

ENVIRONMENTAL DETERMINANTS

Smoke, smoking and cessation: the views of children with respiratory illness

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Abstract

Objective: To explore the attitudes of Māori (indigenous New Zealanders) and Pacific children with respiratory illness towards smoking, secondhand smoke (SHS) and smoking cessation. **Methods:** Forty-one Māori and Pacific children (aged 6–11 years) in New Zealand (NZ) were interviewed about their attitudes towards smoking, how SHS affects them and their respiratory disease, ideas they have about how to reduce SHS exposure, their fears and concerns about smoking, and experience asking parents to quit smoking. The interviews were transcribed and deductively analysed. **Results:** The children said that SHS made them feel “bad,” “angry,” “uncomfortable” and “really sick,” making them want to get away from the smoke. They were aware that smoking “is dangerous” and that “you could die from it.” Many children had fears for smokers around them. The children reported on rules restricting smoking around children: “You’re not allowed smoke in the car where babies are.” A number of children reported that adults complied with those rules, but some reported that people still smoked around them. The children had experienced people around them quitting and had an awareness of how difficult it is to quit smoking. The most common reason perceived for quitting was concern for children. A lot of the children thought they could ask parents to quit and other suggestions included hiding people’s tobacco, and use of smoke-free pamphlets, or signs. **Conclusions:** Even young children from low socioeconomic minority groups are aware of the dangers of smoking and SHS, and hold negative views about smoking. Health promotion messages for parents could have more weight if they convey the concerns voiced by children.

Introduction

There is strong and consistent evidence that exposure to secondhand smoke (SHS) causes chronic respiratory symptoms and induces asthma in children [1,2]. There is a link between household smoking and childhood asthma [3]. Further, exposure to SHS has also been associated with increased severity of asthma in children [4]. The prevalence of asthma is higher for Māori (the indigenous people of New Zealand (NZ)) children than Pacific Island or European children (20%, 15% and 15%, respectively) [5]. A larger proportion of Māori and Pacific Island, compared with European, children have symptoms of severe chronic asthma [6]. Between 2003 and 2005, the leading cause of admission to a public hospital among 1–4 years old was respiratory disease [7]. In children aged 0–14 years, hospitalisation rates for bronchiectasis were twice as high in Māori children than

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non-Māori children (29.1 per 100 000 in Māori compared with 14.2 per 100 000 in non-Māori) [7]. Although there are multiple determinants of acute respiratory illness amongst children (such as low social class, poor housing and poor nutrition), SHS exposure is arguably the most readily amenable risk factor to modification. It is likely that exposure to SHS contributes to ethnic health disparities for children [8]. Unfortunately, the inequality between European and Māori or Pacific Island children is increasing: between 1993 and 2003, the prevalence of current wheezing increased for Māori and Pacific Island (0.12% and 0.49%, respectively) and decreased for European children (–0.25%) [9].

Eighteen per cent of NZ adults smoke cigarettes regularly. However, the prevalence is substantially higher among Māori and Pacific Island people (41% and 26%, respectively) [10], and has shown few signs of reducing between 2006 and 2012 [10]. Furthermore, 62% of Māori and 45% of Pacific Island 14- to 15-year-old children report that one or both of their parents smoke, which is substantially higher than for NZ European 14- to 15-year-old children (31%) [11].

Although it has been found that children’s asthma negatively impacts on parents’ quality of life [12], few studies have investigated how parental smoking impacts on children’s quality of life or children’s attitudes to smoke, smoking and quitting. One study of children with pulmonary disorders

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found that children thought smokers should try to quit, and were in favour of smoking bans [13]. Another study, conducting focus groups with asthmatic Puerto Rican children, found that children identified a need for reduction in SHS exposure [14]. Parents influence the development of their children's attitudes and values towards health behaviours, such as smoking [15]. However, the influence is bi-directional: children and adolescents also influence parents' health behaviours [15–18]. For example, daughters give their mothers health advice [16,18], parents “give in” to children and buy unhealthy food [19], and children have been shown to influence parents in a cessation intervention [15]. Thus, to increase efficacy, health promotion campaigns should consider both parents and children as a source of influence on changing health behaviour [17].

In NZ, it has been found that for Māori and Pacific Island smokers, the most important reason for quitting is: for their children, in order to be a positive, smoke-free, role-model and for children's health [20]. Furthermore, it has been found that NZ parents want to quit smoking to reduce the risk of their children becoming smokers [21]. The Government recognises that children are particularly vulnerable to SHS exposure, and that children are often not able to avoid the exposure [22].

Given the devastating effects of smoking on respiratory health, and the high smoking prevalence among Māori and Pacific Island people, reducing smoking among Māori and Pacific Island people, in particular parents of asthmatic children, is urgently needed. The need to understand more about children's exposure to SHS was identified as a research need in the Governments response to the Māori Affairs Select Committee's Report on tobacco [23]. However, although there has been some previous research into children's perceptions relating to parents' health behaviour, there has been no research in NZ investigating children's perceptions of parents' smoking. The aim of this study was to explore the attitudes of Māori and Pacific children with experience of respiratory illness towards smoke, smoking and smoking cessation.

Methods

Design

Given the dearth of literature on children's attitudes to smoking, especially in NZ and among Māori and Pacific children, a qualitative exploratory approach using focus group [12] and individual interviews [7] was used.

Participants

Participants were 41 children recruited from the North Island of NZ. Inclusion criteria were a respiratory condition such as asthma, Māori or Pacific Island, and aged 6–10 years. Participants were recruited in May and September 2012 from two low socioeconomic primary schools in South Auckland, August 2012 from Hapai Te Hauora Tapui Ltd Auckland, September 2012 from West Fono Health Trust in West Auckland, September 2012 from Kokiri Marae Tukotahi Māori Asthma in Wellington, October 2012 from The Asthma Society Whangarei and November 2012 via researchers' networks. Contacts from these organisations helped identify eligible children. If three or more children of similar age (e.g. 6–7 years or 8–9 years) were identified, they were interviewed as a group if this was able to be arranged. Single children of an age recruited in a location were interviewed alone.

Data collection

The interview schedule contained questions and prompts on: (1) children's attitudes towards smoking; (2) how SHS affects them and their asthma or respiratory disease; (3) ideas they have about how to reduce their exposure to smoking; (4) their fears and concerns about smoking for themselves and their parents and (5) experience asking parents to quit smoking.

Procedure

Focus groups and interviews were conducted at schools, health care provider sites or at marae (a Māori meeting place). The interviewer informed the children that they would be watching four short video clips. Videos of actors smoking cigarette at a park, a bus stop, a family BBQ and in a vehicle had been produced and were shown to the children (Table 1). The video clips showed a non-Māori non-Pacific person smoking amongst Pacific or Māori people in areas readily recognised by children. Because Māori and Pacific children have a higher risk of smoking initiation, we used non-Māori non-Pacific actors to avoid reinforcing the normalisation of Māori and Pacific adult smoking. Some focus groups were shown all four video clips in succession and some one by one interspersed with discussion. The videos were shown on an iPad. An iPad was used because of its high attractiveness to children. It is a form of koha (gift) to give them some experience with new technology in return for their participation. Use of computers as a tool for prompting discussion,

Table 1. Video vignette context.

Video	
Park	Asian adult female sitting on a park bench smoking a cigarette whilst children are playing with a ball in front of her. The ball rolls towards her, she puts the cigarette behind her back, picks the ball up returning it to the child. She then resumes smoking.
BBQ	European adult female, standing with three Pacific women talking. She starts to light up her cigarette near the children playing close by. There are also four male youths (17–19 years) standing around the BBQ drinking coke and PowerAde whilst looking at the food on the BBQ
Vehicle	Pacific adult male waiting in the car with his Indian friend (adult male). Pacific adult male calls out to his younger brother (Pacific boy 11 year) to come so that they can take him to school. Indian adult male starts lighting up his cigarette just before the young boy gets in and then they drive off
Bus stop	Asian adult male waiting at the bus stop with a young Pacific boy (11 years) and his older brother (19 years). Whilst waiting, the Asian adult male starts smoking, blowing smoke both directions (left and right) whilst looking for the bus.

in this case an iPad, also buffers potential discomfort and power imbalance between participants and researchers [24]. Participants were given an opportunity to play a game on the iPad, after which the researcher started the focus group or interview. Before showing the video clip/s, the facilitator asked the participants to “tell me what’s the first thought that comes into your mind about them.” Depending on participant responses, prompts were used to encourage discussion, for example, if the children expressed an attitude towards smoking, they were asked “what do you think about smoking?” or “what do the rest of you think about that?” At the end of the interview, participants received a \$10 PaperPlus (PaperPlus is a NZ book and stationery retail store) voucher for taking part in the study.

Data analysis

Interviews were recorded using a digital recorder, then transcribed and entered into NVivo (software that supports organisation and analysis of qualitative data) (QSR International Pty Ltd, Doncaster, Victoria, Australia). Data were predominantly analysed using a deductive approach (i.e. data were categorised using the framework formed by the order of questioning) [25]. Any data that did not fit the categories provided by the questions was treated inductively (i.e. new categories or themes were allowed to emerge). Two of the researchers (MG, AK) independently coded the data. The researchers discussed any discrepancies. When an agreement could not be reached, a third researcher (JF) was included in the discussion until an agreement had been reached.

When quotes from specific participants are used, demographics: age, ethnicity and gender, for example, 8 years old, Māori, female (8 yr, Māori, F), are provided, but no identifying information is included.

Ethics

Ethics approval was obtained from the University of Auckland Human Participant Ethics Committee in March 2012. A participant information sheet and consent form was sent to parents either directly or via the providers. Parental consent was obtained for all participating children. Verbal informed consent was given by each child.

Results

Seven children were interviewed individually and 34 in focus groups. There were 20 girls and 21 boys ranging in age from 6 to 11 years (Table 2).

Children’s attitudes towards smoking

The children’s attitudes towards smoking cigarettes and their exposure to SHS were mostly negative. There were only two comments that could be construed as favourable towards smoking, “I just like the smell [of smoking]” (8 yr, Samoan, M) and “it [SHS exposure] makes you wanna smoke” (7 yr, Tongan, F). However, both of these children also made many negative comments about smoking and SHS exposure.

The children were well aware that smoking had many serious and some fatal ill-health consequences. They said

Table 2. Demographics of participants.

Ethnicity	N	%
Māori	27	66
Pacific Island	13	32
European	1	2
Male	20	49
Female	21	51
Age (years)		
6	5	12
7	6	15
8	12	29
9	8	20
10	9	22
11	1	2
Respiratory illness		
Asthmatic	32	78
Other respiratory ^a	8	20
No respiratory condition	1	2

^aIncluding frequent coughs/cold.

“it is dangerous” (6 yr, Samoan/Tongan, F), “it can damage your body” (8 yr, Māori, F) and if people smoke, they are “going to die” (10 yr, Māori, F). Specific illnesses they mentioned included “cancer... and then you’ll die” (8 yr, Māori, F), “brain damage and rotten teeth” (9 yr, Tongan, M) and “wrinkles” (7 yr, Māori, F). There was even awareness of the ill-effects of smoking when pregnant. One child stated that “when you’re smoking and you’re pregnant it damages the baby” (11 yr, Tongan, M).

If you smoke too much you’ll have to go to the hospital and get your body fixed (7 yr, Māori, F).

Given their knowledge of the ill-effects of smoking no matter how general, it is unsurprising that the children strongly condemned smoking. For example, they said “I think that it’s bad to smoke” (7 yr, Tongan, F) and that “no one should smoke!” (10 yr, Māori, F).

Like, it is not right to smoke and I don’t like it (8 yr, Māori, F).

Even though there was no alcohol drinking shown in the video clip showing the family having a BBQ in a backyard, the scene was seen by some children as one associated with smoking, drinking, getting drunk, getting injured and fighting. A girl participant said “when people get drunk they smoke” (8 yr, Tongan, F) and the converse appeared true for the children as well, as another girl said “When you smoke and when you drink, you get drunk... there’s a mail box and you might hit your head on it” (7 yr, Tongan, F). One child said that it “looks like they’re gonna drink and they might fight” (8 yr, Tongan, M).

SHS exposure

Beliefs about the effect of SHS

The children appeared to extrapolate the potential ill-effects of direct smoking to bystanders exposed to SHS. For example, one boy explained that the adult’s smoke in the video clip was blowing towards a girl and “it could’ve got in her... face and

then she could've got sick . . . and could've died'' (8 yr, Māori, M). There were several comments linking exposure to SHS to cancer (8 yr, Tongan, F) even for children exposed to SHS. One Māori 8 year old girl said that exposure to smoke was 'bad for kids . . . It can give them like, have a heart attack and die' (8 yr, Māori, F).

The boy might not breathe . . . like stop breathing . . . 'cause the smokes are coming into his nose (8 yr, Tongan, M).

Their lungs start to go all red and black (8 yr, Tongan, F).

The children used a wide range of words to describe how badly they felt about being exposed to SHS: 'unhappy' (9 yr, Tongan, M), 'angry' (6 yr, Samoan/Tongan, F; 11 yr, Tongan, M), 'uncomfortable' (8 yr, Samoan, M), 'annoyed' (9 yr, European, M) and 'really sick' (6 yr, Māori, F). There were many comments about the negative impact SHS exposure had on their own respiratory conditions. In particular, many children mentioned that being around smoking gave them a 'tight chest' (8 yr, Māori, F), 'headaches' (10 yr, Māori, F), it made them cough and smoke made it difficult for them to breathe.

It made my asthma bad and then I coughed hard (7 yr, Māori, F).

It makes you can't breathe . . . and then you have to go to the doctors (7 yr, Tongan, F).

Ideas children have about reducing their exposure to smoking

The effects of smoke on the children did make them ' . . . want to get away from them [smokers]' (8 yr, Māori, F) and some children said they 'usually just go away' (8 yr, Māori, F). Some children talked about asking smokers to not smoke around them, for example, one child says to smokers 'you're not allowed to smoke around me 'cause I have asthma'' (10 yr, Māori, F). Another said he asks smokers to go outside: 'I'll go up to them and say, can you smoke outside because it might give me asthma' (8 yr, Samoan, M). In contrast, other children did not feel they could talk to smokers, or when they did the response was dismissive or ineffectual. For example, one girl (7 yr, Māori, F) would ask her mother and uncles not to smoke around her because of her asthma, but they would just say 'oh it's alright, I'll just go away from you. Go on another chair.'

All that some children did was gesture that smoke was unacceptable to them, for example, one boy (8 yr, Samoan, M) said he blocks his nose and waves the smoke away. One Māori/Pacific girl (7 yr, Māori, F) said when walking in public past a person smoking that she covered her nose and mouth with her hand and looked at them and the man said 'Sorry.'

Rules relating to exposing children to SHS

Many of the children believed that there were rules against smoking around children or indoors. There are no laws in NZ that restrict smoking in cars with children present or at playgrounds, but some children even thought that these were enforceable laws, for instance, one child thought smoking in a

park could be reported to the police (7 yr, Tongan, F). Many children reported that their family 'go to the back and don't smoke around us' (10 yr, Māori, M). 'Not near the kids' (11 yr, Tongan, M) one Tongan boy said. Children also perceived that there were rules to restrict SHS exposure to others, such as 'you're not allowed smoke in the car where babies are' (11 yr, Tongan, M), 'you can't smoke at the bus stop' (8 yr, Māori/Cook Island, M) and 'no smoking in front of kids' (7 yr, Tongan, F). The children expressed surprise that the male actor, in the bus stop video, smoked in front of a child and seemed to not care. However, despite perceived rules existing, a number of children reported that people still smoked inside (9 yr, Tongan, M) or around them.

In my room dad smokes and my nanna smokes and my aunty and my uncle smokes (9 yr, Māori, M).

Fears and concerns

Believing as they did in the serious risks to people who smoke, reinforced by the effects of SHS on themselves, it is no wonder that some of the children expressed fear for their mother or father or other family members who smoked.

They might get cancer and die and we'll feel sorry (9 yr, Tongan, F) . . . and we won't have parents to look after us (8 yr, Tongan, F).

Asking parents to quit

Many children had experience with people around them quitting, including their mother (10 yr, Māori, F; 7 yr, Māori, F; 9 yr, Māori, M; 8 yr, Tongan, M), father (9 yr, Māori, M), grandparents (8 yr, Māori, F) and aunts (8 yr, Māori/Cook Island, M; 10 yr, Māori, F; 8 yr, Samoan, M).

Mum has tried to give up smoking and she has. So it's really changed my life. So it's changed everyone's (6 yr, Māori, F).

Many children expressed positive feelings when someone had managed to quit smoking. It made them feel 'happy' (11 yr, Tongan, M, 8 yr, Tongan, F, 9 yr, European, M, 8 yr, Māori, F), 'good' (9 yr, Tongan, M) and 'well [physically]' (10 yr, Māori, F). Someone quitting made them 'feel really good inside' (8 yr, Māori, F).

This time they [mum and dad] have stopped [smoking]. So I gave them a high five. I felt very happy and very proud of them (6 yr, Māori, F).

The most common reason the children perceived for people quitting smoking was concern for children (9 yr, European, M; 7 yr, Māori, F; 8 yr, Tongan, F), 'because [people] doesn't want them [the children] to get sick' (7 yr, Māori, F). Other reasons for smoking cessation were because they were 'not allowed to smoke' (8 yr, Māori, M) at work or because they had seen smoking cessation TV campaigns

that “said if you smoke then you won’t breathe and then they [the parents] gave up” (7 yr, Tongan, F).

A number of children had not experienced anyone quitting smoking. Some children appeared to be aware that “smoking is hard to stop” (10 yr, Māori, M), as one child said about his mother who “started [smoking] again... But she can’t help it” (10 yr, Māori, F); and they reported that smokers say that they “will stop smoking but [they] won’t” (9 yr, Māori, M). Some children were even aware of the increased difficulty of stopping smoking, when “they [people at marae] all like smoking” (9 yr, Māori, F).

Support for adult cessation

Some of the children mentioned family, such as a mother (9 yr, Māori, M, 10 yr, Māori, M), dad (7 yr, Māori, F) or aunties (8 yr, Niuean, F), supporting people with quitting. Some parents were reportedly influenced by medical people: “He smokes a lot and he never stop smoking. But when the nurse said to him to stop smoking, he does from now” (6 yr, Samoan/Tongan, F). There was also mention of “tablets from the doctors” (11 yr, Tongan, M) which the children believed had helped with smoking cessation. However, some children felt that there was no one available to help people quit smoking (8 yr, Samoan, M; 8 yr, Tongan, M).

Ideas to increase adult smoking cessation

The children had a range of ideas on how to increase adult cessation. A lot of the children suggested “talking to them [smokers]” (11 yr, Tongan, M). This included the children telling the smoker about the fear they held for the smoker. They suggested telling parents “to stop smoking, before you end up in hospital” (10 yr, Māori F) or “say please can you stop smoking... because they [the parents] might die” (9 yr, Tongan, M). Other suggestions related to playing on the concerns of SHS harms that the smoker has relating to the children. The children also suggested asking parents “to stop smoking... you give me asthma” (9 yr, Māori, M). A number of children said to “hide all the smokes away” (8 yr, Māori, F) or “go chuck his smokes in the rubbish” (11 yr, Tongan, M). However, they also expressed trepidation about doing that.

Last time when I saw my aunties pick her cigarettes, I was like should I pick them up and put them in the bin, and I was like oh nah she might give me a growling (10 yr, Māori, M).

Children also suggested showing the smoker a “pamphlet of the lungs [affected by smoking]” (10 yr, Māori, M), to “put a sign” (8 yr, Tongan, M) or “sticker that says no smoking” (7 yr, Tongan, F). A number of the children made comments relating to policy. There were suggestions to write a letter to the Prime Minister of NZ, John Key (10 yr, Māori, F) asking him why he won’t ban smoking (10 yr, Māori, M).

Discussion

This is the first NZ research that has investigated children’s perceptions of smoking. The children had very afflictive

feelings or emotions, such as anger, towards smoking and were aware of some dangers associated with smoking. However, the children’s beliefs about the effects of smoking were quite fatalistic, lacking an understanding of risk – the message they receive is not “smoking increases the risk of cancer” but that “if you smoke you will get cancer.” The children also had strong negative feelings towards SHS exposure and the effect it had on their respiratory condition. The children appeared to extrapolate the potential ill-effects of direct smoking to bystanders exposed to SHS, including how the SHS exposure could impact on a respiratory condition. Believing as they did in the serious risks to people who smoke, reinforced by the effects of SHS on themselves, it is no wonder that some of the children expressed fear for themselves as well as other family members who smoked. The children expressed pride and happiness if someone important to them quit smoking. Despite their relatively powerless position in the family to do anything about adults smoking, the children still wanted to help people who smoked to stop.

The most common suggestion for reducing smoking prevalence and exposure to SHS was to appeal to smokers. However, some children did not feel they could talk to smokers about not smoking in the vicinity of the child. As in this study, international studies have also found that children thought smokers should try to quit, that there should be smoking bans [13] and that there is a need for reduction in SHS exposure [14]. However, this article adds to previous research by identifying that the children were aware of “wrong” smoking behaviour, i.e. smoking in cars or public places where children are present. Some of the children knew that SHS made their asthma worse sometimes resulting in their needing medical attention, even hospitalisation. However, children in this study thought that smoking in cars or public places where children are present had already been banned. This group of children were supportive of such policy measures restricting smoking in certain areas. They would even go further towards restricting access to tobacco by introducing a total ban on tobacco sales.

The results of this study will be helpful for tobacco control programmes. The children’s views could help inform the composition of smoke-free messages for Māori and Pacific Island parents of children especially when those children have respiratory illnesses. Messages that the community and mass media give to parents will have more weight and salience if they are consistent with the concerns voiced by their children.

Quitting for children is a prevalent and powerful motivation for parents. If the NZ Government wants to reach its goal of a smoke-free NZ by 2025 (a smoking prevalence of less than 5%), we need nearly every smoker to attempt to quit once a year from now on. Although some of the children thought that they could ask their parents to quit smoking, this could put some children at risk of an abusive response from the adult. The children were also tempted to throw out people’s cigarettes but this could increase risk of abuse. Health providers and tobacco control providers need to be careful of encouraging “pester power” and need to consider how to enable children to act on their fears for smokers in their life without putting themselves at risk. It would be safer for stop smoking campaigns to be the voice of the children.

More hard hitting campaigns showing the devastation children suffer at the loss of a parent, such as those that have contributed to the successful decline of alcohol and speed-related road crashes [26] could be utilised to reduce smoking among parents.

Many of the children reported that people still smoked around them, with a smaller number still exposed to SHS inside their homes. Another NZ research study with older pre-adolescents (aged 10–13 years) found that parents could be underestimating their children's exposure to SHS [27]. There was a consistent mismatch between parental reports of smoke-free home and car status and their children's reports of exposure to SHS in the home or in a vehicle by about 30% [27].

Future work

Children could be safely resourced to support their parents to quit. For example, children could be provided with smoke-free home or car stickers and pamphlets or websites on how to support their family members to stop smoking. In recognition of children's desire to reward parental and whānau (family) quitting, they could be guided in how to reward quitting, for example, how to make a card, reward coupon or savings jar. Smoke-free messages could also be delivered by children to their parents in the form of performance, such as theatre and other Māori and Pacific cultural performing arts. Further work is warranted to identify, develop and test messages and vehicles for quitting messages that could be used by Māori and Pacific children.

Limitation and strengths

A limitation of this study is the non-generalisability due to the small specific sample. However, this is also a strength since this sub-group – Māori and Pacific Island children with respiratory disease – is a particularly vulnerable population that experience disproportionately higher prevalence of immediate harm from SHS. Some of the findings relating to the negative feelings towards and knowledge of harmful effects of smoking may be specific to this population, due to their condition. Whilst the use of an iPad may have worked to keep participants interested, it could have increased the likelihood of response bias occurring, particularly social desirability bias whereby the children try to give the morally "right" answers in order to please the researcher to get to play on the iPad. The chances of this occurring were minimised by use of an interview schedule providing non-leading prompts to use. Furthermore, early transcripts were checked by the senior researchers and feedback was given to the facilitator on how to reduce leading.

Conclusion

This study set out to explore the attitudes of children with respiratory illnesses towards smoking, SHS and cessation. The children had very negative attitudes towards smoking and SHS exposure, and were doubly motivated to reduce smoking prevalence in NZ: (1) because they are directly and immediately harmed by SHS and (2) they are afraid that their father, mother, nannies, uncles and aunties who smoke will die from smoking. The children thought that they could help

by talking to adults who smoke, but we propose that health workers and tobacco control could do more to voice children's concerns and provide cessation support to parents. In addition to telling parents about the causal effect of their smoking on their child's illness, clinicians could talk to parents about children's fears that the smoking parents will die and deep wish for the parents to stop smoking. Furthermore, clinicians could say that NZ research suggests that children are exposed to SHS quite a bit more than parents realise. Even if the home and car are reportedly smoke-free, it is worth asking parents to check that others respect that and are not smoking around the child, for instance, when giving them a lift in a different vehicle.

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Declaration of interest

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