



**Women
and Smoking**

**Time to Face
the Crisis**

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Foreword

The news in 2011 that more Irish women are now dying of lung cancer than breast cancer was a turning point. It had us, and others, see the extent of the crisis that we are facing and that we have no choice but to act to deal with it.

Women are dying of a preventable disease and it has to do with the high rates of smoking, particularly among one social group, young disadvantaged women.

We in the Irish Cancer Society know we cannot deal with this alone, but what we can do is to work with others to look at the reasons why women start to smoke, why some women smoke more than others and why many women believe they cannot stop. We know that the reasons are many and complex and not fully understood, but that it is now urgent that we begin to grasp them.

The conference Women and Smoking: Time to Face the Crisis, is our first major response. We believe it has been very successful in highlighting the issue and in particular in beginning to build the relationships necessary to fight this together.

We were hugely encouraged by the passion and commitment of all those who engaged with us in this event, to work together to face this crisis. There is a solid commitment to act and our intention is to continue to facilitate this co-working in any way we can.

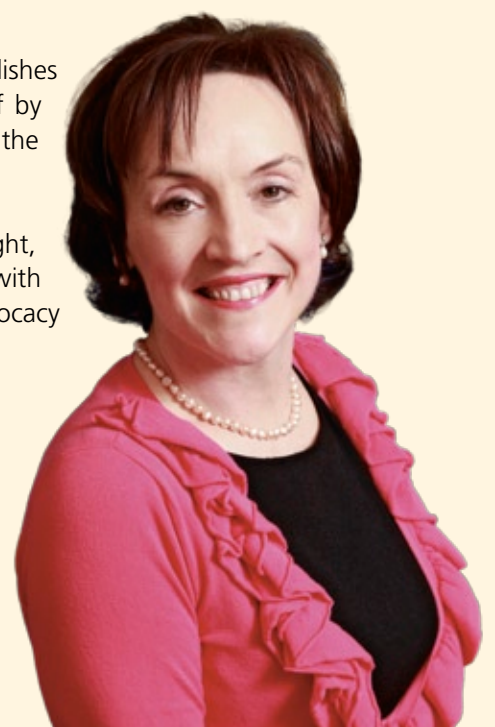
The contribution of our speakers Dr Jude Robinson and Professor Amanda Amos has been very valuable and continues to inform our work around this issue. We were pleased to have contributors from Ireland on the day also – Sineád Pentony and Dr Finbarr O’Connell.

This report is not only an important record of the conference itself but also publishes the very valuable results of the focus group research conducted on our behalf by Ignite Research whose qualitative research provided us with valuable insights into the attitudes and behaviours of female smokers.

Finally, I want to use this opportunity to acknowledge the work of Rachel Wright, Advocacy Officer at the Irish Cancer Society who devised and executed the event, with support from Valerie Abbott, Events Officer and the Communications and Advocacy Team at the Irish Cancer Society.

Kathleen O’Meara

Head of Advocacy and Communications
Irish Cancer Society



Executive summary

Introduction and background

In 2011, the Irish Cancer Society was shocked to learn that more women in Ireland are now dying from lung cancer than from breast cancer. Smoking is the leading preventable cause of lung cancer. Despite all that is known about the dangers of smoking, almost 1 in 3 women in Ireland smoke. Women and girls in Ireland are in the midst of an epidemic of smoking related disease and the burden of this disease is being carried by women who are socio-economically disadvantaged.

In order to address the crisis of women and smoking, the Irish Cancer Society set out to investigate why such high numbers of women are smoking and what can be done to tackle the problem. This marked the beginning of a collaboration with the National Women's Council of Ireland, which resulted in the Women and Smoking: Time to Face the Crisis conference. The conference was held in Dublin in July 2012 and brought together policymakers, healthcare professionals, academics, and representatives from women's groups to explore why women are smoking and how they can be supported to quit.

In order to better understand the attitudes and behaviour of women who smoke, the Society commissioned research into female attitudes to smoking and quitting. The results of the research and the key findings of the conference are summarised in this report.

Key findings

Smoking is the leading cause of preventable death and disease in Ireland. Half of all smokers will die because of a tobacco related illness (Peto et al, 1994).

Smoking causes 9 in 10 lung cancers (IARC, 2004). Lung cancer has now become the main cause of cancer death in women, outnumbering breast cancer deaths. Lung cancer is the biggest cancer killer in Ireland for both men and

women with 1,708 people dying in 2010 (1,006 men and 702 women) (CSO, 2011). Breast cancer deaths for the same period amounted to 634. New cases of lung cancer in women have increased by 17.6% in 2010 whereas breast cancer cases are increasing at a much lower rate (NCRI, 2011). Smoking also causes other cancers including cervical cancer, mouth, head and neck cancers, oesophageal cancer, stomach cancer, pancreatic cancer, cancer of the kidney and cancer of the bladder.

Smoking also causes cardiovascular disease, chronic obstructive pulmonary disease and fertility problems.

Prevalence

Despite the introduction of significant measures to reduce smoking in Ireland such as the workplace smoking ban, Ireland's smoking rate remains stubbornly high at 29% (Brugha et al, 2009). Twenty-seven percent of women now smoke but the highest rate is seen among women aged 18 to 29 in the more deprived social class groups (SC) 5-6. More than half of women in these groups smoke. This is twice the rate among women in more affluent SC 1-2.

Health inequalities

The differences in smoking levels based on social class groups show that female smoking cannot be separated from the issue of health inequalities. Levels of smoking are highest in the poorest communities and are linked to multiple social and economic disadvantages, ill health, and poor life expectancy (Graham, Inskip, Francis, & Harman, 2006; Marsh & McKay, 1994).

Disadvantaged groups in society are disproportionately likely to smoke and least likely to give up cigarettes. Those who can least afford to smoke the most and suffer the most from it. Children growing up in poverty experience social environments where the majority of adults smoke. Smoking therefore becomes normal and acceptable adult behaviour (Jarvis and Wardle, 1999).

The health inequalities associated with smoking are highlighted by the fact that incidence of lung cancer among the most deprived women in Ireland is 1.7 times that of the least deprived (NCRI, 2011). The incidence of lung cancer among women is higher in areas of high unemployment and lower levels of degree level education (National Cancer Registry/Northern Ireland Cancer Registry, 2011).

Social aspects of smoking

An analysis of the factors mediating the effects of social class in Ireland has suggested that social deprivation accounts for the higher levels of smoking and lower likelihood to quit smoking among lower socio-economic groups (Layte and Whelan, 2008).

Smoking is a cultural and social issue for women. A culture of smoking is embedded in many women's lives. Smoking provides opportunities for social bonding for women and this often reinforces addiction to smoking (Brigham, 2001).

Many women believe that smoking helps them to cope with stress. Over a third of women agreed that quitting smoking would make it harder to cope with stress (SLÁN, 2009). Smoking is used as a form of stress management by some women, and more so by women in the lower social classes.

The Irish Cancer Society's focus group research found that many women feared that quitting smoking would affect their social lives, cause them to gain weight and make them irritable and difficult to live with.

Marketing

The tobacco industry constantly needs to recruit new smokers to replace the smokers who die because of their addiction. Female smokers are a lucrative market for the tobacco industry which is experiencing a decline in smokers. The tobacco industry has long recognised that women represent a different market from men and has developed policies to target women by segmenting the market by socio-economic grouping and developing products for these groups.

Tobacco companies recognise the power of packaging. The growth in new brands and packaging is aimed at

appealing to young female smokers. Women say they hear about new brands via word of mouth. Women think lighter coloured packs are more elegant and feminine and less harmful. The introduction of plain packaging would reduce the appeal of cigarettes, increase the salience of health warnings and reduce consumer confusion about harm.

Recommendations

Some of the key recommendations to emerge from the group consultation at the conference and from the focus group research are outlined below:

- **The barriers to quitting smoking are multi-faceted and include psychological barriers, social factors, access and availability of services, attitudes of health professionals, and tobacco industry manipulation;**
- **Smoking provides a sense of solidarity and belonging for many women and is the cultural norm in many communities. Community-based cessation programmes which encourage social interaction are needed to overcome these barriers;**
- **A national strategy and standards for cessation services are required;**
- **Communities need to be supportive environments for people who want to quit;**
- **All healthcare professionals should have the capacity to conduct cessation intervention and be encouraged to do so;**
- **The tobacco industry is targeting young women through innovative packaging. Plain packaging would help counteract this.**

Why women smoke: Focus group research

In June 2012, the Irish Cancer Society commissioned some focus group research to gain an in-depth understanding of why women smoke and to explore the motivations for and barriers to quitting smoking.

Specifically, the research aimed to:

- Gain an understanding of general smoking behaviours and attitudes;
- Explore triggers to smoking as well as motivations for continuing to smoke and barriers to quitting;
- Understand the role of cigarette brands in women's lives – image, packaging, price, level of promotion;
- Understand any messages which resonate or any short/long term triggers to quitting.

Research methodology

Three discussion groups were conducted lasting one hour with six smokers in each session. Each discussion group was held with women from different age and social class groups (see *Figure 1 below*).

A good spread of smokers of different cigarette brands were represented in the groups as well as a mix of "happy smokers" and those who would like to give up. A series of attitudinal statements was used to identify those who were "happy smokers" and those who "would like to give up".

Before attending the discussion groups, participants were asked to text a web hub to record:

- When they were smoking;
- How they felt when they were having a cigarette;
- If anything caught their attention that made them think about giving up.

Research findings

Smoking attitudes and behaviours

When?

The time of the day when women smoke varies but common times include:

- Morning times: After waking or on the way into work (mainly in car);
- Break times: Either at work or at home;
- Evening times: Watching TV during quiet evening times or on night out.

BC1s were more concerned with hiding behaviour in workplace and smoking alone; C2Ds' smoking patterns were more accepted among peers.

Figure 1

Group	Smoker type	Age	Social class	Location
1	Regular smokers (mix of "happy smokers" and those who would like to give up)	18-24	C2D	Dublin
2		25-34	BC1	Dublin
3		22-27	C1C2	Dublin

Where?

Smoking in the home is very uncommon and most women smoke in their cars and/or outside.

Most common places to smoke include:

- Outside the workplace (BC1s hide due to embarrassment);
- Outside the back of the home;
- Smoking area in bars/clubs – this is the most enjoyable area for women to smoke.

How often?

The number of cigarettes smoked per day varies from 5-20. During the week women have a routine and smoke a similar amount each day. However, at the weekend women smoke far more and often tend to lose count when socialising.

Attitudes to smoking

Changes to the law and increased education have moved smoking from an acceptable habit for women to something they are ashamed about. Women reported feeling embarrassed to smoke in front of non-smoking colleagues, friends or members of the opposite sex. They were conscious of how their smoking affects others and how others perceive them.

Smoking in the home is no longer acceptable and the women felt that the only place left to go is the designated smoking area.

In the past the women were part of a big circle of regular smokers where most friends and family smoked. Now there is an increase in the number of social smokers with many people only smoking on nights out.

The triggers for smoking which women reported are multi-faceted. There is a very strong association with socialising, alcohol and a good night out. Smoking on a night out usually equates to more fun and increased opportunity for social interaction. Many of the women feel that smoking is a great way of meeting people of the opposite sex on

nights out. Alcohol and cigarettes go hand in hand. The smoking area is a fun place to be and it is easier to start a conversation with someone in the smoking area than it is in the bar.

There is an emotional connection with smoking for women. Women feel that smoking acts as a stress reliever providing temporary relief from stress. Women are most likely to report feeling relaxed after having a cigarette.

Smoking is habitual and is part of the daily routine. Having a cigarette is part of a ritual. A cigarette is often an accompaniment to the enjoyable parts of the day e.g. after a meal with a coffee. Often smoking provides women with something to do and a release from mundane daily life.

Motivations and barriers to quitting

Awareness of the negative health implications of smoking is high. Women are very aware of the various health risks associated with smoking. Unprompted top of mind associations include: Lung/throat/cervical cancer, heart and circulatory problems, emphysema, damage to the foetus and limb damage.

However, action taken through increased education is low. Women are now de-sensitised from hearing about all the ill effects smoking can have. This had led to a "we're all going to die anyway" attitude and a feeling that "everything is tied back to smoking" so a lack of credibility in relation to the actual direct effects of smoking is starting to creep in.

Stories of those who smoked heavily and lived long lives provide hope to female smokers. The invincibility of youth is very apparent as 18 to 24 year olds are least concerned about health risks.

In the short-term, two scenarios prompted consideration of quitting or a period of abstinence: a serious health scare of a family member or a minor personal illness or health scare. However, smoking resumes once the shock has worn off or women recover.

Women rationalise the long-term effects of smoking through avoidance, denial and scepticism but some powerful motivators to quitting were identified with vanity and shame being most prevalent. Finances, pregnancy and children were also mentioned.

There is a big difference between short-term triggers and long-term motivations to quitting smoking. Short-term triggers are transient and easily overcome; long-term motivations run deeper and if tapped into can be huge opportunities to encourage permanent smoking cessation.

The negative effects of smoking on their physical appearance and fear of speeding up the ageing process both resonate strongly with women. All acknowledge the contradiction between investing heavily in beauty products (especially anti-ageing products) and the corresponding perceived detractor of beauty due to smoking.

Improved finances can often reward quitters or form part of goal setting to aid quitting, however, it is not a major deterrent to smoking regardless of age or social class. Saving money is seen as more of a benefit to quitting than a strong motivator. Smoking is factored into the budget - women will scrimp in other areas in order to keep smoking. Hand rolled cigarettes are becoming more popular due to cost savings.

Women were aware of the black market but not drawn to it. Some had friends/family who had purchased black market cigarettes but no participants had pursued them first-hand. Fear about the ingredients was the main deterrent to purchasing tobacco on the black market. Most stocked up on duty free cigarettes or "foreign" cigarettes when abroad.

Pregnancy is the one tangible event in life that all women claim would make them quit immediately and for good. However, the reality was different for existing young mums. Mothers in the group had successfully given up while pregnant but resumed smoking once their baby was born. This created an additional layer of guilt for young mums. Despite efforts to conceal smoking, most children know their mothers smoke - *"he refers to them as mammy's smokes and I hate it"*. Mothers (regardless of social class) want to quit so children do not learn the habit.

The barriers to quitting smoking are multi-faceted.

1. *"It will mean the end of my social life"*
Most feel it would be impossible to get through a weekend without smoking and claim they would have to give up going out. The opportunities to meet people would diminish and it is much better fun in the smoking area.
2. *"I'll get fat"*
Women ate more during previous attempts to quit and are afraid of weight gain.
3. *"I will be impossible to live with"*
Women fear the mood swings they assume will come with quitting.
5. *"I am a happy smoker "*
A minority are happy smokers and have no plans to give up.
4. *"I see no reason to"*
Majority believe they can reverse the effects of smoking after a certain period of time.

Previous quit attempts

Many previous attempts to quit smoking have been unsuccessful. Most resumed smoking during a moment of stress or weakness but despite this, they still feel they can give up no problem; failed past attempts do not dampen their beliefs about future success.

Despite the failure of previous quit attempts, most feel they would just go "cold turkey" when giving up and that simple willpower would be enough although support through a helpline was welcomed to help get through the initial craving period.

Impact of stop smoking campaigns

Almost all of the smokers had seen previous communications which were designed to encourage them to quit smoking. Women claim to be de-sensitised from smoking communications and switch off. Ultimately, the communications do have an impact on women. Making the conscious decision to switch off or ignore means they feel uncomfortable enough to take action.

Brand

Strong brand loyalty exists particularly among heavier smokers. Women feel that often the brand smoked says something about them and the type of smoker they are. Traditional brands have a very specific consumer profile and command long-term loyalty from consumers. Marlboro Lights and John Player Blue were the most popular brands smoked.

Taste

Taste is important for all; described as "pull", "drag", "how it feels in throat". Heavy smokers are less easily swayed from the taste they are used to.

Packaging

New packaging designs on the market create buzz and word of mouth is very powerful. Packaging changes have an effect.

Value for money

Value for money is not a massive consideration for most but some do move to value for money cigarettes when times were tough or "at the end of the month".

Health

Hand-rolled tobacco and menthol cigarettes are erroneously seen as being less harmful. Due to the hassle of rolling cigarettes, many claim to smoke less so they feel healthier. Menthol cigarettes are seen as a way of cutting down.

Impact of packaging

Women were shown examples of cigarette products which have been designed specifically to appeal to women. Pack design peaks female interest – many are drawn to "elegant", "feminine" packaging and would like to be seen with these packs. Slim cigarettes were perceived as being "light" and "better for you". These cigarettes particularly appealed to those who identify themselves as "social smokers".

Packaging developments across various brands were well known – word of mouth is the most powerful way of discovering new packaging. New packaging generates a buzz among female smokers and a desire to try a new brand – "for a change", "when cutting down", or for the "novelty effect".

Brands have definite consumer profiles - white packs appeal more to women, especially social smokers, as they are more feminine and elegant looking.

While there may be no commitment to permanently switch, new packaging generates interest, motivation to purchase and a general buzz among female smokers.

All claim that while packaging is not the primary decider when choosing cigarettes, it does have an influence and the more "feminine" the packaging, the more appealing it is to them. Packaging makes a difference and while smoking is perceived as anti-feminine by many, any efforts to counteract this are welcomed wholeheartedly – Vogue & Marlboro Lights were most commonly mentioned as "female oriented".

Facing the Crisis: Conference report

In response to this serious problem of women and smoking, the Irish Cancer Society and the National Women's Council of Ireland held a landmark conference which had the following objectives:

- **Explore why such high volumes of women are smoking;**
- **Encourage collaboration and partnership in tackling the problem of female smoking;**
- **Consult with policymakers, healthcare professionals and women's organisations on the barriers to quitting and supports needed to encourage women to quit smoking.**

Sixty delegates attended the conference for a day of information sharing and consultation. Participants to the conference included HSE representatives and smoking cessation officers, representatives from women's groups, lay community smoking cessation officers, and healthcare professionals. A full list of participants is included in Appendix 2.

Speakers



Sineád Pentony is Associate Director at Trinity Foundation, Trinity College Dublin. At the time of the conference Sineád was Head of Policy at TASC. Sineád has a background in economics and equality. Sineád's recent work includes an examination of the gender

impacts of budgetary measures – *"Winners and Losers? Equality Lessons for Budget 2012"*. Sineád also contributed to TASC's series of essays on a flourishing society – *"The Role of the Economy in a Flourishing Society"* and she co-authored with Sara Burke on TASC's Eliminating Health Inequalities – A Matter of Life and Death. Sineád also manages a number of other TASC research projects in the area of industrial policy and economic inequality. Previously, Sineád spent ten years heading up Pobal's research programme where she managed the evaluation of a range of programmes and contributed to OECD conferences and publications on the evaluation of social inclusion programmes.



Dr Jude Robinson is a social anthropologist at the University of Liverpool, and for the last 15 years has researched choice in constrained circumstances, specifically the complex issues that people, particularly women, experience when attempting to make *"positive"*

changes to their lifestyles to improve their health and wellbeing. Much of her recent research has been on smoking and second-hand smoke, linking tobacco use to issues of gendered inequalities, social justice, alternative moralities and the politics of representing the health of women and children living in the UK.



Professor Amanda Amos is professor of Health Promotion at the Centre for Population Health Sciences at the University of Edinburgh. She has been teaching and researching health promotion for over 25 years. Her main area of research is smoking and tobacco control.

Her current research includes evaluating interventions on smoking in the home and smoking cessation, reducing inequalities and smoking, and investigating young people's sources of cigarettes. Amanda is a member of the UK Centre for Tobacco Control Studies, the Scottish Ministerial Working Group on Tobacco Control and the Board of the International Network of Women Against Tobacco (Europe).



Finbarr O'Connell is a Consultant Respiratory Physician and Clinical Director of Respiratory Medicine at St James's Hospital Dublin (which sees over 25% of all Irish lung cancer patients and carries out 50% of Irish lung cancer surgical resections). He

was a co-founder of the All-Ireland Lung Cancer Forum and principal author of the 1st All-Ireland Guidelines for Clinical management of Lung Cancer. He has a particular interest in rapid diagnosis and staging of lung cancer.



Health inequalities in Ireland today

Sineád Pentony

Head of Policy, TASC

TASC is an independently funded think tank which conducts research and policy work on a number of issues such as economics, social policy, open government and tries to influence policy on these issues. TASC published a report called Eliminating Health Inequalities – a Matter of Life and Death which looked at the international and national evidence on the relationship between economic and health inequalities.

People's health depends on a wide range of factors such as where you live, where you grow up, your education, what you earn, where you grow old and inequality. People often think the health system has a big impact on one's health but social determinants of health such as income, wealth, housing, life opportunities and inequality have the most impact on our health. However, an inadequate health system and restricted access to that system exacerbates health inequalities. At present, there is a focus on treatment rather than prevention and this is impacting on inequalities.

The other factor in relation to the social determinants of health is the distribution of wealth and income. Overall levels of wealth and income are not as important as how wealth and income are distributed. In 2008 the Gross National Product of the US was higher than that of New Zealand. However, in New Zealand life expectancy was 1.5 years higher because of more even distribution of income and wealth.

We have made progress on health in general in Ireland. We compare well internationally in terms of measures

such as life expectancy and child mortality. However, we have not made progress on reducing health inequalities. So while we have done well in terms of life expectancy, we have not achieved the same levels of life expectancy across different social classes.

Research by the CSO has looked at life expectancy across the social classes. Professional males can expect to live to 81, while unskilled manual workers have a life expectancy of just over 75. An unskilled manual worker is more likely to live in a deprived area and have less access to education. The difference is not as great for women- a professional women can expect to live to around 86 while an unskilled worker will live to around 82 (CSO, 2010).

According to data from Census 2011, when participants were asked to rate their own health, approximately half of those who reported having "very bad health" belonged to the lowest socio-economic group (unskilled). In contrast, approximately 3 per cent of the highest socio-economic group (professional) reported themselves as having "very bad health" (CSO, 2012).

As we can see in Figure 2 (CSO, 2010), disposable income increased until 2008 when it began to fall for economic reasons. Poverty was falling until 2009 and we are now beginning to see the impact of austerity. GINI coefficient, which is used to measure income inequality, was reducing until 2008 but this is now increasing, as is income distribution which measures the gap between the lowest and highest earners.

Figure 2

	2006	2007	2008	2009	2010
Income (€)					
Disposable income	21,229	23,610	24,380	23,326	22,168
Poverty (%)					
At risk	17.0	16.5	14.4	14.1	15.8
Consistent	6.5	5.1	4.2	5.5	6.2
Indicators of income equality					
Gini coefficient	32.4	31.7	30.7	29.3	33.9
Income distribution	5.0	4.9	4.6	4.3	5.5

These changes are relevant to the issue of women smoking, women are concentrated in lower income brackets and international evidence shows that in more unequal societies, women are more likely to smoke, have chronic illness and die earlier.

In December 2011, the Council of European Union adopts the conclusion that *“closing health gaps within the EU though concerted action to promote healthy lifestyle behaviours”* was essential. The European Public Health Alliance were of the opinion that this conclusion didn't go far enough and criticised the Council's conclusion because of an over-emphasis on *“downstream”* policy solutions such as prevention instead of addressing *“upstream”* issues such as addressing the root causes of inequalities.

More equal societies almost always do better in areas of mental health, child mortality, and obesity. So equality is very important for health (Wilkinson and Pickett, 2009).

The Programme for Government includes a commitment to free GP care and greater health equity through universal health insurance. We will also have a new public health policy which is being written at the moment - *Your Health is Your Wealth: A Policy Framework for a Healthier Ireland 2012-2020*. The terms of reference for this policy aim to address the wider determinants of health and health inequalities in addition to looking at chronic disease and lifestyle.

“We have made progress on health in general in Ireland. We compare well internationally in terms of measures such as life expectancy and child mortality. However, we have not made progress on reducing health inequalities. So while we have done well in terms of life expectancy, we have not achieved the same levels of life expectancy across different social classes.”

Health inequalities in Ireland today / continued

TASC's submission on the new public health strategy advocated that public health policy should aim to protect the whole population from ill health; facilitate people to live longer, healthier and more fulfilling lives; and reduce health inequalities by improving the health of the poorest, fastest. TASC highlighted the importance of examining health holistically and beginning with the early years; then moving on to children and young adults; followed by an examination of employment and working conditions; and more broadly, giving consideration to healthy communities, health and wellbeing in old age. The provision of high quality, publicly funded and universally accessible public services with a strong focus on preventative measures is also important.

TASC has been making the case for a different economic model, one which is based on productive investment rather than speculation; is job rich; and maximises our competitive advantages e.g. agriculture and renewable energy. We need to make the most of what we're good at. There is a relationship between the health of the economy and the health of the nation, and employment plays a big part in people's health.

I stated earlier that income, wealth, housing, the environment, education, life opportunities and the level of inequality have an impact on health. This means that government decision on taxation and public spending (fiscal policy) has a direct impact on income equality. TASC's research *Winners and Losers? Equality Lessons for Budget 2012* shows that Budget 2011 affected women more in lower income groups in terms of income reductions. More specifically, the research found that single parent families, who are primarily lone parents, lost more of their income than any other type of household. This research highlights the need for proposed budgetary measures to be equality proofed to ensure that they do not have a disproportionate affect on low income and vulnerable groups. This is common practice in a number of countries, so there is plenty of evidence that we can draw on to develop a similar process here in Ireland because we cannot address health inequalities until we have a more equal distribution of income and resources.

Public services are also important. The international evidence points to two areas that have the biggest impact on reducing health inequalities. These include investment in early childhood education and public health systems. We are in an EU/IMF bailout fund but we still have choices. Primary care has been "the poor relation" of the health services. However, the Programme for Government gives us some hope that primary care is finally a political priority. If we can succeed in developing a primary healthcare system that is of the same standard as our European neighbours, we will make a lot of progress in terms of developing preventative measures; treating illness at the lowest level of complication in a community setting; reducing the cost of healthcare; and ensuring it is accessed on the basis of need and not ability to pay.

It is important to remember that health inequalities are a preventable cause of death but these inequalities cannot be addressed without political leadership, institutional reform, evidence-based policy making and a health financing system that is founded on the basis of solidarity.



Women and smoking: understanding the generational cycle of inequalities

Dr Jude Robinson

Reader in the Anthropology of Health and Illness,
School of Law and Social Justice, University of Liverpool

Population based interventions, such as media campaigns and legislation may change wider social attitudes towards smoking and reduce both rates of smoking and numbers of cigarettes smoked across a population, but they do not necessarily reduce health inequalities (Greaves, Vallone, & Velicer, 2006; Thomson, Wilson, & Howden-Chapman, 2006). While overall smoking rates are dropping in Ireland to around 23% (Department of Health, 2011), smoking rates in poorer communities remain high. High levels of smoking are linked to multiple social and economic disadvantages, ill health, and poor life expectancy (Graham, 2012; Graham, Inskip, Francis, & Harman, 2006; Marsh & McKay, 1994).

Despite comprehensive tobacco control policies and media campaigns, health warnings and advice do not always resonate with people who smoke who have their own explanations of the reasons for their own and their children's poor health (Robinson & Kirkcaldy, 2007).

Other challenges to tobacco control initiatives and media campaigns, include the reaction of smokers to the "denormalisation" of tobacco, as some smokers report that they now feel "stigmatised" by their smoking (Ritchie, Amos & Martin, 2010) and are reluctant to talk about their smoking and so remain "hard to reach" in terms of service delivery, suggesting a need for innovative thinking and practice to (re-)engage with them (Parry, Bancroft, Gnich, & Amos, 2001; L. Thompson, Pearce, & Barnett, 2007).

Smoking relates to widely held cultural and social norms within communities and households which can act to

sustain smoking even among people who would like to quit (Poland, 2000). Smoking behaviours remain deeply embedded in people's lives and when combined with addiction to nicotine, make it very difficult for them to quit (Bancroft, Wiltshire, Parry & Amos, 2003).

"Women are sicker, but men die quicker"
(Quoted in Gatrell 2008: 2).

We are looking at a situation of uneven distribution of smoking not only within the population but within communities where smoking rates are high, as younger people aged 18 to 44 years are more likely to smoke than people aged 65+ (13.5%). While around 23% of adults smoke, around 30% of these are people aged 25 to 34 years. Rates of smoking are linked to social class and in Ireland 56% of women aged 18 to 29 years from SC 5-6 are smokers, which is twice the rate among women in SC 1-2 (28%) and significantly more than women in SC 3-4 (36%) (SLÁN, 2007). As women in Ireland live around 4.8 years longer than men with healthy life expectancy for females of 81.6 years compared to 76.8 years for men (CSO, 2009), there is a temptation to overlook women's health issues. However it is important that as many of these years as possible are lived in good health and disability-free life years for women in many EU countries are actually less for women than men. In Ireland, women are more likely to be hospitalised than men, with 343 hospital discharges per 1,000 women compared with 305 discharges per 1,000 men (Women and Men in Ireland 2011, CSO).

Disability-free, healthy futures for women are important as women make a critical contribution to family life and often act as the main or sole carer of children and maintain the health (directly and indirectly) of other family members, so the future health of the entire population more or less depends on women (Blaxter, 1981; Graham, 1984). In addition to maintaining their families' physical health and wellbeing, women invest energy in the "emotional work" required to keep families together and to make them function effectively. Married women suffer from poor mental health compared to married men and single women, attributed to a loss of identity, change of status from independence to dependence, the toll of routine domestic work and caring responsibilities for others and their lesser role in major household decision making, including such as where they live and whether they move house, contributing to this.

The cycle of smoking inequalities for women

We know that as more women started to smoke, they also began to change their smoking habits to smoke more and inhale more deeply, leading to an increase in their risks of developing serious diseases and dying prematurely (Payne 2001). The incidence of lung cancer amongst the poorest women in Ireland is 1.7 times that of the most affluent (NCRI, 2011).

Thinking about women's smoking it is possible to extrapolate a model of smoking whereby smoking behaviours and the adverse economic, social and health consequences of smoking are passed on from women, to their daughters and sons, and this makes it more likely that in turn their children, particularly any smoking daughters will pass these (preventable) risks to their children (see *Figure 3*). While this negative cycle of smoking behaviour can be extended to include men, their smoking is less likely to directly affect children, as women who spend more time in the home caring for children, are more likely to be heads of lone parents households, other women (grandmothers/ aunts) are more likely to support mothers in caring for children, and the effects of smoking during pregnancy are more immediate if it is the mother who smokes (Hofhuis & Merkus, 2003). However, male smoking remains problematic, as women who are exposed to second-hand smoke (SHS) can develop health problems, and inhaling SHS is a risk for pregnant women. In addition, women smokers whose partners smoke are less likely to be able to quit, more likely to resume smoking after the birth of their child if they did

quit during pregnancy (Bottorff, Kalaw, Johnson, Stewart, Greaves & Carey, 2006) and so male smoking does affect a family's health and sustains the smoking behaviour of women, even if the man smokes outside (Robinson, Ritchie, Amos, Cunningham-Burley, Greaves & Martin, 2010).

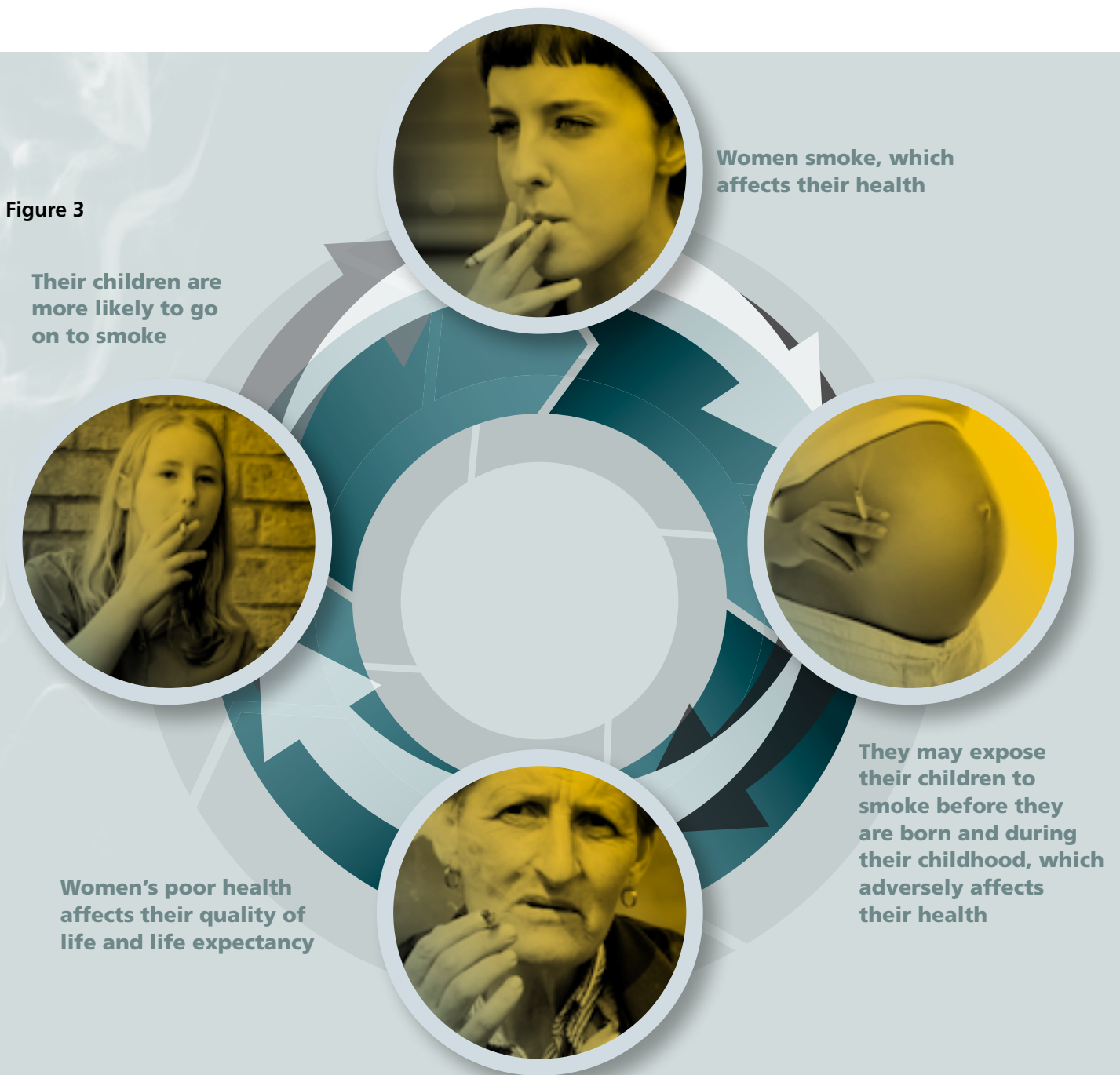
Starting smoking

The most effective tobacco control initiatives intervene to stop people smoking in the first place. Encouragingly, while one in seven 15 to 17 year-olds (14.3%) reported smoking, current smoking rates for those aged 15 to 17 years have decreased for both adolescent boys and girls between 2002 and 2006 (SLÁN, 2007). While in 2006, smoking rates among girls aged 15 to 17 were five to eight percentage points higher compared to boys of the same age within the same social class groups (SLÁN, 2007), more recent data from the Health Behaviours of School-aged Children Study (HBSC) 2010 showed a drop in ever smoking among older girls (47% in 2010 vs. 57% in 2006). However once people have started smoking it is hard for them to stop, and the 36% of 15 to 17 year-old female adolescents in SC 5-6 who reported smoking in the HBSC 2002 survey now form part of the 55% of 18 to 23 year-old women in SC 5-6 who reported smoking in SLÁN, 2007, and who are likely to be current smokers. These data suggest that not only is there a high level of smoking initiation among young women from 15 years especially in SC 5-6 (SLÁN, 2007), but women are also taking up smoking later in life after they have left school. It is worth noting that smoking initiation is linked to other risk taking behaviours and one of the consequences from this can be unplanned pregnancy.

Smoking and pregnancy

The Irish Cancer Society focus group research found that young smokers think they are "invincible" but many believed that they would quit if they became pregnant. However, we know that around 20% of women in Ireland smoke during pregnancy and that smoking during pregnancy has been normalised in some communities (Growing Up in Ireland, 2010). Women under 25 years who become pregnant are more likely to smoke and are less likely to take folic acid than older mothers (Tarrant, Younger, Sheridan-Pereira & Kearney, 2011). We also know that many women who quit during early pregnancy relapse during the later months or may resume soon after the birth of their child (Bottorff, Johnson, Irwin, & Ratner, 2000). That women can quit and then resume smoking indicates that smoking is more than a physical addiction, and that women have a psychological need or

Figure 3



desire to smoke. 40% of smokers had lower educational attainment, associated with leaving education early.

Smoking around babies and young children

Exposure to tobacco for babies and young children is linked to risk of pre-term birth, low birth weight, Sudden Infant Death Syndrome (SIDS), respiratory illness, glue ear and hearing problems, poor educational attainment and poor health over their life-time (Muller, 2007; Hofhuis & Merkus, 2003; Cook & Strachan, 1999). Children exposed to second-hand smoke are likely to live in neighbourhoods where smoking is high, live in poorer quality housing and generally suffer from multiple disadvantages, leading to serious health inequalities. Being born to a smoking mother

(and/or father) puts a child at serious disadvantage, and they are more likely to try smoking at a young age and go on to smoke themselves throughout their adulthood (Amos, Wiltshire, Haw, & McNeill, 2006) taking us back to the start of the cycle of smoking. After the introduction of smoke-free initiatives, children who live with non-smokers have experienced the highest reductions in exposure to second-hand smoke compared to children who live with smokers (Sim et al. 2010; Akhtar et al. 2007; Borland et al. 1999; Jarvis et al. 2000) and so exposure for children who live with two or more smokers has not really been affected by the legislation, increasing health inequalities between the poorest and the most affluent children.

Why do women smoke?

It is surprising that the mothers of young children, who invest much of their physical, mental and financial resources in raising children, are more likely to smoke rather than women without children (Graham, 1994; Graham, Inskip, Francis, & Harman, 2006), suggesting that smoking and caring go hand in hand. Analysis of the Living in Ireland 2000 data concluded that poverty, not a lack of willpower was the main factor as to why women in lower socio-economic groups continue to smoke. Layte and Whelan (2008) concluded that "measures of economic resources and enduring economic and social difficulties" accounted for the largest part of the differential between social classes. Women living in poverty experience issues of agency and control, with limited capacity to control other peoples' smoking, compounded by (mutual) obligations towards kin and friends (Lister, 2004; Robinson & Kirkcaldy, 2007a; Robinson 2008). Women can find it difficult to control the smoking behaviour of people around them, although recent research suggests that more women are able to ask their family and friends not to smoke near their children (Robinson, Ritchie, Amos, Greaves, Cunningham-Burley, 2011). It can be harder for women to leave the room or go outside if they do not live in affluent and safe areas, as fears for their own and their children's safety may mean that they believe it is better for them to smoke indoors (Robinson & Kirkcaldy, 2007).

How do these women justify smoking as carers? There are macro-societal discourses of them as "bad mothers" but these are countered by narratives of their being "good mothers" – with "moral tales" constructed to justify their smoking (Holdsworth & Robinson, 2008). Women tend to try to move away from the danger of smoking and talk about more immediate risks and also use humour to justify their continued smoking (Robinson & Kirkcaldy 2007; 2009). This is a coping mechanism but it is also a barrier to listening. Women talk about immediate risks like not wanting to leave a child unattended to go outside and smoke. Smoking is seen as a means of coping and taking a time-out, and an important de-stressor where control could hang by a thread. When asked if giving up smoking would make it harder to deal with stress in their lives, 33% of smokers from lower social classes (SC 5-6) and 33% of women overall agreed that it would make it harder, compared to 22% of smokers from higher social classes (SC 1-2) and 23% of men overall (SLÁN, 2007). The likelihood of stress was reported by half of female respondents from SC 5-6, indicating that smoking is used as a form of stress management by some women, and more so among those in lower social classes.

Smoking is an expression of mutuality, solidarity and sharing between women and a sign of their togetherness as well as "otherness". Smoking is an expression of self and identity and can remind the smoker that they were a person with needs, a narrative that has not really changed since Hillary Graham's research in the 1980s, suggesting that while legislation and the wider tobacco environment has moved on, these women's lives have remained largely unchanged.

Links between (under-) occupation and smoking

In SLÁN 2007, smoking rates among people in employment stood at 29% rising to 49% among the 3% of respondents who were "unemployed and currently looking for work" and 44% among the 4% who had "long-term sickness and disability". Smoking rates among people in employment are lower than those seeking work or on sick leave, suggesting a subtle relationship between smoking and employment. Research suggests that women working outside their homes are too busy to smoke, but women are under-employed when they are at home and so smoke more (Robinson, Ritchie, Amos, Cunningham-Burley, Greaves & Martin, 2010). There is a lot of work involved with caring for a child at home but this work may be mentally unchallenging. Although women in Ireland are more likely than men to have a third level qualification, Irish women work fewer hours, earn less and are under-represented in the Oireachtas and in local and regional authorities compared to men (Women and Men in Ireland 2011, CSO). Women are also more likely to have part-time, or insecure jobs, and more likely to suffer from stress, and have less power at work and take on large amounts of unpaid work associated with low-status and low self-esteem, exhaustion and depression. The leads us right back to emotional work and mental health issues women have and back to smoking. Hard work and being poor lead to stress, and as stress is linked to increased smoking, the cycle continues.

Quitting

We know that health workers sometimes find it difficult to raise the issue of smoking, or focus on smoking if there are competing health priorities, and fear compromising their relationship with their patients. However other research indicates that women expect to be spoken to about their smoking, as long as it is not a "lecture", doesn't patronise them and demonstrates some understanding of their day to day lives (McLeod, Benn, Pullon, Viccars, White, Cookson,

& Dowell, 2003). Targeted approaches with particular occupational groups and the unemployed need to avoid stigmatising these groups and should take account of how the "lived experience of socio-economic deprivation" reinforces and sustains smoking behaviour (SLÁN 2007). Any new measures should take into account how daily life makes it more likely that some people may smoke, and creates barriers to quitting. Barriers to quitting smoking, or smoking outside the home are experienced differently by mothers and fathers, reflecting the gendered roles of caring (Graham, 1994; Greaves & Jategaonkar, 2006; Greaves, Kalaw, & Bottorff, 2007; Royce, Corbett, Sorensen, & Ockene, 1997; Thompson, Parahoo, McCurry, O'Doherty, & Doherty, 2004). Women were less likely (16%) than men (23%) to report successfully quitting smoking. 36% of female smokers (compared to 27% of men) expected that they would put on weight if they stopped smoking, suggesting that some women may be using smoking as a method of controlling their weight (SLÁN 2007). There is evidence that women and men respond somewhat differently to nicotine. For example, female addiction may be reinforced more by the sensory and social context of smoking rather than by nicotine itself (Brigham, 2001). Smoking is often one part of a constellation of behaviours and mental states. Smoking links with excess alcohol intake, lack of physical activity, mental health problems and poor quality of life. Multifaceted interventions to promote physical and mental health are thus needed (SLÁN, 2007).

Concluding remarks

Intervention at every point of this cycle is essential, and by breaking the cycle, the social, economic and health

benefits are passed on not only to the women smokers, but to their children and to other family members who they care for and support. Current legislation does not touch this group of women as they smoke in the home or outside their places of work and it is not illegal to smoke during pregnancy. Cessation is the ultimate goal when it comes to smoking, but some projects resulted in major cutbacks and harm reduction. We cannot call these project failures because they did not get total quits but do result in women cutting back on smoking.

We need to understand the sustaining benefits of smoking for women, as if women do see smoking as a distressor and as a bonding agent, then what are offering women in return? We need to be critical in our public health perspective to understand why women still smoke, and why women in developing countries may take up smoking. We need to find the motivator for individual women and make sure they do not feel that smoking supports them and their caring more than other supports available to them. However women are unlikely to be motivated to quit solely by concerns for their own health and wellbeing but rather the health of others, particularly their children. Some of the most successful interventions are done by touching on the harms of smoking to the whole family and by emphasising the positive message of future economic and health benefits. There are key moments, teachable moments when people are more likely to quit, for example when women are young, when women are pregnant, when the baby is born. These are the times when we need to engage with women and their families to ensure they are motivated and supported to reduce and quit their smoking and that such behaviours are sustained in the longer term.

"Intervention at every point of this cycle is essential, and by breaking the cycle, the social, economic and health benefits are passed on not only to the women smokers, but to their children and to other family members who they care for and support. Current legislation does not touch this group of women as they smoke in the home or outside their places of work and it is not illegal to smoke during pregnancy."



Marketing tobacco to women

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The tobacco industry has been targeting women for almost 100 years. The views which women have about smoking are not accidental. These views have been manipulated by the tobacco industry to continuously portray positive images of smoking. Since starting to target women in North America and Northern Europe in the 1920s and 1930s the tobacco industry has become more sophisticated in its marketing strategies, developing a diverse range of messages, products and brands to appeal to different segments of the female market.

One of first campaigns was the Lucky Strike campaign "Reach for Lucky instead of a Sweet" in 1925 which targeted women's weight concerns. This was one of the first media campaigns targeted at women. The message was highly effective and more than doubled Lucky Strike's market making it a best-selling brand.

Practically everything women aspire to has been targeted by the tobacco industry.

Smoking has been promoted to girls and women as being:

sophisticated
sporty glamorous romantic healthy
sexy emancipated sociable COOL
rebellious relaxing fashionable
liberating slimming fun calming

It is not just advertising that the tobacco industry uses, they have also used actors, people we look up to, and have promoted smoking through product placement in films. The tobacco industry used Hollywood stars in ads and also ensured that Hollywood stars were well supplied with cigarettes and often paid them to give endorsements in advertisements. Even nowadays, western celebrities are used in third world countries to promote brands.

Legislation in Ireland and the UK has been extremely effective. There has been a change in attitudes to smoking and major restrictions have been imposed on the tobacco industry. Women know about the dangers of smoking so tobacco companies have a challenge; they have to make smoking something which women want to do and to make it acceptable. Tobacco control legislation has shifted the ground, but the tobacco industry knows that cigarettes need to be accessible, at a price women can afford and they want to keep women addicted and to make it difficult to quit.

The tobacco industry faces challenges marketing its products to women. It needs to make cigarettes and smoking:

- Aspirational (desirable and fashionable);
- Acceptable (socially and culturally);
- Accessible (available and affordable);
- Addictive (long term behaviour).

Smoking is declining and Ireland has taken important action on tobacco control including bans on many forms of tobacco advertising and promotion. But experience in many countries has shown this just makes the industry more creative in using the marketing mix to exploit loopholes and reach girls and women in new ways.

The industry markets its products using the Four Ps of the marketing mix:

- *Promotion* - e.g. advertising (billboards, press), sponsorship, point of sale, merchandising, mail, internet, brandstretching, product placement;
- *Product* - e.g. cigarette, packet, pack size;
- *Price* - e.g. range, smuggling;
- *Place* - e.g. shops, vending machines.

The Marketing mix – Ireland:

- *Promotion* - e.g. merchandising, mail, internet, brandstretching, product placement;
- *Product* - e.g. cigarette, packet;
- *Price* - e.g. range, smuggling;
- *Place* - e.g. shops, vending machines.

Promotion can be advertising, sponsorship, or it can be on the internet. The tobacco industry also looks at what they can do with cigarettes and the packets they come in. They offer a range of prices that people can afford and this links in with smuggling, as some tobacco companies have been complicit with this in the past. Cigarettes are easily available at any time of the day or night.

Ireland has taken some important action on the promotion and marketing of tobacco. Advertising has been banned, promotion is banned, point to sale advertising is gone and they have stopped selling packs under 20. Pictorial warnings are being introduced in Ireland next year, however most available pictures are male so we need to consider whether they be attractive to women. Will women connect to these pictures?

The tobacco industry recognises the power of packaging. There has been huge growth in new types of brand and packaging. BAT's Chief Executive, Paul Adams, has said, "*BAT have done well on innovations. Product and packaging innovations are very important, particularly in relation to the consumer. We have recently introduced new flavours, new formats, new filter technologies, new blends and new packaging in terms of design and functionality – anything that delights or excites the consumer. Judging from the growth of our global drive brands, this is the right strategy*" (Tobacco Journal International, 2006).

Manipulating the product has become increasingly important not only in countries where there are ad bans- where the packet is the main form of communicating with smokers and potential smokers, but more widely particularly through "women only" brands and versions of brands that are designed to appeal to girls and women e.g. superslim, low tar. The tobacco industry also looks at what they can do with cigarettes and the packets they come in.

Marketing tobacco to women / continued

Superslim cigarettes are targeted at women. The colours used are appealing to women.

Quotes from the tobacco industry discuss the reasons for and benefits of superslim cigarettes: *“Gallaher is launching a range of super-slim cigarettes under its Silk Cut brand packaged in “perfume-shaped” boxes to appeal to the female market. Silk Cut Superslims is positioned as a premium cigarette that rivals Vogue Superslims from BAT. The female-friendly pack design would give it an edge”,* said Jeremy Blackburn, Head of Communications at Gallaher.

“The new design brings elegance and quality to the superslim cigarette sector, which is in its infancy but offering great potential.” (The Grocer, 2008).

Demislim cigarettes were released in 2011: *“Vogue Perle delivers a new modern format for the female smoker. The premium quality cigarette provides a satisfying taste experience similar to standard King Size (KS) cigarettes, only designed into a new feminine format and style. The new packaging, designed in Paris also reflects the more refined and accessible cigarette size, with rounded edges, and a soft yet tactile texture”* (Talking Retail, 2011).


There are Superslim brands that target disadvantaged women: *“Imperial Tobacco is delighted to announce the arrival of Richmond Superslims, the UK’s first “superslim” brand in the “value priced” cigarette sector. Super slim and super stylish, the unique pack design provides a smaller, discreet format that is convenient to complement busy modern lifestyles. Richmond Superslims’ novel size*

and contemporary design delivers added value and its proposition and price-point will undoubtedly prove to be a popular addition to Imperial Tobacco’s category-leading portfolio in the UK. The superslim and menthol segments of the tobacco category have seen significant, and consistent, growth in recent years and our on-going market monitoring told us the time is right to launch this new elegant superslim brand, at a great value price” (Talking Retail, 2011).

One would wonder how do women in Ireland know about new brands if they cannot see them in the shops? Women say they hear about new brands via word of mouth. Focus group research carried out by the Irish Cancer Society (Irish Cancer Society/Ignite Research 2012) found that packaging developments across various brands were well known- word of mouth is the most powerful way of discovering new packaging. New packaging generates a buzz among female smokers and a desire to try them – “for a change”, “when cutting down”, the “novelty effect”. Brands have definite consumer profiles - white packs appeal more to women especially social smokers, as being more feminine and elegant looking.

Packaging makes a difference. Smoking is perceived as anti-feminine by many, thus any efforts to counteract this are welcomed wholeheartedly. White packaging is seen as more feminine. Vogue and Marlboro Lights were most commonly mentioned as female oriented. While there may be no commitment to permanently switch, new packaging generates interest, motivation to purchase and a general buzz among female smokers

“Manipulating the product has become increasingly important not only in countries where there are ad bans- where the packet is the main form of communicating with smokers and potential smokers, but more widely particularly through “women only” brands and versions of brands that are designed to appeal to girls and women e.g. superslim, low tar. The tobacco industry also looks at what they can do with cigarettes and the packets they come in.”



The tobacco industry is continuing to innovate. The “click” cigarette, a cigarette that has a click in filter to make the cigarette turn menthol has been launched in the UK. This is a novelty. In Germany, there are mango, and mojito flavoured cigarettes. These are flavours young people like and we need to think about regulations being imposed there.

We need to think seriously about plain packaging. In Australia, where plain packaging is being introduced according to Citigroup, this will affect sales. Adam Spielman of Citigroup, April 2010 has said that they view *“generic packaging as the biggest regulatory threat to the industry as packaging is the most important way tobacco companies have to communicate with the consumer and differentiate their products.”* This demonstrates how plain packaging will affect sales of cigarettes.

The Framework Convention on Tobacco Control and the World Health Organisation position on plain packaging is that it will: reduce the appeal of smoking, increase salience of health warnings, and reduce consumer confusion about harms arising from misleading colours and descriptors. This has been supported by a recent systematic review of the evidence carried out for the British Government. Evidence shows plain packaging will reduce smoking rates, especially among younger people.

It is rather ironic given concerns about the devastating effect of smoking on women’s health, that one of only four women to head up UK FTSE 100 company is from Imperial Tobacco. In April 2010, Alison Cooper, Chief Executive of Imperial Tobacco said that *“The lion’s share of our attention has to be on driving sales”*.

In summary, the Irish Government should seriously consider introducing plain packaging and restrictions of cigarette modifications. We also need to work with the media because women and girls are still seeing positive images of women smoking.



Health effects of smoking

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There are approximately 7,000 deaths per year in Ireland from smoking related illnesses. These deaths can be broadly broken down as a third of deaths from cancer, a third from cardiovascular disease and around a third are from other lung diseases such as Chronic Obstructive Pulmonary Disease (COPD).

The TV ads running that tell us smokers have a 50/50 of dying from a smoking related illness are totally correct. Not many people know that the average number of years lost due to smoking is 16.

Heart disease accounts for approximately 40% of Irish deaths (Irish Heart Foundation, 2001). Arteries supply blood to the muscle, and heart disease is due to a build-up of abnormal matter called plaque which progressively blocks these arteries. Cardiac mortality is down by 20% over the past 15 years due to prevention and good intervention measures. The risks for heart disease are genetic, dietary, diabetes, cholesterol and smoking. The main preventable risk is smoking.

Of the cancers that are caused by smoking, four out of five cases are lung cancer but there are others including bladder, cervical, stomach, mouth and cancer of the upper airways. Lung cancer is the biggest cancer killer in Ireland for both sexes. This year lung cancer overtook breast cancer as the biggest cause of cancer death in women (National Cancer Registry/Northern Ireland Cancer Registry, 2011).

There are more cases of breast cancer but there is a better survival rate. Mortality rates for lung cancer are bad and there is a big difference between men and women. In men, cancer incidence is decreasing by about 2% per annum since 1994 and is now below the EU average. However, in women, lung cancer incidence is increasing and is double the EU average. Irish women are smoking for Europe.

The latest data from St James' Hospital shows that lung cancer in men versus women now stands at 54% v 46%. There was a six month period in 2010 where more women than men were attending with lung cancer. Women have caught up with men. It is worth noting that St James's Hospital is home to a lower socio-economic group so this is probably why there are more women attending than men as women smoke more in lower socio-economic groups.

Statistics show that women get lung cancer younger. Cancer is mostly a disease of people in their 60s and over but women get it younger. Until relatively recently the younger sufferers had bad survival rates, but this is starting to change as there are new treatments which are effective for non-smoking women with genetic mutations.

How do you get lung cancer? Contributing factors include genetic material from parents. There other risks which impact on genetic materials in the lining of the lungs. Smoking results in more genetic hits and can cause cancer in the lung. It is about how many genetic

hits you get over the years, there are parental genetic impacts which you cannot help but there are other impacts such as smoking that you can help.

Statistics show that if you can quit by the time you are 35 and you do not get cancer by the time you are 40, you are almost certain not to get it. If you can give up smoking in your early thirties your lifetime risk of lung cancer is almost as low as that of a non-smoker. If you are smoking at over 40, you will carry some of effects over.

If lung cancer is detected early and is only in the lung, it may be curable but if it is more advanced, it is almost never curable. Almost 75% people with cancer present at later stages. So what can we do to prevent cancer?

1. When someone presents, the doctor must diagnose the cancer correctly and provide the right treatment.

2. Data shows that lung cancer screening probably works and may decrease mortality and save money in the long run.

3. Prevention, this is the big one. 95% of the cancer in Ireland is related to smoking. Most of our efforts need to go here.

COPD is a smoker's disease. It is a combination of three diseases; chronic bronchitis, emphysema and asthma in some cases. Chronic bronchitis results from cigarette fumes in the lungs over long periods, phlegm gathers in the lungs and it is difficult to breath. Emphysema is where alveoli are dissolved by toxins. Asthma is where the muscles of the lungs contract.

In a normal healthy person, their lungs should deteriorate by 50% by time they are 90. If you smoke, you have a one in four chance of developing of COPD and if you have COPD your lungs will deteriorate more rapidly. COPD is purely a smoker's disease, and as women are smoking as much as men, they are getting it as much as men.

Messages about what smoking does to hair, skin should be used as a deterrent for women. For men, the message about impotence should be a strong message as impotence is caused by vascular degeneration.

In the past ten years, it seemed that smoking figures in Ireland had bottomed out but they have gone back up and 29% of people in Ireland now smoke. There used to be ten cases of lung cancer in men for every case in a women but it is now almost even. Men seem to have gotten the smoking message more than women.

There is no question that the tobacco industry is targeting young smokers, one tobacco executive when asked how young they want smokers said, *"if they have lips we want them"*!

Research from ten years ago shows that one in ten 6th class pupils smoke at least one cigarette a day and half had tried smoking. These figures are shocking considering the children involved are only eleven.

No matter how good health care professionals are, it looks like the tobacco industry is winning as one in four adults are still smoking. Professional carers should pick their targets, know who is looking for help, be firm and supportive, and give them plenty of information.

Prevention of commencement of smoking is the most difficult issue and in this area, the tobacco industry seems to be winning. This is a major challenge for society.

Coming together: Group consultation

In the afternoon, conference attendees participated in a group consultation in order to gain insights into the barriers and supports for quitting. Participants discussed the following questions:

- 1. Is tobacco on the health agenda of your organisation?**
- 2. What do you think the barriers to quitting smoking are for the women with whom you work or in your community?**
- 3. What supports are in place for women who want to quit smoking in your community?**
- 4. What do you think is needed to help women quit smoking?**
- 5. What do you think can be done at a community level to prevent women from smoking/ support women to quit?**
- 6. What do you think needs to happen at a national level to prevent women from smoking/ support women to quit?**
- 7. What do you think the NWC and Irish Cancer Society need to do to address the problem of women and smoking?**

The consultation provided valuable insights into the smoking behaviour of women and potential solutions to tackling the smoking epidemic. The key points from the consultation are summarised below.

Health agenda

All participants stated that tobacco was on the agenda of their organisation but they would like more to be done about it. Many felt that overall health is a priority, not smoking specifically and that smoking is not seen as a priority healthcare issue in the HSE.

Many felt that women are not fully aware of the effects and dangers of smoking. Women prioritised the health of their families over their own. Women were motivated to quit during pregnancy but often relapsed after birth. It was agreed that smoking is a complex issue which requires a different approach. We need to support women to be prepared for life and other conflicts that put pressure on their health and should use healthy living programmes to introduce women to the idea of quitting smoking.

Barriers to quitting

Participants were asked about barriers to quitting smoking. They identified a range of barriers to quitting including individual psychological barriers, social factors, access and availability of services, attitudes of health professionals, and tobacco industry manipulation.

For many women smoking is a coping mechanism. Smoking is used to relieve stress. Many women smoke out of boredom, particularly women who are at home for most of the day.

Smoking is an addiction and needs to be treated as such. Failed attempts to quit can make women think that quitting is impossible and nothing will work. Having support in place to show that relapse is a part of the cycle of change can combat this. Many women feel disempowered and unable to quit. They want something to do the quitting for them. Many women have an *"It won't happen to me"* attitude and do not think that they are vulnerable to the health effects of smoking.

Smoking plays an important role in social bonding for some groups. It is part of people's social lives and makes them feel like they belong and are part of a group. Smokers

have a sense of solidarity with other smokers and see themselves as a club under threat. This sense of solidarity has been reinforced by the smoking ban- smoking has been denormalised among people who do not smoke.

Social and family norms contribute to a culture of smoking. For many smoking is still considered normal and acceptable. Smoking is socially and culturally embedded in some communities. Many environments do not support women to quit. Communities are not smoke-free.

Smoking cessation services are inadequate and under-resourced considering the scale of the problem. Resources are too limited to provide training to health professionals and there are problems getting staff released to attend training. Smoking cessation services are not consistent across the country- there are waiting lists for smoking cessation services in some parts of the country. There is no network for smoking cessation officers. The title smoking cessation officer is off-putting to people.

Centralisation of the medical card system is causing a backlog and preventing people from visiting GPs and using Nicotine Replacement Therapy (NRT).

The public sector moratorium has created unfilled gaps in the health service. Health professionals do not have enough time to support people to quit

There are problems with some healthcare professionals' attitudes to smoking. Many clinicians hate asking adults if they smoke. Some staff enable smokers. In hospitals, nicotine addiction is not treated as a vital sign. Smoking is hardly mentioned in clinical care progression – there is only a 25% referral rate from consultants to smoking cessation staff. In the hospital setting, all programmes for developing clinical care pathways for chronic diseases need to include smoking as a risk factor and provide referral guidance for patients who are smokers to enable them to get support to quit.

The health promotion module for medical students and nurses is optional in practical terms as it is not part of the exam structure. The content needs to be part of their exams. Training of all healthcare professional and students of health promotion in tobacco, the health effects of smoking, and first level/ front line brief intervention in smoking cessation for patients is required

There are problems with access to services. Literacy problems are a barrier to accessing smoking cessation services and resources. Travellers face discrimination when accessing the health service. This prevents them from using services. Services will not come in to some areas.

Online support is good but not accessible for many travellers and people in disadvantaged areas or those with literacy problems.

Tobacco is legal and easy to get. Tobacco industry marketing is tapping into gender stereotypes- women do not realise they are being conned. Women's fears over weight gain are being manipulated. Countering the tobacco industry requires a bottom up strategy for communities to get behind.

Supports to help women quit

Participants were asked about supports to help women quit smoking. The following supports were identified, however it was agreed that the scale of these services and the formal support available in community settings, need to be increased and delivered more systematically.

- Online support such as Quit.ie and Facebook;
- Smoking cessation officers;
- Community lay advocates;
- GPs;
- Pharmacies;

“Social and family norms contribute to a culture of smoking. For many smoking is still considered normal and acceptable. Smoking is socially and culturally embedded in some communities. Many environments do not support women to quit. Communities are not smoke-free.”

- Nicotine replacement treatment through the GMS;
- Interventions by dentists.

Participants identified a variety of supports and initiatives which are needed to tackle the problem of female smoking.

A flexible approach to tackling female smoking is needed. There is no “one size fits all model” and issues such as literacy, language and access to internet need to be considered. Different social groups will need different approaches and resources. The needs of traveller women in particular were highlighted.

Participants identified the importance which smoking plays in social bonding and the sense of solidarity which smokers share as a barrier to quitting. Community-based cessation programmes that encourage solidarity among women who want to quit smoking are needed. Cessation groups should use a Weight Watchers model where women support each other in reaching their goal. Social elements that promote healthy lifestyles and combat the isolation women may feel when they stop smoking such as walking groups and stress management sessions should be incorporated into programmes.

Community level support

Community “health awareness and personal development” programmes are needed to support people to get to the pre-contemplation stage of the cycle of change. Programmes should incorporate stress management and breathing exercise to address the perceived stress relief women get from smoking.

Women feel a lot of shame about smoking and any efforts to encourage women to quit require a non-judgemental approach.

Supportive environments for women who want to quit smoking are crucial. The Fresh UK model of Smoke Free

Communities was highlighted as a successful approach. Fresh UK work with a wide range of stakeholders and services in the local communities to tackle smoking on many levels.

The Smoke Free Hospital Campus initiative was welcomed and should be extended to cover college campuses. Companies should provide opportunities for employees to seek help to quit smoking. Local gyms and sports facilities should provide front-line brief interventions as part of fitness assessments.

Women’s groups are a good channel through which to reach out to the community by providing information.

National level support

All healthcare professionals should be involved in frontline interventions with smokers. Healthcare professionals should be trained to provide brief interventions with smokers. There must be support from management for smoking cessation interventions and healthcare professionals should be encouraged to carry out interventions as a vital part of their work.

Well Woman Clinics should collect data on smoking and abnormal smears.

Participants felt that a national strategy and standards for cessation services are required. The impact of services should be measured annually and this is information should be readily available.

People must be able to access cessation services in the community and not just hospitals. Community based smoking cessation services should be made available to all who need them. Group and individual services are needed. The HSE should develop services to meet the needs of different communities using community champions and training. The cessation services should consult with MABS to highlight the financial impact of smoking and recruit people from smoking cessation programmes.

The services need to be proactive rather than reactive. They need to go where smokers are and make sure information and support goes to the people who need it most.

Awareness campaigns should use shocking images to make younger women think about the consequences of smoking.

Well-resourced cessation clinics should be available in all maternity hospitals as pregnant women are most likely to want to quit. Women continue to need support after birth to prevent relapse.

The tobacco element of SPHE is not mandatory. A mandatory anti-smoking programme for all 1st year students should be introduced. Parents should be involved and encouraged to reinforce the messages at home.

Participants felt strongly that initiatives outlined above require a policy shift at Government level.

A reality TV programme that follows a group of smokers trying to quit should be developed.

Role of the Irish Cancer Society and the National Women's Council of Ireland

Advocacy and awareness raising about the harms of smoking are important. The Irish Cancer Society and tobacco control organisations should advocate for the introduction of plain packaging. "Out of the blue" lobbying on the issue by organisations who are not usually associated with tobacco control should take place.

The EU Presidency should be used as an opportunity to promote messaging around industry manipulation. A smoke-free taskforce similar to the drugs taskforce should be established.

No Tobacco Day and National Women's Day should be used to promote messages about women and smoking.

We need to make non-smoking "normal" like it is in Canada where people have to go out the way to find somewhere where you can smoke.

Summary of group consultations

Some of the key themes to emerge from the consultation groups were:

- **Smoking is on the agenda of organisations working with women or in the health sector, however it needs to be prioritised as an issue and more resources need to be available to tackle the problem;**
- **The barriers to quitting smoking are multi-faceted and include psychological barriers, social factors, access and availability of services, attitudes of health professionals, and tobacco industry manipulation;**
- **Smoking provides a sense of solidarity and belonging for many women and is the cultural norm in many communities. Community-based cessation programmes which encourage social interaction are needed to overcome these barriers;**
- **Participants felt that a national strategy and standards for cessation services is required. Smoking cessation services in Ireland are under-resourced;**
- **Communities need to become supportive environments for people who want to quit;**
- **Many healthcare professionals are not as active in encouraging people to quit as they could be. All healthcare professionals should be involved in frontline interventions with smokers.**

Conference programme

Women and Smoking: Time to Face the Crisis

Ashling Hotel, Parkgate Street, Dublin 8

Wednesday, 4th July 2012

PROGRAMME

10.00am	Registration
10.30am-12.20pm	PLENARY SESSIONS
10.30am	Introduction and welcome
10.45am	Health Inequalities in Ireland Today Sinead Pentony, Head of Policy, TASC
11.00am	Women, Smoking and Inequalities Dr Jude Robinson, Reader in the Anthropology of Health and Illness, Department of Sociology, Social Policy and Criminology, University of Liverpool
11.30am	Marketing Tobacco to Women Professor Amanda Amos, Professor of Health Promotion, Centre for Population Health Sciences, University of Edinburgh
11.50am	Health Effects of Smoking Dr Finbarr O’Connell, Consultant Respiratory Physician, St James’s Hospital, Dublin
12.05pm	Questions & Answers
12.30pm-1.30pm	Lunch Served
1.30pm-2.30pm	WORKSHOPS
	<i>Workshop 1: Smoking and Pregnancy</i> Ms Denise Cahill – Senior Health Promotion Officer Ms Joan O’Sullivan – Smoking Cessation Officer
	<i>Workshop 2: Tobacco Control – Advocacy Workshop</i> Ms Rachel Wright - Advocacy Officer, Irish Cancer Society Ms Aoife Sadlier- Research Director, Ignite Research
	<i>Workshop 3: X-HALE Youth Awards - Tackling smoking with young people in their communities</i> Ms Joanne Vance, Senior Health Promotion Officer, Irish Cancer Society
2.30pm – 2.40pm	Coffee Break
2.40 pm -3.30pm	Group Consultations
3.30pm	Feedback & Closing Remarks
4.00pm	End

Conference attendee list

Ms Valerie Abbott Irish Cancer Society	Ms Elaine Gillespie Irish Cancer Society	Ms Ciara McKenna National Maternity Hospital
Dr Jose Ayala HSE	Ms Geraldine Gleeson Marie Keating Foundation	Ms Anna Marie McNiff
Ms Alison Begas Dublin Well Woman Clinic	Mr Shane Griffin	Ms Jean Molloy HSE
Ms Mary Briscoe Irish Cancer Society	Ms Frances Guiney	Ms Amanda Murphy Ballymun Women's Resource Centre
Ms Ruth Buckley HSE	Ms Miriam Gunning HSE	Ms Cliona Murphy Alcohol Action Ireland
Ms Frances Byrne OPEN	Ms Carmel Halpin HSE	Ms Mona O'Donoghue
Ms Gobnait Byrne	Ms Jacqueline Healy National Women's Council of Ireland	Ms Pauline O'Reilly HSE
Ms Stephanie Casey Irish Cancer Society	Mrs Carmel Heneghan	Ms Rose-Marie Plant HSE
Ms Kate Cassidy HSE	Dr Fenton Howell HSE	Mrs Eve Rigo Northside Partnership
Ms Claire Connolly National University of Ireland, Galway	Ms Joan Keane	Ms Ann Scanlon Irish Heart Foundation
Ms Eimear Cotter Irish Cancer Society	Ms Madeleine Kennedy HSE	Ms Roisin Thurstan Children's University Hospital, Temple Street
Ms Edel Cribbin Irish Cancer Society	Ms Sheila Keogan Tobacco Free Research Institute	Ms Joanne Vance Irish Cancer Society
Ms Laura Curtin	Ms Marie Killeen HSE	Ms Noeline White Mater Hospital
Ms Sharon Daly	Ms Brid Leahy ASH Ireland	Ms Brenda Whiteside St Vincent's Hospital
Ms Marie Daly Pavee Point	Ms Mary Loftus Irish Cancer Society	Ms Rachel Wright Irish Cancer Society
Ms Carmel Doherty St James' Hospital	Ms Jackie Lynch HSE	Ms Margaret Rush
Ms Brenda Flannery Irish Cancer Society	Ms Cliona McCormack Irish Heart Foundation	Ms Brid King
Ms Mary Gaffney HSE	Ms Bernie McDermott Northside Partnership	Ms Noeleen Smith Irish Nurses and Midwives Organisations
Ms Marian Gibbs Rotunda Hospital	Ms Maureen McGovern	
Mrs Michelle Gifford Ballymun Women's Resource Centre	Ms Lillian McGovern Marie Keating Foundation	
	Ms Carmel McGuigan HSE	

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