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| **CCG Final Report**  **Factors influencing smoking behaviour in Hull; an in-depth study of local women to understand motivators, attitudes and access to smoking cessation advice and services**  Trish Green, Judith Dyson, Helen Gibson, Una Macleod |

**BACKGROUND**

Smoking is the main cause of preventable death in the UK (ASH 2010). In Hull levels of smoking are high but they are particularly high amongst women; 33.9% of women aged over 16 in Hull smoke compared to 18% in England. Similarly, two thirds more 15 year old girls in Hull smoke (24%) compared with 15 year old boys (15%). High levels of smoking clearly take their toll on health and place a burden on local health services both now and in the future. Local statistics on smoking mortality amongst women are startling; between 2009 and 2011 an estimated 800 women (22%) in Hull died as a result of an underlying cause directly linked to smoking (Hull Public Health 2013:2). Statistics such as these raise questions as to why so many women in Hull smoke, and what health professionals can do to encourage long term cessation.

Smoking is now recognised as ‘*a gendered activity with sex and gender-specific uptake trends and cessation patterns*’ (Greaves 2015; 1449). However, in combination with gender, socio-economic status has been identified as a key determinant of women’s smoking behaviour. Graham (2006) has contributed to our knowledge and understanding of how gender and disadvantage collide to shape women’s smoking behaviour

Smoking status - including uptake, persistence, consumption, and cessation – is influenced by biographies of disadvantage. These biographies begin with poor circumstances in childhood, and are subsequently shaped by both educational trajectories and reproductive careers. (Graham 2006:ii11)

However, ‘disadvantage’ as a determinant of smoking behaviour amongst women only explains in broad terms why cigarette smoking is particularly prevalent in some communities. Greaves (2015) has suggested that in order to target interventions for women smokers a good starting point is to understand the meaning and function of smoking in women’s lives. Understanding meaning is the domain of qualitative research and few studies have addressed this. Graham (1994) has suggested that

Smoking is a way of living with and living through the experiences that go with social inequality. In the context of gender and class oppression, it provides a resource which can be accessed instantly when caring responsibilities are many and material resources are few. (Graham, cited in Wilkinson and Kitzinger 1994:121)

Other qualitative studies that have explored the meanings and functions of smoking have identified cigarettes as a ‘friend’, offering solace and comfort; controlling emotions; and carving out ‘space’ for oneself (Greaves 2015).

This proposed piece of qualitative research aims to contribute to the scarce qualitative literature on women and smoking but specifically with a focus on Hull women.

**AIMS AND OBJECTIVES**

The overall aim of this study was to understand in greater depth the factors that influence smoking and attitudes and access to smoking cessation services. Our specific objectives were:

1. To explore the factors that influence smoking behaviour amongst women living in deprived areas of Hull;
2. To explore why some local women choose not to take up smoking to see what we can learn from their attitudes and motivations;
3. To explore attitudes to smoking cessation advice and services amongst women living in deprived areas of Hull;
4. To understand what motivates local women to access smoking cessation advice and services;
5. To understand the barriers faced by local women living in deprived areas in accessing smoking cessation advice and services.

**LAY INPUT**

Three female members of the SEDA Patient and Public Involvement (PPI) group read through the study materials to assess their accessibility and suitability for potential participants. They suggested: adding an assurance of confidentiality to the poster; adding how much time participation might take. These suggestions were included in the documents. Their more general comments were positive and encouraging, e.g., ‘The leaflet is clear and I think very accessible to women age 16+’; ‘your document is good and easy to read’.

**METHODS**

The theoretical underpinning used in the focus groups and interviews was the Theoretical Domains Framework (Michie et al. 2005) as it offers a comprehensive, flexible and accessible way of questioning and understanding smoking behaviour, including elements such as beliefs about the consequences of a behaviour, self-efficacy, motivation, social influences, environmental factors, priorities and emotion.

***Sample:*** One of the main principles behind sampling decisions within qualitative research is that people included in the sample are knowledgeable about the topic of interest. With this in mind, the sample comprised two groups;

1. Women aged 16 and over who were current smokers
2. Women aged 16 and over who were non-smokers or ex-smokers

As identified above, disadvantage is a key determinant of smoking behaviour amongst women. The forty women who participated in the study were predominantly from areas of Hull with the highest indices of multiple deprivation (IMDs). Amongst smokers and ex-smokers was a minority of women who had accessed smoking cessation services.

***Identification of Participants:***

Participants were identified in two ways (see diagram 1 for breakdown):

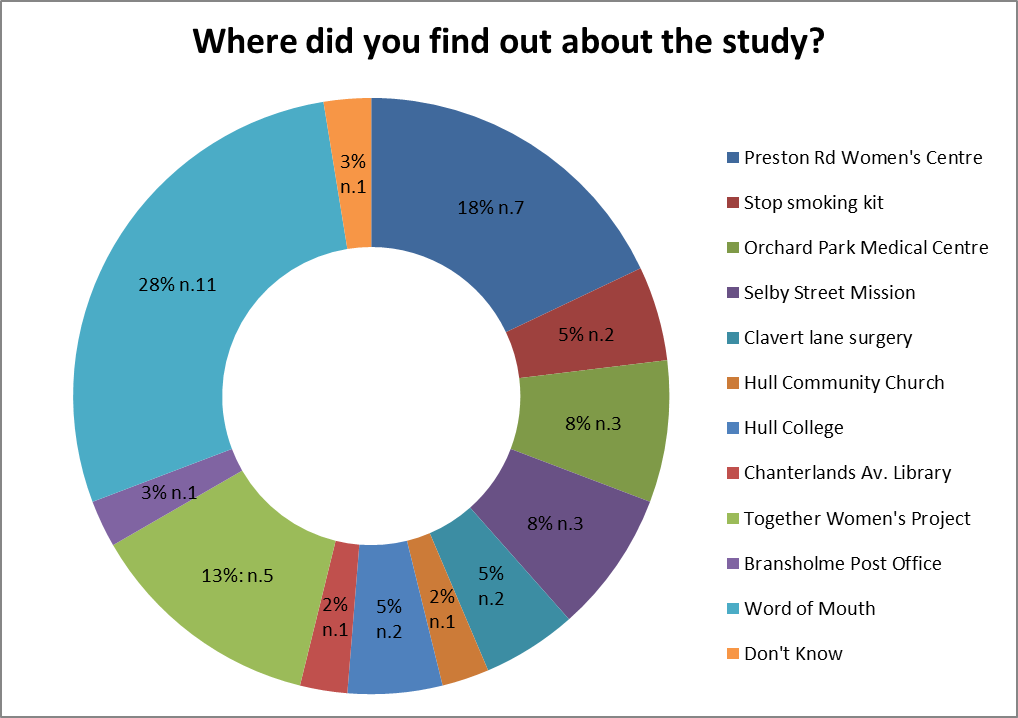
1. ***Local Community***

Posters advertising the research were displayed in community venues: GP surgeries, community centres, church halls, children’s centres, nurseries, libraries, and women’s centres. The online community was also utilised, with an advert for the research being placed on the local section of the Netmums website and on the Active Hull website.

1. ***Local Smoking Cessation Services***

Venues where Hull City Health Care Partnership ‘stop smoking’ groups were run displayed a poster to assist with recruitment. In addition, women registered with the ‘ready to stop smoking’ service who had attended stop smoking groups in the year prior to the study start date were invited to participate.

**Figure 1: Breakdown indicating where women found out about the study**

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***Data Collection***

We used two methods of data collection; focus groups and semi-structured interviews. Participants were invited to attend either a focus group or an interview dependent on their preference: We conducted the following:

16 x one-to-one semi-structured interviews

3 x paired semi-structured interviews (6 participants)

4 x focus groups (18 participants)

Total number of participants = 40

***Focus groups*** were facilitated by an experienced researcher (TG) and participants interacted with both the researcher and other participants during all discussions. Eighteen women chose this method. Focus groups are ‘particularly useful for exploring people’s knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way’ (Kitzinger 1995:299). They were thus an appropriate method of data collection for this study. Four focus groups were conducted in total; one at a participant’s home, two in women’s centres and the fourth at a community trust centre.

***Semi-structured interviews*** offer flexibility in terms of the order that questions are asked of interviewees and are purported to enable the participant to speak more widely on the subjects raised by the interviewer ([Denscombe 2003](#_ENREF_28)), which can result in participants raising ‘important issues not contained in the schedule’ (Denzin 1989:106). Twenty-two women opted for this method of data collection, 16 individuals and three pairs (two mother/daughter pairs, one pair of cousins). Fourteen interviews took place in participants’ homes, one in a café local to the participant’s home and one in a local community centre sited near the participants’ place of work.

All participants provided signed consent and focus groups and interviews were digitally recorded (with participants’ consent) and transcribed verbatim. Women were assured of confidentiality and pseudonyms have been assigned to each participant.

**Ethics**

The study was submitted to the Hull York Medical School Ethics Committee for ethical approval and to the HRA integrated Service and relevant NHS R&D departments. The main ethical issues related to confidentiality of participants and to storage of data. Participants were assured on the issue of confidentiality, and all data are anonymized accordingly and stored securely. Ethical approval for the study was obtained from the Hull York Medical School Ethical Committee in June 2016 and HRA ethical approval was granted in September 2016 (REC Ref: 16/EE/0347).

**Analysis**

Data were analyses thematically according to the aims of the study and following the six steps suggested by Braun and Clarke (2006).

**Results**

Participants’ ages range from 16 to 81 per figure 2. Twenty five participants (62.5%) were smokers, five (12.5%) were ex-smokers, nine (22.5%) were non-smokers and one participants did not declare their smoking status. Deprivation was established using the index of multiple deprivation where a score of 1-10 is allocated; 1 being the highest levels of multiple deprivation and 10 being the lowest (<http://imd-by-postcode.opendatacommunities.org/>). Most participants lived in areas 1 to 5 (n=33). The majority of smokers lived in areas 1 to 5 (n=33). Deprivation indices are illustrated in figure 3 and are presented according to smoking status in figure 4. (NB one participant did not declare their smoking status).

**Figure 2: Participant Ages**

|  |  |
| --- | --- |
| Age | Number (%) |
| 16-25 | 5 (12.5) |
| 26-35 | 7 (17.5) |
| 36-45 | 11 (27.5) |
| 46-55 | 5 (12.5) |
| 56-65 | 8 (20) |
| 66+ | 4 (10) |

**Figure 3: Deprivation of participants**

|  |  |
| --- | --- |
| Index of Multiple Deprivation | Number (%) |
| 1 | 15 (37.5) |
| 2 | 3 (7.5) |
| 3 | 5 (12.5) |
| 4 | 5 (12.5) |
| 5 | 5 (12.5) |
| 6 | 2 (5) |
| 7 | 1 (2.5) |
| 8 | 1 (2.5) |
| 9 | 1 (2.5) |
| 10 | 1 (2.5) |

**Figure 4: Deprivation index according to smoking status**

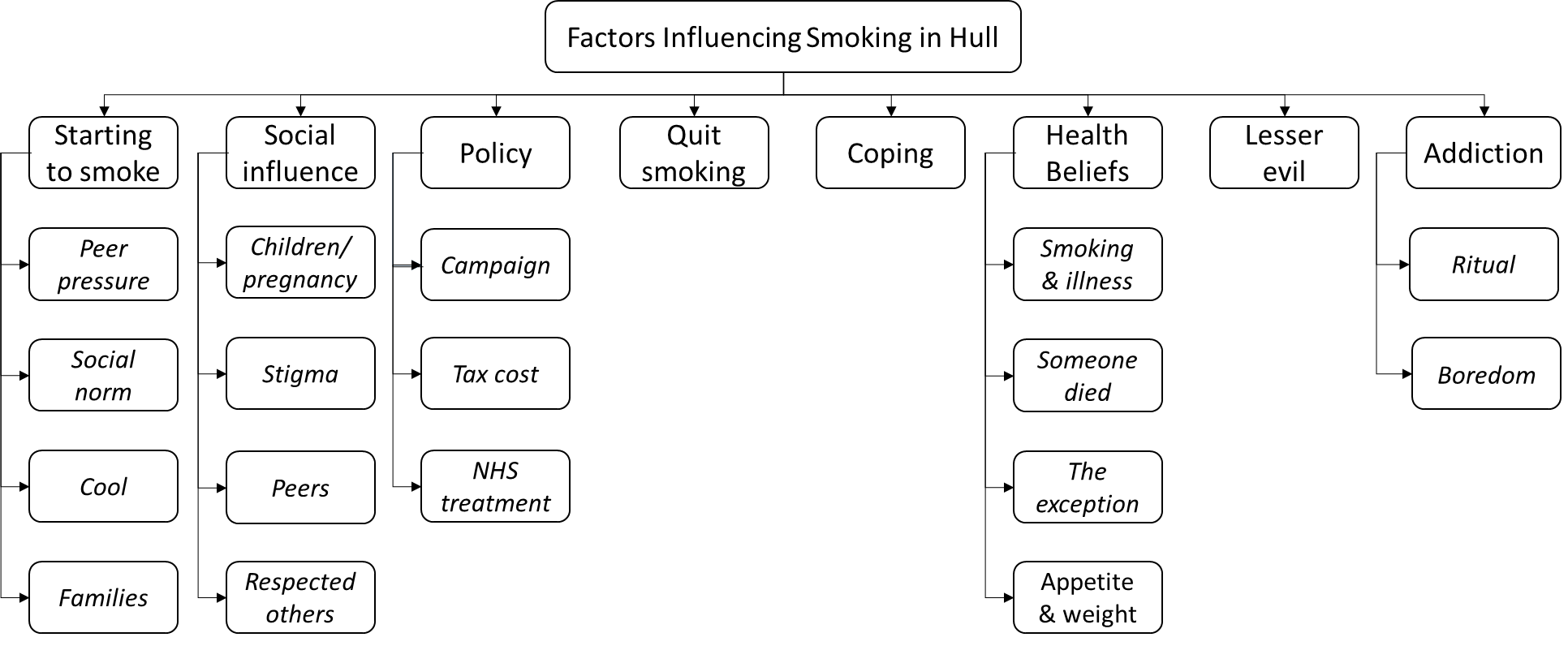
|  |  |  |  |
| --- | --- | --- | --- |
| Index of Multiple Deprivation | Smokers | Non-Smokers | Ex-Smokers |
| 1 | 11 | 2 | 1 |
| 2 | 1 | 0 | 2 |
| 3 | 2 | 3 | 0 |
| 4 | 4 | 1 | 1 |
| 5 | 3 | 1 | 1 |
| 6 | 2 | 0 | 0 |
| 7 | 0 | 1 | 0 |
| 8 | 1 | 0 | 0 |
| 9 | 0 | 1 | 0 |
| 10 | 1 | 0 | 0 |

**Themes**

Eight themes (and x sub-themes) were identified from the data. These were, i) Starting to smoke (the social norm and peer pressure, its “cool”, the role of families), ii) social influences (peers and respected others, children and pregnancy, it’s not “cool” any more), iii) the influence of quit smoking policy (campaigns, tax cost, NHS treatment) which linked into experiences of iv) quit smoking services, smoking as a way of v) coping with life/poverty, vi) health beliefs (links between smoking and illness, knowing someone who died as a result of smoking, the exception to the rule, appetite control), this was linked to theme vii), the lesser evil, where participants believed smoking a preferable option to other vices such as drink or drugs and viii) addition (ritual, boredom). Figure 5 illustrates themes and subthemes and each are described in turn below and supported with supporting excerpts of data (pseudonyms are used).

pregnancy

**Figure 5: themes and subthemes**

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***Starting to smoke***

Participants spoke at length about the factors that led them to smoking or not. These were largely related to the influences of others and the social norm. Specifically participants talked about pressures and norms at school and with peer groups and the influences and attitudes of their family growing up.

***The social norm and peer pressure***

*“I was thirteen and it was through friends through school. . . I just wanted to blend in with everybody else”*  Coral

“. . . . *I just wanted to smoke to be in that little group at the time”* Cleo

*“I don't think I felt pressured, I think it was just one of them things, everybody smoked and you just did it”* Viviene

*“Everybody just did it because it was in fashion”* Morgan

*“Just playing on the corner of the street and stuff like that, erm, and then course when you get to the teenage years it's, er, what everybody else is doing, the other kids and that was it, it just started from there and I've smoked ever since”* Nina

*“Probably because everybody I knew smoked”* Adriana

***It’s cool to smoke***

A number of participants suggested they started smoking because it was considered “cool” or “sophisticated”.

*“Just appear more sophisticated, I, I don't know, there's lots of reasons. Wasn't it sort of de rigour to have a cigarette after sex?”* Muriel

*“You pick it up, you smoke it, you dot it out. When you’re younger you feel like you’re cool, you look up and everyone’s looking at you when you’re taking a drag of your cig. You’re thinking everyone’s looking at you”* Cleo

*“And I got on a number forty nine bus at the top, you could smoke on buses in those days and I lit one and I didn't like it very much but I thought it was nice just to wave it about as if I was, you know, accomplished smoker, and that's really all I smoked for”* Rona

However, there were clear differences according to the generation or age of participants.

*“Well as I say, certainly with me in the, in the sixties, I was, you know, it was a peer pressure thing, it's what everybody did and you didn't want to be the odd one out and I can't see that anything's changed in that respect”* Rona

*“Somehow it's not in fashion, before it was in fashion, you know, like, even if you not smoke, I remember it was some, just, they just keep like this, a cigarette five metres long, you know, like and just like holding it, you know, like now it's not in fashion, it's something eek, you know, like”* Alma

***The role of families***

Some participants considered children adopted parents behaviours if parents smoked.

*“Kids is kids but it is starting from family, can see what your parents do and you do it exactly the same is it? And it goes circle circle circle circle like, unless somebody will break circle once”* Alma

Equally, if parents didn’t smoke sometimes children adopted this behaviour.

*“none of my family smoke, absolutely none, they hated it, they hated smoking, they hated like being anywhere near it so none of us smoked*” Ariel

But usually this was not the case, even when parents didn’t smoke participants who smoked reported that they started anyway.

*“Well I, I, but I, I started smoking, it's funny, me and my friend, I mean she smokes, started going out with her, smoking, blah de blah, and my mum was quite shocked”*  Ellen

*“My mam was quite disappointed because it was something they'd never done and they was quite disappointed that we all smoked, erm, and they all still do smoke, my brothers still do smoke and I'm the odd one out now when we go out* Mandy

*“And my mum was saying why you start smoking? You're all the time checking these girls and say how they're smoking, it's not nice, why they do it, me, I will never do it, why you start doing it?* Jessica

*“Yeah, so she's like, when, when she found out I was smoking, it was even 'til I was about twenty one she wouldn't walk with me in the street if I was having a cig, she'd walk ahead of me or walk behind me, because she hates that I smoke, she really hates it, so she'd absolutely love it if I stopped smoking”* Lyn

*“I remember my dad saying to me you'll never have any money and that's all the advice he said to me, he said you'll never have any money because I, I suppose again, my parents just, because they smoked, they couldn't say a great deal could they?”* Gail

*“I was only fourteen and they saw me sat smoking and I got grounded for the rest of the holiday;. . .it didn’t stop me, no”* Keira

***Social Influences***

The influence of others didn’t only determine women’s behaviour in terms of choosing to take up smoking or otherwise, social influences had a bit part to play in maintaining smoking behaviours. Peers (friends and colleagues) played a part in maintaining smoking behaviours. When it came to considering quitting it was participants children who were likeliest to influence these thoughts of and attempts to quit. Being pregnant also influenced participants in terms of wanting to quit. Conversely, participants seemed to resent being told to quit smoking during pregnancy by professionals such as midwives.

***Peers and respected others***

*“Yes, some people do [smoke] at work but I know, my friend, she told me, they do go to smoke for this, it's like to be part of the team because if you're not smoking, like ten people in a group is it?”* Alma

Respected others were mentioned within the context of continuing smoking behaviour either because they too smoked or because they didn’t discourage smoking.

*“Yeah, you go to the doctor's, are you a bit stressed. Have a cigarette. . . my GP smoked, well he used to, he used to, because I remember when he came to visit* [name] *when she was first born, I can remember he, he'd obviously waited outside and had a cigarette before he came in”* Marina

*“I don't think they do enough in school to tell them to stop smoking. I, I've not heard of one thing in Bradley's school to tell him to stop, not smoke, erm, even the teacher, they smoke in school when they're, in the playground, the teachers don't stop them. Why don't they stop them? Go up to them, right, we're confiscating all your, they know where they're smoking, they go in one place every dinner time and break time, why can't they go there and stop them?”* Dory

***Children and pregnancy***

In terms of considering quitting children were often mentioned as influencing the decision of leaving the parent feeling uncomfortable about smoking.

*“My* daughter.. . . she used to come in and go mummy, you'll kill yourself one day. . . . it was more for the sake of Sarah, erm, I knew she was the most important thing in my life so I knew for the bairn's sake I have to quit” Cordelia

*"Colin and I both give up, erm, Jamie, our son, used to say, [laughs] as I call him, which makes us laugh because he's a smoker now, ooh that's what, every time you light up a cig Dad, that's one minute off your life, and he really nagged us, erm, and as I say I don't smoke that much but Colin was a heavy smoker but we did give it up”* Viviene

During pregnancy participants reported cutting down on cigarette smoking or quitting completely.

*“I've done it, each time I'm pregnant [stopped smoking], if I've got a focus then I'll do it but I know that if I stopped, I'd have to stock in the chocolate bars and the crisps and then my weight'd just balloon so that's what, that's the only reason I smoke, don't like the taste of it, I don't like doing it, don't like smelling of it but I do it because if I don't do that I would have weight issues”* Melanie

*“I've always said that I'd only stop like if I got pregnant because obviously I wouldn't want to smoke if I was pregnant, so that's what would make me stop, erm, so I'd probably, like that'd, I would hope that would be a good enough incentive to, to, to be able to just stop but then if I was like struggling, I'd go, go to like my GP or something”* Lynn

*“I stopped a few times, I've stopped and I always stopped through the pregnancy, erm, and then through things that happened at, in your life that you start again and I think the longest I stopped was when I had my second two and I stopped for about ten years”* Gail

Conversely, participants appeared to resent the advice of professionals during pregnancy.

*“The baby might grow properly, it might not develop properly, if you smoke it might affects its speech. . . . . . they used to try and absolutely scare ya.. . . I used to sit there and think ‘ooo’ but then I walk out after my appointment, first thing I do is go outside and have fag”* Coral

*“We lie, we lie. . . .II did. When they ask how many you smoke, you always knock another three or four fags off”* Cleo

***It’s not “cool” to smoke anymore***

Although smokers reported smoking as being “cool” as kids they also described recent experience of negativity toward smoking taking about stigma and judgement. This was not only from members of the public but also from health care practitioners (examples above). The negative judgement of others didn’t seem to influence participants’ smoking behaviour

*“People are disgusted with you, how dare you be smoking? But you don't see people doing that who've sat in binge drinking on their alcohol on a weekend and going to hospital because they've had too much of it but no, if you're a smoker you are a loser to society”* Melanie

Furthermore, both non-smokers and smokers acknowledged feelings of distaste at being mistaken for or seen to be a smoker.

*“Yeah, and if you want anything from, the, customer service or whatever you've got to wait, or a Lotto ticket, you've got to wait with all the smokers”* Kendra

*“I'd never used to do it like in a public place if I knew that I might see someone that I know. I just didn't like people knowing that I smoked or people, like if I saw someone that I knew I just used to like throw it really quickly and be like, oh . . . . . I think it's something to be ashamed of really if you smoke”* Rose

***Quit smoking policy***

The policy led strategies to support quitting that were identified and discussed by participants included health promotion campaigns (posters, leaflets and TV), no smoking areas, tax cost, plain packet/pack warnings on cigarettes and reports of the NHS restricting/refusing to treat smokers. Often comparisons were made with alcohol or drugs which participants considered more damaging than smoking and as above this linked in with feelings of being stimgmatised.

***Campaigns***

*“It's a good idea* [stop smoking campaigns], *don't get me wrong but if you think about it they only do it for cigs and bacca, where there's people out there that do drugs and they don't turn round and say oh don't do drugs, you don't see that on the telly do you every day? Don't do drugs, don't do drink, it'll do this to you, do that to you, the only ones that you see is cigs and I'm thinking but there's worse stuff out there that can kill you, not a cig but like drugs and alcohol but they're only, they just target one thing and it's like well they're not doing it right, they're not doing it right, they say yeah, go take, because it's, to me it, saying to me go take drugs, go take drink but don't smoke because smoking will kill you. But you never see it on telly. You don't have people coming round saying oh you need to stop drinking, do you want help stop drinking, do you want help stop drugs? You've got to go looking for that, where for smoking you'll see them on the street, here have this notice to stop smoking, then you're like okay, fair dos.”* Carrie

***Tax Cost***

*“Look at drink and, you look at the drink, look how cheap it is.”* Lorraine

*“No, yeah, but, you know what I mean, but, but like sitting, oh I'll have a cig and you're, and you can get up and then go function and do your job but you have a couple of glasses of wine, you can't function, you can't drive, you can't go up and do, you know, your work, yet it's easy available. . . . I don't think the Government want us to not smoke, they earn too much money out of smokers”* Mandy

*“You wonder, yeah, because it's a huge source of revenue for the Government, they must have very sort of mixed feelings about stuff and people smoking, although I suppose it would save the NHS a fortune”* Marina

***NHS restricted treatment for smokers***

*“Because it's almost, it is right, because it's almost like with the Government, and everybody else are saying you smokers have to stop, you're costing the NHS and now we're not going to actually operate on you if you're smoking until you stop smoking. It's like, so now again you're telling me what to do, you're saying I can't have certain services, which everybody else can have, you could be drinking ten pints a day or six bottles of whisky and everything”* Gail

***Stop Smoking Services***

Of those participants that had tried to stop smoking few of them had accessed any help from health services (e.g. GP or Smoking Cessation). Those that had, spoke primarily about nicotine replacement therapy and how the service is restricted to six weeks of contact.

*“He* [gp] *gave me some numbers to go through and . . no I didn’t do that. . . I went on the chewy but that was disgusting . . I am not one of those to go and sit in and ask for help at all.”* Cleo

*“I think it’s a long term thing, you go to a smoking clinic, no disrespect, the facility’s there and people are grateful for it, but you need to go to a no smoking clinic for six weeks and that’s not enough, you need long term support, because even if you do stop smoking after that six weeks it’s so easy to get a knock in your life and go back to it.”* Flo

***Coping with life/Poverty***

Participants often spoke about the pressures of life, poverty and smoking being a way of coping with these. Although some participants said that saving money was a driver to encourage them to stop smoking others were clear that they would find a way to smoke even when they had no money at all.

*“Another side to it, where your deprived of money and then sometimes you’re in a little club, aren’t you, with your smoking. .* . . . *I wish we could stop. . I with there could be summat out there, but again, you know, Hull’s a deprived city, I mean we’ve got city of culture, Hull, but . . what have we got for stimulation*?” Shelly

*“Just, I don’t want to stereotype, there’s a lot of areas of Hull which are known for being the chavvy areas, so I think it’s mainly like, you know there’s a lot of people, like for example, there’s low employability rates so people get stressed and like I’m going to go for a cig. . .”* Coral

*“To, to really, really, and that when people have mundane and stressful lives and, you know, everything's a chore, if you've got a release like that, I can, I can understand that and I can understand it when people say do you know what, life's too short?”* Meredith

*“. . . . me and my mate, if we didn’t have a cig we used to go tabbing in the streets, bring them back, all the tabs, I used to, on the old-fashioned coffee percolators with the metal ring, do you remember them? Where it heat the coffee up, we used to come back and dry that bacca on there and we used to smoke . . . and maybe we’d be as sick as a pig but that how addicted I’ve been.”* Marina

***Health beliefs***

Most participants, smokers and non smokers recognised smoking led to poor health and some chronic as well as potentially life-shortening and life-threatening illnesses. Sometimes this knowledge deterred smoking but sometimes the temporal gap between smoking and contracting the health problems was so vast it lacked the immediacy to influence smoking; participants were more likely to consider quitting when a health problem actually arose (rather than the potential of a problem). In some cases, knowing someone who had died from an illness related to smoking influenced participants intention to quit, though, other participants protected their wish to smoke by offering examples of people who had smoked excessively and had never suffered any ill effects.

***Links between smoking and illness***

*“The advantages of being a non-smoker is that I think I've got, I don't have to, not, not that I don't have to worry but I have, erm, I don't have to have a worry about my lungs being damaged.”* Dory

*“I know that it's like not good and I can tell from, erm, like when I joined the gym, you know, like how out of breath and unfit I am, erm, in my throat, one of my best friends, she's a respiratory nurse so she always goes on at me about not smoking.”* Jessica

*“my mam got diagnosed the following October with breast cancer so then she's decided to stop but she'd tried several times before that, stop started, stop, started.”* Lorraine

*“I think of, like the, oh like lung cancer or like throat cancer and just the general, general poor health that you get from smoking”* Lynn

Sometimes illness deterred smoking.

*“the advantages of being a non-smoker is that I think I've got, I don't have to, not, not that I don't have to worry but I have, erm, I don't have to have a worry about my lungs being damaged and my liver and things like that but again I still get worried when I hang around people who smoke”* Dory

But some participants perceived link between smoking and illness to be week due to the temporal gap.

*“Yes, it's hard, you know, it's still hard because not, if you smoking for ten, twenty years, unless somebody will tell you maybe, you know, like you're dying tomorrow, not everybody will drop anyway is it quite?”* Alma

Sometimes when a health problem arose people stopped.

*“She* [developed] *arrhythmia it's called, with the heart. You know, like when it's going too fast. And she stopped. . . . she never smoked after that”* Alma

*“Yeah, up to about seventy, sixty, seventy, and then she had a big massive heart attack and she said to me other sister, here you can have them and it's killing me”* Doris

*“It was when one really was supposed to go in for a heart operation that made him stop”* Dory

***Knowing someone who died***

Knowing someone who had died from a smoking related illness had led to some women quitting, or to them believing such a situation would result in them quitting. Sometimes this was not the case.

*“Lost* [his] *dad to cancer and it was due to his smoking, so he really gets annoyed with me, erm, and my partner and we go round and we're out in the garden smoking, hates it, it's got to the point where he used to bring us tobacco back from abroad and he won't do it anymore.”* Victoria

*“The fear factor is not there, I haven't got anybody in the family who's died of smoking related diseases, and every member of the family who has smoked died really, you know, lived a really long life anyway, so the fear factor's never been there for me.”* Adriana

*“My mum and dad died of cancer, I helped my mam nurse my dad and then I helped to look after my mam and if that doesn't put you off smoking nowt will because I enjoy it.”* Melanie

*“I mean I wish I didn't smoke and I wish my two kids that do didn't because I lost my mum with oral cancer.”* Dylan

***The exception to the rule***

Participants who smoked often talked about people who had smoked for a long time and had never been unwell and others that had never smoked and suffered ill health.

*“People still die of lung cancer if they don't smoke.”* Alma

*“Little grandma, she wasn’t a drinker, she wasn’t a smoker and she died at the age of sixty-summat me mam’s mam”* Coral

*“I mean my friend Rod, who I mentioned earlier, his mother was ninety three, you know, when she popped off and she, she smoked and drank like a fish, you know, so.”* Morgan

*“One chap, well he was ninety and he had a whisky every day and has smoked twenty cigarettes and he lived 'til he was ninety. There are some people who do.”* Meredith

***Appetite Control***

Several participants who smoked believed that smoking was an appetite suppressant and so prevented weight gain. Others were deterred from quitting smoking as they believed that such action would lead to comfort eating and subsequent weight gain.

*“Smoking obviously acts as a suppressant so it might be that you skip dinner, you don't eat or you don't realise that you're doing that.”* Beverley

*“I was in my mind, one of the reasons I do smoke is to keep my weight down because I am overweight anyway and I tried to stop smoking and I did stop smoking, for two years I went to a no smoking clinic and I actually was successful and I stopped smoking for two years but in that two years I put loads of weight on, I put about three stone on because I just reverted from smoking to comfort eating.”* Coral

*“I substituted food, I substituted food and I put a lot of weight on.”* Gail

*“I put three stone on. So I forced myself to start smoking after three years because I just couldn't shift the weight and I've never felt as unfit in my life carrying the extra weight about.”* Dylan

***The lesser evil***

Participants often cited smoking as the preferable option to drinking, taking drugs or even eating based on a range of factors such as associated health benefits or harm, antisocial behaviour and cost to the NHS.

*“I'm thinking but there's worse stuff out there that can kill you, not a cig but like drugs and alcohol.”* Carrie

*“It sounds stupid but I think I would rather be a smoker than a drinker. With smoking, you know what you’re doing. . drinking, you don’t know. . . after a few pints. . you don’t know what you do.”* Cleo

*“My mam was dying of cancer . . had weeks to live right and she had to go to Hull Royal to get this -x-ray. . with smoking her arm used to swell up. . it was the same with her legs. They put her in this room, waiting for the ambulance. . . that was a bit slow. . the ambulance driver got a call and it was to pick someone up in town, it was either drugs or alcohol. . they’ve got to go to them and leave a patient dying.”* Mandy

***Habit***

Smokers referred to smoking as an addiction. However they rarely referred to a physical dependency on nicotine, when they did this was limited to a bad temper or mood when they tried to quit or needing to eat more. Mostly participants spoke of a habit or ritual; smoking was part of their daily routine. Participants talked of both being bored without a cigarette and how being busy was likely to prevent the need to smoke. Participants considered there was less meaningful local activity for young women to engage in compared with young men.

**Addiction**

*“Yeah. Stressing, short temper fuse, any… it didn’t matter who it was if I didn’t have one* [a cigarette] *. . . I snapped . . . yeah, I only did two weeks* [quitting]*and I couldn’t do it anymore**I really tried, I really tried.”* Coral

*“But I, I know that I'm addicted, I get snappy.”* Melanie

*“I've been desperate, I've gone outside looking for cigs, half cigarettes on floor, I've been desperate to smoke. And that's how it gets you, it gets you where you go tabbing, you're that addicted.”* Jeanette

**Ritual**

*“A little ceremony getting the cigarette out.”* Morgan

*“I don't really enjoy it, I don't, it's an ‘abit.”* Jeanette check name

*“It's just engrained unfortunately isn't it?”* Viviene

*“I wouldn't say I enjoy it and I wouldn't say I didn't enjoy it, I think it's just that natural habit that you get into.”* Cordelia

*“Because she's constantly got a cig in her hand, erm, even though half the time she doesn't smoke it, she just holds it in her hand.”* Lynn

**Boredom**

This theme linked with the theme “coping with life/poverty”; participants perceived those who had opportunity to be occupied (work or leisure) were less likely to need to smoke.

*“Because if you're busy doing stuff and do you really want to drop something really important? Oh I want a cig. You'd rather complete what you're doing and then if you really want a cig, at the end of it go for one, if not then you won't”.* Cordelia

*“Because if you was in a job all day, say for example, in an office or a factory, you wouldn't be smoking because you wouldn't be able to smoke but if you sat at home all day, you've got loads of time on your hands, bit at a loose end, oh I'll just light up, cup of tea, cigarette, something to do, through boredom.”* Dory

*I do admit though if I'm knitting or. . . .you don't, you won't smoke. . . because your mind's occupied.”* Marissa

*So many sporting things. . . . are male orientated. . there isn’t the opportunities for girls. .. like boys don’t, boys have far more choices I think.”* Marissa

*“I think half of it is boredom, I mean I say the area we come from there's not a lot for young kids to do.”* Nina

**Conclusions**

Summary: This study has allowed for a unique insight into the smoking practices of forty women who live in Hull. Our purposive sampling in areas of high deprivation in the city means that women’s smoking narratives have been contextualised and thus analysed accordingly and in relation to other studies that have looked at women and smoking. The wider literature tell us that women living in areas of lower SES are disproportionately more likely than their more affluent counterparts to have financial difficulties, including debt problems, be unemployed and be more dependent on addictive substances such as tobacco. The data collected for this study corroborate these previous findings. Our findings illustrate how peer-pressure and social norms among peers influence women in starting to smoke and continuing to do so. Equally, our data suggests that having children, being pregnant and the role modelling/support by respected others may influence women in quitting smoking. Women reported smoking as a way of coping with life and was a better choice than drugs or alcohol. Although participants generally accepted that smoking was detrimental to their health, this belief didn’t appear to influence their smoking behaviour unless they knew someone who had died. Although women discussed the concept of being “addicted” to smoking they reported this in terms of the ritual of smoking, a relief for boredom and spoke very little about the physical symptoms of addiction.

Recommendations: From participants reports, smoking cessation services appear to offer opportunity for nicotine replacement therapy and time limited face to face support. Our studies identified a range of barriers to quitting (including, difficulty coping with life, social influences, distorted outcome expectancies from smoking and quitting, habits and rituals). Participant accounts offered no indication that these barriers were assessed, acknowledged or addressed by stop smoking services. Many participants were struggling to manage the day to day problems of lives with little money, relief from stress or enjoyment in their day to day lives; these participants suggested that cigarettes were all they had. It is recommended that the factors determining smoking and preventing quitting are assessed on an individual basis and techniques to support change are tailored accordingly.

Limitations: As with all qualitative research, the findings are not generalizable and we acknowledge that they reflect the views and perceptions of those interested in the topic. We also state that the interpretation and subsequent analysis of what women told us are the authors’ subjective and reflexive. These data might be interpreted differently by other researchers.

Next steps: We have a rich and extensive data set. Our initial analysis has given an overview of the factors influencing smoking behaviour among Hull’s women. We intend to disseminate these findings through peer review journals and conference presentations. However, we have a vast and rich data set and there are two areas where we have scope and intend to further interrogate our data to add more detail to our results; i) gendered factors relating to smoking and smoking cessation and ii) the influence of poverty.

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