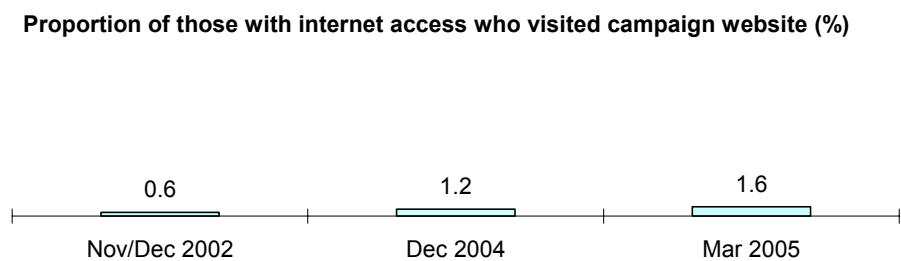


The proportion reporting having seen press or magazine ads was similar to previous waves of research. There has been a small, but significant increase in the proportion reporting having seen posters or brochures on the subject of children and passive smoking, with around one in four of respondents recalling these materials. As shown above, about a quarter report having seen stickers, fridge magnets, or key rings with the slogan 'Car and home, smoke free zone' during the last month, which is similar to the results from previous surveys.

Internet access and campaign website

Participants were asked whether they had Internet access, either at home or at work. Those who did were asked whether they have ever visited www.smokefreezone.org Only a very small percentage of those with

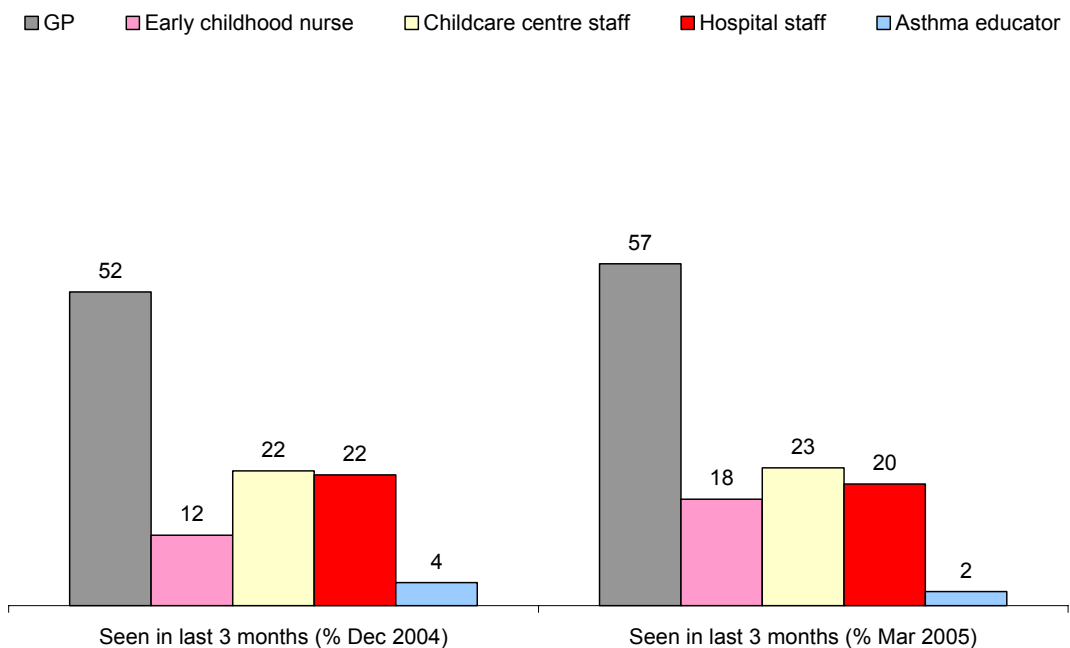
Internet access reported having done so, as shown in the following chart.



Although 1.6% of those with internet access may equate with sizeable number of hits to the campaign website, the vast majority of the primary target audience will not have visited the campaign website.

Consultation with health and other professionals

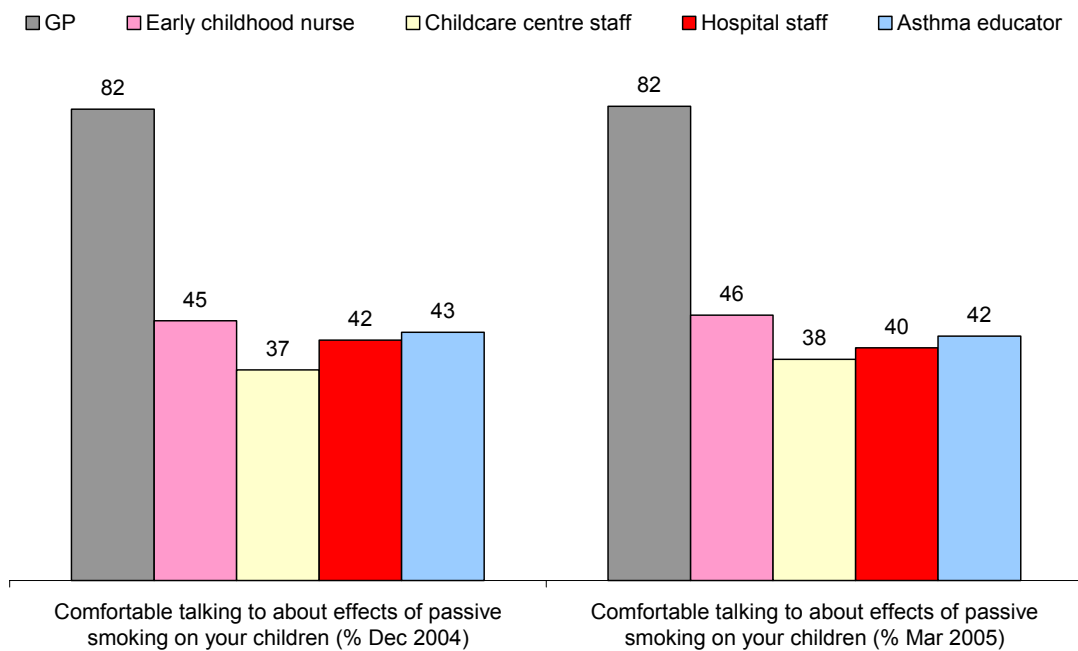
Respondents were asked a series of questions about a range of health and other professionals who work with children. In relation to the three months before the final survey, over half (57%) reported having seen their GP. Just under a quarter (23%) reported having seen childcare centre staff and a fifth (20%) indicated that they had seen hospital staff. Fewer report seeing an early childhood nurse (18%) and 2% has seen an asthma educator. As would be expected, these proportions are very close to those found in the December 2004 research.



In total, 72% of those surveyed had seen one or more of the nominated health or other professionals during the last three months. This finding supports the notion that health professionals are a potentially useful avenue for reaching the primary target audience.

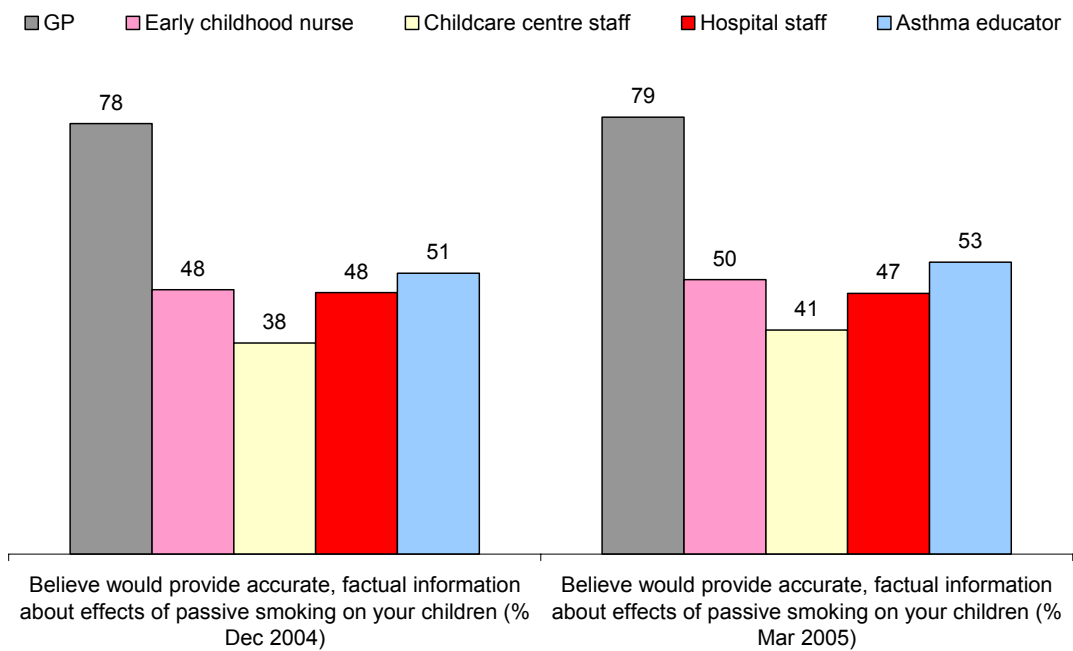
Participants were also asked, in relation to these same professionals, whether they would feel comfortable talking to them about the effects of passive smoking on their children. More than four-fifths of respondents (82%) indicated that they would feel comfortable talking to their GP about the effects of passive smoking on their children. As shown in the following chart, the corresponding figures for other health professionals were lower. Again, the results were similar across the last two waves of research.

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ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



Respondents were also asked, for each professional, whether they believe they would provide accurate, factual information about the effects of passive smoking on their children's health. There appears to be most confidence in GPs, with 79% believing them to provide accurate, factual advice on this subject. The results are shown in the following chart.

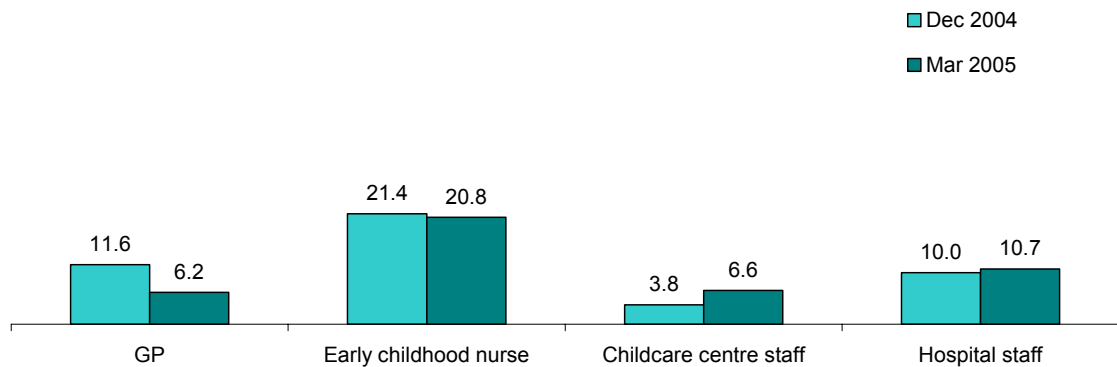
THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION



Analysing the pattern of responses given by each participant, 93% indicate that they believe at least one of the nominated professionals would provide accurate, factual advice about the effects of passive smoking on their children.

Those who had seen a given health professional were also asked whether they had spoken to them about the effects of passive smoking on their children. The results (shown as percentages based on those who have seen each of these professionals during the three months before being surveyed) are presented in the following chart.

Spoken to health professional in last 3 months about effects of passive smoking on your children (%)



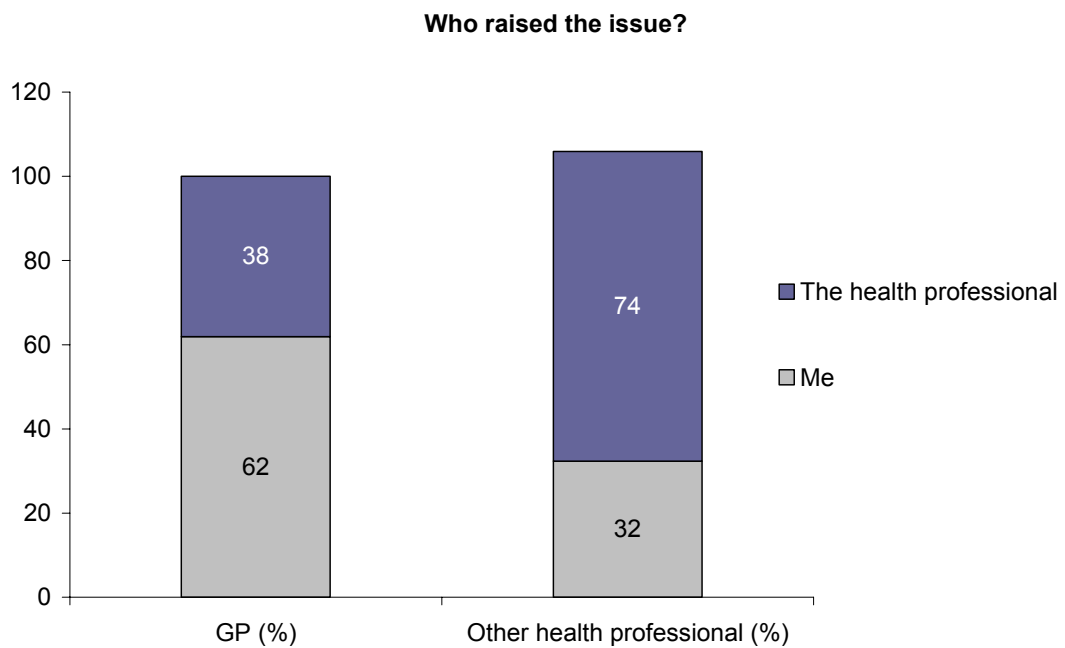
Base: Those who have seen each of the specific professionals.

Of those who had seen at least one of the nominated professionals in the last three months, 10.9% indicated that they had spoken to them about the effects of passive smoking on their children. This was not significantly different from the corresponding proportion in the December 2004 research (13.2%).

Participants were also asked whether they themselves raised the issue, or whether the health professional did. Given the very low bases for this question:

- the professionals other than GPs have been grouped together for the purposes of analysis
- care should be taken in interpreting the results, because the bases remain very low (GP = 21, Other health professionals = 34)

The results are shown in the following chart.



Base: Those who have spoken to health professional about effects of passive smoking on their children.

Although the bases are very small, it appears that targeted health professionals are taking the initiative to raise the issue of children's exposure to passive smoking. There are a range of possible reasons why GPs may be less likely to initiate the conversation. Firstly, given the high proportion that indicated that they would feel comfortable talking to their GP about the effects of passive smoking on their children, this might translate into a greater propensity for the patient to raise the subject. Being particularly time pressured and charging on a per consultation basis may also decrease the likelihood that the GP would initiate such a conversation.

Conclusions

This evaluation research has found significant and sizeable behavioural changes since the implementation of this campaign. The number of households within the sample reporting smoke free homes has increased by 17.4% since the pre-2005 media research and by 55.7% since the implementation of the campaign. There has also been a significant increase (41.8%) in the number within the sample reporting that all cars that children have travelled in during the last month have been smoke free. The impact of the campaign on behaviours may in fact have been underestimated, given that only households where a smoker lives are eligible to participate in the survey and some people will have quit smoking as a result of the campaign.

The campaign appears to have made a greater impact on smoking behaviours in the home than in the car. It is plausible to suggest that prohibiting smoking in the car is actually a more difficult thing than not smoking inside the home, for various reasons.

There appears to still be much mileage in the campaign, with around two thirds of those who still permit smoking indoors, and nearly three-quarters of those who still permit smoking in cars in which children ever travel, agreeing that they can foresee a time when their household will ban smoking in such homes/cars.

In addition to significant behaviour change, the evaluation research has identified significant improvements in some of the key attitudes that link children's exposure to ETS in the home and car to harm. The final campaign evaluation shows that there is now almost universal acknowledgement that child's lack of choice means adults must take responsibility for children's exposure to ETS. Furthermore, the small, yet significant, shifts in perceived barriers to smoking outside suggest that smoking in homes where children live is becoming less socially acceptable.

Comparing the final campaign evaluation results with the baseline measures, there have been no significant changes in the target audience's knowledge of specific illnesses associated with children's exposure to ETS. It is possible that previous increases found in December 2004 may

stem from increased media attention relating to exposure to second hand smoke in licensed premises. Increased and sustained improvements in knowledge are most likely to be gained via health professional intervention, which is yet to increase significantly.

Although some significant knowledge gaps remain, greater proportions reject the idea that only children with asthma or a breathing problem can be harmed by passive smoking. Further, more were found to reject inadequate protection strategies (such as smoking in a separate room or winding down the windows in the car), suggesting some improvements in knowledge of when children can be at risk passive smoking. There is also some evidence that the campaign has helped to dispel the myth that only visible smoke is potentially harmful.

With respect to awareness of the campaign, the reach of the campaign has been somewhat limited, with only two-fifths having seen the TVC. Among those who report seeing the campaign, however, there has been acceptable frequency.

Among those who recalled seeing the TVC, around a fifth recalled the slogan, which represented an improvement from previous media waves. The organisational branding of the advertisement is somewhat weak, yet this does not represent a major concern for a campaign of this type. In general, the messages of the campaign appear to be being effectively communicated.

Reach of posters and other collateral materials was reasonably limited, and largely comparable with the results obtained in earlier waves of research. Usage among the campaign website among the primary target audience was also found to be low.

In sum, the research suggests that the campaign has achieved remarkable behavioural change, as well as small, yet significant changes in some key attitudes and relevant knowledge. Given behavioural change has been the ultimate outcome of this campaign, the campaign has certainly been extremely successful.

Appendix A – Questionnaire

RECORD POSTCODE

RECORD SECTION OF STATE INDICATOR

QUOTAS AS PER FOLLOWING TABLE.

Location	Number of interviews	
Major urban	364	
Other urban	172	
Bounded locality		64
Rural balance		
Total	600	

Introduction

Hello, my name is [INTERVIEWER] from Eureka Strategic Research. We are conducting an important research project, and would like to include the views of someone in your household.

Please be assured that this is a genuine research project, that's completely confidential.

Could I please speak to someone aged 18 or over?

[IF NECESSARY, REPEAT INTRODUCTION]

[DO NOT REVEAL SUBJECT MATTER. IF QUERIED: It's about health issues facing households in NSW. ONLY IF QUERIED FURTHER: The subject matter will become clear once we've started.]

[IF CLIENT QUERIED: I'm sorry, I can't tell you the client's name until the end of the survey, because it might affect the way you answer the questions, but I will be able to tell you at the end.]

IF NECESSARY: I can give you the number of the researcher if you want more information. [Jenny Crawford or Christina Falsone, 9519 2021. OFFER TO CALL REVERSE CHARGES]

Screen

S1. RECORD OR ASK GENDER

- 0 MALE
- 1 FEMALE

S2 To begin with, I need to ask a few questions about your household. Could you please tell me how many children aged 6 years or under live in your household? [NOTE: INCLUDES ALL CHILDREN NOT YET SEVEN YEARS OLD]

[NUMERIC]

[IF ZERO, TERMINATE WITH THANKS]

QD1 Into which of the following age brackets do you fall?

READ

- 1 18-29 YEARS
- 2 30-39 YEARS
- 3 40-49 YEARS
- 4 50-59 YEARS
- 5 60 YEARS OR OVER

S3 How many smokers live in your household?

[NUMERIC]

[IF ZERO, TERMINATE WITH THANKS]

QD2 How many cars does your household have?

[NUMERIC]

Behaviour

When you are answering the following questions, please remember that your answers are strictly anonymous.

Q1 Firstly, has anyone smoked inside your home in the last month?

- 1 YES
- 0 NO
- 98 DON'T KNOW [DO NOT READ OUT]

Q2 [IF QD2=1] Thinking about the car in your household, has anyone smoked in this car in the last month?

- 1 YES
- 0 NO
- 98 DON'T KNOW [DO NOT READ OUT]

Q3. [IF QD2>1] Thinking about the cars in your household, in how many of these has anyone smoked in the last month?

[NUMERIC]

[CODE DON'T KNOW AS 98]

Q4. [IF QD2=1 AND Q2=1] Still thinking about the car in your household, (has the child/have the children) travelled in this car in the last month?

- 1 YES
- 0 NO
- 98 DON'T KNOW [DO NOT READ OUT]

Q5. [IF QD2>1 AND Q3>0 AND Q3 IS NOT 'DON'T KNOW'] Still thinking about the cars in your household, in how many of these cars (has the child/have the children) travelled in the last month?

[NUMERIC]

[CODE DON'T KNOW AS 98]

Q6. [IF QD2>1 AND Q3>0 AND Q5>0 AND QD2 does not equal Q3 AND QD2 does not equal Q5] Now thinking about the car(s) in which (the child/the children) have travelled in the last month, has anyone smoked in (this/these) car(s) in the last month?

- 1 YES
- 0 NO
- 98 DON'T KNOW [DO NOT READ OUT]

Q7. [IF YES AT Q1] You mentioned that people have smoked inside your home in the last month. During this time, has anyone smoked when there are children indoors?

- 1 YES
- 0 NO
- 98 DON'T KNOW [DO NOT READ OUT]

Q8. [IF YES AT Q7] And in the last month, has anyone smoked when there were children in the same room?

- 1 YES

0 NO

98 DON'T KNOW [DO NOT READ OUT]

Q9. [IF QD2=Q2=Q4=1 OR

QD2=Q3>0 AND Q5>0 AND Q5 IS NOT 'DON'T KNOW' OR

D2=Q5>0 AND Q3>0 AND Q3 IS NOT 'DON'T KNOW' OR

Q6=1]

You mentioned that people have smoked in your car(s) in the last month. In this time, has anyone smoked when there were children in the car?

1 YES

0 NO

9 DON'T KNOW [DO NOT READ OUT]

Attitudes

Q10 In general, which one of the following things do you think would make the biggest difference to children's health? [READ OUT, RANDOMISE]

SUN PROTECTION

BRUSHING TEETH

MINIMISING EXPOSURE TO TOBACCO SMOKE

DIET AND NUTRITION

KEEPING IMMUNISATION UP TO DATE

REGULAR EXERCISE

[OFFER TO REPEAT IF NECESSARY]

Q11 I'm going to read out some statements relating to the child(ren) aged 6 or under living in your home. Please tell me how strongly you agree or disagree with each one.

OK, here's the first one. [READ OUT FIRST STATEMENT, DO NOT RANDOMISE]. Do you agree or disagree? Is that strongly or just a little?

I BELIEVE THAT SMOKING IN THE HOME IS UNLIKELY TO AFFECT CHILDREN'S HEALTH

I BELIEVE THAT SMOKING IN THE CAR IS UNLIKELY TO AFFECT CHILDREN'S HEALTH

IF NO-ONE BLOWS SMOKE IN THEIR DIRECTION, THE CHILDREN WILL PROBABLY BE FINE

IF THE WINDOWS ARE WOUND DOWN, IT'S SAFE TO SMOKE WITH CHILDREN IN THE CAR

IF THE CHILDREN ARE IN A SEPARATE ROOM, IT'S SAFE TO SMOKE IN THE HOME

BECAUSE CHILDREN DON'T HAVE A CHOICE, IT'S UP TO ADULTS TO THINK ABOUT WHETHER THERE IS TOBACCO SMOKE AROUND THE CHILDREN

[IF 'YES' AT Q1] SOMETIME IN THE FUTURE, I THINK OUR HOUSEHOLD WILL BAN SMOKING INSIDE THE HOME

[IF D2=Q2=Q4=1] SOMETIME IN THE FUTURE, I THINK OUR HOUSEHOLD WILL BAN SMOKING IN THE CAR

[D2=Q3>0 AND Q5>0 AND Q5 IS NOT 'DON'T KNOW' OR

D2=Q5>0 AND Q3>0 AND Q3 IS NOT 'DON'T KNOW' OR

Q6=1]

SOMETIME IN THE FUTURE, I THINK OUR HOUSEHOLD WILL BAN SMOKING IN ANY CAR IN WHICH THE CHILDREN SOMETIMES TRAVEL

5. STRONGLY AGREE

4. AGREE

2. DISAGREE

1. STRONGLY DISAGREE

3. UNSURE [DO NOT READ OUT]

Knowledge

Q12. The next set of statements is about passive smoking. As before, please tell me how strongly you agree or disagree with each one.

OK, here's the first statement. [READ OUT FIRST STATEMENT, DO NOT RANDOMISE]. Do you agree or disagree? Is that strongly or just a little?

THERE IS NO HARD EVIDENCE THAT PASSIVE SMOKING IS HARMFUL TO CHILDREN

MOST HEALTHY CHILDREN WOULD BE UNLIKELY TO BE HARMED BY EXPOSURE TO PASSIVE SMOKING

TOBACCO SMOKE YOU CAN NO LONGER SEE STAYS IN THE AIR FOR HOURS

PASSIVE SMOKING CAN ONLY HAPPEN WHEN YOU CAN SEE CIGARETTE SMOKE IN THE AIR

ONLY CHILDREN WHO HAVE ASTHMA OR A BREATHING PROBLEM CAN BE HARMED BY PASSIVE SMOKING

PASSIVE SMOKING IS MORE HARMFUL TO CHILDREN THAN TO ADULTS

5. STRONGLY AGREE

4. AGREE
2. DISAGREE
1. STRONGLY DISAGREE
3. UNSURE [DO NOT READ OUT]

Q13 Which illnesses or health problems, if any, do you think children may experience as a result of exposure to passive smoke? [OPEN-ENDED – DO NOT READ OUT. PROBE ONCE ONLY.]

SIDS (SUDDEN INFANT DEATH SYNDROME)
BRONCHITIS
COUGHING
CROUP
ASTHMA/ASTHMA ATTACKS
PNEUMONIA
OTHER BREATHING/LUNG PROBLEMS
THROAT INFECTIONS
EAR INFECTIONS/MIDDLE EAR INFECTIONS (OTITIS MEDIA)
NOSE INFECTIONS / IRRITATE SINUSES
EYE IRRITATION
CANCER (ANY TYPE)
OTHER [RECORD]
NO ILLNESSES OR HEALTH PROBLEMS

Barriers

Q14 Are you, yourself a smoker?

- 1 YES
- 0 NO – SKIP TO NEXT SECTION

Q15 [IF YES AT Q14] The following three statements are about your views on your own smoking. Again, please tell me how strongly you agree or disagree with each one.

Okay, here's the first statement. [READ OUT FIRST STATEMENT, RANDOMISE]. Do you agree or disagree? Is that strongly or just a little?

THERE IS NOT ALWAYS A SUITABLE PLACE OUTDOORS FOR ME TO SMOKE

I WOULD SOMETIMES HAVE TO LEAVE THE CHILDREN UNSUPERVISED TO
SMOKE OUTDOORS

I SMOKE TOO OFTEN TO BE GOING OUTDOORS EVERY TIME

- 5. STRONGLY AGREE
- 4. AGREE
- 2. DISAGREE
- 1. STRONGLY DISAGREE
- 3.UNSURE [DO NOT READ OUT]

Awareness of campaign

These next few questions cover information about passive smoking and children.

Q16 Have you seen any television advertisements in the last month on the subject of passive smoking and children?

- 1 YES
- 0 NO
- 8 HAVE NO TELEVISION – Skip to Q25
- 98 UNSURE

Q17 I'm now going to read a description of a television advertisement. We see a number of parents sharing experiences with their children: such as a mother cuddling her baby, a little girl blowing bubbles and a family on a car trip. While this is happening, a voice talks about the hidden dangers that may be in your home, like the poisonous substances from cigarettes, and we see a cigarette being lit. Towards the end of the advertisement, we see a woman going outside to smoke. The ad ends with a slogan.

Do you recall having seen this particular ad on television in the last month?

- 1 YES
- 0 NO – Skip to Q25
- 98 UNSURE – Skip to Q25

Q18 [IF YES AT Q17] And how many times would you say you have seen this particular advertisement?

[RECORD]

Q19 [IF YES AT Q17] What was the slogan at the end of this advertisement?

[RECORD]

NO RECALL/UNSURE

Q21 [IF YES AT Q17] And which organisation or organisations were behind this advertisement? [DO NOT READ OUT]

CANCER COUNCIL/CANCER COUNCIL NSW

NSW HEALTH/HEALTH DEPT

SIDS AND KIDS NSW

ASTHMA FOUNDATION / ASTHMA FOUNDATION NSW

HEART FOUNDATION / HEART FOUNDATION NSW

OTHER

NO RECALL/UNSURE

Q22 [IF YES AT Q17] Which one or more of the following does the television commercial recommend? [READ OUT, RANDOMISE, ACCEPT MULTI]

IF YOU DO HAVE A SMOKE, SMOKE OUTSIDE

TO GIVE UP SMOKING COMPLETELY

UNSURE [DO NOT READ]

Q23 [IF YES AT Q17] As far as you can recall, which of the following was the main message of this advertisement? Was it [READ OUT, RANDOMISE] ...

DO NOT SMOKE IN YOUR HOME OR CAR WHEN CHILDREN ARE NEARBY, OR
DO NOT SMOKE IN YOUR HOME OR CAR EVEN WHEN CHILDREN ARE NOT
PRESENT

UNSURE [DO NOT READ] – Skip to Q25

Q24 [IF YES AT Q17] What was main reason the advertisement gave for this? Was it [READ OUT, RANDOMISE] ...

TO PROTECT CHILDREN FROM THE HARMFUL EFFECTS OF PASSIVE SMOKE,
OR

TO HELP PREVENT CHILDREN FROM BECOMING SMOKERS LATER IN LIFE

UNSURE [DO NOT READ]

Q25 Have you heard any radio advertisements in the last month on the subject of passive smoking and children?

- 1 YES
0 NO
98 UNSURE

Q26a In the last month, have you seen any other advertisement or promotional material about passive smoking and children? What have you seen? [DO NOT READ OUT. ACCEPT MULTI REPOSE]

PRESS OR MAGAZINE ADVERTISEMENTS ON THE SUBJECT OF PASSIVE SMOKING AND CHILDREN

BILLBOARDS ADVERTISEMENTS ABOUT PASSIVE SMOKING AND CHILDREN

A COLOURING-IN COMPETITION ABOUT PASSIVE SMOKING AND CHILDREN

POSTERS OR BROCHURES ON THE SUBJECT OF PASSIVE SMOKING AND CHILDREN

STICKERS, FRIDGE MAGNETS, OR KEY RINGS WITH THE SLOGAN 'CAR AND HOME, SMOKEFREE ZONE'

OTHER (PLEASE SPECIFY)

NONE OF THESE

Q26b [FOR EACH ITEM NOT MENTIONED AT 26A] And in the last month, have you seen any ... [READ OUT THOSE ITEMS NOT MENTIONED AT 26A. RANDOMISE. ACCEPT MULTI REPOSE]

PRESS OR MAGAZINE ADVERTISEMENTS ON THE SUBJECT OF PASSIVE SMOKING AND CHILDREN?

BILLBOARDS ADVERTISEMENTS ABOUT PASSIVE SMOKING AND CHILDREN?

A COLOURING-IN COMPETITION ABOUT PASSIVE SMOKING AND CHILDREN?

POSTERS OR BROCHURES ON THE SUBJECT OF PASSIVE SMOKING AND CHILDREN?

STICKERS, FRIDGE MAGNETS, OR KEY RINGS WITH THE SLOGAN 'CAR AND HOME, SMOKEFREE ZONE'?

- 1 YES
0 NO
98 UNSURE

Q27 Do you have access to the Internet, either at home or at work?

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION

- 1 YES
- 0 NO
- 98 UNSURE

Q28 [IF YES AT Q27] And have you ever visited the website www.smokefreezone.org?

- 1 YES
- 0 NO
- 98 UNSURE

Q29 I'm going to read out a list of health professionals and other professionals who work with children.

a. In the last three months, which, if any, of these people have you seen? [READ OUT. RANDOMISE. ACCEPT MULTIPLE RESPONSES.]

[RANDOMISE b AND c]

b. Please tell which of the following, if any, you would feel comfortable talking to about the effects of passive smoking on your child(ren). [READ OUT. ACCEPT MULTIPLE RESPONSES.]

c. Please tell which of the following, if any, you believe would provide accurate, factual information about the effects of passive smoking on your child(ren). [READ OUT. ACCEPT MULTIPLE RESPONSES.]

d. [FOR EACH PROFESSIONAL MENTIONED AT 29A] And thinking about the time you saw the [INSERT FIRST HEALTH PROFESSIONAL MENTIONED AT Q29A] during the last three months, have you spoken to them about the effects of passive smoking on your child(ren)?

YES

NO

UNSURE

E. [IF YES] And who raised the issue? Was it you, or was it the [INSERT PROFESSIONAL]? [REPEAT D AND E FOR EACH HEALTH PROFESSIONAL MENTIONED AT 29A]

	a	b	c	d	e
--	---	---	---	---	---

GP	1	1	1	1	1-respondent 2-professional 9-unsure
EARLY CHILDHOOD NURSE	2	2	2	2	1-respondent 2-professional 9-unsure
CHILDCARE CENTRE STAFF	3	3	3	3	1-respondent 2-professional 9-unsure
HOSPITAL STAFF	4	4	4	4	1-respondent 2-professional 9-unsure
ASTHMA EDUCATOR	5	5	5	5	1-respondent 2-professional 9-unsure
UNSURE	9	9	9	9	

Demographics

Thanks for all that. Lastly, I need to ask a few questions to ensure that we have spoken to a good cross-section of people.

Q31 You mentioned that you have [a child/children] aged 6 years or under living in your home. Are you the parent or carer of [this child/any of these children]?

- 1 YES
- 0 NO
- 98 UNSURE

Q32 Could you tell me the highest level of education you have ever attempted?

- 1. NO FORMAL SCHOOLING
- 2. PRIMARY SCHOOL
- 3. JUNIOR HIGH SCHOOL (YEARS 7-10)
- 4. SENIOR HIGH SCHOOL (YEARS 11-12)
- 5. TAFE/TECHNICAL COLLEGE
- 6. UNIVERSITY, OR
- 7. ANOTHER TERTIARY INSTUTION
- 8. OTHER (Please specify)
- 98. UNSURE [DO NOT READ OUT]

Q33 Is the main income earner currently working in paid employment full time, part time or not at all?

- 1 FULL TIME
- 2 PART TIME
- 3 NOT IN PAID EMPLOYMENT.....Go to Q35
- 98 DON'T KNOW
- 99 REFUSED.....99 Go to Q36

Q34 What is the occupation of the main income earner in your household?

[RECORD POSITION & OCCUPATION]

[CODE AS PER ASCO 1 DIGIT]

REFUSED CODE AS 99

Q35 [IF 'NOT IN PAID EMPLOYMENT' AT Q33] Which of the following best describes what they currently do?

- 1 HOMEMAKER/DOMESTIC DUTIES
- 2 FULLTIME STUDENT
- 3 RETIRED
- 4 UNEMPLOYED
- 5 OTHER (PLEASE SPECIFY)
- 98 DON'T KNOW [DO NOT READ OUT]
- 99 REFUSED

Q36 Roughly speaking, is your annual household income before tax more or less than \$40,000? Which of the following ranges would your annual household income fall into? [READ OUT RELEVANT RANGES]

- 1 LESS THAN \$10,000 (\$200 PW)
- 2 \$10,000-\$19,999 (\$200-\$400 PW)
- 3 \$20,000-29,999 (\$400-\$600 PW)
- 4 \$30,000-\$39,999 (\$600-\$800 PW)
- 5 \$40,000-\$49,999 (\$800-\$1,000 PW)
- 6 \$50,000-\$59,999 (\$1,000-\$1,200 PW)
- 7 \$60,000-\$69,999 (\$1,200-\$1,350 PW)

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION

- 8 \$70,000 or over (\$1,350 PW + over)
98 DON'T KNOW [DO NOT READ OUT]
99 REFUSED [DO NOT READ OUT]

Q37 What is the main language spoken in your home?

ENGLISH

OTHER [RECORD]

Q38 Do you identify as an Aboriginal or Torres Strait Islander?

- 1 YES
0 NO
99 REFUSED

Sign off

That's the end of our survey. Thank you for participating. This research is being carried out for the Cancer Council of NSW.

Could I please have your first name, just in case someone from our project team wishes to re-contact you in the next few days to verify some of the information we just collected?

[IF NAME PROVIDED] Once the validation period has finished, please be assured that your name and contact details will be removed from your responses to this survey. In the meantime, you will be able to contact us about your answers. Just to remind you, I'm calling from Eureka Strategic Research. If you have any queries, you can call the Market Research Society's Survey Line on 1300 364 830.

Appendix B

Summary of statistically significant changes in knowledge and attitude statements

The following table shows, for each agree/disagree statement that was used as a knowledge or attitudinal measure, whether any significant changes have occurred in that variable:

- since before the implementation of the campaign (i.e. comparing the final campaign evaluation results with the February/March 2002 baseline data)
- since the pre-2005 media survey (i.e. comparing the final campaign evaluation results with the December 2004 data)

An alpha level of 0.05 has been used as the criterion for determining statistical significance.

Statement	Sig different from baseline survey? (Feb/Mar 2002)	Sig different from pre-2005 media survey? (Dec 2004)
I BELIEVE THAT SMOKING IN THE HOME IS UNLIKELY TO AFFECT CHILDREN'S HEALTH	Yes	No
I BELIEVE THAT SMOKING IN THE CAR IS UNLIKELY TO AFFECT CHILDREN'S HEALTH	Yes	No
IF NO-ONE BLOWS SMOKE IN THEIR DIRECTION, THE CHILDREN WILL PROBABLY BE FINE	Yes	No
IF THE WINDOWS ARE WOUND DOWN, IT'S SAFE TO SMOKE WITH CHILDREN IN THE CAR	Yes	No
IF THE CHILDREN ARE IN A SEPARATE ROOM, IT'S SAFE TO SMOKE IN THE HOME	Yes	Yes
BECAUSE CHILDREN DON'T HAVE A CHOICE, IT'S UP TO ADULTS TO THINK ABOUT WHETHER THERE IS TOBACCO SMOKE AROUND THE CHILDREN	Yes	No
THERE IS NO HARD EVIDENCE THAT PASSIVE	No	No

THE ETS AND CHILDREN PROJECT TASKFORCE
ETS AND CHILDREN: FINAL CAMPAIGN EVALUATION

SMOKING IS HARMFUL TO CHILDREN		
MOST HEALTHY CHILDREN WOULD BE UNLIKELY TO BE HARMED BY EXPOSURE TO PASSIVE SMOKING	Yes	No
TOBACCO SMOKE YOU CAN NO LONGER SEE STAYS IN THE AIR FOR HOURS	No	No
PASSIVE SMOKING CAN ONLY HAPPEN WHEN YOU CAN SEE CIGARETTE SMOKE IN THE AIR	Yes	No
ONLY CHILDREN WHO HAVE ASTHMA OR A BREATHING PROBLEM CAN BE HARMED BY PASSIVE SMOKING	Yes	No
PASSIVE SMOKING IS MORE HARMFUL TO CHILDREN THAN TO ADULTS	No	No
THERE IS NOT ALWAYS A SUITABLE PLACE OUTDOORS FOR ME TO SMOKE	Yes	No
I WOULD SOMETIMES HAVE TO LEAVE THE CHILDREN UNSUPERVISED TO SMOKE OUTDOORS	No	No
I SMOKE TOO OFTEN TO BE GOING OUTDOORS EVERY TIME	Yes	Yes