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What factors are important in smoking cessation and relapse in women from deprived communities? A qualitative study in Southeast England

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ABSTRACT

Objectives: Women are relatively more susceptible to smoking-related diseases and find it more difficult to quit; however, little research exists on factors associated with smoking cessation and relapse in women. We examined attitudes towards and perceptions of factors associated with smoking cessation and relapse in women from deprived communities.
Study design: Qualitative interview study.
Methods: Participants included eleven women, smokers and ex-smokers, from disadvantaged communities in East Sussex, England, who had used the National Health Service (NHS) stop smoking service. Data were collected through a focus group and semi-structured interviews, and subjected to thematic analysis.
Results: Participants opined that it is more difficult for women to quit smoking than men. Women felt that postcessation weight gain was inevitable and acted as a barrier to quitting. Hormonal fluctuations during the menstrual cycle and greater levels of stress were perceived as obstacles to quitting and reasons for relapse. Conversely, the women cited effects of smoking on physical appearance, oral hygiene and guilt about exposing children to passive smoke as powerful motivators to quit; and highlighted the impact of public health campaigns that focused on these factors. Views diverged on whether quitting with someone close to you is a help or hindrance. Other themes including alcohol intake, daily routine and being in the presence of smokers emerged as situational triggers of relapse.
Conclusions: Interventions that address women's concerns related to postcessation weight gain, hormonal fluctuations during the menstrual cycle and stress may aid with smoking

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cessation and reduce relapse. Public health campaigns should consider the impact of smoking on physical appearance and the effect of passive smoke on children.
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Introduction

Smoking is the primary cause of preventable morbidity and premature death, and is the single most important cause of health inequalities between the rich and most deprived in the community. Due to public health efforts to prevent smoking initiation and to promote and facilitate cessation, the prevalence of smoking in the United Kingdom (UK) has steadily declined over the past 30 years. However, there has been little change since 2007, and the prevalence of smoking among adults in England is now static around 20%.[1] In contrast with previous decades, where men generally had significantly higher prevalence of smoking, there is now little difference in the prevalence between the two sexes.[2]

In a recent study of cancer mortality in the European Union (EU), it was estimated that the steady increase in lung cancer mortality rates in women will continue, with a 7% rise in lung cancer deaths between 2009 and 2013; and in a few years, lung cancer will likely become the leading cause of cancer mortality in women.[3] It is noteworthy that it is already the leading cause of cancer death in women in UK and Poland, the two countries with the highest rates in EU.[3] Modelling of the smoking epidemic by Lopez et al. (1994), using smoking-related deaths due to lung cancer, suggests that the gap between the two sexes is still decreasing in size and that whilst the proportion of smoking attributable deaths due to lung cancer in men will continue to fall, the proportion in women is likely to remain static into the near future.[4]

Several studies have suggested that dose for dose women are relatively more susceptible to developing certain smoking-related diseases and that smoking has a relatively greater impact on women's health. Compared with men, women have a relatively increased risk of lung cancer, stroke (particularly among those who take oral contraceptives) and osteoporosis, and higher rates of asthma and chronic obstructive pulmonary disease (COPD).[5–8] Smoking has also been linked to cervical and breast cancers.[9,10] In addition, women who smoke are more likely to experience abnormal inter-menstrual bleeding, premature menopause, subfertility, and adverse pregnancy outcomes (including rupture of membranes, miscarriage, stillbirth, premature and low birth weight baby, birth defects).[11,12] It has also been suggested that although women may be more motivated to quit smoking, they generally find it more difficult to quit than men. Data from smoking cessation services show that women have relatively lower quit rates (at four weeks) and are more likely to relapse than men.[13,14]

In most societies, there is a clear gradient in smoking with social class: smoking prevalence is markedly higher among deprived communities. In the UK, smoking prevalence is 36% for men and 25% for women in routine and manual occupations, compared with 15% for men and 18% for women in managerial and professional groups; and over 70% in most deprived groups.[15,16] Findings from the British Women's Heart and Health Study show that residential area deprivation is a stronger predictor of smoking behaviour among women than individual life-course socio-economic position.[17] It has also been shown that although the motivation to quit smoking is similar across social groups, smokers in deprived communities find it more difficult to quit, and are more likely to relapse.[18,19]

Although women are relatively more susceptible to smoking-related diseases, find it more difficult to quit and are more likely to relapse, very little research has focused specifically on effective smoking cessation interventions in women. Given the relatively high prevalence of smoking among women from deprived areas compared with those from the least deprived areas (26% vs 10%, respectively; England 2012); and that women from deprived areas are less likely to successfully quit smoking than those in the least deprived areas (49% vs 76%, respectively), it is of particular interest to identify factors associated with smoking cessation and relapse in this group.[2] We conducted a qualitative study in Southeast England to elicit perceived barriers to quitting smoking among women from deprived communities. The aim of the study is to provide insight into what factors may contribute to more effective and tailored smoking cessation services and interventions, to reduce the prevalence of smoking in women, particularly in those from the deprived communities.

Methods

Procedure

Participants included 11 adult women, living in disadvantaged neighbourhoods (as defined by the Index of Multiple Deprivation) who had accessed the East Sussex National Health Service (NHS) stop smoking service between the two-year period February 2009 and February 2011. Of the eleven women, two were aged between 18 and 29 years; two 40–49; three 50–59; two 60–69; and, one 70–79. Four of the women were current smokers and seven were ex-smokers, four were employed and six lived with a smoker.

The study was approved by the NHS Brighton East Research Ethics Committee. Information on women who had used the service during the two-year period was obtained from the records of the service. Potential participants were initially contacted over the phone and invited to take part in the study by a staff member of the stop smoking service. Those interested in taking part were posted an information sheet that outlined the study. Each participant was

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