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Original Investigation

New Zealand Smokers' Perceptions of Tobacco Endgame Measures: A Qualitative Analysis

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Abstract

Introduction: New Zealand's equity-focused endgame goal (Smokefree 2025) aims to reduce smoking prevalence to minimal levels (ie, <5%) in all population groups by 2025. Inadequate progress has stimulated discussion of innovative measures to reduce prevalence; because few studies have explored how marginalized groups perceive these measures, we addressed this knowledge gap.

Aims and Methods: In November and December 2020, we conducted 20 in-depth interviews with people who smoked daily, were aged between 21 and 53, earned less than the median income (NZD33 900), and had marginal or inadequate income sufficiency. We explored participants' smoking history and used an elicitation exercise to probe their views on smokefree policies, including potential endgame measures. We used qualitative descriptive analysis and reflexive thematic analysis to interpret the data.

Results: Participants favored increasing personal support to quit and reducing nicotine levels in cigarettes, but generally opposed tobacco excise tax increases and paying people to quit. While many privileged their right to "choose," some recognized that stronger policies could restore the loss of agency addiction caused. Participants felt smoking's powerful addictiveness remained poorly understood, and called for smoking to be recognized and treated as an addiction.

Conclusions: Several participants supported intensifying existing measures or introducing new measures. However, their use of tobacco industry rhetoric to frame smoking as a choice they had made could inadvertently reinforce the stigma they experienced. Reframing cigarettes as an addictive product engineered by a deceptive industry, may make it easier for participants to access the expanded support and compassion they sought.

Implications: Policy measures, such as reducing the nicotine level in cigarettes, could support endgame goals; however, greater public understanding of addiction is needed to reduce stigma, support self-efficacy, and foster smoking cessation. Industry denormalization campaigns could challenge views of smoking as a personal choice, decrease self-blame among people who smoke, and present endgame goals as likely to enhance agency.

Introduction

First proposed by Māori health leaders in 2010, New Zealand's equity-focused tobacco endgame goal (the Smokefree 2025 goal) aims to limit tobacco availability and reduce smoking prevalence to less than 5% in all population groups by 2025.[1] It represents a fundamental shift away from a "tobacco control" philosophy, which implicitly accepts tobacco use will continue in regulated settings.

Further, it requires greater consideration of groups bearing a disproportionate burden of tobacco-related harm,[2,3] including people experiencing higher material deprivation,[4] and Indigenous peoples.[1,5] The goal recognizes that tobacco use compounds existing social inequalities; people who use smoking to cope, and who live in settings where smoking is normative, often have lower self-efficacy for quitting.[6,7] People with fewer financial resources, and less social support, may also be less likely to become smokefree.[6,7]

Population measures to reduce smoking prevalence have decreased overall smoking rates in New Zealand, although marked disparities in smoking prevalence persist.[1,4] For example, policies removing tobacco point of sale displays, increasing tobacco tax, and introducing plain packaging have contributed to declines in current smoking prevalence from 18.2% in 2011/12 to 13.4% in 2019/20.[8,9] Nonetheless, smoking prevalence remains more than twice the 2025 goal, prompting concerns the goal will not be met without new measures that ensure equitable outcomes for all population groups.[10,11]

Public support for further tobacco control measures has provided the NZ Government with a mandate to explore new policy options, particularly those reducing the availability and addictiveness of tobacco.[12–14] Growing international discussion of endgame approaches that go beyond "business as usual" strategies has also emboldened thinking and stimulated interest in structural changes, where tobacco is no longer considered a legitimate consumer product entitled to be sold alongside everyday products.[5,15–18] However, perceptions of endgame strategies have varied and will have greatest impact on population groups already experiencing other forms of disadvantage.[12] For example, increased excise taxes may increase financial stress among people who have lower material well-being while expanded smokefree areas could compound experiences of stigma and exclusion.[19,20] Before introducing further measures, it is important to explore perceptions held by the people these policies target.[21,22]

Earlier work with people who smoke has highlighted a tension between their desire to become smokefree and measures introduced to decrease smoking prevalence. For example, some view excise taxes as inherently unfair because the policy affects people on lower incomes more than those on higher incomes,[19] while others report smoking's increased denormalization has created stigma they find hard to manage.[20,23] Yet, despite these insights, we lack in-depth knowledge of how people experiencing higher material deprivation perceive enhanced existing policies and novel measures that could achieve the Smokefree 2025 goal. We addressed this knowledge gap using in-depth qualitative interviews to probe people's experiences and sense-making in ways not possible using quantitative approaches or other qualitative approaches such as focus groups.

Methods

Sample and Recruitment

IB and JH recruited participants using social media posts on local Facebook groups and community advertising, targeting organizations (eg, Salvation Army and St Vincent de Paul) that support people experiencing higher deprivation. Interested people were directed to an online eligibility survey where we collected information on their smoking practices, income, and income sufficiency (among other topics). People meeting our inclusion criteria (daily smoking, overall income less than 40% of the median income, and marginal income sufficiency or below)[24] were sent a copy of the information sheet and, if they wished to participate, an interview was organized. Of the 96 contacts, 64 met the inclusion criteria and were sent an information sheet; of these, 32 agreed to participate in the study, and 20 aged between 21 and 53 successfully completed an interview (Supplementary File 1 outlines the recruitment phases). A delegated authority from the University of Otago's Human Ethics Committee reviewed and approved the project (ref. D20/383). A Māori colleague provided feedback and we consulted with the Ngāi Tahu Consultative Committee, which advised on the study's relevance to Māori.

Interview Protocol and Data Collection

All participants gave written consent after reviewing a hard copy of the information sheet with the researchers, who answered any questions they had. We used a semistructured interview guide that enabled flexible movement between topics to explore participants' smoking history and perceptions of the Smokefree 2025 goal. We examined eight potential measures, including endgame interventions (eg, reducing nicotine to non-addictive levels, greatly reducing the number of outlets permitted to sell tobacco products) and intensified existing measures (eg, tobacco excise taxes). Using an elicitation exercise, we asked participants to rank each measure according to how effective they thought it would be in achieving the 2025 goal. We offered participants a $40 gift voucher (not redeemable for tobacco) to recognize any costs they incurred by participating in the study. Supplementary File 2 contains the interview materials.

Interviews took place from November to December 2020 and lasted between 42 and 66 minutes; they were conducted in private offices and meeting rooms within a downtown university building. We prepared notes following each interview and reviewed the interview guide to incorporate ideas elicited during earlier interviews. We ceased recruitment when we reached data saturation (defined as no new idea elements evident in two consecutive interviews and tested in two further interviews).

Data Analysis

With participants' permission, we audio-recorded interviews; an online transcribing service (rev.com) transcribed these verbatim and IB checked all transcripts for accuracy. We first examined responses to the different measures participants considered using qualitative descriptive analysis, an approach Sandelowski described as staying close to participants' words.[25] IB and JH treated each intervention as a code and developed subcodes to group common responses to the measures explored. To develop an initial descriptive coding framework, we analyzed three transcripts independently, reviewed and agreed on draft subcodes, then coded a further two transcripts and undertook a similar review to reach consensus. IB used this initial framework to code the transcripts using NVIVO 12. IB and JH met frequently during this period to discuss and develop codes that represented new ideas we identified as we read, reread, and discussed the transcripts. Supplementary File 3 contains a summary of the descriptive codebook developed.

During this iterative process of reading and rereading transcripts and interview notes, we paid particular attention to recurring metaphors that indicated shared meanings and used these to develop themes, or "organising constructs."[26] Following Braun and Clarke's reflexive thematic analysis approach, we again read and reread transcripts and our interview notes, reflected on our interactions with participants, and developed, debated, and refined the themes reported.[27–29] In creating these latter themes, we used a social constructionist epistemology that aligned with our interest in

participants' lived (and projected) experiences of changing policy and social contexts.

As health researchers, we brought diverse research knowledge to this study[26]; nonetheless, we differ from our participants in our life experiences and current tobacco use. To maintain sensitivity to these differences, we consulted members of our wider research group and drew on past experiences working with marginalized populations when formulating the research questions and study design. While interpreting the data, IB and JH frequently contrasted the roles tobacco played in participants' lives with the wider tobacco endgame goal sought by health researchers. These contrasts informed the overarching themes presented, which we subsequently shared with participants to invite their feedback.

Results

Seven participants were male; 20 identified as New Zealand European (NZE), and two as NZE and Māori; education levels varied from no formal qualification to postgraduate qualifications. All reported daily smoking (mean: 18 cigarettes per day; range: 2–60 cigarettes per day). Table 1 contains each participant's demographic details (names are pseudonyms).

Although they had differing interpretations of the Smokefree 2025 goal, participants generally supported the idea of reducing smoking prevalence to 5% or below.[30] We present their reactions to the eight interventions explored according to each measure's perceived effectiveness and ranking in the elicitation exercise (see Supplementary File 4).

More Extensive Personal Support

Without exception, participants had found quit attempts to be isolating journeys, often with little social support or follow-up from professionals: "*It's one of the hardest things I've had to do*" (Megan). They felt judged and had tried to distance themselves from the stigma of smoking which, ironically, prevented them from accessing support. Holly explained: "*I'd felt a little bit embarrassed by them trying to give me support…cause I just didn't want to admit to myself that I was a smoker at the time…I didn't want to have that label on me*."

Participants called for more intensive face-to-face personal support and follow-up, and wanted access to services similar to those used to treat other addictions. They made repeated requests for personal outreach, tailored advice, and more diverse support options when discussing other measures. However, many wanted support on their terms and believed decisions about whether, when, and how to quit should reside with them: "*It's still a choice thing. You can't ram it down* someone's *throat*" (*Olivia*).

Reduce Nicotine to Non-addictive Levels

Participants agreed that reducing nicotine levels to non-addictive levels would simplify quitting: "*I think it would work because, yeah, it is the nicotine that gets you addicted and the less of it you have, the less you need to satisfy that itch*" (*Samantha*). Some believed nicotine levels already varied between different cigarette brand variants, or thought they should so people could titrate their own dose. A minority opposed this measure, which they thought would deprive them of nicotine and complicate stress management: "*Nicotine is what we need…you decrease that, you're not treating stress levels*" (*Olivia*).

A small group felt concerned about unintended responses, such as growth of a black market; others thought compensatory smoking would follow and exacerbate financial hardship (as well as health risks): "*Well, you'd like to think they'd smoke less as their body's needing less, but it could backfire couldn't it? And go totally the opposite direction and they might want more, then spending more money to buy more*" (*Katie*). Despite these minority views, participants generally supported this measure.

Remove Additives

Several participants supported removing additives from tobacco to reduce the pleasure of smoking, which they felt would motivate them to quit. "*Um, that would definitely put me off…this sounds really silly, but, um, my smokes smell like raisins to me, and that probably does actually help me smoke them. But if they were really harsh…I*

Table 1. Participants' Demographic Characteristics and Smoking Behaviors

Pseudonym	Gender	Age	Ethnicity	Education	Income	Cig/day
Alan	NB	31	NZ Euro	No formal qual	$15–20k	30
Charlotte	F	38	NZ Euro	Bachelor's Degree	$25–30k	20
David	M	24	NZ Euro	Certificate/Diploma	$5–10k	8
Emma	F	28	NZ Euro/Māori	No formal qual	$10–15k	30
Fran	F	48	NZ Euro	Certificate/Diploma	$15–20k	60
Gavin	M	21	NZ Euro/Māori	School-level	$20–25k	10–15
Holly	F	25	NZ Euro	Bachelor's Degree	$20–25k	5
Ian	M	38	NZ Euro	Certificate/Diploma	$15–20k	18
James	M	45	NZ Euro	School-level	$20–25k	20–25
Katie	F	52	NZ Euro	Certificate/Diploma	$15–20k	30
Laura	F	28	NZ Euro	School-level	$25–30k	2
Megan	F	53	NZ Euro	No formal qual	$30–35k	10–20
Nick	M	45	NZ Euro	No formal qual	$15–20k	10–15
Olivia	F	38	NZ Euro	Bachelor's Degree	$15–20k	20–30
Paul	M	48	NZ Euro	Bachelor's Degree	$25–30k	6
Quinn	F	35	NZ Euro	School-level	$30–35k	20
Rebecca	F	38	NZ Euro	Post-grad	$30–35k	10–15
Samantha	F	22	NZ Euro	Certificate/Diploma	$5–10k	5–10
Tom	M	37	NZ Euro	Certificate/Diploma	$25–30k	16
Ursula	F	26	NZ Euro	Certificate/Diploma	$25–30k	2

probably wouldn't be inclined to bother with them, or not as much, anyway" (*Holly*). Some thought lower palatability would also discourage smoking uptake: "*It will just completely turn a lot of people off*" (*David*).

However, others felt cigarettes already tasted unpleasant and thought smokers' overwhelming need for nicotine would outweigh the less appealing taste: "*If I was desperate, I would smoke anything.*" (*Charlotte*) Fran described how, in desperation, she had smoked discarded butts and suggested people would grow accustomed to less pleasant experiences, so long as they could still access nicotine: "*By the time you've rerolled something the third time, it's pretty freaking hard on your throat but…it actually doesn't matter. You're going to do it anyway…as long as you're getting your hit.*"

Subsidized Electronic Nicotine Delivery Systems

Most participants supported reducing cost barriers impeding Electronic Nicotine Delivery Systems (ENDS) use and thus the risk of buying an ENDS and discovering they did not like it. Fran explained: "*When you are transitioning, so you're still smoking tobacco and you're vaping, it ends up becoming more expensive because you're buying both*" (*Fran*); some thus wanted expert advice to support switching. However, others saw ENDS as potentially as risky as smoking: "*It took them how many years to figure out that smokes kill us, the same could be for vapes, you know?*" (*Quinn*). Even those who saw ENDS as less risky, found themselves in a minority, as Laura explained: "*Lots of people think that everything in e-liquid is the same as what's in cigarettes and that it's better the devil you know than the devil you don't know.*"

Others worried ENDS may not support switching and would instead continue their nicotine dependence: "*I don't know if I would use a vape to personally try and quit smoking myself. Yeah. 'Cause then I just know I'd get hooked on the vape. And that the vape wouldn't actually be a- I wouldn't progress off the vape and to nothing. I would just keep the vape*" (*Holly*).

Expanded Smokefree Areas

Those who supported expanding smokefree areas felt this measure would reduce cues to smoke and the ease with which they could currently light up; Emma explained: "*If I'm shopping, I have a smoke out the street. Whereas if you can't then you hold off that extra hour…the little things like that all lead up to…like giving up*." Many thought it important to respect nonsmokers and the measure sat well with their "considerate smoker" identity: "*Smokers make the choice to smoke. Non-smokers make their choice. Smokers shouldn't be making that choice for non-smokers…, I feel horrible if I'm walking down the street and I'm having a cigarette and somebody walks by.*" (*Tom*) Some saw environmental benefits, with less tobacco waste in public areas, though others thought acceptability would vary according to how open an area was; they supported restrictions in crowded spaces, such as shopping areas, though not in more open spaces, such as beaches.

Several felt monitoring and enforcement would be required; others questioned whether expanding smokefree areas would support the 2025 goal, and some felt this measure could be circumvented. Holly explained: "*If you've got an addiction to smoking… you'll go back to your car, you'll go around the corner, you'll find somewhere*."

Greatly Reduced Retail Availability

Most participants thought reducing the availability of tobacco would not be effective as people would drive "*even if they're on gas light*" (*Gavin*) and go "*until the end of the earth probably*" (*Paul*) to satisfy their cravings. Others disagreed and acknowledged that wide availability made smoking easier; they thought fewer outlets would encourage cessation and reduce children's exposure: "*Having it around less would also be good for the fact of children seeing it, um, and that is partly the problem*" (*Ian*).

Participants valued the convenience of obtaining tobacco yet detested the temptation it presented: "*It's just so easy, isn't it, to get 24 hours a day now*" (*Charlotte*). Some strongly opposed dairies selling tobacco because of poor compliance, robberies, and exposure to children; however, a minority felt concerned about the impact removing tobacco from small businesses could have on these stores' viability.

Payments to Quit

While participants liked the idea of receiving money to quit smoking, they felt skeptical about the likely outcomes: "*If I was paid to give up smoking, I would like to say yes, but there's no guarantees that I could*" (*Megan*). Some thought the money would support tobacco purchases: "*People will probably spend their money on cigarettes anyways…the incentive is always spent on where it shouldn't be*" (*Olivia*). Others echoed "personal responsibility" arguments, thought people might game the system, and opposed paying people who had initially chosen to smoke: "*I really don't like that one…I see how that would be a great incentive, but I also see how unfair that it is on the rest of New Zealand who doesn't smoke. Because at the end of the day, we've made a choice, we shouldn't get rewarded for not doing a bad thing*" (*Laura*).

Continued Tax Increases

Some participants recognized that rising tobacco prices had prompted them to consider quitting: "*Money's one of my real big, um, motivations for quitting. Uh, but I think nicotine is kind of too addictive to keep putting up the price*" (*Samantha*). However, several believed people would smoke regardless of price by displacing other purchases: "*I'll buy smokes regardless. If they're $100 this week I'd still buy them…but then I'd have to go without something else*" (*Ian*). Most thus strongly opposed continued tax increases, which they thought ignored addiction, exacerbated financial hardship and stress, penalized children, and disproportionately affected people with low incomes or little agency. Nonetheless, a minority supported further tax increases, provided that the revenue generated was used to help people quit.

Overarching Themes

As they considered different measures, participants often referred to what they saw as their right to choose whether, when, and how to quit smoking. While most privileged freedom above constraint, others recognized that constraint could be a prerequisite for freedom and were willing to forgo some autonomy if doing so would rid them of their addiction. Alongside asserting their rights, several people reflected on the loneliness of managing denormalization, which some experienced as stigma, and called for greater recognition of smoking as a powerful and all-consuming addiction. We discuss these two overarching themes below.

Autonomy

Several participants erroneously interpreted the Smokefree goal as banning tobacco, which they saw as removing a fundamental freedom: "*It's a choice that we make for ourselves. It's not a choice that the government should be making for us*" (*Olivia*). Using metaphors of constraint and retribution, they described a ban as akin to living "*in a dictatorship*" (*Rebecca*) and analogous to punishment meted out to those who transgress against society: "*When you go to prison, you can't smoke…that's your punishment. Punishing just the general public is wrong*" (*Ian*).

This view shaped assessments of different measures; several saw tax increases as attempts to restrict choice: "*It would probably make people angry, it takes people's choices away*" (*Rebecca*). However, some instead suggested reducing tobacco prices, which could create agency, enhance self-efficacy, and support quitting. "*I know it wouldn't be a popular opinion but to reduce the price to help people, sort of, not become stressed in their own life…it would help them to have more money in their pocket, and then they may begin to like it, and then want to step away from smoking too*" (*David*). Similarly, rather than constrain choice by reducing nicotine in cigarettes, some proposed selling cigarettes with different nicotine levels, to enhance choice: "*It's gotta be people's choice because otherwise they will just end up smoking another cigarette, and another cigarette, which is damaging their lungs even more*" (*Ian*). More fundamentally, perceptions that measures would remove autonomy posed an existential challenge and led several participants to assert that, no matter what the government might decide, "*people will always find a way*" (*Tom*).

However, a parallel perspective sat alongside these trenchant assertions of choice and participants differed according to whether they wanted to assert or relinquish autonomy. Some favored even stronger measures than those others had rejected, including prohibiting smoking; Nick explained: "*I think the aim should be 0%* [smoking prevalence]. *Straight up…If you don't have a choice, then you don't have a choice. Simple as that.*" Laura presented similar arguments: "*… if we're going to do this, let's do this. But my goal* [banning smoking] *makes more sense…this* [reducing smoking to five percent or below] *isn't going to help people stop smoking. This is just, 'Oh, we're going to try.'*" These participants saw the short-term discomfort of managing without tobacco as a pathway to greater freedoms: "*Wouldn't bother me. In all honesty, if they* [cigarettes] *weren't on the shelves, or I didn't probably notice it around as much, I probably wouldn't feel as compelled*" (*Tom*). Some went further and saw the route to autonomy requiring a voluntary relinquishment of their freedoms; they sought a rehabilitation program where others would make their day-to-day decisions. Fran declared: "*I need to [be] locked up in a place for a fortnight, or whatever it is,…and have a real full on programme around addiction and everything*" (*Fran*).

Search for Understanding

Regardless of their views on autonomy, participants saw smoking as a physiological dependence that undermined their choice and shaped their priorities. Fran explained: "*A lot of people say it's a habit or, you know…Why are you doing that? You can't afford it? Or why are you buying that instead of food or whatever? Well, I mean, when you are addicted to, to, to something, then it becomes the priority.*"

They felt hurt by others' judgment, which they felt stemmed from a pervasive misunderstanding of addiction. Ian told of his experiences: "*People tend to look at you like in disgust if you are smoking. But a lot of them, they, they don't understand what it's actually like to be a smoker, and it's not as easy as just throwing them away and never smoking again.*" Quitting required them to put aside the tool they used to manage difficult, lonely and sometimes chaotic lives, a thought that caused great anxiety: "*I'm really scared of it* [quitting]*…I'm scared of losing it a, a best friend*" (*Katie*).

Some, like Samantha, supported smoking's loss of social acceptability, which she thought could deter uptake among young people: "*I don't think it* [smoking] *should be seen as cool… because that's how I got started when I was young… I'm quite glad that society looks down upon it.*" However, she felt "anyone" could be a smoker and did not have the same intense experience of negative stereotypes that affected others. who desperately wanted to belong to the socially normative group. Their history of failed attempts undermined their confidence in quitting, which was their pathway to acceptance. They felt trapped outside social norms, yet powerless to comply with these, and saw themselves as worthless in others' eyes: "*I think most people who don't smoke view smokers as lesser humans*" (*Laura*) and "*It* [people staring] *makes me feel bloody small. Like I'm not worth anything to them*" (*James*). These metaphors of diminishment threatened participants' agency and may have left them less able to make a successful quit attempt.

Participants called for smoking to be treated in the same way as other addictions, such as alcohol dependence, with similar support provided. Emma explained: "*People don't necessarily reach out a hand to help someone that says, 'Ah, I don't wanna smoke,' you know? Like you can go and say, 'Hey, I've got a drug problem,' and you get…you know what I mean? But if you go to someone and say, 'Hey, I have … a smoking addiction,' people don't look at you like, 'Oh hey, I'll help you.' That's more of a, 'Oh, give up.' You know?*" (*Emma*).

As well as increasing understanding of smoking as an addiction, participants sought greater understanding and compassion from others: "*People respond better to positive affirmation and positive feedback…I just think it needs to be handled really carefully so that people who are smokers aren't made to feel bad or lesser than*" (*Fran*). Thus although they supported the smokefree goal, they worried that people who continued to smoke would become increasingly isolated: "*It'd be a pretty lonely place at the end of the day wouldn't it*" (*Tom*).

Discussion

Participants' views on enhanced and novel endgame measures varied; they mostly favored increasing personal support and reducing nicotine levels in cigarettes, but opposed further excise tax increases and paying people to quit smoking. Despite resisting measures they felt would coerce quitting, some recognized addiction had robbed them of agency and thought innovative measures, such as reducing tobacco supply, could support them to quit. However, several felt marginalized, unsure if they could manage without tobacco, and despondent that repeated failures to quit had left them on the fringes of a society that did not understand their predicament.

Although participants supported the smokefree goal in principle,[30] they wanted to realize it on their own terms; nonetheless, some recognized that ceding autonomy could create a pathway to becoming smokefree.[22] Few considered the tobacco industry's role in causing addiction; none recognized that asserting smoking as a right, or accepting they had "chosen" to smoke, mirrored industry "personal responsibility" rhetoric.[12,31] California has successfully used an industry denormalization strategy (ie, exposing underhand tactics used to promote tobacco products and undermine public health

measures designed to reduce smoking prevalence) to reduce youth smoking. Several studies report associations between anti-tobacco attitudes and lower risks of smoking experimentation.[32–35] Adopting this approach could increase understanding of how tobacco companies have shaped public discourse, and potentially increase support for measures that may appear more coercive, such as reducing nicotine content in tobacco products or restricting where tobacco may be sold.[12–14,21,36,37]

Participants' strong desire for increased personal support and their experiences of stigma and social exclusion align with earlier findings.[19,22,38] Hypothecating excise tax could fund the more intensive personal support participants sought, as well as other interventions, though NZ governments have not yet adopted this recommended measure.[39] International interest in reducing nicotine to nonaddictive levels has grown and creates new intervention opportunities[40]; this measure has support from people who smoke,[12,14] and could dramatically reduce harms caused by smoking by increasing quitting,[41] particularly if paired with greater ENDS availability.[42]

Predictably, most participants did not favor interventions that would reduce the convenience of smoking and challenge the autonomy they privileged. They opposed reducing tobacco's availability and further excise tax increases,[13] though their lack of support may also indicate a measure's potential effectiveness.[22] Nonetheless, participants cited potential adverse outcomes noted in earlier studies,[19] making it crucial that interventions likely to increase hardship are accompanied by increased support and greater access to lower risk alternatives.

Earlier studies of smokers, nonsmokers, and former smokers found support for ending tobacco sales in Hong Kong, Canada, Australia, and New Zealand, a stronger measure than we explored.[12,43–45] Participants' lack of support for reducing tobacco availability may reflect their reliance on smoking as a coping tool as much as their nicotine dependence. These responses suggest a communications campaign, developed with communities to explain the goal, describe and justify new measures, and outline cessation support available, could assuage concerns and potentially increase support. A denormalization campaign exposing how the tobacco industry has undermined autonomy, and framing the goal as enhancing rather than detracting from agency, could also facilitate acceptance of new measures.

Participants' reaction against what they perceived as coercion, and their assertion of agency over smoking and quitting, reinforces earlier studies examining nicotine and addiction.[22,46] We extend these studies by presenting autonomy as a continuum anchored by those calling for autonomy, at one end, and those willing to cede autonomy to gain freedom from addiction, at the other. Participants' implicit reliance on tobacco industry arguments regarding choice suggests greater industry denormalization could reframe endgame goals as empowering. However, successful reframing requires a more supportive cessation environment; as smoking has lost social acceptance, participants have felt unsupported, stigmatized, and excluded, which risks diminishing the self-efficacy they need to quit.[19,23] Future work could explore participants' call for enhanced support and identify service attributes they would find most helpful.

Our study has several limitations. Because we aimed to develop an in-depth knowledge of how lower income smokers perceived potential smokefree interventions, we recruited a diverse rather than representative sample, though we note diversity is typically regarded as a strength of qualitative work.[25] Surveys are needed to quantify the responses we elicited, though it will be important to consider that estimates may indicate the least inconvenient, rather than the most effective, measures. Although we cannot generalize our findings, they provide rich insights into how new or expanded interventions could affect smoking's position in people's everyday lives.

Despite aiming to recruit people with diverse ethnicities, only two participants identified as Māori and we had no Pacific participants; given higher smoking prevalence among these groups, further targeted research, conducted by Māori and Pacific peoples, will be important. We explored only eight interventions; other measures may have elicited stronger support or been seen as more effective than those we used, and future research could expand the ideas tested. Despite explaining each measure, participants' understanding of novel and rapidly evolving measures, such as denicotinized cigarettes and e-cigarettes, varied; further work is required to probe perceptions of more complex interventions.

Our research raises important questions about how tobacco industry arguments have infiltrated public discourse and shaped views of smoking as a choice or habit, not an addiction. We believe policy makers could challenge this discourse by implementing measures that recognize tobacco products are not normal consumer items. Pursuing an endgame goal could change current perceptions, which implicitly blame people for continuing a behavior many are desperate to stop. Several participants sought greater understanding and support; as 2025 draws closer, fostering greater compassion for people who smoke could be as crucial as changing the environment to reduce tobacco products' availability and addictiveness.

Supplementary Material

A Contributorship Form detailing each author's specific involvement with this content, as well as any supplementary data, are available online at https://academic.oup.com/ntr.

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Declaration of Interests

None declared.

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