

YOUNG WOMEN AND SMOKING



*AN INVESTIGATION OF
FACTORS INFLUENCING
YOUNG QUEENSLAND WOMEN
TO INITIATE, MAINTAIN AND
STOP SMOKING TOBACCO*

April to December 2003

A Project Funded by
Queensland Health through Health Promotion Queensland

Cancer Prevention Research Centre, School of Population Health, The University of Queensland

EXECUTIVE SUMMARY

The Young Women and Smoking Consortium have listened to the ideas and opinions of many young women – smokers, ex-smokers and non-smokers.

We have examined large, representative population surveys with data from young Queensland women.

We have conducted focus groups and in-depth interviews.

We have considered the implications of recent research findings.

We have gathered expert opinion from tobacco-control practitioners, researchers and evaluators.

The facts and ideas here are consistent across the several sources of evidence.

This *Young Women and Smoking* project report makes recommendations for action on two fronts:

For Queensland Health, we identify immediate and longer-term actions that can be taken to change the social and environmental influences that determine smoking in young Queensland women; we also make recommendations on opportunities for new campaigns and services.

For Health Promotion Queensland, we identify priority areas for practically grounded research and development, to extend and deepen the base of knowledge needed for future health promotion actions by Queensland Health and related instrumentalities.

Young Women & Smoking: The Challenge

Much of the damage caused by smoking to women's reproductive health and damage to the health of children and damage to women's health through chronic diseases (heart disease and cancer particularly), can be averted. This can be achieved by seriously addressing the determinants of nicotine addiction among the thousands of young Queensland women who have not yet gone on to be regular, dependent, addicted smokers.

Tobacco control experts agree that education and information directed solely at school children has been shown not to be a strongly an effective approach in and of itself. However, children (and teenage girls), can be influenced by strategies designed for the broader adult population and by changes in community norms and behaviours.

There is broad agreement that the most productive focus will be on preventing progression to the regular, addicted long-term smoking habits that are consolidated during young adult life transitions (particularly in the 18-24 years age group).

Action is particularly needed to change those environmental and social influences that lead first to 'social smoking' among young women and then to addicted smoking. Particularly strong influences are:

- environmental tobacco smoke;
- social cues and incentives to smoke, particularly in nightclubs, pubs and other venues;
- point of sale visibility of cigarette packs;
- tobacco promotion activities.

All of these influences act together to normalise cigarette smoking and to make it particularly attractive to children and young adults.

These influences need to be addressed seriously, and in concert.

The Facts

Young Queensland women do not differ from young women in the broader Australian population in terms of smoking prevalence and related attributes.

More than two-thirds of young Queensland women do not smoke.

There are clear and consistent relationships between socio-economic disadvantage and an increased likelihood of smoking among young Queensland women.

Factors strongly associated with young Queensland women being more likely to consolidate a smoking habit in their early 20s, and also to take up smoking as a young adult, are:

- higher levels of alcohol consumption;
- not being physically active in leisure time;
- use of illicit drugs.

Young Queensland women are generally aware of the health dangers of smoking to which they are exposed.

Young Queensland women are aware of the deleterious effects of smoking on others' health – particularly the health of babies and children.

Some young Queensland women express strong concerns about their future addiction to cigarettes.

Young women who smoke are supportive of initiatives that would decrease their own smoking and the effects of their smoking on others.

An Opportune Social Climate Exists

Young women's perceptions of the costs and benefits of smoking, the role smoking plays in their social identities, group loyalties, the social values they form and adhere to, and the impact of communication from their families, friends,

and peers, act together to make up a normative climate that can promote or inhibit smoking.

Recent changes in the normative climate around cigarette smoking emerged in our conversations with young Queensland women. It appears that as smoking has become less socially acceptable, many young women smokers have responded by taking on board the principle of not exposing others to their cigarette smoke.

These social changes provide opportunities for regulatory initiatives, campaigns and other interventions that will be personally relevant and well accepted by young women in Queensland.

There would be a high level of acceptance and the potential to extend and elaborate upon a 'smoke-free' ethos, consistent with young women's stated concerns and the social norms identified.

Many young Queensland women work in settings (particularly nightclubs, pubs and gambling venues) where exposure to environmental tobacco smoke is unavoidable for them. Serious action on this front would be well accepted by young women, and by unions and the general Queensland public.

Recommendations: Priorities for Queensland Health

Reducing smoking rates in young Queensland (women) directly addresses the prevention of major chronic disease (cancer and heart disease particularly), and is also a major step towards improving reproductive and child health.

There would be high levels of public acceptance and strong support of initiatives by Queensland Health from medical, health and community groups and for young women themselves

Changes can be made in the short and medium term to address the factors that influence young Queensland women to become addicted to cigarette smoking.

This can be through the full enforcement of existing legislation and regulations and through new legislative initiatives and pursuing new policy strategies, including:

- Fully eliminating environmental tobacco smoke in nightclubs, pubs and other social and hospitality venues.
- Eliminating all point-of-sale visibility of cigarette packs.
- Developing a systematic, well-researched and adequately resourced state-wide mass media campaign, that is also designed to influence young women.
- Providing practical cessation assistance services that are widely-available adequately resourced and rigorously benchmarked against national best practice, particularly through the Quitline and through innovative uses of the Internet and other delivery tools.
- Monitoring tobacco promotions and sales to children and establishing stronger mechanisms (including 'stings' of tobacco retailers) for identifying and prosecuting infringements.

- Providing family-oriented assistance through the midwifery, obstetric and child health systems to help pregnant women to remain smoke-free both during pregnancy and after childbirth, also with engagement of their partners and extended families.
- Developing and resourcing an ongoing population monitoring system to systematically track (for urban and rural Queenslanders) the prevalence and changes in behaviour, knowledge, attitudes and awareness on tobacco health and smoking cessation. Such systems are invaluable in evaluating the effects of social and legislative changes and in the planning and targeting of campaigns and services (especially so for young women).
- Working intersectorally with unions, consumer and industry, and health-care groups to involve them in devising the best ways to implement those tobacco control initiatives.
- Making the case for more limited, stringent and costly licensing systems for the sale of cigarettes; using relevant revenues to fund tobacco control activities.
- Making the case that the state of Queensland allocates a substantial portion of its Federal tobacco tax revenues, to fund an integrated portfolio of adequately resourced tobacco control activities. This would be the most valuable investment that could be made in the future health prospects of young women and all Queenslanders.

Recommendations: Priorities For Health Promotion Queensland

Changes to eliminate exposure to tobacco smoke and the availability and promotion of cigarettes will make a difference. Coordinated mass-communication campaigns and setting-specific and social change initiatives (particularly in nightclubs, pubs and other social settings) can do much to change how young women think and act in relation to smoking cigarettes. High quality cessation services can be provided for young women.

In concert with the Queensland Health initiatives described above, all of these areas can be informed by a staged, three-year programmatic approach to research and development on young women and smoking. This would provide ongoing input on key areas of evidence of practical relevance to Queensland Health's initiatives.

It would identify, progressively, the unique options for soundly based, sustained and acceptable future actions to reduce smoking among young Queensland women.

There are opportunities for original, strategically targeted, practically-grounded research and evaluation studies, to develop and extend the tobacco control agenda for the benefit of young Queensland women and the whole Queensland population.

These research opportunities are identified throughout this report, and should include:

- Development and evaluation of a well-founded, carefully targeted Queensland-wide public information and cessation campaign. This should be progressively built upon a new, unique local knowledge base on behaviours, attitudes and beliefs, and trends over time in these factors. Research can inform how campaign elements can be made relevant to and accepted by young women, by young men, by the general population and by community opinion-leaders.
- Identifying, through further research (observational and interview studies particularly) the current and likely future levels of public acceptance of initiatives that reduce young Queensland women's exposure to environmental tobacco smoke and the normalisation of tobacco products; attitudes to future initiatives should also be examined.
- Identifying in more depth and detail the social group, social identity and normative influences around cigarette smoking that act on young women. Identifying ways to use this knowledge as a basis for acceptable and substantial initiatives to deal with factors promoting progression from experimental, irregular and low-rate smoking (that characterises children and youth who smoke) to the regular, addicted smoking that is consolidated in the young adult (18-24) years.
- Trialling innovative methods of changing the normative climate to reduce the acceptability of smoking among smoking of young Queenslanders who smoke, through the use of opinion leaders.
- Building a more in-depth understanding of how smoking is promoted and socially-cued in particular environments and community settings (nightclubs, pubs, and other hospitality settings; also, university, college and TAFE settings, and the surrounds of workplaces and shopping venues).
- Trialling innovative smoking cessation services for young women, through midwifery, obstetric, child and family health services, the Quitline, the Internet and other media.

Young Women and Smoking

A Research and Development Project for HPQ

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1 CONTEXT, AIMS AND STRUCTURE OF THE YOUNG WOMEN AND SMOKING PROJECT

1.1 WHY FOCUS ON SMOKING AMONG YOUNG WOMEN?

Although the proportion of Australian women who smoke cigarettes has declined in Australia since 1976, this decline is less marked than that for men.^{1,2} Moreover, young women aged 12-17 appear to be taking up smoking at greater rates than their male counterparts.³

In line with prevalence, the proportion of all deaths caused by cigarette smoking has increased for women, reaching the rate of 10% of all deaths amongst Australian women in 1998. Smoking-related diseases are responsible for a large proportion of years of healthy life lost in women.⁴

In addition, cigarette smoking is related to other detrimental effects on women's health and that of their children such as decreased fertility, poorer birth outcomes⁵ and respiratory diseases exacerbated by exposure to parental cigarette smoke.^{6,7}

Smoking rates are consistently higher in younger women than in older women. These rates climb for women aged between 16 and 19 years, peaking between the ages of 20 and 24 years at around 32-35%.² Rates then remain high among women aged 25 to 29 years, after which age they decline. Cigarette smoking is thus a serious current health issue for women in Australia. This is especially the case for young women, 16-28 years, the age group in which smoking rates are highest. If we are to try to reduce these rates of smoking amongst young women, then it is important to find out why smoking continues to increase in this group from adolescence into their twenties and to identify factors that influence their initiation, maintenance and cessation of smoking.

Such information can guide the selection of strategies for young women that are likely to be successful in areas of public health policy, service provision, media campaign messages and community based approaches. Better information would also allow the targeting and tailoring of cessation assistance specific to young women.

There is a particular need to understand the impact of contexts and settings (such as nightclubs and pubs) and how peer group affiliations (including workplaces), social identity, self-esteem and body image issues can act to increase or decrease the probability of smoking uptake, maintenance and cessation.

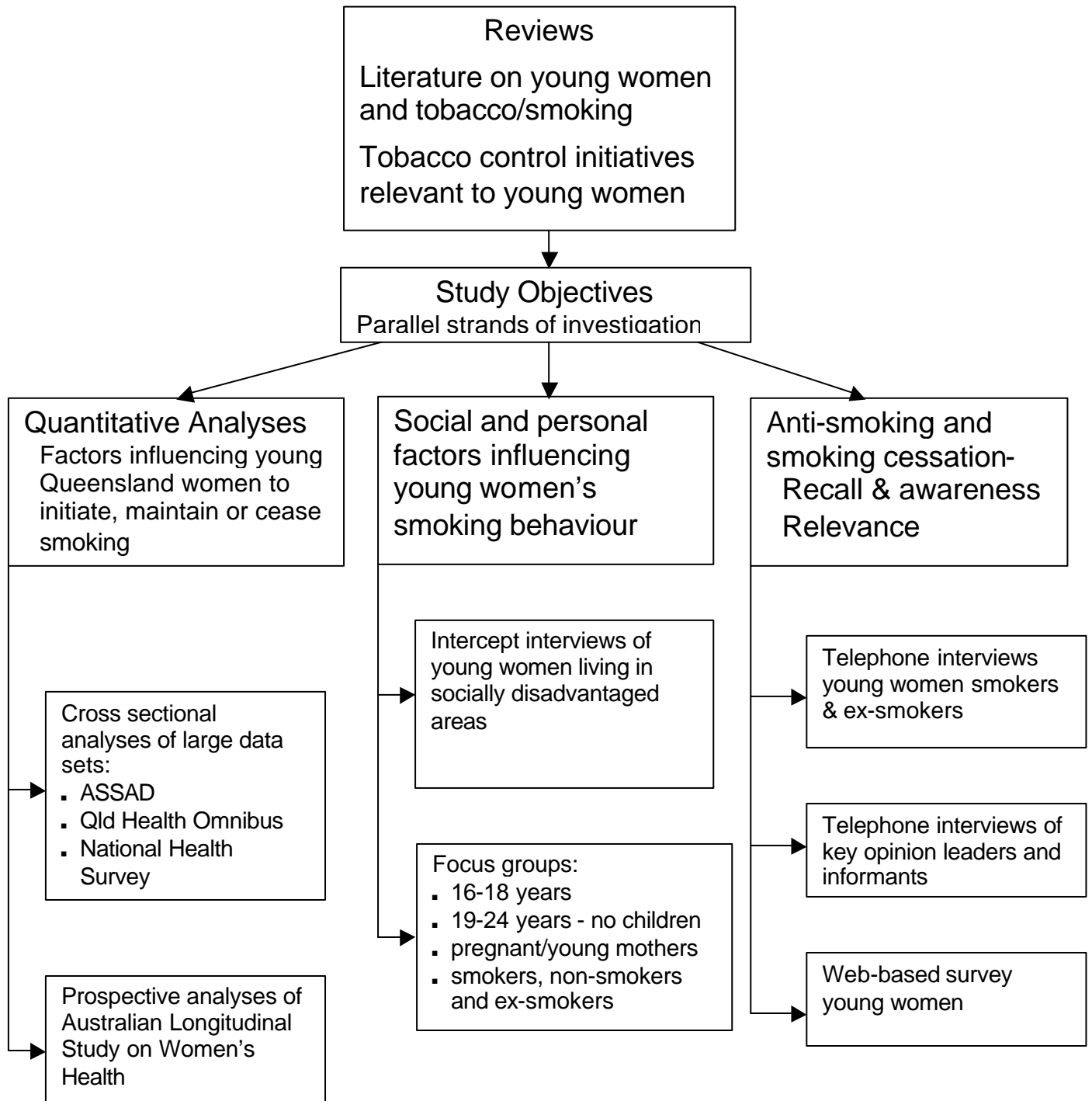
This knowledge will provide important bases for developing innovative strategies to discourage uptake and promote cessation that have direct relevance to young women, and which can be made more relevant and effective for socially disadvantaged groups.

1.2 AIMS OF THE YOUNG WOMEN AND SMOKING PROJECT

Young Women and Smoking has been a short-term (8 month) developmental project that aims to establish an initial knowledge base and to make recommendations for further research and development initiatives. Its aims are:

- To investigate factors that influence young Queensland women to initiate, maintain or stop smoking tobacco and to identify relevant personal and social attributes, contextual factors and service-delivery system factors.
- To identify any factors unique to young Queensland women that may act to influence the adoption, maintenance or cessation of smoking
- To engage experts from the broader state, national and international research and public health constituencies (the Research Advisory Network) to advise on the focus and development of the project and the integration and connection of the findings.
- To communicate the findings in ways that are most relevant and informative to public health policy-makers, practitioners and researchers.
- To provide guidance and recommendations on ways to develop the most productive strategies for reducing cigarette smoking as a public health problem for young Queensland women.
- To recommend, based on those findings how best to develop the policy, environmental, campaign and health-service strategies that can most usefully be mobilised to reduce uptake and increase cessation of cigarette smoking among young Queensland women.

1.3: Conceptual Outline Of The Young Women And Smoking Project



1.4 THE YOUNG WOMEN AND SMOKING PARTNERSHIP

Cancer Prevention Research Centre, School of Population Health, The University of Queensland

The Cancer Prevention Research Centre (CPRC) provided the scientific base and management for the project. The Centre was responsible for project coordination and for financial and administrative coordination through Professor Neville Owen (Director of the Centre) who was the Chief Investigator on the project. Ms Liane McDermott provided expert advice and guidance and carried out the qualitative study that formed one of the major bases for the project. Professor Annette Dobson, Professor of Biostatistics in the School of Population Health, coordinated the data analyses and provided advice and guidance on strategic and population health matters. The Project Coordinator, Alexia Lennon, was appointed by the Centre to undertake the overall coordination of the project and worked within the Centre.

Centre for Social Research in Communication, The University of Queensland

The Centre for Social Research in Communication (CSRComm) conducts research and training in social aspects of communication. Under the leadership of the Centre's Director, Professor Cindy Gallois, CSRComm worked in collaboration with the Partnership to guide the project's qualitative studies. CSRComm provided expertise and advice particularly in the areas of health communication, including health promotion messages (both interpersonal and mass mediated), mass and online communication and inter-group and interpersonal communication.

Women's Health Queensland Wide Inc.

Women's Health Queensland Wide (WHQW) provides information and education services for women and health workers throughout Queensland. Current state and national policies and demographic information about women in Queensland provide the focus for WHQW's activities. WHQW Manager, Jennifer Gale and Health Information Officer, Kirsten Braun brought to the project an extensive network of community and health care providers and opportunities for accessing young women. They provided expertise on current issues in women's health, policy and services. Staff of WHQW provided key inputs into the project's investigations of potential intervention strategies for reducing cigarette smoking among young women.

Queensland Cancer Fund

The Queensland Cancer Fund (QCF) is a leading agency in tobacco control in Queensland, initiating activities encompassing research, education, advocacy, intervention programs and resource development. QCF brought program and research expertise to this project as well as important links at a local, State wide and national level. Each year, in collaboration with Queensland Health, QCF manages the Queensland Quit Campaign utilising mass media strategies to promote anti-tobacco messages. Ms Rebecca Lowe, Deputy Director, Community Services, and Ms Susan Greenbank, Manager, Prevention and Early Detection Unit, provided the Partnership with advice regarding past and current

programs and strategies from State and national campaigns. In addition, QCF provided the project with important perspectives and contextual information based on community links through its six regional offices and more than 50 volunteer branches across the state.

National Heart Foundation of Australia (Queensland Division)

The National Heart Foundation of Australia (NHFA) has a long history of working in tobacco control and advocacy, and tobacco intervention programs both at a state and national level. The NHFA (Queensland Division) brought to this project experience and linkages. This experience extends beyond tobacco control to include the management of previous and current Health Promotion Queensland grants (Healthier Bowen Shire Partnership and 10,000 Steps Rockhampton). Dr Peter Abernethy, Director, Cardiovascular Health Programs provided valuable strategic advice and expertise in smoking related issues and initiatives.

Project Investigators

Neville Owen
Annette Dobson
Liane McDermott
Cynthia Gallois
Eva Leslie
Jennifer Gale

Project Research Team

Alexia Lennon, Project Co-ordinator
Kirsten Braun, WHQW Information Officer
Anne Russell, Statistician
Ester Cerin, Data Analyst
Phoebe Kearey, Research Officer

Advisory Network

In addition to the Partnership, a network of colleagues provided relevant specialised advice on elements of the project. The thoughtfulness and suggestions of David Hill, Robert Donovan, Ian Ferretter, Jane Martin, Victoria White, Melanie Wakefield, Jonathan Lieberman, Ron Borland and Michelle Scollo are greatly appreciated. Many thanks also to the Queensland experts who provided important perspectives.

Project Reference Groups

Two Reference Groups of young women, one of young women aged 18-24 with no dependents and one of young pregnant women and young mothers participated in the planning and focusing of the research strategies in an advisory role to the Partnership. Their advice was sought on the relevant issues to be addressed and on appropriate ways of approaching young women and of formulating intervention strategies. The young women advisors to the project were Melissa, Kylie, Tiffany, Lyndall, Justine and Jaycell.

2. WHAT IS KNOWN ABOUT TOBACCO USE AND ITS DETERMINANTS AMONG YOUNG WOMEN?

2.1 HEALTH EFFECTS OF WOMEN'S SMOKING

Earlier and recently - published comparative studies have shown that since the 1960s, when extensive publicity about the health-damaging effects of cigarette smoking first began,⁸ there had been a substantial fall in the percentage of Australian men who smoke (45% in 1974 to 27% in 1995).^{1,2} In contrast, for women, the prevalence of cigarette smoking had declined to a lesser extent (31% in 1976 to 23% in 1995).^{1,2}

While the proportion of all deaths caused by cigarette smoking has declined in men, it has increased in women (in line with the trends in smoking prevalence). In 1998, an estimated 6075 women died in Australia as a result of cigarette smoking, approximately 10% of all deaths among women in that year.⁴ In addition, smoking related diseases in Australian women account for almost half of the years of healthy life lost due to premature death, impairment and disability.⁹

Cigarette smoking is related to menstrual symptoms and early menopause and has detrimental effects on fertility (including a lower probability of conception and increased risk of infertility), pregnancy complications (including miscarriage and birthing difficulties) and birth outcomes.⁵

Furthermore, there are adverse health effects for children due to passive smoking. Exposure to environmental tobacco smoke in childhood is associated with asthma and lower-respiratory illness, and for children with asthma, it is associated with impaired lung function and increased sensitivity of the airways.^{6,7,10}

2.2 PREVALENCE AND SOCIAL DISTRIBUTION OF WOMEN'S SMOKING

Among women, prevalence of smoking increases from adolescence through to the mid-to-late twenties, after which age it declines.² For example, recent analyses of existing data sets have shown that in 1995, national prevalence rates for current smoking among young women ranged from 31% for women aged 16 to 19 to 35% for women aged 25 to 29. In 1998, the proportion of Australian women who were recent (regular and occasional) smokers was 26% for women aged 14 to 19 and 37% for women aged 20 to 29.¹¹ In Queensland, 31% of women aged 14 to 19 and 43% of women aged 20 to 29 were recent smokers in 1998.¹²

Cigarette smoking is associated with a range of demographic characteristics.¹³ Married women (and men) are less likely to smoke than women who were previously married or never married. Smoking prevalence is reduced with

increasing socio-economic advantage and family income, and is lowest among those with more years of formal education.^{2,13}

2.3 INITIATION OF SMOKING

As the majority (60%) of smokers report starting to smoke between the ages of 15 and 19 years,¹⁴ most research on smoking initiation focuses on adolescents. Numerous inter-related psychosocial factors are associated with adolescent smoking, including environmental factors (family and peer smoking, accessibility, advertising and promotion); socio-demographic factors (age, gender, parental socio-economic status, personal income); behavioural factors (risk-taking lifestyle factors such as physical exercise); and personal factors (knowledge, attitudes, beliefs, self-esteem, self-image, personal health concerns).^{15,16}

There are strong indications in the research literature that different patterns of determinants exist for young women compared to young men.¹⁷ Factors such as concerns about body weight are associated with a higher risk of smoking initiation amongst adolescent girls.^{18,19}

While most young women start to smoke in their teens, smoking uptake continues into the young adult years and we have new evidence on how this occurs among women. The Australian Longitudinal Study on Women's Health (ALSWH) found that 3% of young women aged 18 to 23 in 1996 took up smoking in the four-year period from 1996 to 2000.²⁰ This 'late adoption' of smoking was significantly associated with a higher frequency of alcohol bingeing and younger age. Women who were not born in Australia were more likely to adopt smoking, as were women who reported higher stress scores.²⁰

2.4 MAINTENANCE OF SMOKING

There is evidence that women may continue to smoke because of alcohol consumption, physiological addiction to nicotine and psychosocial factors such as stress, depression, weight concerns.⁵

Stress

Epidemiological research has consistently found higher rates of psychological distress in women than in men²¹. In addition, several studies have found self-reported stress to be a significant predictor of smoking among women.^{22,23} Women smokers have reported that cigarettes help them to cope with feelings of anxiety and tension^{24,25} or with stress¹⁰.

Additionally, these feelings have been linked to smoking maintenance in women, with approximately 46% of young women in an Australian study by Milligan and colleagues²⁶ considering 'being tense, anxious or stressed' as a barrier to smoking cessation compared to 34% of men. Consistent with these research findings, young women in the ALSWH who smoked were more likely to report being stressed and to have experienced more major events in their lives in the previous 12 months than women who had never smoked.²⁰

Weight Concerns

Women may also adopt smoking as a means of weight control and continue to smoke rather than risk gaining weight.¹⁵ In the ALSWH, 32% of young women who smoked reported using smoking to control their weight.²⁰ Regular smokers have been found to have significantly lower median body mass index than never smokers.²⁷ Smokers weigh on average around three kilograms less than non-smokers,²⁸ and smoking cessation can lead to a net mean gain of two to five kilograms.²⁹

Women in particular, show concern about gaining weight if they stop smoking.³⁰ In the study by Milligan and colleagues,²⁶ a significantly greater proportion of young women who smoked (27%) considered weight gain as a barrier to changing to a non-smoking lifestyle than young men who smoked (14%). Pirie and colleagues³⁰ found significantly more women who smoked (58%) than men who smoked (26%) endorsed the statement, 'If I quit smoking, I would probably gain a lot of weight'. Furthermore, weight gain was cited as a withdrawal symptom by 26% of women who smoked and 15% of men who smoked. In some studies, women cited weight gain as an important factor in failure of previous quit attempts.¹⁰

Alcohol Consumption

A number of studies have found that smoking and alcohol consumption frequently occur together. In a study of tobacco and alcohol use among women aged 18 to 44 years, Ebrahim and colleagues³¹ found that 25% of pregnant women and 56% of women who were not pregnant who smoked, also drank alcohol. The Australian National Drug Strategy Household Survey of 1998,¹¹ showed that almost nine out of ten females (aged 14 years and over) who were recent smokers also drank alcohol. Among young women in the ALSWH, binge drinking of alcohol was the factor most strongly associated with smoking adoption and current smoking.²⁰ It was also a significant predictor of not quitting.²⁰

2.5 SMOKING CESSATION

National smoking prevalence data show the quit proportion (i.e., the proportion of ever smokers who have given up smoking) was 0.28 for women aged 16 to 19 years and 0.31-0.33 for women aged 20 to 29 years in 1995.² Pregnancy or the desire to become pregnant is a strong motivational factor for women to give up smoking. Among young women in the ALSWH, current pregnancy was the most powerful predictor of quitting. Australian data indicate that approximately 20-30% of women who were smokers at the time they became pregnant quit smoking.^{32,33} In the ALSWH, the proportion of young women who reported smoking in 1996 who said they were no longer smoking in 2000 was 54% among those who were pregnant.²⁰ However, other studies have shown that approximately half of the women who quit smoking during pregnancy relapse within six months of delivery³⁴ and approximately 70% relapse within 12 months.³⁵

Other Factors Influencing Cessation

Apart from pregnancy, there are a number of other factors associated with the likelihood of smoking cessation. The proportion of women who quit smoking generally increases with educational and occupational levels,^{2,20} and numerous studies have found that people who are married are more successful in quitting than those who are not married^{36,37}. Social support, smoking fewer cigarettes per day, being highly motivated, expecting to succeed in quitting and having the skills to cope with adaptation and change have also been identified as indicators for successful smoking cessation⁸. There is some evidence that, for women who are concerned about weight gain, interventions that address these concerns specifically improve success in quitting.³⁸

Cessation Methods Used By Women

The 1998 National Drug Strategy Household Survey found that the most common means of smoking cessation reported by women was 'discussing smoking and health at home' (47%), followed by reading 'how to quit' literature (23%).¹¹ Only 14% of women asked a doctor for help, 13% used a nicotine gum or patch and 6% telephoned the 'Quit' line.¹¹

While most women who give up smoking quit by the 'cold turkey' method (i.e., stop smoking all at once without help),¹⁷ those who have made more quit attempts and heavier smokers, are more likely to use a cessation program or other smoking cessation strategies such as pharmacological interventions³⁹. There is good evidence that strategies such as nicotine replacement therapy, help from doctors or nurses, and individual or group behavioural therapy can improve quit rates by at least 50%⁵.

In developing and delivering smoking cessation strategies for young women, we predict a greater likelihood of success, if the benefits of quitting smoking for the sake of their own health and that of their children are emphasised, and their concern about weight gain taken into account.

There is general agreement among tobacco control researchers and policy makers that educational efforts directed solely at school children tend to have limited sustained impact after the children leave school. Children are likely to be effected by broader community campaigns and associated changes in policy and practice and the normative climate around cigarette smoking³. Focussing efforts on young adults and on the general adult population is seen as the most useful approach^{3,5}.

2.6 LIFE TRANSITION EVENTS AND SMOKING BEHAVIOUR

While a great deal is known about the socio-demographic and psychological characteristics of smokers in general, and the initiation of smoking in adolescence, there is less understanding of socio-cultural and environmental factors influencing smoking behaviour of young women at different stages of their lives.

- Greene and colleagues⁴⁰ identify the relevant stages in terms of four major life transitions:

- leaving the parental home
- occupying an instrumental role (such as employment, college or university)
- marriage
- parenthood.

While pregnancy and its consequent impact on cigarette smoking, particularly quitting, has been extensively studied,⁴⁰⁻⁴² less attention has been given to the influences of other life transition events on smoking behaviour.

Life Transitions And Smoking: The Preliminary Qualitative Study

Liane McDermott, one of the investigators on the Young Women and Smoking Project, initiated exploratory qualitative research that built on the current understanding of factors that can influence young women to smoke. Her study aimed to identify life-stage transitions relevant to young women and to clarify how these relate to smoking behaviour. Her project was a sub-study of the ALSWH. Her study examined the influence of life-stage transitions on the adoption of cigarette smoking, maintenance of smoking and smoking cessation among young women.

Using the ALSWH baseline survey (1996) of women aged 18-23 years and the first follow-up survey (2000) when these same women were 22-27 years old, women were identified according to smoking status.

- 'Never smokers' were those women who were not current smokers and had not smoked more than 100 cigarettes in their lifetimes.
- 'Ex-smokers' were those women who previously smoked regularly or occasionally, but no longer did and who had smoked more than 100 cigarettes in their lifetimes.
- 'Smokers' were women who currently smoked regularly or occasionally and who had also smoked more than 100 cigarettes in their lifetimes.

Eighty women aged between 24 and 29 years in 2002 agreed to participate in standardised, structured, open-ended telephone interviews that focussed on the factors that had influenced their smoking behaviour at critical life stages.

Life Transitions And Smoking: Main Findings

The findings of Liane McDermott's study indicated that several life-stage transitions or contextual factors appear to influence the smoking behaviour of young women.

Smokers and ex-smokers reported that leaving home, and the increased importance of socialising that came with that transition, was instrumental in increasing their smoking. The influence of their social networks and social environment, particularly going out to pubs and clubs and drinking alcohol, were important factors at that time. Stress levels and increased independence were also salient factors influencing the young women's smoking when they first left home.

Turning 21 years old was another critical life transition with ex-smokers reporting that after this time they became more conscious of the health impact and other negative aspects of their smoking and wanted to quit

While social networks and social environments were once again reported as the main influence on smoking, both smokers and ex-smokers reported that addiction and habit also influenced their smoking during this time.

For never-smokers, early decision-making to be a non-smoker was an important influence on not smoking when they first left home. This early decision-making not to smoke stemmed from having a negative 'first time' experience of cigarette smoking and from an awareness of the negative aspects of smoking (such as health effects and the financial cost of cigarettes).

However, after turning 21, some of the never smokers reported being tempted to try smoking. The main influence was going to pubs and clubs with friends who smoked, and drinking alcohol. For most of the never-smokers however, awareness of the negative effects of smoking on health and their concern about addiction were the main influences on choosing not to smoke.

Whether their partner smoked or not was a considerable influence on smoking for many of the ex-smokers and current smokers. Having a partner who smoked increased the amount they smoked and made quitting more difficult, whereas having a partner who did not smoke was a motivating factor for reducing the amount they smoked or for quitting.

Motherhood emerged as a strong influence on quitting, with almost all the women saying they were concerned about the effect of smoking on the health of unborn children. Some ex-smokers used pregnancy as an opportunity to quit, while others (current smokers in the study) cut down their tobacco consumption.

Life Transitions And Smoking: A Key Issue

Several of the life-transition and contextual factors described above are explored in the quantitative and qualitative analyses in subsequent sections of this report. In particular, the analyses of the data from the ALSWH have been built on these findings. The findings from Liane McDermott's study were presented at the Annual Meeting of the Public Health Association of Australia. (see Appendix 1)

3. FACTORS THAT INFLUENCE YOUNG QUEENSLAND WOMEN TO INITIATE, MAINTAIN OR STOP SMOKING TOBACCO: FINDINGS FROM POPULATION DATA

3.1 METHODS

Quantitative analyses of factors associated with smoking adoption, maintenance of smoking and smoking cessation were conducted using existing data sets with large population samples that included information that could be extracted specifically on young Queensland women. These data sets were:

Australian Longitudinal Study On Women's Health (ALSWH) 1996, 2000

This study was established in 1996 with three cohorts of Australian women aged 18 to 23, 45 to 50 and 70 to 75 at recruitment⁴³. This study is designed to track the health of these women over a period of up to twenty years and aims to examine the relationships between biological, psychological, social and lifestyle factors and women's physical and emotional health⁴³. Data were available from the 14779 young women aged 18 to 23 who participated in the 1996 baseline survey and from 9657 of these same young women who completed the follow-up survey four years later in 2000 when they were aged 22 to 27.²⁰

The ALSWH is a rich data set that allows a range of potential determinants of smoking behaviour in young women to be examined. These include:

- Demographic factors (socio-economic status, education levels, occupation, marital status)
- Psychological factors (such as depression, anxiety, stress, loneliness)
- Intrapersonal factors (such as weight concerns, body image, dieting behaviour)
- Social factors (such as social support)
- Familial factors (such as motherhood and pregnancy)
- Lifestyle factors (such as physical activity, alcohol and other drug use).

Australian Secondary School Alcohol And Drug Survey (ASSAD) 2002

This is a cross-sectional national survey of secondary school students aged between 12 and 17 years⁴⁴. The survey is conducted triennially with the most recent survey being in 2002. Initially we planned to use the ASSAD data set to inform the project. However on the advice from Queensland Health this did not eventuate because the results from Queensland had not been approved for release in time.

National Health Survey (NHS) 2001

This is a cross-sectional national survey conducted across Australia⁴⁵. The survey collects information about the health status of the population, use of

health services, health related behaviours and characteristics. Data were available from the 2001 survey involving respondents from 17,918 private dwellings.

Queensland Health Omnibus Survey (QHOS) 2002

This is a cross-sectional survey of Queensland residents aged 18 years and over. The most recent QHOS conducted in 2002⁴⁶ included questions relating to smoking behaviour. For the purposes of this project, data from Queensland women aged 18 to 29 years related to smoking behaviour and demographic details were examined. Other data from the QHOS were not directly relevant to this project.

3.2 STATISTICAL ANALYSES OF SMOKING AMONG YOUNG QUEENSLAND WOMEN

Qualitative analyses of smoking behaviour, attitudes and beliefs were undertaken using the data sources described above, including comparisons between social groups to identify factors associated with late adoption, smoking maintenance and cessation.

3.3 FINDINGS

Prevalence Of Smoking Behaviour Among Young Queensland Women

Prevalence of current smoking, ex-smoking and never smoking among women aged 18 to 29 in Queensland are presented in Table 1. Prevalence of smoking was broadly similar across the different surveys although the percentage of new smokers was higher in the ALSWH.

Data from the ALSWH for the year 2000 showed that there were no differences in prevalence of smoking behaviours between Queensland and other Australian states or territories (see Appendix 2)

Table 1: Prevalence of smoking behaviour among young women (16-29 years) in Queensland

Data source	Current smoker	Ex-smoker	Never smoker
Australian Longitudinal Study on Women's Health, 2000 Age group: 22-27 N = 1720	23.3	14.0	62.7
Queensland Health Omnibus Survey, 2001 Age group: 18-29 N = 172	26.2	20.4	53.4
National Health Survey, 2001 Age group: 18-29 N = 339	30.1	17.7	52.2

As the Data sets of Queensland were too small to provide reliable estimates for country areas, data for the whole of Australia were used.

Prevalence of smoking was compared for young women living in rural, remote and metropolitan areas using the ALSWH national sample. Results are shown in Table 2.

Prevalence of smoking tended to be higher, and never smoking lower, in remote areas than in metropolitan or rural centres. The factors associated with smoking across rural, remote and metropolitan areas were similar (see Appendix 3). The same was true of smoking adoption and for quitting.

Table 2: Prevalence of smoking behaviour among young Australian women living in metropolitan rural, remote and metropolitan areas (ALSWH 2000)

Smoking behaviour	Metropolitan area N = 5424	Large rural centre N = 916	Small rural centre N = 876	Other rural / remote areas N = 1772
Never smoker	60.2	58.1	55.0	54.9
Ex-smoker	13.7	14.7	17.4	16.2
Irregular smoker	6.0	3.6	4.3	4.4
Weekly smoker	2.8	2.6	3.2	1.9
Regular smoker	17.3	21.0	20.1	22.6

Factors Associated With Smoking Behaviour

Using data from the ALSWH and NHS, factors hypothesised to be associated with smoking adoption, maintenance of smoking and smoking cessation were analysed. These included socio-demographic factors (socio-economic status, education level, employment status, marital status), psychological factors (depression, anxiety, stress, loneliness), intra-personal factors (weight concerns, body image, dieting behaviours), social factors (social support), familial factors (motherhood), lifestyle factors (physical activity, alcohol and other drug use, leisure activities).

Current smoking: socio-demographic factors

Marital status, cultural background, education level, employment status and household income were associated with prevalence of smoking (Table 3). Smoking prevalence was lower among women with higher socio-economic status (household income and employment status, more years of formal education). Also, women from an English-speaking background were more likely to smoke than women from a non-English speaking background.

Table 3: Prevalence of current smoking among Queensland young women with various socio-demographic characteristics

	NHS, 2001 (18-29 years)	ALSWH, 2000 (22-27 years)
Marital status		
Married	24.0	13.4
Not married	34.9	27.6
Education level		
University	15.5	12.8
Trade/diploma/certificate	22.1	24.4
Year 12	22.1	28.1
< Year 12	48.1	38.8
Language spoken at home		
English-speaking	31.6	23.6
Non-English speaking	11.5	18.5
Employment status*		
Employed	27.4	22.5
Unemployed /Not in labour force	35.0	28.4
Household income**		
1 st quintile	42.6	36.1
2 nd quintile	38.8	25.7
3 rd quintile	24.1	22.2
4 th -5 th quintile	20.3	16.8

Note: * workers compared to women who were not working full-time or part-time ** definitions of quintiles differ between NHS and ALSWH.

Current smoking: social factors

Data from the ALSWH showed that there was a relationship between smoking prevalence and social support. Amongst women who said they had social support, all of the time, 19% were smokers. Amongst women who said they had social support “most of the time” 26.5% were smokers whilst, amongst those who reported they had social support only ‘some of time’ or ‘not at all’ 31.3% were smokers.

Current smoking: pregnancy

Pregnancy was associated with lower smoking prevalence in the ALSWH. In 2000, smoking prevalence amongst women who were pregnant was 12.9% compared to 38% for women who had been pregnant in 1996, but were not pregnant in 2000 and 23.4% for women who reported having never been pregnant. This result supports previous observations that smokers are more likely to stop smoking when they become pregnant, but to relapse after delivery.^{47,48}

Current smoking: body image

Dissatisfaction with their weight or shape, dieting and wishing to weigh less had some associations with higher prevalence of smoking (Table 4). On further analysis taking other factors into consideration, this effect was no longer statistically significant.

Table 4: Body image and prevalence of current smoking (ALSWH 2000)

Measure	n	Prevalence of smoking (%)
Dissatisfaction with weight		
Not at all	501	19.2
Intermediate	798	23.6
Markedly	417	28.1
Dissatisfaction with shape		
Not at all	392	17.6
Intermediate	908	23.2
Markedly	417	29.0
Preferred weight		
Happy as is or like to weigh more	438	19.9
1-5 kg less	618	21.4
6-10 kg less	319	27.3
Over 10 kg less	336	28.0
Dieting during the last year		
Never	865	21.0
1-4 times	639	23.6
5 or more times or always	211	31.8

Current smoking: psychological factors

Data from the NHS and the ALSWH showed that depression, anxiety, non-specific psychological distress, stress and loneliness were associated with an increased prevalence of smoking (Table 5, p.27).

Again, once other factors were taken into account in subsequent analyses, these psychological factors were no longer significant.

Lifestyle factors

Higher alcohol consumption, use of illicit drugs and more time spent in passive leisure activities but not physical activity and active leisure activities were associated with higher prevalence of smoking (Table 6, p.28).

Table 5: Psychological factors associated with prevalence of current smoking

Psychological factor	NHS (18-29 years)	ALSWH (22-27 years)
Psychological distress¹		
Low	24.3	N/A
Moderate	31.4	
High or very high	43.0	
Depression		
No symptoms	N/A	19.4
Depressive symptoms		31.6
Anxiety disorder		
No	N/A	22.2
Yes		38.1
Intense anxiety in last 12 months		
No	N/A	24.3
Yes		33.6
Stress		
No	N/A	19.2
Yes		31.1
Feel lonely even when in company		
Never	N/A	17.8
Rarely		19.5
Sometimes		27.4
Often		29.7

Note. ¹ Kessler Psychological Distress Scale. N/A: not applicable; the variables were not included in the survey.

Current smoking: multiple factors

The factors associated with smoking behaviour in Tables 4 – 7 may be interrelated. Therefore multiple logistic regression was used to assess their joint effects on smoking.

Illicit drug use, alcohol consumption, education level, marital status and engagement in active leisure activities remained significantly associated with smoking prevalence when all the factors were taken into account (Table 7, p.29).

Of these, illicit drug use was the factor most strongly associated with current smoking. Current users of multiple drugs had much higher odds of being smokers (OR = 17.1; 95% CI 11.0-26.4) compared to women who had never used illicit drugs. Even women who were not currently using illicit drugs, but who had been in the past, had much higher odds (OR = 5.5) of smoking than those who had never used of illicit drugs.

Compared to women who were low risk alcohol drinkers, high risk drinkers had higher odds of smoking (OR = 2.4; 95% CI 1.3-4.3). Those women who were

low risk drinkers and who binge drank weekly had higher odds for smoking (OR= 1.7; 95% CI 1.2-2.6) compared to low risk drinkers.

Women with a lower education had a higher prevalence of smoking. For instance, those with 10 years or less schooling had odds of smoking of 5.8 (95% CI 3.7-9.0) compared to women with a tertiary education.

Women who were not married or who were in a de facto relationship had a higher odds of smoking compared to married women (OR = 1.8; 95% CI 1.3-2.6).

Additionally, engagement in active leisure time was associated with a lower odds of smoking (Table 7, p.29).

We anticipated that smoking maintenance would be greater among young women reporting body image dissatisfaction, weight concerns, regular dieting behaviour, low self-esteem, depression, anxiety disorders and stress. However, these factors were not statistically significant in the analyses that controlled for the influence of other factors.

Table 6: Lifestyle factors and prevalence of current smoking

Life style factors	NHS (18-29 years)	ALSWH (22-27 years)
Alcohol consumption		
Non-drinkers	27.5	14.1
Rarely drinks	21.8	20.6
Low risk	32.9	24.0
Risky	54.6	58.3
Illicit drug use		
Never		8.8
Ex cannabis user		24.6
Current cannabis user		41.1
Ex multiple drug user		34.3
Current multiple drug user		67.4
Physical activity		
None	34.1	28.4
Low	26.9	24.2
Medium	31.6	19.2
High		23.3
Active leisure (last week)		
None		29.1
Some		20.8
Passive leisure (last week)		
Up to 15 hours		21.3
16 hours or more		28.9

Table 7: Factors associated with smoking multivariate analysis (ALSWH 2000)

Factor	Odds ratio	95% confidence intervals
Illicit drug use		
Never	1	
Ex cannabis user	3.2	2.2 – 4.5
Current cannabis user	5.9	3.8 – 9.2
Ex multiple drug user	5.5	3.3 – 9.1
Current multiple drug user	17.1	11.0 – 26.4
Alcohol consumption patterns		
Low risk drinker, binges less than weekly	1	
Non-drinker	0.7	0.5 – 1.3
Low risk drinker, binge drinks weekly	1.7	1.2 – 2.6
Risky or high risk drinking	2.4	1.3 – 4.3
Education		
University	1	
Trade / apprenticeship / diploma / certificate	2.6	1.8 – 3.9
Year 12	3.1	2.2 – 4.5
Year 10 or less	5.8	3.7 – 9.0
Marital status		
Married	1	
De facto	1.4	0.9 – 2.0
Not married / separated / divorced / widowed	1.8	1.3 – 2.6
Active leisure (last week)		
Some	1	
None	1.6	1.2 – 2.1

N = 1,720

Adoption of smoking: socio-demographic, psychological and social factors

Data from the ALSWH showed that marital status, education level, depression and social support were associated with adoption of smoking by young women between 1996 and 2000 (Table 8, p30).

Never smokers in 1996 who were not married or in a de facto relationship reported the highest percentage of smoking adoption (7.4%) by 2000. The percentage of never smokers in de facto relationships who adopted smoking by 2000 was 3.7%. Only 1.7% of the married women adopted smoking in the four years between the surveys.

Adoption of smoking was lower for women with more years of formal education. Only 2.9% of tertiary educated never smokers at baseline adopted smoking by 2000, whilst smoking adoption amongst those with 10 or less years of schooling was 7.4%.

Table 8 Young Queensland women who did not smoke in 1996 but who adopted smoking by 2000 by socio-demographic, psychological and social factors (ALSWH 2000)

Factor	% adopting
Marital status	
Married	1.7
De facto	3.7
Never married/separated/divorced/widowed	7.4
Education level	
University	2.9
Trade/diploma/certificate	6.0
Year 12	5.9
Year 10 or less	7.4
Depression	
No symptoms	4.0
Depressive symptoms	6.8
Social support	
All of the time	3.7
Most of the time	5.1
None or some of the time	9.5

Adoption of smoking: body image

Dissatisfaction with their weight was associated with greater rates of smoking adoption in the ALSWH, but these results were not statistically significant once further analysis took other factors into account.

Table 9: Measures of dissatisfaction with body image and smoking adoption between 1996 and 2000 for young Queensland women (ALSWH 2000)

Measure	n	%
Dissatisfaction with weight		
Not at all	354	3.7
Intermediate	524	4.6
Markedly	252	7.1

Source: ALSWH, 2000. N= 1,134. The table represents the percentage of never smokers in 1996 who adopted smoking by 2000.

Adoption of smoking: lifestyle factors

Smoking adoption was associated with current use of illicit drugs, binge drinking and risky drinking behaviour, more time spent in passive leisure activities, and non-engagement in physical and active leisure activities (Table 10, p.31). For instance, 16.0% of risky drinkers and 25.0% of current multiple drug users who were never smokers in 1996 had adopted smoking by 2000. In contrast, only 3.5% of non-drinkers and 2.8% of women who never used illicit drugs and who were never smokers in 1996 adopted smoking between 1996 and 2000.

Table 10: Lifestyle factors and smoking adoption between 1996 and 2000 for young Queensland women (ALSWH 2000)

Life style factor	ALSWH (22-27 years) % adopting smoking
Alcohol consumption	
Non-drinker	3.5
Low risk drinker, binges less than weekly	3.8
Low risk drinker, binges weekly	11.6
Risky or high risk drinking	16.0
Illicit drug use	
Never	2.8
Ex-user cannabis	3.8
Current cannabis user	11.0
Ex-user multiple drugs	5.7
Current multiple drug user	25.0
Physical activity	
None	6.1
Low	6.7
Medium	3.0
High	4.1
Active leisure (last week)	
None	7.1
Some	4.1
Passive leisure (last week)	
Up to 15 hours	4.3
16 hours or more	6.4

N = 1,134. The table represents the percentage of never smokers in 1996 who adopted smoking by 2000.

Adoption of smoking: multiple factors (ALSWH)

After controlling for the effect of other factors, illicit drug use, marital status and leisure activities were significantly associated with smoking adoption (Table 11, p.32).

Current multiple drug users had significantly higher odds of becoming smokers (OR = 10.4; 95% CI 4.8-22.7) compared to women who had never used illicit drugs. This was also true for women who reported they were currently cannabis users (OR = 3.9; 95% CI 1.7-9.1).

Never smokers in 1996 who were not married or in a de facto relationship had higher odds of adopting smoking by 2000 (OR = 3.1; 95% CI 1.3-7.7) compared with married women.

Finally, women who were not engaging in active leisure activities had higher odds of adopting smoking (OR = 2.1; 95% CI 1.2-3.8) compared with women who were involved in more active leisure.

Table 11: Factors associated with smoking adoption in young Queensland women between 1996 and 2000 (ALSWH 2000) after adjustment for other factors

Lifestyle factor	Odds ratio	95% confidence intervals
Illicit drug use		
Never	1	
Ex cannabis user	1.4	0.6 – 3.2
Current cannabis user	3.9	1.7 – 9.1
Ex multiple drug user	2.0	0.4 – 8.9
Current multiple drug user	10.4	4.8 – 22.7
Marital status		
Married	1	
De facto	1.5	0.5 – 4.4
Not married / separated / divorced / widowed	3.1	1.3 – 7.7
Active leisure (last week)		
Some	1	
None	2.1	1.2 – 3.8

Quitting smoking

In the tables below, quit percentages are given. For the NHS, the quit percentage is the number of women who reported being ex-smokers divided by the number of ever-smokers (current plus ex-smokers) in the survey. For the ALSWH, the quit percentage is the percentage of women who were smokers in 1996 who reported being ex-smokers when resurveyed in 2000. Although the percentages calculated in these two surveys differ, the trends shown in Table 12 are quite consistent.

Quitting smoking: socio-demographic factors

Marital status, education level, employment status and household income were associated with smoking cessation (Table 12, p.33).

A greater percentage of married women in comparison to not-married women quit smoking. Higher socio-economic advantage was associated with greater quit percentages (Table 12, p.33).

Young women not in the labour force include those mothers of young children who do not work outside the home and so the higher quit rates are as might be expected.

Table 12: Quit percentages among Queensland young women with various socio-demographic characteristics

	NHS, 2001 (18-29 years)	ALSWH, 2000 (22-27 years)
Marital status		
Married	47.8	33.7
Not married	29.0	19.9
Education level		
University	42.1	33.3
Trade/diploma/certificate	53.1	22.8
Year 12	38.8	20.2
Year 10 or less	35.1	16.2
Language spoken at home		
English	36.9	22.5
Non-English	40.0	38.5
Employment status		
Employed	34.1	21.0
Unemployed /Not in labour force	40.8	29.3
Household income		
1 st quintile	25.9	15.9
2 nd quintile	36.7	27.4
3 rd quintile	50.0	25.7
4 th -5 th quintile	44.4	24.0

Quit smoking: pregnancy

Pregnancy was associated with higher rates of quitting smoking for women in the ALSWH. Of women who smoked in 1996, 61.1% of those who were pregnant in 2000 reported having quit smoking, compared with 21.0% of those who were not pregnant.

Quit smoking: psychological factors

Data from the NHS and the ALSWH showed that depression, non-specific psychological distress, stress and loneliness are inversely associated with smoking cessation (Table 13, p.34). Women with psychological and emotional problems were less likely to quit smoking than those who did not report such problems.

Table 13: Psychological factors and quitting smoking (quit percentages) for young Queensland women

Psychological factor	NHS (18-29 years); lifetime	ALSWH (22-27 years) lifetime
Psychological distress¹		
Low	46.1	
Moderate	28.3	N/A
High or very high	30.0	
Depression		
No symptoms	N/A	25.9
Depressive symptoms		17.3
Stress		
No	N/A	25.6
Yes		19.3
Feel lonely even when in company		
Never	N/A	37.1
Rarely		26.2
Sometimes		15.2
Often		19.6

Note. ¹ Kessler Psychological Distress Scale. N/A: not applicable; the variables were not included in the survey.

Quitting smoking: use of illicit drugs and alcohol

Women with a higher level of alcohol consumption or who were using illicit drugs had lower quit percentages than women who did not (Table 14).

Table 14: Illicit drug use and alcohol consumption and quitting smoking (quit percentages) for young Queensland women.

Life style factors	NHS (18-29 years)	ALSWH (22-27 years)
Alcohol consumption		
Non-drinkers	45.0	37.5
Rarely drinks	41.5	22.0
Low risk	38.2	24.2
Risky	0.0	5.4
Illicit drug use		
Never		27.3
Ex-user cannabis	N/A	31.6
Current cannabis user		16.7
Ex-user multiple drug		36.0
Current multiple drug user		9.0

Note. N/A: not applicable; the variable was not included in the survey.

Quitting smoking: multiple factors

Illicit drug use, current pregnancy and loneliness were significantly associated with smoking cessation even after controlling for the effect of other factors (Table 15).

Current pregnancy emerged as the most important factor associated with quitting smoking, with pregnant women having odds of quitting smoking more than 6 times (OR = 6.5; 95% CI 2.2-19.2) that of never pregnant or previously pregnant women.

Women who had stopped using illicit drugs had greater odds of quitting smoking (OR = 2.0; 95% CI 0.8- 4.7) compared with never users and women who were currently using illicit drugs had lower odds of quitting.

Feelings of loneliness were also associated with lower odds of smoking cessation.

Table 15: Factors associated with quitting smoking for young Queensland women (ALSWH 2000)

Predictors	Odds ratio	95% confidence intervals
Illicit drug use		
Never	1	
Ex-user cannabis	1.8	0.8 – 3.8
Current cannabis user	0.7	0.3 – 1.9
Ex-user multiple drug	2.0	0.8 – 4.7
Current multiple drug user	0.4	0.2 – 1.1
Pregnancy		
Never	1	
Pregnant at survey 1, not at survey 2	1.1	0.3 – 3.8
Pregnant at survey 2	6.5	2.2 – 19.2
Feeling lonely even in company		
Never	1	
Rarely	0.6	0.3 – 1.3
Sometimes	0.3	0.2 – 0.7
Often	0.6	0.2 – 1.4

Source: ALSWH, 2000; N = 362

4. SMOKING AMONG YOUNG WOMEN FROM A SOCIALLY DISADVANTAGED AREA IN BRISBANE

To examine the influence of social and environmental factors on young women's smoking, structured intercept interviews were undertaken in Woodridge and Kingston, areas of Brisbane defined as socially disadvantaged using the 2001 Census data^{49 (1)}.

4.1 PARTICIPANTS AND PROCEDURES

Young women were approached at shopping malls and transport stations in Woodridge and Kingston and invited to participate in a brief personal interview. They were assured of anonymity, confidentiality and the freedom to withdraw at any stage.

Selection criteria were: being female, aged between 18 and 30 years, residing in the local area, a current smoker and not making any attempts to quit. The final criterion was used as a method of screening to control for those individuals who might be using nicotine patches and/or gum and to ensure that participants' current smoking behaviour reflected stable smoking patterns. At the conclusion of the interviews, participants were thanked for their time and asked if they were interested in obtaining any further information regarding the study, as well as quit smoking programs and contacts for quit help lines and support groups.

Overall, 150 current smokers were interviewed. For the purposes of data analysis, 32 were classified as occasional smokers (smoking 0-5 cigarettes a day), 58 were low rate smokers (smoking 6-15 cigarettes a day) and 60 were high rate smokers (smoking 16 or more cigarettes a day).

4.2 THE SURVEY FORM

The interview was divided into six sections, each asking about a different factor associated with smoking. At the conclusion of the interview, general demographic information on the participants was gathered (see Appendix 4). The six sections were as follows:

Domestic and social factors: Questions 1-5 examined the smoking restriction rules at home, number of friends who were smokers, smoking patterns in presence of children and respondents' beliefs about the appropriateness of smoking in the presence of their own children.

Smoking patterns: Question 6 asked respondents whether they smoked daily or only occasionally. Question 7 was "how many cigarettes do you smoke per day?" which allowed smokers to be categorised into three categories: occasional

¹ The major contributions of Samantha Ward, Cara Gould and Nicole Bartels to this element of the project are gratefully acknowledged. Samantha, Cara and Nicole completed this work as a fourth-year Psychology thesis project at the University of Queensland, supervised by Neville Owen and Liane McDermott. Their expertise and initiative in designing this sub-study, creating the interview instrument and carrying out the interviews is much appreciated.

smokers (smoking 0-5 cigarettes a day), low rate smokers (smoking 6-15 cigarettes a day) and high rate smokers (smoking 16 or more cigarettes a day).⁵⁰

Level of addiction: A shortened and modified version of the Fagerstrom's (1978) Tolerance Questionnaire⁵¹ (Questions 8-13) was used to assess level of cigarette addiction. A composite score was obtained by summing the scores on the single items. Scores ranged from 6 (low addiction) to 15 (high addiction).

Motives for smoking: Thirteen items rated on a 6-point Likert scale were used to assess motives for smoking: addiction, socially cued motives and psychological motives (positive affect increase and negative affect reduction). Horn's Reasons for Smoking Scale – Addictive smoking⁵² (Question 18; *e, h*) items were used to assess *addiction-related motives for smoking*. Items derived from McKenel and Thomas' (1967) Occasions for Smoking Questionnaire – Social Factor,⁵³ identifying everyday events that influence smoking behaviour, were simplified and used to gauge *socially cued motives for smoking* (Questions 18 *g, j, k, l, m*). Individual items assessing psychological motives for smoking were adapted from Thomkins' (1966) Reasons for Smoking Scale – Positive Affect Smoking, Negative Affect Smoking⁵⁴, and McKenel and Thomas' (1967) Smoking Motivation Factors Questionnaire – Inner Need Smoking⁵³. Specifically, *positive affect smoking* was assessed using Question items 18 *a, f, i*, whilst *negative affect regulation smoking* was assessed using items *b, c, d*. To provide a single score for each type of motive, an average of the scores on those items hypothesised to gauge specific motives was taken.

Impact of smoking restrictions in social venues: Participants were asked whether or not they believed the implementation of smoking restrictions in social venues would alter their smoking habits (Question 17 *a, b, c, d*). A composite score was computed by summing the scores on the specific items. Scores ranged from 4 (no impact) to 12 (high impact). To examine the effect of social venues on smoking, participants were asked to report how many cigarettes they smoked on days when they visited social venues and on days they did not visit social venues (Questions 15-16).

Smoking behaviour in social, non-social, stressful and non-stressful situations: Participants were asked to rate on a 5-point Likert-like scale (1 = *never* to 5 = *always*) how likely they were to smoke in a range of situations (Question 19). To assess certainty of being able to refrain from smoking in social/non-social and stressful/non-stressful situations, a 6-point Likert-like scale (1 = *very uncertain*; 6 = *very certain*), based on a similar item by Ausems, Mesters, Breukelen and De Vries (2002), was used (Question 20)⁵⁵. The participants were asked to report how certain they were to be able to refrain from smoking in three social and stressful situations, three non-social and stressful situations, three social and non-stressful situations and three non-social and non-stressful situations. Composite scores were calculated (mean score on the corresponding items) for each of the four types of situation. Possible scores ranged from 1 (very uncertain) to 6 (very certain).

4.3 FINDINGS: DOMESTIC, SOCIAL, AND STRESS RELATED FACTORS ASSOCIATED WITH SMOKING AMONG YOUNG WOMEN

Household Rules On Smoking

Stricter home smoking rules were associated with lower daily cigarette consumption and lower addiction levels. More occasional (21.9%) than light (5.2%) or heavy smokers (5.1%) had household rules not allowing smoking, either outside or inside (Table 16, p.39).

Nearly half of the heavy smokers lived in households where smoking was allowed anywhere (45.8%) compared to very few (6.3%) of the occasional smokers.

As might be expected, more occasional smokers (21.9%) lived in totally smoke-free households compared to either light (5.2% smoke-free) or heavy smokers (5.1% smoke-free). In addition, over 90% of the occasional smokers permitted smoking outside only, compared to 74.2% of light and 54.3% of heavy smokers. This pattern was repeated for visitor smoking, where most occasional smokers (87.1%) restricted visitor smoking compared to 64.3% of light and 45% of heavy smokers.

It is notable that, even among heavy smokers, more than half of the women surveyed lived in homes with some kind of smoking restriction. Smokers with no smoking restrictions at home had a higher level of cigarette addiction than smokers who had smoking restriction rules. Smokers who were allowed to smoke outside but not inside their home had a higher level of addiction than smokers who were not allowed to smoke at home (Table 16, p.39).

Smokers from households with smoke restrictions for visitors had a lower level of cigarette addiction than their counterparts (Table 16, p.39).

Friends Who Smoke

Daily cigarette consumption level was positively related to the proportion of smokers amongst the respondent's friends.

Nearly 4/5ths of the heavy smokers (79.4%) reported that all or most of their friends were smokers. More than half of the light smokers (56.2%) reported that this was the case for them also. Occasional smokers tended to have friends who were not smokers, with only 9.7% saying that all or most of their friends were smokers.

Presence Of Children

Most respondents (93.5% of occasional, 84% of light; 68.3% of heavy smokers) reported that they would smoke less or not at all in the presence of children. Only about one third (31.7%) of the heavy smokers said they would smoke the same amount around children.

Table 16: Association of domestic smoking restrictions, friends' smoking and smoking near children with smoking category and levels of addiction

Factors	Categories of smokers			Level of addiction Mean (SD)
	Occasional (N=32)	Light (N=58)	Heavy (N=60)	
Home smoking restrictions for residents				
Only smoking outside	71.9%	69.0%	49.2%	11.5 (2.5)
Smoking allowed anywhere	6.3	25.9	45.8	14.0 (2.4)
No smoking allowed anywhere	21.9	5.2	5.1	9.5 (2.5)
Home smoking restrictions for visitors				
Yes	87.1%	64.3%	45.0%	11.1 (2.6)
No	12.9	35.7	55.0	13.6 (2.5)
Friends smokers				
All	3.2%	8.8%	32.8%	14.5 (2.5)
Most	6.5	47.4	46.6	12.5 (2.5)
About half	32.3	22.8	17.2	11.5 (2.5)
Less than half	54.1	21.1	3.4	9.9 (2.3)
Smoking in presence of children				
Same	6.5%	16.1%	31.7%	14.6 (2.3)
Less	25.8	53.6	51.7	12.3 (2.5)
Not at all	67.7	30.4	16.6	10.2 (2.9)

Note. The scores on the addiction scale ranged from 6 (low addiction) to 15 (high addiction).

Respondents generally felt strongly that parents should control their smoking in the presence of their *own* children (Table 17). Occasional smokers (mean score = 5.0) agreed very strongly; light smokers agreed a little less strongly, (mean score = 4.8), as did heavy smokers (mean score = 4.3).

Table 17: Perceived inappropriateness of smoking in front of children and smoking category

Category of smoker	n	Mean score (SD)
Occasional	32	5.0 (0.9)
Light	58	4.8 (1.0)
Heavy	60	4.3 (1.2)

Note. The scores on the scale gauging perceived inappropriateness of smoking in front of their own children ranged from 1 (*very appropriate to smoke in front of children*) to 6 (*very inappropriate to smoke in front of children*).
M = means; SD = standard deviation

Addiction-related, social and emotional motives for smoking

Addiction, emotionally and socially related motives for smoking differed markedly between occasional, light and heavy smokers (Table 18).

Smokers with higher rates of smoking had stronger addiction-related motives for smoking.

Occasional smokers had the highest and heavy smokers the lowest level of socially cued motivation for smoking.

It seems likely that occasional smokers may smoke in the main when they socialise, to “be part of the crowd”. Emotional motives for smoking were stronger in light and heavy smokers than in occasional smokers.

The patterns shown in Table 18 suggest that, compared to occasional smokers, light and heavy smokers seem to use smoking for mood regulation, to increase positive emotions and to decrease negative emotions.

Table 18: Addiction-related, social and emotional motives for smoking by category of smoker: mean (SD)

Motives	Occasional (n=32)	Light (n=58)	Heavy (n=60)
Addiction-related	2.5 (0.7)	3.9 (1.0)	5.1 (0.7)
Socially cued	4.3 (0.5)	2.7 (1.0)	1.8 (0.6)
Positive affect	4.1 (0.6)	4.7 (0.6)	4.5 (0.4)
Negative affect	3.5 (0.9)	4.6 (0.7)	4.8 (1.2)

Note. The table presents the means and the standard deviations on the four motives for smoking scales by category of smokers. The theoretical range of scores on these scales was from 1 (low motive) to 6 (high motive).

Smoking Behaviour In Social Situations And Stressful Situations

Impact of visits to social venues on numbers of cigarettes smoked

Visits to social venues, such as pubs or nightclubs appear to have a marked impact on how much young socially disadvantaged women smoke.

Young women reported smoking many more cigarettes on days when they went to a social venue (mean = 26.9; SD = 12.3) than on days when they didn't (mean = 14.14; SD = 9.6).

Occasional smokers were affected the most, reporting that they smoked up to 6½ times the number of cigarettes on days that they went to social venues than they normally would. However, light smokers and heavy smokers were also inclined to smoke more, with light smokers reporting smoking twice as many while heavy smokers smoked about 1.6 times as many cigarettes as usual on those days.

Reported likelihood of smoking in various social/non-social situations

Overall, smokers say they are less likely to smoke when alone or in the company of non-smokers. However there were differences between the categories of smokers. While occasional smokers said they would hardly ever smoke in these situations, heavy smokers still thought they would smoke almost always in these situations.

In contrast, social settings such as parties, pubs, nightclubs and the company of smokers are strongly conducive to smoking for all categories of smoker. It is noteworthy that in social situations such as parties, pubs, nightclubs and the company of smokers, all these young women thought they would smoke (Table 19).

Table 19: Reported likelihood of smoking in social and non-social situations, by smoking category and level of addiction

Situation	Category of smokers; M (SD)			Correlation with level of addiction; r
	<i>Occasional</i> (n=32)	<i>Light</i> (n=58)	<i>Heavy</i> (n=60)	
When socialising	4.0 (1.1)	4.5 (0.7)	4.6 (0.5)	0.23
With non-smokers	2.0 (0.5)	3.3 (0.9)	4.0 (0.6)	0.67
When alone	2.8 (1.1)	3.8 (1.0)	4.7 (0.5)	0.52
With smokers	4.2 (0.7)	4.5 (0.7)	4.9 (0.3)	0.28
At party	4.3 (0.8)	4.5 (0.5)	4.7 (0.5)	0.25
At pub/club	4.1 (1.1)	4.6 (0.8)	4.9 (0.4)	0.30

Note. Likelihood of smoking was measured on a 5-point scale ranging from 1 (*never*) to 5 (*always*). Means and standard deviations are reported for categories of smokers and Pearson coefficients of correlation are reported as measures of associations between likelihood of smoking and level of addiction.

Smokers' reported ability to refrain from smoking in social and in stressful situations

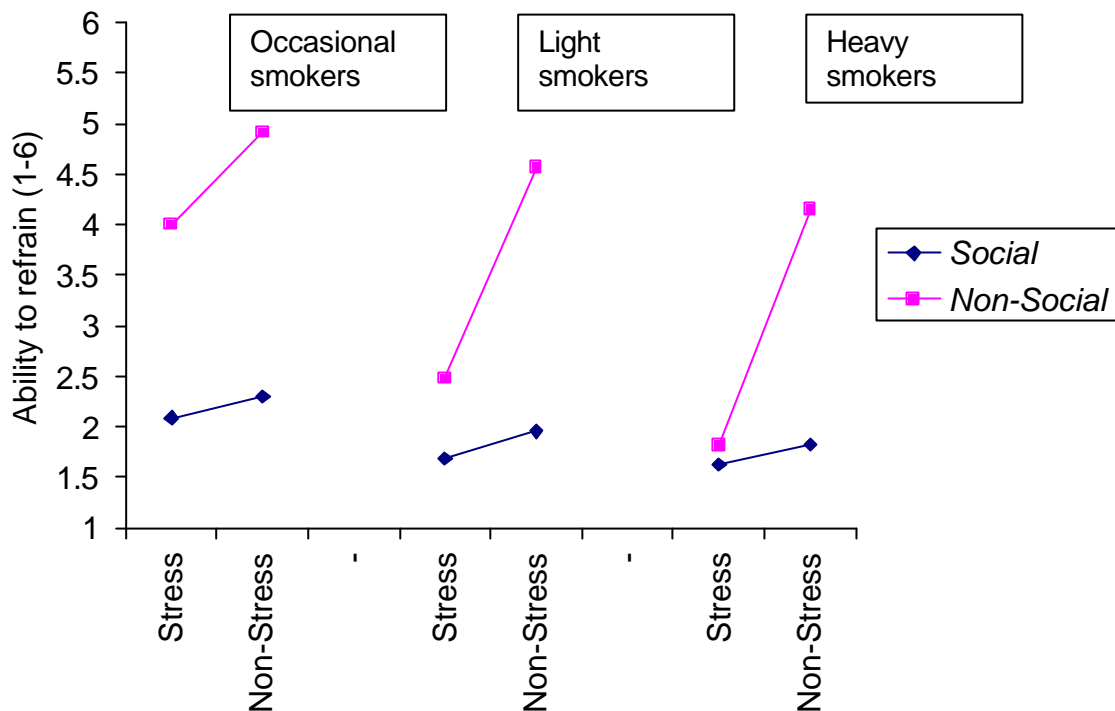
Social situations and stress were strongly associated with young socially disadvantaged women's perceived ability to refrain from smoking.

In social situations occasional, light and heavy smokers all reported low levels of certainty that they would be able to refrain from smoking, regardless of the level of stress associated with them.

Stress was associated with lower perceived ability to refrain from smoking in both social and non-social situations for all categories of smokers.

However, heavy smokers reported being much less confident that they could refrain from smoking in stressful, non-social situations (see Figure 1, p.41).

Figure 1: Perceived ability to refrain from smoking in social, non-social, stressful and non-stressful situations among occasional, light and heavy smokers



Note: Ability to refrain from smoking was rated on a 6-point scale ranging from 1=very uncertain to 6= very certain.

Perceptions Of The Influence Of Further Smoking Bans In Social Venues

Significant differences emerged between occasional, light and heavy smokers on agreement with the potential of smoking restrictions in social venues to affect their smoking behaviour.

Overall, occasional smokers reported stronger agreement that bans would affect their smoking behaviour [mean (SD) = 10.6 (2.12)] and differed significantly from light [mean (SD) = 9.3 (1.97)] and heavy smokers [mean (SD) = 7.5 (2.34)].

Overall, more than half of these young women (54%) believed that the implementation of smoking restrictions in pubs and clubs would decrease their current amount of smoking.

A further 19% said that such bans “maybe” would decrease their amount of smoking, while 27% said that bans would *not* decrease their amount of smoking. When asked whether bans on smoking in these venues would encourage them to quit, only thirty-eight percent of women said “yes”; 26% said “maybe” and 36% said “no”.

Some 18% of the young women interviewed believed that bans would result in them giving up smoking altogether, while 29.3% reported that it would not result in them giving up.

The remaining 52.7% responded “maybe” when asked if they would quit in response to such bans.

4.4 SUMMARY

The results of the interviews of 150 young women smokers from socially disadvantaged areas of Brisbane show a clear pattern of findings. The data are from a cross-sectional survey, so they identify associations rather than causes and effects.

- More heavy smokers (46%) than occasional smokers (only 6%) were in households that allowed smoking anywhere at all.
- Occasional smokers (87%) were much more likely to live in a household in which visitors were discouraged from smoking than were heavy smokers (45%).
- More-stringent household smoking restrictions were associated with lower smoking rates and lower addiction levels
- Respondents generally felt strongly that parents should control their smoking in the presence of their *own* children. Occasional smokers agreed very strongly; light smokers and heavy smokers agreed a little less strongly.
- Daily cigarette consumption and level of addiction were positively related to the reported proportions of friends who smoke.
- Occasional smokers appear to smoke in the main when they socialise, to “be part of the crowd”.
- Compared to occasional and light smokers, heavy smokers seem to use smoking for mood regulation – that is, to increase positive emotions and to decrease negative emotions.
- Visits to social venues (pubs and nightclubs in particular) appeared to have a marked impact on how many cigarettes young socially disadvantaged women smoked.
- Young women smoked more on days when they went to such social venues than on days when they did not. This difference was much greater for occasional and light smokers than for heavy smokers.
- Overall, smokers, but particularly occasional smokers, are likely to smoke less when alone or in the company of non-smokers.
- Occasional, light and heavy smokers all reported low levels of confidence in being able to refrain from smoking in social situations, regardless of the level of stress associated with them.
- Overall, more than half of the 150 young women interviewed (54%) believed that smoking restrictions in pubs and clubs would act to decrease their rate of daily smoking.
- Occasional smokers particularly strongly agreed that smoking restrictions in pubs and clubs would reduce their levels of cigarette consumption.

5. PERSONAL AND SOCIAL INFLUENCES RELATED TO SMOKING INITIATION, MAINTENANCE AND CESSATION: FINDINGS OF QUALITATIVE STUDIES

Three sub-studies were conducted in order to explore personal and social influences on young women's smoking behaviour. These were: focus groups; a web-based survey and a telephone survey.

5.1 Young Women's Views on Smoking: The focus groups

Focus groups and in-depth interviews were used to examine the personal and social influences on young women's smoking behaviour. A qualitative approach was used in order to come to grips with subtle cognitive and social factors, which are not able to be addressed in sufficient depth using other forms of data collection. The intention here was to focus on themes and issues deriving from social identity theory.⁵⁶ Social identity theory has been extremely influential in communication⁵⁷ and provides a framework for understanding behaviour as it is influenced by membership of salient social groups.

Understanding how these memberships affect young women's smoking behaviour may lead to both a better understanding of potentially modifiable factors and to identification of relevant opportunities for intervention strategies for reducing cigarette smoking among young women.

In addition, using open and unstructured interviewing techniques, this qualitative part of the research focussed on the influence of group norms and social networks, self-concept and self-esteem, body image and significant influences and significant messages. The intention was to allow us to understand issues important to young women which have been shown to be related to tobacco use.^{18,19,58,59} These issues were considered in the context of potentially modifiable factors in young women's social, community and workplace environments in order to identify opportunities for recommendations regarding how media campaigns targeting young women might be approached and the potential for policy and environmental changes relevant to addressing determinants of tobacco use in young women.

Participants In The Qualitative Study

Small focus group discussions were held with young women living in rural and urban areas. In deciding on the number of groups and their composition, the principle of homogeneity in facilitating an effective focus group discussion was incorporated. After discussion the Partnership members identified three groups of young women who were seen as having sufficiently different life-stage or transition issues or interests to warrant separate groups for each. Hence three partitions were used: very young women, 16-18 years old, women aged 19-24 years with no dependents; and young mothers or expectant mothers, 16-28 years old. Half the groups were planned for rural areas and half for urban areas to allow any differences due to living in different locations to emerge in the

analysis. Groups were also separated into smokers groups and non-smokers or ex-smokers groups in each age/life stage.

Recruitment Of Participants

Urban groups

Young urban mothers were recruited through the networks of Women's Health Queensland Wide (WHQW). We wish to acknowledge the assistance of the young parents program, Brisbane Youth Service and Youth and Family Services (Logan City) for their involvement.

As a result of advice from the network organisations that young mothers would not attend meetings in unfamiliar places, we used a piggyback strategy. Focus groups were arranged so that they either took the place of an established mothers' meeting at the usual venue or were tacked on to it afterwards. This was very successful and four groups of young mothers, 2 smoking, 2 non-smoking, were held in the urban areas.

For the 19-24 year old urban groups, we used a snowball technique. Personal contacts who fitted the required profile were recruited and asked to approach others they knew and arrange a group time. We then arranged a venue to suit. One non-smoking and one smoking group were recruited this way.

The youngest sample, 16-18 year old young women smokers and non-smokers were difficult to recruit in the urban areas. It was decided to use intercept interviews in public venues. Interviewers were instructed to approach small groups of women who appeared to be in the 16-18 year old category and ask them to participate in a short discussion of smoking issues.

The intercept interview schedule was brief, consisting of demographic details, smoking status and 5 research questions based on the focus group questions. These were:

- What sorts of things come to mind when you think about smoking?;
- When do you think young women smokers are most likely to smoke (what situations or times)?;
- Why do you think young women start smoking at first?;
- Why do you think they keep smoking?;
- What do you think makes it hard for young women to quit smoking?

Six pairs of young women agreed to participate.

Rural recruitment

Rural women were more difficult to recruit than the urban women. In rural areas over 20 youth/health workers were contacted concerning their participation.

Using this network, youth workers in Kingaroy, Gympie and Mackay arranged three groups conducted by videoconference. Two of these groups were with 16-18 year olds (1 smoking, 1 mixed group) while the third was a group of 19-24 year old smokers.

For recruitment of the rural 16-18 year old women, the most successful strategy was our attendance at Youth Speak Out, an event organised by Maryborough and Hervey Bay Junior Councils. This event involved several hundred young women from locations all over Queensland. A total of five focus groups were held at the Youth Speak Out. Four of these groups were with 16-18 year olds (2 mixed groups, 2 non-smoking groups) and one was with 19-24 year old non-smokers.

Focus Group Methods

The questions used in the focus group discussions were general and only partially structured. Groups began with a short explanation of the purpose of the study and a statement about the research interest in getting different views on smoking. Participants were then asked what sorts of things came to their minds when they thought about smoking. They were asked about the positives and negatives of smoking as well. From this point, questions and probes followed the interests of the participants, but with special attention to trying to elicit information related to key attributes of salient in-groups and out-groups that are central to understanding from a social identity theory perspective. Examples of such follow up questions were: “what made that group cool?” (in response to use of the descriptor cool about smokers) “what was it about them that was cool?” “did you want to be like them?”

We were particularly interested in how young women saw and experienced smoking in social scenes so we asked them about where they socialised and how smoking fitted in to those social environments. Again, probe questions followed the direction of the discussion and were designed to get participants to elaborate on the themes they were presenting.

Group discussions generally finished with questions that asked the participants to give the project team advice on what might be useful to young women smokers who wished to quit.

The focus groups were recorded. This recording was carried out by either a research assistant trained in court reporting and using specialised equipment or the discussion was audio-taped or video-taped (in the case of the videoconferences) and later transcribed. Theme analysis was then conducted using Q.S.R NUD*IST Vivo 1.1 software to aid the analysis procedures.

Qualitative Findings: Themes Related To Smoking

Connotations of smoking

In response to what sorts of things come to mind when thinking of smoking, young women reported both positive and negative connotations to smoking. The young women in this study saw the negative side of smoking in similar terms to those identified in other studies. Thus the smell of cigarettes, cigarette smoke and smokers after smoking, were mentioned frequently as negative aspects of smoking by both smokers and non-smokers alike. Words like disgusting, revolting, stinky and gross appeared often in these accounts. The cost of cigarettes and the sense that the money spent on them was wasted also appeared in the descriptions given by both smokers and non-smokers. Positive connotations came from smokers or ex-smokers only and referred to the

enjoyment and “fun” of smoking and to smoking as a way of relieving stress or enhancing relaxation. One group of women referred to the physical pleasure of blowing the cigarette smoke out as the most enjoyable aspect and one of the most difficult to relinquish in quitting.

For smokers, having a cigarette was also seen as something that ‘went with’ other activities. So, for instance, drinking coffee or chatting with friends was something that involved smoking as part of the activity. As well, smoking had become part of the routine of everyday living for smokers, and clearly remembered by those who had given up:

*When I was smoking there was an everyday routine. You wake up, have a coffee and cigarette. It was a real routine.
(Young mother, ex-smoker, urban)*

Ex-smokers spoke of seeing the whole image of smokers differently now from when they first admired smokers and wanted to be like them. For them, smoking had become the opposite of what it was when they smoked:

I find it looks really unattractive. I used to think when I smoked that it was a feminine thing. Now when I look at girls and they do it, it is a really unattractive look. (Young mother, ex-smoker, urban)

Starting smoking: the need to fit in

Young women spoke about why they thought they had experimented or begun to smoke initially or why they thought others had taken up smoking while growing up. Generally they reflected on their school years in doing this, as none of the women who took part in this study had adopted smoking after their teen years. Smoking to fit in with peers was cited as an important influence on both experimenting and smoking regularly. However, some young women denied that this was peer pressure. In these accounts, young women didn’t refer to being pressured to accept cigarettes from their friends so much as experiencing a sense of fitting in better when they were smoking. Thus:

Basically, like I say, a lot of my friends were smokers. They were smoking quite a lot. The only way I could fit in was by doing the same thing. (19-24 year old, smoker, rural)

Smoking was remembered as something which “everyone” was doing at the time and so experimenting or smoking regularly was seen as normal behaviour. It was also a new experience which the women recalled wanting to try as a teenager and seeing as just one of many other new experiences:

It was the same when we were growing up as well. Everyone smoked so why not? I had to have a go. Like trying a different drink, I had to have a go, I suppose. (19-24 year old non-smoker, urban)

Images of smokers as “cool” were frequently cited as the reason young women had smoked in their younger years. The cool people at school were seen as those who were also popular and behaved in ways that participants remembered wanting to behave themselves. Cool smokers were often those who rebelled against authority, either of teachers or of their parents. This theme is elaborated below.

Smoking as a social bond

Smoking was seen as a way of bonding with other smokers, especially in social situations, and of giving people something in common.

I used to smoke when there were people around. I used to enjoy it when you are sitting around and your friends are sitting around. When you had a drink, it felt really nice. You all had something in common. It gave you that friendly feeling. You were sitting around. (Young mother, ex-smoker, urban)

This social bonding was noticed by non-smokers as well and seen as a potentially strong influence on them to begin to smoke as illustrated here:

I've got a few friends that smoke and I can't smoke with them - I can't be with them when they're smoking because it makes me sick - physically sick. But I know that if I was always with them and it didn't have that effect on me there might be a temptation because they are always together and that's something that keeps them together, is the fact that they all smoke together. (16-18 year old, non-smoker, rural)

An unexpected finding, generally confined to the young mothers in this sample, was that those who had given up smoking felt some regret about losing this social aspect of fitting in, as shown in the following quote from a young pregnant woman who had quit for her pregnancy.

I miss it. I loved it. I enjoyed just sitting there being able to talk to your friends and have a smoke. I loved it. I will most likely go back to it. I'm not quite sure. (Young mother, ex-smoker, urban)

*You feel left out when you are not smoking and everybody else is.
(Young mother, relapsed smoker, urban)*

Triggers to smoke or companion activities

Smokers saw many activities or situations as 'going with' smoking. Examples of these were social occasions with smoking friends, when driving a car, drinking coffee, when bored, after a meal or during the ad breaks on television, when on the phone to friends and when experiencing stress. A widely mentioned trigger for smoking was drinking alcohol and going to venues where alcohol was a primary feature, such as clubs, parties and pubs. This association between smoking and alcohol was also given by non-smokers, some of whom described themselves as smoking socially or experimenting with smoking when going to pubs, clubs or parties where others were smoking and socialising.

Stress was particularly seen as a trigger or as a justification for smoking. Young women regarded any stressful situation as relieved by a cigarette during or afterwards so that smoking was seen as a legitimate form of stress management or a coping strategy. This stress management aspect was cited as a significant barrier to quitting by many of the smokers in the study and a strong reason for relapse, as shown in the following quote from a young mother currently not smoking for her second pregnancy:

*I don't know [if I will start smoking again when the baby is born]. I said I wouldn't with my last baby. But the more stressed I got the more I just wanted to have one. So I ended up having them.
(Young mother, ex-smoker, urban)*

Smoking as normative behaviour with alcohol

Young women identified a few situations in which smoking seemed more acceptable or where smoking behaviour was increased. These were social occasions with smoking friends (as mentioned previously), parties and the pub or club scene.

Non-smokers made very similar comments about smoking in these sorts of venues to those of their smoking counterparts. They described socialising with alcohol, particularly in pubs and clubs as leading to high numbers of people smoking. Smokers reported that when drinking they consumed many more cigarettes than usual. Some non-smoking women, particularly those in the youngest age group (16-18 years) said that socialising with alcohol had led them to experiment with smoking. Others described themselves as only smoking in these circumstances, that is, they were 'social smokers'. Even ex-smokers reported an impact from alcohol on their smoking as captured by the following quote:

I think everyone does [smoke a lot when drinking]. I gave up smoking. When I went out drinking I would have a couple of

cigarettes. When I was drinking I still smoked even though I was a non-smoker. (Young mother, relapsed smoker, urban)

There was a sense that the rules for smoking were somehow different when alcohol was involved and that cigarettes and alcohol formed a natural partnership, as illustrated here:

You just feel like it [smoking while drinking]. It's like chocolate topping and ice-cream just go together. Alcohol and cigarettes just go together. (Young mother, ex-smoker, urban)

These findings suggest that smoking is normative behaviour when associated with alcohol and socialising. Thus, in situations where young women are drinking and socialising, this social norm results in considerable pressure on people, even non-smokers, to smoke cigarettes.

The norm of 'considerate smoking'

Young women noted that smoking is becoming much less socially acceptable in many public places. Some smokers saw this as unjust while others were not only sympathetic, but spoke of a sub-group of "inconsiderate" smokers who were perceived as forcing their habit on others around them. These young women saw smoking as a personal choice, but the health impact was seen as sufficient reason to restrict this choice in some situations. The following quote captures this:

I got really annoyed at inconsiderate smokers because I swear I have never done this as a smoker, I never, ever smoked around children and pregnant people and around where people can't, you know, get away and they have to be waiting there. (Young mother, trying to quit, urban)

Smokers should care about non-smokers. They have made that decision not to slowly kill themselves with nicotine. That is their choice. We need to respect that and leave that with them. If I am in an outside area sitting close to someone, even if they are at a different table - that has a lot to do with the way I was raised-my father is no longer smoking. He gives me hell when I smoke. It's all usually in good fun between dad and I. He is quite down the line [in giving up smoking]. If my smoke is annoying him I will get up and move away. I am conscious that it may be annoying other people. (19-24 year old, smoker, rural)

Most notable among these situations were those that involved children, whether one's own or other people's. For instance:

My friend has a young baby. I will take the baby out of her arms and walk away with her kid. I go "Why don't you stick the cigarette in the kid's mouth, get it in nice and early?" (19-24 year old, smoker, rural)

Non-smokers too saw smokers as divided into considerate and inconsiderate or selfish smokers. Considerate smokers were those who thought about the impact of their behaviour on others and didn't impose their smoke on people. For instance:

Speaker 1: Now we go to parties and stuff but usually people just drink. But smokers, they'll go outside and smoke on a veranda.

Speaker 2: Yeah.

Speaker 1: Yeah, they're pretty good.

Speaker 2: Yeah, they're pretty good and they won't smoke inside where the party is and they won't force you - they'll ask you, "Do you want some?" [If] You say, "No" [then] That's fine.

Speaker 1: I find they respect you. They're a lot more considerate. (Members, 16-18 year old, non-smokers, rural)

Mothers smoking around their children and pregnant smokers formed a special sub-group of inconsiderate smokers. They were highly visible and were seen as doing the wrong thing by their children (also see quote above). One participant went as far as to use the term 'child abuse' in relation to smoking around children, illustrating the frequently judgemental tone of comments. This view was shared by many of the mothers themselves, as shown by this next quote:

When I was pregnant he [partner] was really angry [at me for smoking] and I was angry at myself too because I was pregnant. I couldn't help it. (Young mother, relapsed smoker, urban)

However, some young women recognised the effect of addiction and tried not to judge pregnant smokers who had (presumably) been unable to give up while pregnant.

Sub-typing of smokers into considerate and inconsiderate smoker groups suggests that smokers as well as non-smokers are aware of the negative social impact of smoking. Smokers appear to deal with this by claiming membership of the 'better' social group, the 'considerate smoker' that allows them to continue to smoke around non-smokers.

Quitting

Young women were asked about their views on what was required for people like themselves to want to quit. Willpower was seen as very important to the process of quitting and young women thought only people who really wanted to quit could do so. Smokers expressed a certain level of admiration towards those who had displayed this willpower by managing to quit either permanently or for periods of several months or more. Some expressed doubt that they could ever do this themselves. Quitting was seen as difficult or even insurmountable, something too permanent in the light of recognition of addiction and previous failed attempts. One young woman expressed this in talking about her current quit attempt:

You just think it is too hard and you put it in the too hard basket and light up again. Whereas, if you focus on the positive things and think of it in baby steps. To say "quitting" to a smoker is so - to me, I don't know if it is the same for you, but it was so far-fetched. Quitting was like a real deadline. Like, "Okay, tomorrow I'm going to quit and tomorrow there's going to be no cigarettes." And as fast as I quit, as fast as I would start up again. And every time that failed but if you just think of it like a diet, you know, "I'm going to be less reliant on cigarettes." Don't say "quit", but just less reliant and then you kind of cut back as much as you can. (Young mother, trying to quit, urban)

Quitting also required attention to alternative ways of dealing with those factors that respondents saw as being their reasons to smoke. Prime amongst these factors were stress and boredom. Successful quitting was a matter of replacing other associated aspects of smoking such as having something to do with one's hands, filling the gaps created by not smoking and re-establishing routines, especially enjoyable ones, disrupted by not smoking. Replacing the social facilitation offered by smoking was mentioned too. For instance, for an ex-smoking young mother:

I find it's hard for me socially. When you talk about things sometimes there is that awkward pause and someone is having a conversation. I would feel uncomfortable when I was talking. I am doing something [when I smoke]...I don't have something to keep me busy all the time [now that I don't smoke]. (Young mother, ex-smoker, urban)

The imposition of further smoking restrictions was seen as likely to help women to quit, particularly in the face of the difficulty smokers attached to giving up. As one young mother said:

I can't see anything helping me give up unless they ban it completely. (Young mother, smoker, urban)

Non-smokers too saw smoking restrictions as helpful to reducing the number of smokers, and tied this to the rights of non-smokers, as here:

Speaker 1: I think also to get the number of smokers dropped down you need to limit the areas they can smoke.

Speaker 2: Yeah, definitely.

Speaker 1: If you can't smoke anywhere around you, you can't smoke.

Speaker 2: Can them at bars, can them at clubs, can them everywhere unless it's outside.

Speaker 1: Yeah, because inside you want fresh air. (Members, 16-18 year old, non-smokers, rural)

Smokers expressed some expectation that smoking would be subject to more restrictions in the near future. They appeared to accept this and view it as part of being a considerate smoker. However, some smokers were vocal about the rights of smokers to smoke in environments where they did not see themselves as having an impact on non-smokers. This applied to outdoor areas of restaurants and social venues. On this point, non-smokers seemed to agree as indicated in the quote above.

Non-smokers

As found in other studies, non-smokers reported having decided to be a non-smoker early in their lives. For some, the fear of becoming addicted to nicotine was a strong feature of this decision, while for others, it was simply lack of interest in smoking as a habit. Some non-smokers who had experimented with smoking found the experience so unappealing they decided not to repeat it.

Many non-smokers clearly thought that smoking didn't make sense: if everyone, including smokers thinks smoke is stinky and leads to unpleasant health effects, then why do smokers smoke? While they tried to understand the addictive side of smoking, they had trouble understanding why anyone would smoke 'socially' or why a person addicted to nicotine would choose cigarettes as the form of delivery rather than a nicotine patch or inhaler. One young woman put it this way:

I don't get how they [smokers] can't stop. But that is because I have never been, like, addicted. It's something hard to grasp. Why can't you just put it down and not do it anymore? How come you still have to keep having them? (16-18 year old, non-smoker, urban)

In some instances, non-smokers applied considerable pressure on smokers close to them to give up. Young women reported hiding smokers' cigarettes or flushing them away. Some used emotional pressure such as indicating their disappointment verbally or making frequent requests for the smoker to quit. One young woman reported promising her friend money if he would quit.

Benefits and costs of smoking

All the women in the groups were aware of the health costs involved in smoking. Most seemed to be aware of the dangers posed by smoking during pregnancy, though some of the pregnant smokers either denied or dismissed this reasoning that giving up was so stressful that it created more harm to the baby than continuing to smoke. Other costs mentioned were the cosmetic effects (wrinkles, yellowing, smelliness etc) and financial impact of smoking, as mentioned above.

One possible distinction between smokers and non-smokers was that, while smokers could cite enjoyable aspects of smoking and benefits to themselves, non-smokers were not convinced of these at all. Thus smokers talked about the physical enjoyment, stress relief, anxiety management and the social benefits of fitting in and having a conversation starter or taking time out for themselves.

Non-smokers however, though they could cite many of the same reasons to smoke as smokers did themselves, saw these as trivial, immature or false. This suggests that a possible predictor of smoking behaviour may be the ability to appreciate smoking as beneficial in some way, rather than being unable to make sense of smoking.

Influence Of Social Groups Or Networks On Smoking Behaviour

Being cool

As mentioned above, many of the young women who became regular smokers at some stage reported that smoking initiation was influenced by images of smokers as cool, especially during the early high school years. Smoking at that time was seen as the way to join this cool group who were characterised as rebellious, independent, tough or aggressive and fun loving.

When I hit high school and saw people were smoking and it was generally what I thought was cool people doing it, I thought, to be with them, that's what I have got to do. Once you are there it's the other way around. The smart people, the better people [don't smoke]. You think at this stage they [smokers] are being rude to the teachers and smoking. Everyone looks up to them. They are cool. It's not like that [in reality]. (Young mother, ex-smoker, urban)

In contrast, the uncool groups or squares were more interested in their studies, were non-smokers, non-drinkers and were seen as less popular.

mother. This also fits with claiming membership of the 'considerate smoker' sub-group.

Young pregnant women who see themselves as considerate smokers and 'good mothers' because they have given up smoking for the duration of the pregnancy express some regret. Unless they maintain the attitude that they will not expose their babies and children to their smoking, they may relapse as they return to their social environment. If such women do not begin to see themselves as members of a different social group, with a different set of acceptable behaviour around smoking, their quitting during pregnancy may be a temporary phase undertaken to remain part of the good mother/considerate smoker group and not a permanent change in behaviour. The attitude of their partner is likely to be a key factor in this process.

6. AWARENESS, USE AND RELEVANCE OF ANTI-SMOKING AND SMOKING CESSATION INITIATIVES AMONG YOUNG QUEENSLAND WOMEN

6.1 Web-Based Survey of Young Women

A web-based survey was developed to explore where young women receive anti-smoking messages from and how they view the relevance of these (see Appendix 5).

A link to the survey was established from Women's Health Queensland Wide's web-site.

WHQW promoted the survey via media releases to metropolitan and regional newspapers, email lists (such as Australian Women's Health Network and Youthgas), key website managers (eg. Visible Ink, Generate), the coordinator of the school based youth health nurses and other people who had shown an interest in the project. The survey was available for approximately 4 weeks.

The opening page of the survey explained the study, its purpose and assured respondents of confidentiality and anonymity. Initial questions helped classify respondents into smoking categories (never smoker = never smoked daily or occasionally, fewer than 100 cigarettes smoked in lifetime; current smoker = smokes daily or occasionally and has smoked > 100 cigarettes in lifetime; ex-smoker = previously smoked daily or occasionally, currently not smoking, smoked > 100 cigarettes in lifetime).

Results

Using postcode and age criteria, responses from young Queensland women were extracted from the survey data. A total of 42 valid responses were received, consisting of 7 ex-smokers, 17 non-smokers and 19 current smokers.

Sources of anti-smoking messages

All participants were asked to indicate all the sources they received anti-smoking messages from. They were also asked to rate how relevant they thought those messages were to themselves (smokers and ex-smokers) or people like themselves (non-smokers) on a five-point scale (1= not at all relevant, 5= very relevant). Results are displayed in Table 20.

Table 20: Sources of anti -smoking messages and the perceived relevance to young women

Source	Ex-smokers (n=7)			Non-smokers (n=17)			Smokers (n=19)		
	Number indicating source	Relevance M (SD)		Number indicating source	Relevance M (SD)		Number indicating source	Relevance M (SD)	
Spouse/partner	5/7	71%	4.2 (0.8)	2/17	12%	3.5 (2.1)	14/19	79%	2.2 (1.3)
Other family members	5/7	71%	4.0 (1.0)	15/17	88%	3.6 (1.1)	17/19	90%	2.9 (1.2)
Friends	5/7	71%	3.4 (1.5)	9/17	53%	3.7 (1.0)	13/19	69%	2.6 (1.1)
School-based programs	4/7	57%	3.8 (1.0)	14/17	77%	3.8 (0.8)	10/19	52%	2.0 (1.5)
Television	6/7	86%	4.0 (0.6)	15/17	88%	4.3 (0.7)	17/19	90%	3.0 (1.5)
Women's magazines	2/7	29%	3.5 (2.1)	9/17	53%	3.2 (0.7)	10/19	52%	2.0 (0.9)
Health magazines	2/7	29%	3.5 (0.7)	2/17	12%	3.0 (0.0)	7/19	37%	2.4 (1.4)
Print mass media	3/7	43%	3.3 (1.5)	9/17	52%	3.6 (1.1)	13/19	68%	2.5 (1.3)
Health professionals	3/7	43%	5.0 (0.0)	2/17	24%	3.8 (1.0)	14/19	79%	2.9 (1.3)
Cigarette packaging	5/7	71%	2.2 (0.8)	7/17	41%	2.9 (1.5)	16/19	84%	2.1 (1.5)
Radio ads	5/7	71%	2.0 (1.4)	4/17	24%	3.3 (1.7)	9/19	47%	1.8 (1.0)
Cinema ads	3/7	43%	3.7 (0.6)	14/17	77%	4.1 (1.0)	9/19	47%	2.8 (1.4)
Quit smoking brochures	2/7	29%	4.0 (1.4)	N/A	N/A	N/A	11/19	58%	2.5 (1.3)
Other	0	0		2/17	121%	5.0 (0.0)	0	0	

Note: Relevance measured on 5 point, Likert scale, 1= not at all relevant, 5= very relevant. N/A- Quit smoking materials were not included as a source of message for non- smokers.

Almost all the young women regardless of smoking status, recalled receiving anti-smoking messages from television. These were also rated as relevant to them, especially for non-smokers (Table 20).

Family members (other than spouse) were the second most cited source of anti-smoking message. Again, this was true for all the young women. Ex-smokers and non-smokers rated these messages as relevant, however, the average rating from smokers was only 2.9 suggesting that smokers did not see the messages as relevant (Table 20).

While smokers and ex-smokers cited spouses as common sources of anti-smoking messages, their ratings of the relevance differed, with the majority of smokers (11 of the 14 giving this source) seeing those messages as less relevant to themselves than ex-smokers did. The results for friends had a similar pattern, with both smokers and ex-smokers citing friends as a source, but with smokers seeing those messages as not particularly relevant (Table 20).

For non-smokers, all the messages they received seemed relevant to people like themselves.

Overall, smokers said they received messages from a greater number of sources than ex-smokers or non-smokers, with over two thirds citing at least 7 sources including health professionals (79%), cigarette packaging (84%) and print media (69%) as well as friends, family and spouse or partner. However, disappointingly, smokers rating of these messages suggests they were not seen as very relevant to themselves (Table 20).

Most Relevant sources of anti-smoking messages

Women were asked which message had the most relevance for them and why.

Health professionals were the most relevant source of message for around a quarter (5/19) of the smokers (Table 21, P.59). Their reasons centred on the perceived expertise of the professional as well as on the direct information they had received about the detrimental effects on their own health.

Of the 19 smokers, 4 cited spouse as the most relevant source of message and 3 cited other family members. Here, the explanations were concerned with the smoker's impact on those most important to them. For instance one young smoker wrote:

My spouse is the centre of my universe. If he believes in me and wants to look ahead to the health of our unborn children then perhaps it is worth the effort.

Smokers who said that television was the most important message source (4/19) all said that the graphic visual effects of smoking made this the most important message.

Table 21: Most relevant source of anti -smoking message (proportions)

Source	Ex-smokers n=7	Non-smokers n= 17	Smokers n= 19
Spouse/partner	4/7	1/17	4/19
Other family members	2/7	6/17	3/19
Friends	0.0	1/17	1/19
School-based programs	0.0	1/17	0.0
Television	0.0	4/17	4/19
Women's magazines	0.0	0.0	0.0
Health magazines	0.0	0.0	0.0
Print mass media	1/7	1/17	0.0
Health professionals	0.0	0.0	5/19
Cigarette packaging	0.0	1/17	0.0
Radio ads	0.0	0.0	0.0
Cinema ads	0.0	1/17	0.0
Quit smoking brochures	0.0	0.0	1/19

Note: Non-smokers and smokers each had 1 missing result for "most relevant source"

For 4 of the 7 ex-smokers, spouses were the most relevant source of message, with other family members the most relevant for another 2 of these women.

More than a third of the non-smokers (6/17) said family (other than spouse) was the most important source. Television was given as the most relevant source by a further 4 of the non-smokers.

Quitting behaviour

Smokers and ex-smokers were asked about their quitting behaviour and whether they had sought help to quit. Those who had sought help were asked to rate how useful that help had been.

Most ex-smokers did not seek help to quit, though over 40% indicated they had tried 6 or more times to quit before succeeding. The two women who did seek help (1 from the chemist; 1 from a self-help quitting book) indicated that it had been very useful to them at the time (Table 22, P.61).

All except one of the smokers said they had tried to quit at least once. However, like their ex-smoking counterparts, many (11/19) did not seek help to do so.

Chemists (4/19), friends or family (6/19), and GPs (2/19) were the most common sources the women tried for assistance, with GPs seen as very useful and chemists as useful in this process.

Table 22: Sources of quit smoking help and the perceived usefulness

Source	Ex-smokers (n=7)		Smokers (n=19)	
	Number indicating this source	Helpfulness M (SD)	Number indicating this source	Helpfulness M (SD)
None	5/7	NA	11/19	NA
Quit line	0	-	1/19	3.0 (-)
GP	0	-	2/19	5.0 (0.0)
Other health professionals	0	-	0	-
Chemist	0	-	4/19	3.5 (1.3)
Friends/family	1/7	5.0 (0.0)	6/19	2.7 (0.6)
Other quitters	0	-	1/19	2.0 (-)
Internet	0	-	0	-
Other sources	1/7	5.0 (0.0)	1/19	2.0 (-)

Note. Usefulness was measured on a 5-point Likert-like scale (1= not at all useful to 5= very useful).

Notable for its absence is the Quitline as a smoking cessation resource used by young women. Only 1 smoker had used it and rated its usefulness as 3 on the 5-point scale. This result bears out findings of the Queensland Health Omnibus survey, that smokers tend not to seek help to quit and when they do, Quitline is not one of the resources commonly accessed.

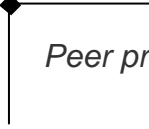
Smoking experimentation among non-smokers

Non-smokers were asked whether they had ever experimented with smoking, and if so, what form this experimentation had taken. Possible responses were “Took a few drags when others were smoking”; “Smoked a few cigarettes (but less than 100 cigarettes total)”; “Smoked only when drinking alcohol and partying (but less than 100 cigarettes total)”; “still smoke occasionally when around friends who are smoking (but less than 100 cigarettes so far”.

Two thirds (11/17) said they had experimented. Of these, over 90% said they had taken a few drags when others were smoking. Qualitative explanations for this experimentation fell into two types. The first type (7 of the 11 experimenters) referred to being curious and wanting to know what smoking was like. In the words of one woman:

When you're young, alcohol and cigarettes are seen as being one of those things you “just have to try”. Even if it's just once, to dispel any curiosity

The second type of response (4 of the 11) referred to peer pressure as their reason:



Peer pressure and that it was cool and rebellious

Costs of smoking

The non-smokers were also asked why they thought they had *not* become smokers. Several of the responses to this question were quite lengthy, suggesting that the non-smokers felt quite strongly about their reasons.

Responses varied, however, all except one contained reference to at least two of the perceived costs of smoking. Disgusting smell and taste, high financial cost and negative health impact were frequent responses. Two women referred to negative images of smokers and one referred to the impact on her fitness.

Fear of addiction was also mentioned, as was negative impact on beauty and appearance.

It seems that non-smokers saw the costs of smoking very clearly and these were convincing enough to prevent them from experimenting or from progressing from experimentation to smoking regularly.

6.2 Telephone Survey of Current and Ex-Smokers

This survey was administered to young women callers to the Women's Health Queensland Wide Health Information Line between the months of September and November 2003. The procedure was that, where appropriate, young women in the target age range were asked at the conclusion of their calls whether they wished to participate in a survey on smoking. The survey consisted of simple, structured, open-ended questions that investigated what sources of anti-smoking messages young women smokers and ex-smokers were aware of and asked about their perceptions of the relevance of these messages to themselves (see Appendix 6 for the survey form). The questions also sought information about whether smokers had attempted to quit previously, and if so, where they had sought help. Ex-smokers were asked whether they had sought help to quit and how useful that help had been at the time.

Findings

Sources of anti-smoking and smoking cessation messages

The sources of anti-smoking and quit smoking messages given by young women smokers and ex-smokers are displayed below in Tables 23 and 24.

Nearly all of the women surveyed recalled anti-smoking messages from television advertisements (94% of smokers; 94% of ex-smokers). These included the National Tobacco Campaign advertisements ("Every Cigarette is Doing You Damage", "Tar", "Artery"), the "Marshall Menthol" campaign aired by the Queensland Quit campaign, "John Clarke recall" aired by the Queensland Cancer Fund, and "Cigarette Smoke is Poison" from Queensland Health though some women mentioned commercial nicotine replacement product advertisements. Of those smokers who reported television as a source of

message, two-thirds saw these as relevant to themselves. For ex-smokers, one-third saw these as relevant.

Around one fifth of all women surveyed reported receiving anti-smoking messages from their partners or husbands. These had high salience: all those (100%) who said they received such messages from their partners perceived them as relevant to themselves.

For half of the smokers other family members were also sources of anti-smoking messages. Almost all these women (88%) saw messages from their family members as relevant to themselves. Only 28% of ex-smokers reported messages from other family members. Of these, 80% saw them as relevant to themselves.

Table 23: Smokers' sources of anti-smoking and quit smoking messages

Message source (multiple responses possible)	Smokers n = 18	Percent	Percent of women citing the message source who also saw the message as relevant to themselves
TV ads (National Tobacco Campaign)	17/18	94	53 (9/17)
Partner/husband	3/18	17	100 (3/3)
Other family member	9/18	50	89 (8/9)
Friends	4/18	22	75 (3/4)
Cigarette pack	9/18	50	33 (3/9)
Other (includes print media, signs, Quit materials)	4/18	22	50 (2/4)

Table 24: Ex-smokers' sources of anti-smoking and quit smoking messages

Message source	Ex-smokers n = 18	Percent	Percent of women citing the message source who also saw the message as relevant to themselves
TV ads (National Tobacco Campaign)	17/18	94	29 (5/17)
Partner/husband	4/18	22	100 (3/3)
Other family member	5/18	28	80 (4/5)
Friends	3/18	17	33 (1/3)
Cigarette pack	4/18	22	50 (2/4)
Other (includes print media, health professional, signs, Quit materials)	10/18	56	30 (3/10)

Friends and cigarette packs were the next most common sources of message. Around a fifth of the respondents indicated anti-smoking messages came from friends. For current smokers this was an important message source, with three quarters of those reporting this source seeing the message as relevant. One third of ex-smokers who received messages from friends saw them as relevant.

Half the current smokers reported receiving anti-smoking messages from cigarette packaging. Of these women, 33% saw those messages as relevant to them. Nineteen percent of ex-smokers reported messages from packaging, with two-thirds seeing these as relevant.

Other sources of anti-smoking messages were print media, GPs, billboards, signs on vending machines, and school-based health lessons.

Sources of help to quit

Of the 18 ex-smokers, 13 had not smoked for over 12 months, with 8 of those having quit for 2 or more years. Nearly all the successful quitters, that is the ex-smokers (16/18; 89%) reported having quit without help. One person reported having used Quitline materials to stop smoking, while another person said she had sought help from her father and her boyfriend.

All except two of the current smokers surveyed reported at least one attempt to quit smoking. Smokers seemed more inclined to seek help to quit than the ex-smokers surveyed, with 28% (5/18) saying that if they were serious about quitting, they would call the Quitline. All those who indicated they would call the Quitline thought that it would be useful, rating it as 3 or better (on a scale of 1-5 where 1 = "not at all useful" to 5 = "very useful"). Other sources of help smokers said they would use were family, friends, GPs and chemists. However half of the smokers (9/18) reported they would not seek help and would attempt to go 'cold turkey' by themselves.

Motivations to quit

Health or fitness reasons for quitting were the most common reasons cited by the ex-smokers surveyed (50%). It was also the most common reason smokers gave for attempting to quit (56%) (see Tables 25 and 26, p.65). Pregnancy or preparation for becoming pregnant motivated one third of ex-smokers to quit. Similarly for smokers, one third said they had tried to quit for this reason.

Seventeen percent of ex-smokers indicated that pressure from their partners or family had motivated their quitting. For smokers, too, 17% said this sort of pressure had led to their quit attempt. For 6 women (3 ex-smokers; 3 smokers) cost had been a motivator. For a few ex-smokers (17%), ridding themselves of a "dirty" or "smelly" habit or making their living environment cleaner was also a motivator.

Table 25: Ex-smokers' motives to quit

Motive (multiple responses possible)	Ex-smokers n = 18	Percent
Fitness/Health	9/18	50
Pregnancy or preparation for pregnancy	6/18	33
Partner or family pressure	3/18	17
Dirty habit/smell/ cleaner environment	3/18	17
Cost	3/18	17
Other	11/18	61

Table 26: Smokers' motives for making a quit attempt

Motive (usually several motives were given)	Smokers n = 18	Percent
Fitness/Health	10/18	56
Pregnancy or preparation for pregnancy	6/18	33
Partner or family pressure	3/18	17
Dirty habit/smell/ cleaner environment	1/18	5
Cost	3/18	17

Summary Of Telephone Survey Findings

Results from the telephone survey suggest that mass media campaigns are reaching their target and are having an impact. Almost all of the women surveyed reported seeing anti-smoking advertisements and more than half of current smokers saw these messages as relevant to themselves. Furthermore, the primary message of these campaigns, that is, quitting for the sake of one's health has clearly been received by young women: the most common single reason cited for quitting or attempting to quit was for personal health/fitness.

In keeping with an underlying contention of this study, pregnancy was the second most common motive cited for quitting or attempting to quit. This highlights pregnancy as a key life-stage for intervention.

Though overall only seven of the women cited partners or family as sources of anti-smoking messages, these sources were highly salient to them. This suggests that interventions focussing on family environments and the impact of smoking on members of the smoker's immediate family may be useful.

The figures regarding help to quit suggest that most people who quit successfully still do so without help, though current smokers seemed willing to explore other options, particularly Quitline.

6.3 SOCIAL AND PERSONAL INFLUENCES ON SMOKING: DISCUSSION OF THE FINDINGS FROM THE FOCUS GROUPS, THE WEB-BASED SURVEY AND THE TELEPHONE SURVEY

The three studies reported above suggest that smokers are receiving many anti-smoking messages from a variety of sources and that awareness of smoking as harmful behaviour is high.

Moreover, findings from the focus groups suggest that smokers are aware of smoking as a minority behaviour. They appear to deal with this by creating a sub-type of considerate smokers, to which they themselves belong, in contrast to the inconsiderate smokers who are characterised by imposing their smoke on others.

Pregnant women and young mothers are a special case of considerate smokers, where smoking ceases in order to be a good mother who demonstrates the ultimate consideration by quitting for the sake of her unborn child.

In one sense the web-based and telephone surveys showed contradictory results regarding the importance or relevance of sources of messages. While smokers who responded to the telephone survey suggested that people closest to them were the most relevant sources of anti-smoking messages, smokers who answered the web-based survey generally did not think this.

However, ex-smokers in both surveys, though few in number were very concerned with those closest to them. Close family and friends may represent another avenue for intervention with some smokers, particularly those who are pregnant or planning to have children in the near future.

There appears to be a shift taking place in the normative climate around smoking in public. Smokers as well as non-smokers are seeing smoking as requiring more careful attention to the health and comfort of other people, and 'inconsiderate' smokers are a sub-group disparaged by smokers and non-smokers alike.

This represents an opportunity to capitalise on social change. Young women may be influenced to alter their smoking behaviour if it fits with the social norms of the 'considerate smoker' group. Young women thus seem predisposed to accept the expansion of smoking restrictions, particularly in social venues where non-smokers are involved. As noted in the findings of the studies above, young women smokers recognise the need for smoke-free venues and are calling for leadership on this from legislators.

An important point is that smokers need to see the impact of their smoking on others before they are likely to activate their considerate smoker identity. Since there was some evidence that smokers and non-smokers were misinformed as to what constitutes safe smoking around others (for instance, some women indicated that blowing the smoke away from others when outside protected them

from harm), this points the way for attempting to influence how smoking in public is viewed in terms of impact and highlights a need for better education as to the harms of tobacco smoke.

For young mothers and pregnant women, considerate smoking represents an opening to influence social norms already strongly influencing this group. Young pregnant women who smoke are already highly aware of their visible status as smokers and the criticism that draws. They are also motivated by their own desires to be good mothers. This needs to be built upon through greater education as to the post-partum harms to children of parents who smoke. Current and future parents need to understand the on-going impact of parental smoking on young children and what they can do about this.

6.4 THE NEED TO SELECT A RANGE OF RESEARCH METHODS

Generally, we found that recruitment and engagement of young women who smoke to take part in a research project is difficult, and that considerable resources must be devoted to it. Furthermore, our results attest to the benefits of triangulating findings from various sources of data and information. Future studies should aim to employ a mix of in-depth interviews, focus groups, intercept interviews, observational studies, and large-scale survey methods to obtain convergent data.

7. TOBACCO CONTROL INITIATIVES OF RELEVANCE TO YOUNG WOMEN

7.1 Legislation

Commonwealth: Legislation to restrict tobacco advertising and sales has been passed at national level. Smoking within Commonwealth buildings has been banned since the late 1980s. The Commonwealth also sets and collects excise on tobacco products. An account of relevant Commonwealth legislation may be accessed via the Action on Health and Smoking Australia website at: <http://www.ashaust.org.au/pdfs/NatLegisl02.pdf>.

State-based legislation also applies to the control of tobacco and environmental tobacco smoke, as below.

New South Wales: NSW amended its tobacco laws in 1999 to increase penalties for sales of tobacco products to minors so that vendors convicted of offences could be banned from selling such products if they committed multiple offences.

In September 2000, the NSW Smoke-free Environment Act came into effect. A ban on smoking in enclosed places was enacted into legislation in 2001 for all public enclosed spaces except for pubs/clubs and private functions rooms, which were required to have smoke-free dining areas (see <http://www.health.nsw.gov.au/health-public-affairs/smokefree/publicnotice.htm>).

From July 1st, 2003 a voluntary agreement between the government and industry groups has seen the introduction of smoking bans in all counter areas where liquor is served. From July 1st 2004, bars and recreational venues with more than room must provide a smoke-free room. Currently the Minister for Health has requested an action plan and timeframe to be developed by May 2004 to phase out smoking in all public places

Victoria: Victorian legislation requires all enclosed public areas to be smoke-free with the exception of licensed premises. Smoke-free dining was introduced in July 2001 and smoke-free enclosed shopping centres in November 2001.

From September 2002, licensed premises that were non-gaming were required to designate a smoke-free room at all times when two or more rooms were operating. Gaming venues must provide one smoke-free room at all times and bingo halls must be smoke-free entirely. The casino is smoke-free except for bar and high roller areas (see <http://www.vctc.org.au/tc-res/regulation.htm>).

Restrictions on tobacco displays and point of sale material were implemented in January 2002. Fines for retailers infringing 'sales to minors' legislation were increased and magistrates were given power to remove a retailer's ability to sell if committing certain sales to minors offences.

South Australia: The smoke-free legislation is under review for extension to the hospitality industry. Acting on recommendations from the Smoke-Free Hospitality Taskforce, the government recently announced its decision to phase in smoking restrictions in hospitality venues. By January 2004, all non-hospitality workplaces are required to be smoke-free, and a 'one-metre' rule will apply to hospitality and gaming venues. By 31 October 2004 multi-bar venues must provide a smoke-free bar. Single bar venues must have 50% of the bar smoke-free. The casino must have 50% of its floor smoke-free as well as 25% of the gaming machine area. Dining area exemptions are removed from that date. By October 2005 50% of the gaming area must be smoke-free, with a complete ban being required from October 2007.

Western Australia: Smoking restrictions came into force in March 1999 and restricted smoking in enclosed public places in Western Australia.

Similarly to South Australia, a review of the effectiveness of smoking in public places legislation in WA has recommended that all places currently exempt from the legislation be included within it by October 2003. In addition, the review has recommended that out-door dining areas and stadia be included legislation to restrict exposure to environmental tobacco smoke.

(See <http://www.population.health.wa.gov.au/promotion/resources/8647%20review.pdf>)

Australian Capital Territory: The ACT was the first jurisdiction to legislate to restrict smoking in restaurants and bars. Currently the government is working to phase out limited exemptions given to premises such as pubs and clubs which allow smoking in specific areas. Total bans for indoor areas in the hospitality industry were to take effect in 2008 but have been brought forward to December 1, 2006.

Tasmania: Smoke-free legislation was enacted in 2001 in Tasmania and banned smoking in enclosed public places such as restaurants, offices, shops and within five metres of entrances to public buildings. Smoking restrictions apply in outdoor dining areas where 50% must be smoke-free.

Following the release of the report (June 2003) reviewing the legislation the Tasmanian government announced it would introduce legislation to ban smoking in all nightclubs, cabarets and gaming areas from the start of 2005. There will be exemptions for one bar or room in hotels, taverns and other licensed venues where smoking will be permitted. In venues with only one bar, 50% must be smoke-free.

(See.

http://www.dhhs.tas.gov.au/publichealth/smokefreeareas/documents/smoke_free_areas_report.pdf).

Northern Territory: In January 2003, restaurants, cafes and shopping centres went smoke-free as well as the dining areas of hotels, bars and licensed clubs. In May 2003, legislation was introduced for workplaces to be smoke-free, with the exception of licensed premises, and smoking was banned within 2 metres of entrances and doorways to enclosed workplaces. Also in May 2003, hotels, bars

and licensed clubs were required to provide smoking and non-smoking areas of equal amenity.

(see

http://www.nt.gov.au/health/healthdev/aodp/tap/smokefree/world_no_tobacco_day.shtml).

7.2 COMPLIANCE MONITORING

In NSW, surveys of compliance with 'Sales to minors' legislation are carried out regularly. Previously this used to be a region by region activity. Now the Health Department of NSW requires that a minimum of 10% of retailers are examined for compliance.

As a result of surveys revealing that most minors reported buying their cigarettes themselves, the NSW Central Coast Health Service launched an initiative to reduce this through awareness raising stickers and media buys in 1993. In 1994 they began their first compliance survey and found that, of the 130 or more venues retailing cigarettes that were surveyed, 38.5% were still willing to sell to minors. Details of high profile prosecutions that followed breaches of the legislation were passed on to major retailers in the area and retailers were encouraged to ask customers for identification of age for cigarette purchases. Further compliance surveys have shown a much reduced rate of willingness to sell to minors so that by 1998-99 none were recorded in the survey. In this area, which had previously had rates of smoking amongst young people that were greater than the State average, rates are below the State average.

The Cigarette Sales to Minors Enforcement Team is a Victorian government funded initiative located within the Department of Human Services. The Enforcement Team works closely with local councils to enforce the laws related to sales to minors. This is done through test purchases using 15 and 16 year old children. Infringements are handled with education, warnings, fines (second offence) and finally prosecution (for a third or subsequent offence). Between January 2001 and November 2002, 3127 retailers were tested. Initially, the non-compliance rate was 32% (January 2001). This rate fell to 17% for the whole of 2001 and to 12% for 2002 until November. Retailers who initially were prepared to sell to minors were targeted for retesting at later dates. Of those retailers who received a formal warning letter following their breach, retesting showed only 25% were willing to sell on the second occasion. In 2002, the first successful prosecution of a retailer for offences against the new legislation occurred.

7.3 INITIATIVES AT NATIONAL AND STATE LEVEL

National Tobacco Campaign - 1996 Onwards

In July 1996, the Commonwealth Minister for Health and Family Services appointed a Ministerial Tobacco Advisory Group (MTAG) to advise on a range of tobacco control activities and to develop a new education campaign. The members of MTAG were recruited from the Federal, State and non-government sectors. MTAG recruited organisations committed to reducing the harm caused by tobacco and has worked on a range of activities and initiatives to support the mass media campaign.

In order to develop the campaign rationale, MTAG conducted an extensive review of tobacco research around Australia. The research identified a need for messages to be targeted to the 18-40 age group, particularly within lower socio-economic groups. Many young smokers believe they will give up by the time they are 30, and it was agreed that this group needed the motivation and resources to put quitting smoking back on their daily agenda as a major priority.

The review also concluded that there were a number of principles or attributes that should underpin the new campaign. These included the need for fresh insights and graphic portrayals of how smoking damages your health, the need to demonstrate the escalating nature of tobacco addiction, the importance of making the campaign personally relevant to the smoker and the need to depict long term gains and acknowledge the real difficulties in quitting. These principles have guided the development of the campaign

(see <http://hna.ffh.vic.gov.au/nphp/key/key7/key7.htm>).

National Tobacco Campaign Evaluation Report Volume II (1999 Follow-Up 2)

This report evaluated the impact of the second phase of the campaign (5 television ads including the original three plus “Brain” and “Call for Help” shown throughout 1998) and compared figures to baseline survey (May 1997) and the first follow-up evaluation (November 1997) of the previous phase (the three original television ads, “Artery”, “Lung” and “Tumour” shown from June to December 1997). Results indicated the campaign, targeted at the 18-40 years old bracket of smokers had been effective in maintaining people’s awareness of the materials as well as increasing knowledge about the health effects of smoking amongst adults and teenagers. Other key findings were that more smokers sought help to quit particularly through discussing smoking and health at home (36% reported discussing these issues at home at follow-up 1 compared to 42% at follow-up 2). An overall reduction in the estimated adult prevalence of smoking of about 1.8% over the 18-month campaign was also reported.

National Tobacco Strategy 1999 to 2002-03

The National Tobacco Strategy (NTS) is a Commonwealth initiative to provide a comprehensive approach to tobacco control. The goal of the NTS is to improve the health of all Australians, but especially target groups of smokers whose health will be affected by smoking; non-smokers, especially children, who may take up smoking; passive smokers, by eliminating or reducing their exposure to tobacco in all its forms. The strategy comprises six key areas: strengthening community action; promoting cessation of tobacco use; reducing availability and supply of tobacco; regulating tobacco; and reducing exposure to environmental tobacco smoke.

(see <http://www.health.gov.au/pubhlth/publicat/document/metadata/>).

National Tobacco Control Conference Established June 2001

This has been held twice – in Adelaide in 2001 and Melbourne in 2003. The next conference is planned to take place in Perth in 2005.

(see <http://tobaccocontrol03.conference.net.au/>)

NSW Tobacco Action Plan 2001-2004

This plan adopts the key strategy areas of the National Tobacco Strategy with priority population groups identified as children, young people, Aboriginal and Torres Strait Islander people, non-English speaking communities with high smoking rates and those people who suffer from a mental illness.

The National Consensus Meeting on Strategic Tobacco Policy Research

“Tobacco Control in Australia: A Priority Driven Research Agenda” is a document produced by the National Consensus Meeting on Strategic Tobacco Policy Research funded by the Cancer Council of Australia and the National Heart Foundation in 1999. This document takes its point of departure as field-worker priorities and thus the intent is to focus on development of policy relevant questions and advice that those who are working in the area of tobacco research, control and policy agree are priorities. It sets out the research needed to support effective tobacco control policy in Australia. Research functions are: to improve understanding of determinants of smoking uptake and cessation; to improve the efficacy of tobacco control interventions; to improve dissemination/uptake of efficacious intervention thereby improving program effectiveness; to monitor progress in achieving tobacco control aims and objectives, that is, population morbidity and mortality, key behavioural outcomes and attitudinal, educational and policy indicators; and to provide data that would justify a particular program or legislative action for example in justifying the need for the tobacco industry to be regulated

(see <http://www.cancer.org.au/content.cfm?randid=861023>).

Victorian Primary Care Partnership Community Projects

These partnerships are affiliations of primary care facilities situated geographically close to each other.

The Goulburn Valley Primary Care Partnership ‘Clean Air’ Initiative is funded through the Department of Human Services. This initiative aims to support the development of policies in relation to cigarette smoking and to support employee assistance programs for quitting smoking.

The Central West Gippsland Smoking Reduction Project is also funded by the Department of Human Services to undertake a smoking reduction project aimed at employees.

The South Coast Health Services Smoking Reduction Program has undertaken to reduce smoking amongst secondary school aged students. A number of schools are involved and have taken part in “Peer Quit Mentors” which trains students to help peers who smoke to move towards the contemplation stage of quitting. Another part of this program has been the training of 15 “Fresh Start” facilitators to hold Quit courses locally.

7.4 MASS MEDIA CAMPAIGNS

Media campaigns are conducted both nationally and by individual states. Resources developed for these campaigns are often ‘shared around’ by permission from the bodies that originate the resources in order to maximise the

use of effective material and reduce costs. Campaigns for 2003 that targeted women or young women are given below.

The Cancer Foundation of Western Australia launched a major media campaign in May 2000 with aim to reduce prevalence of adult smoking in WA to 15% or less by 2010. Young women 18-29 were the target for the 2002-2003 mass media component of this campaign entitled: 'Make Smoking History'. The campaign uses television advertisements, press, posters and information resources. Launching of the media ads occurred in WA in February/March 2003 with a second burst in July/August.

"Make Smoking History" television advertisements were specifically designed to target younger women. They consist of 3 personal testimonials ("No Warning"; "If I'd Quit at 25"; "Staying Stopped") from Jenny, a real 42-year-old mother, diagnosed with lung cancer that spread to her spine and bones. Jenny describes how she had no warning signs and feels she would not have contracted cancer had she stayed a non-smoker at age 30 when she first succeeded in quitting.

Evaluation of the initial media buy in February 2003 showed that 59% of surveyed women aged 18-29 said they were considering quitting as a result of the ads. Of these, 84% said the ads made them consider quitting in the next month.

Victoria, South Australia and Tasmania sought permission to use these materials and ran them for specific 'media buys' in 2003.

Quit SA ran a media buy of the WA "Jenny" ads in March and in August 2003 and is expecting an evaluation of those soon. Their new quit ads will also target young women with the Quit Victoria "Janet" television ad which depicts a young woman "desperate for a smoke" contacting the Quitline instead.

Quit Victoria and Quit South Australia worked together to develop and implement a mass media campaign aimed at parents aged 18-39 who smoke. This campaign went to air during August 2001 and will continue until 2003. Other states and territories received permission to use the material in their mass media campaigns.

In NSW, the Central Coast Area Health Service NSW ran "Out of the Smoke Screen" a 2-year project starting in December 2001 using a cinema screen ad prior to latest blockbuster teenage movie in school holidays. This campaign targeted young women 12-17 who smoke on the Central Coast of NSW. This group was previously identified as having smoking prevalence above state average. The campaign succeeded in raising the awareness of smoking behaviour in the movies amongst the target group. A large percentage of the young women surveyed after the movies reported that they did not see the smoking in the movie as acceptable and were motivated to think about quitting if they smoked themselves.

The Tasmanian Quit campaign targeted young women 18-40 years old in its latest media advertising using the Jenny's story ads from WA over the period May to June 2003. The evaluation of the campaign was carried out by monitoring the calls to the Quitline from the target group. The campaign was judged a huge success and increased calls to the Quitline to over 800 in the period of the media buy. Thirty-one percent of these calls were from women aged 18-40, the target group. A further 22% were from women over 40 years old and 17% were from men aged 18-40.

Quit Victoria regularly runs quit smoking campaigns. In 2001-2002 the target of the campaign was parents who smoke, in acknowledgement of the important influence of parental behaviour on children's smoking behaviour. In addition to this campaign, other smoking cessation projects were: grants to community health service providers so that they could host information sessions for workers on giving smoking cessation advice; workplace smoking cessation grants; development of smoking in pregnancy intervention guidelines to be used in hospitals.

7.5 INTERVENTIONS IN PREGNANCY

In Victoria, a three stage project to reduce cigarette smoking amongst pregnant women, the Smoking in Pregnancy Project was due for completion in December 2002. This Project consisted of a literature review stage, the development of a best practice smoking cessation model (stage 2) and the implementation of guidelines from the model into Melbourne hospitals during 2003 (stage 3).

Antenatal care guidelines were also developed by the Victorian Department of Human Services in conjunction with three major teaching hospitals. These guidelines include a tobacco specific guideline, developed in collaboration with Quit and the Cancer Council of Victoria, in relation to health professionals and smoking cessation advice to patients. Service performance indicators for all public hospitals that provide maternity care in Victoria will now include an indicator that measures the extent to which pregnant women are offered smoking cessation interventions that are known to reduce the rates of maternal smoking. In addition, Quit Victoria has developed specific protocols for pregnant women and will seek to offer additional support to pregnant women who seek it.

'Butt out for Baby' is a South Australian smoking cessation resource developed for young parents and pregnant women, health workers and community workers to inform and support them in reducing smoking rates amongst young parents. The Department of Human Services Tobacco Control Unit South Australia provided funding for the project, which was carried out using young parents themselves to design the resource. The resource consists of an information booklet on the effects of smoking on pregnancy, the barriers for young parents in accessing adequate information about the impact of smoking on their pregnancy and suggestions for health workers in working with young parents. There are also stickers, posters and postcards to raise awareness about the effects of smoking on pregnancy outcomes.

7.6 COMMUNITY BASED INTERVENTIONS

SIDS and Kids Victoria is a not-for-profit organisation with the aim of reducing the incidence of Sudden Infant Death Syndrome. Activities during 2002-2003 were to provide information to midwives, antenatal educators and child health nurses to promote effective smoking cessation interventions with pregnant women.

VicHealth fosters community involvement in tobacco control through “Partnership for Health” which works with sporting associations to assist them to develop smoke-free policies.

The Cancer Council of SA ran a smoke-free houses and cars project from 2000 onwards. This was aimed at reducing the passive smoking exposure of children. Follow-up evaluations have suggested that a reduction in smoking in cars and houses has occurred, though the improvement is modest.

7.7 RECENT RESEARCH INITIATIVES

The VicHealth Centre for Tobacco Control (VCTC) (see <http://www.vctc.org.au/>) conducts research on tobacco use and control. Most recently, a review of over 100 studies examining the economic impact of smoke-free policies in restaurants and bars in 8 different countries was conducted by researchers with the Centre for Behavioural Research in Cancer (CBRC). The review, published in *Tobacco Control*, June 2003, showed that, where studies were conducted by bodies independent of the tobacco industry, no adverse economic effect from smoke-free policies was reported. Of the studies reviewed, 29 reported a negative impact of smoke-free policies on businesses. However, all of these were sponsored by tobacco companies or groups linked to the tobacco industry and were therefore suspect in their conclusions. The review also found that two further studies funded by tobacco related bodies concluded that people would go to smoke free venues. The results of these two studies were not released publicly. The remaining studies examined were clearly independent of tobacco industry connections and in almost all cases found no negative economic impact of smoke-free policies.⁶⁰ Similarly, a local study of the economic impact on smoke-free legislation in South Australia reported no adverse economic impact on the hospitality industry.⁶¹

Other research⁶² on smoking bans in public entertainment venues such as pubs and nightclubs reported that smokers would be more likely to quit and would be less likely to ‘binge’ smoke if smoking were banned in these venues. Around two thirds of regular patrons who smoke said they would either approve or not mind if such venues became smoke-free.

VicHealth Centre for Tobacco Control developed the document “Tobacco Control: a blue chip investment” which argues the economic case for tobacco control and funding for it as well as outlining an agenda for action. It has also examined “low tar” cigarettes and the impact of industry marketing practices and policy changes on smoking behaviour. In addition, the Centre drafted a paper assessing the adequacy of health warnings on cigarette packaging.

Other VCTC and CBRC research includes analysis of the way that tobacco is portrayed in popular films, investigation into retailer and industry compliance with tobacco point of sale advertising and display restrictions, studies of the impact of smoke-free dining on dining patterns, research on the relationship between environmental tobacco smoke and reported respiratory and sensory symptoms, and a study examining the smoking behaviour of pubs, clubs and nightclub users.

Quit Victoria completed three projects related to tobacco control for the Department of Human Services prior to 2002 and planned to undertake a further three during 2002-3. Included in these briefs were research areas of the health, economic and legal issues associated with environmental tobacco smoke, attitudes to smoking in bars, gaming areas and other enclosed public places and examinations of smoking in high risk groups (eg. Indigenous Australians) and in Victorian workplaces.

The ACT Cancer Society is investigating the effectiveness of using the 'Smarter Than Smoking' model of education and intervention with 13-15 year olds in ACT schools. The funding is provided by ACT Health Department and the research component will use private research companies to conduct focus groups and quantitative studies during 2004. The intention is to see whether the factors affecting young people's smoking initiation, maintenance and cessation are the same in the ACT as has been reported elsewhere.

Smoking Cessation for Youth Project (SCYP) This project was undertaken by the Western Australian Centre for Health Promotion Research at Curtin University, with funding by Healthway. The project was a two-year cluster-randomised intervention trial conducted during 1999 and 2000 targeting smoking behaviour in 14-15 year old school students. The intervention consisted of an innovative smoking education program based on harm minimisation principles. In the schools that received the intervention materials, regular smoking, that is smoking on five or more days per week, among students was significantly lower than for students at the comparison schools. A "booster" intervention was also conducted with a sub-sample of year 12 students in the intervention schools. The booster was magazine-style self-help material designed to reinforce the previous behaviour changes from the original intervention. This follow-up booster intervention is currently in the process of evaluation, with preliminary results indicating a small positive impact.

7.8 SCHOOL BASED INTERVENTIONS

In Victoria, the Department of Education and Training in collaboration with Quit Victoria, the Catholic Education Office and the Department of Human Services undertook a tobacco education project using Commonwealth funding. This project aimed to provide schools with up to date tobacco education materials and resources to help them develop policies and address curriculum and welfare issues in relation to smoking. Draft guidelines were trialed in late 2002 and distribution was planned for 2003. In addition to these materials, the Department

of Education and Training was seeking to introduce a smoke-free schools policy to ban smoking on school grounds at all times.

In making recommendations to schools on their approach to students' smoking at school, the Department encouraged incorporation of research findings that supportive interventions, such as tobacco-specific counselling, are more effective than traditional approaches such as suspension.

The "Smarter than Smoking Project" is an initiative of Healthway, WA in conjunction with a number of leading health agencies all committed to reducing the prevalence of smoking amongst 10-15 year olds in WA. Over the five years of the project, a range of strategies such as mass media, school based education, advocacy and sponsorship have been employed to tackle youth smoking. Resources from the "Smarter than Smoking Project" specifically designed for use in upper primary schools, can be viewed via the OxyGen website at http://www.oxygen.org.au/pdf/STSKit6_02Low.pdf.

In WA, "SMART Schools Grants" are a further initiative from the "Smarter than Smoking Project". Healthway is offering grants of up to \$2,500 to school communities to make a commitment to reduce tobacco related harm. In return schools are asked to undertake a range of "Smarter than Smoking" activities (see <http://www.oxygen.org.au/> for more information).

In NSW, "Smarter than Smoking" is being used in schools picking up the WA themes and materials.

7.9 NON-GOVERNMENT ORGANISATION ACTIVITIES

Australian Network On Young People And Tobacco (ANYPAT)

The Australian Network on Young People And Tobacco is a collaboration representatives from each state and territory. ANYPAT operate a web site for young people to inform them of tobacco facts and activities and initiatives associated with preventing smoking uptake. ANYPAT instigated the NYTFD. The inaugural NYTFD was held during National Youth Week in 2002. It ran again in 2003 around the theme of tobacco and the environment. The next NYTFD has been set for 29 March, 2004 with the theme and tagline "Tobacco - wouldn't it be easier to stop before you start?"

Competitions on the website were also run in 2003 for young people with the stimulus "Tobacco what gets up your nose?" Young people were encouraged to put into words their thoughts on the disadvantages of tobacco smoke and smoking.

The Cancer Council Of Australia (TCCA)

The Cancer Council of Australia (TCCA), the National Heart Foundation (NHF) and the Australian Medical Association (AMA) have been active in approaching the Federal Government to examine Canadian findings that graphic health warnings on cigarette packaging affect smokers awareness. In particular, evaluation of the new Canadian package warnings found that 43% of smokers were more concerned about the health effects of smoking, 44% were more

motivated to quit, and 21% said they had decided not to have a cigarette when tempted as a result of the warnings
(see <http://www.cancer.org.au/content.cfm?randid=907897>).

TCCA also produces a regular bulletin *Tobacco Facts for MPs* which is designed to inform those who are key players in the legislative aspect of tobacco control. Contents for 2003 include: 'Tobacco's \$21b national bill; triple the costs of illicit drugs'; 'passive smoking kills 200+ pa'; 'passive smoking kills; push for smoke-free pubs and clubs'; 'tobacco marketing to youth'.

Quit WA

Quit WA is currently designing a media campaign targeting the 18-24 years group, which includes young women. Qualitative research as well as quantitative studies have been conducted with this age group to see what the smoking prevalence rates are in WA and what the influence of social factors is on smoking behaviour. Part of the qualitative approach included investigating the things that current smokers fear most and the results from this will inform the media campaign.

Internet Web Sites

Action on Smoking and Health (ASH)

<http://www.ashaust.org.au/>

ASH (Aust.) focuses on everyone's right to live and work in smoke-free environments. ASH (Aust.) employ a variety of approaches, including public education and advocacy. ASH (Aust.) advocates for smoke-free workplaces and for comprehensive bans on the promotion of tobacco products in Australia. It also provides information and support to others advocating for greater tobacco control. The comprehensive Web site provides access to up-to-date facts and figures, reports, tobacco news and media releases.

OxyGen

www.oxygen.org.au

OxyGen is created and funded by Quit SA, Quit Victoria and the Smarter Than Smoking Project (WA). The colourful and interactive Web site is targeted at young people and provides information on a variety of tobacco-related issues, including health effects of smoking, passive smoking and how the tobacco industry affects the environment. Tobacco resources include local and global news, information sheets, statistics and a calendar of tobacco events occurring around Australia.

Tobacco Control Supersite

<http://tobacco.health.usyd.edu.au>

This Web site provides a wide range of up-to-date information on tobacco control and smoking prevention in Australia, including up-to-date news articles. It provides access to tobacco industry documents relevant to tobacco control and advocacy through the Tobacco Documents System. This is a project of the tobacco document research team at the University of Sydney.

7.10 INTERNATIONAL TOBACCO RESOURCES RELEVANT TO YOUNG WOMEN

INWAT: The International Network Of Women Against Tobacco

<http://www.inwat.org>

INWAT was founded in 1990 by women tobacco control leaders to address the complex issues of tobacco use among women and young girls. The organisation is underpinned by views of women's tobacco use as influenced by political, social, economic, and cultural inequalities experienced by women regardless of age, race, or country of origin.

INWAT provides contacts, primarily women, to individuals and organizations working in tobacco control as well as collecting and distributing information regarding global women and tobacco issues. This organisation is also involved in sharing strategies to counter tobacco advertising and promotion and collaborating on the development of publications regarding women and tobacco issues. INWAT supports the development of women-centred tobacco use prevention and cessation programs and assists in the organization and planning of conferences on tobacco control.

The site links to other tobacco related sites of relevance to women.

TobaccoScam

<http://www.tobaccoscam.ucsf.edu/>

The Tobacco Scam Website is a project of Stanton Glantz, Professor of Medicine at the University of California, San Francisco. This site provides information and research results to show the tobacco industry efforts to target hospitality venues, particularly in the USA in relation to smoke free legislation and initiatives.

Action on Smoking and Health (USA)

<http://ash.org>

Action on Smoking and Health (USA) is a charitable organisation that focuses on legal action regarding tobacco and advocacy for non-smokers rights that was established more than 35 years ago. This organisation advocates for banning smoking in public places and public transport, banning the advertising of tobacco products. The ASH (USA) Web site is very comprehensive and features up-to-date news and information, including information on studies regarding women and smoking.

Action on Smoking and Health (UK)

www.ash.org.uk

ASH (UK) is a public health charity that works towards the reduction and eventual elimination of tobacco-related health problems through a variety of approaches that include advocacy and public education. For example ASH (UK) advocates to ban promotion and advertising of tobacco products, for greater regulation of tobacco constituents, and for smoke-free workplaces. ASH (UK) also conducts public education campaigns regarding the dangers of smoking that encourage smokers to quit and discourage non-smokers from taking up smoking. The Web site provides up-to-date European news items and press

releases, and tobacco facts and figures, a wide range of fact sheets, and information on quitting smoking.

The World Health Organisation (WHO)

In May 2003, WHO asked the film industry to support prevention of youth smoking by signing the world-wide treaty, Framework Convention on Tobacco Control, to ban smoking advertising, promotions and sponsorship. Australia is already a signatory to the treaty.

WHO released a report showing that tobacco company claims that their youth smoking prevention initiatives are effective is unsupported. WHO has called for a halt on these programs, while other organisations have suggested that such programs are actually disguised marketing to youth (eg Action on Smoking and Health, Australia).

World No Tobacco Day (WNTD) is a WHO initiative which acts globally to alert the community to tobacco issues. This event is held every year on May 31st. In 2003 the World No Tobacco Day theme was tobacco free film and fashion.

International Union Against Cancer (UICC GLOBALink)

www.globalink.org

GLOBALink is the “International Tobacco Control Network” for the UICC, which is an independent global organisation for cancer control. Its Web site provides access to up-to-date international news items and tobacco control resources, including a comprehensive online tobacco encyclopedia called “TobaccoPedia”. Membership is required to access some resources but this can be obtained easily on-line and is free.

American Cancer Society

www.cancer.org

In addition to providing support and information to cancer patients and their friends and family, the American Cancer Society provides information on the prevention and early detection of cancer to the public and health professionals. Its Web site provides useful information on tobacco, including the health effects of tobacco, teenagers and smoking, support and tips for people who want to quit smoking, and FAQs (Frequently Asked Questions). This information can be accessed on the Web site by selecting “Prevention and Early Detection” underneath the heading “Health Information Seekers”, then selecting “Tobacco and Cancer”.

American Lung Association

www.lungusa.org/tobacco/

Because most cases of lung cancer, emphysema and chronic bronchitis are caused by smoking (see the 1982 US Surgeon General’s Report “The Health Consequences of Smoking” available online at http://www.cdc.gov/tobacco/sgr/sgr_2000/sgr_tobacco_chap.htm), the American Lung Association devotes a large section of its Web site to tobacco control. It features useful information on the respiratory system and women and smoking, including fact sheets and tips for quitting smoking during pregnancy. The American Lung Association uses a peer teaching model for education about

tobacco use called Teens Against Tobacco Use (TATU) and information and resources can be found on the Web site.

Centers For Disease Control And Prevention, US Department Of Health And Human Services.

www.cdc.gov/tobacco/

The Centers for Disease Control and Prevention has a Web site that provides an array of information on tobacco control called Tobacco Information and Prevention Source (TIPS). It features a variety of educational resources and tobacco fact sheets, including TIPS for youth. The site also provides access to tobacco data and reports on a wide variety of tobacco-related issues, including youth smoking, health effects of smoking, and smoking cessation.

Canadian Health Network

<http://www.canadian-health-network.ca/>

The Web site for the Canadian Health Network allows you to access tobacco resources by clicking the 'tobacco' link. It provides FAQ's on various tobacco-related topics, including tobacco constituents, health effects of smoking, second-hand smoke, smoking and pregnancy, and quitting smoking.

Quit4Life

www.quit4life.com

This is a Canadian site that focuses on teenagers quitting smoking. It has information on the different effects of smoking on men and women and how this may affect quitting.

National Health Service, UK

www.givingupsmoking.co.uk

This is a web site set up by the UK's NHS to provide support to people who want to quit smoking. It includes information on smoking and pregnancy and tips for quitting smoking for pregnant women. It also features a variety of resources and tools including questionnaires that smokers can take to identify their smoking triggers, a cost calculator, and fact sheets.

Arizona Smokers' Helpline

www.ashline.org/ASH/

This is a support service for smokers wishing to quit smoking as well as addressing withdrawal symptoms and coping techniques for common barriers to quitting smoking. The site includes information on why it is important for pregnant women who smoke to quit.

Smoke Free Movies

www.smokefreemovies.ucsf.edu/

This American Web site rates contemporary movies according to whether they are 'smoke free', feature 'smoking with negative consequences', or 'promote smoking'.

Scene Smoking

www.scenesmoking.org/

This is a project of the American Lung Association that also rates movies according to how they portray smoking.

8. ANTI-SMOKING AND SMOKING CESSATION INITIATIVES IN QUEENSLAND OF RELEVANCE TO YOUNG WOMEN

8.1 LEGISLATIVE INTERVENTIONS

Queensland legislation in relation to tobacco control changed significantly in May 2002. The primary aims of the new legislation were to prevent availability of tobacco products to minors and reduce exposure of all Queenslanders to environmental tobacco smoke. There are four main aspects to the legislation: a ban on tobacco product sales to minors; a ban on smoking in enclosed public venues which includes dining areas of pubs and clubs during food service; a ban on tobacco advertising and tobacco promotions; and finally, restrictions on vending machines.

A review of Queensland legislation is currently underway.

8.2 TOBACCO SALES TO MINORS

In Queensland the national recommendations for best practice in reducing young people's access to tobacco have not been adopted in their entirety. In particular, the use of youth in test purchases to monitor compliance has not been adopted, even though international and local evidence points to the ineffectiveness of reducing youth smoking rates unless retailer compliance is high (National Expert Advisory Committee on Tobacco, A national approach to reducing access to tobacco in Australia by young people under 18 years of age, 2000). There have been no prosecutions of breaches since the new legislation to facilitate such prosecutions was implemented in 2002.

The Queensland Cancer Fund is currently undertaking a compliance monitoring study in Queensland to obtain comprehensive baseline data on retail compliance with underage smoking laws, in accordance with the national recommendations and protocols on compliance monitoring.

8.3 SCHOOL-BASED INTERVENTIONS

School based anti-smoking programs are run by individual schools and by Queensland Health. Queensland Health launched a major resource for schools, the 'Cigarette Smoke is Poison' resource kit, which aims to support schools and their communities to develop policy and systematic approaches to preventing tobacco use and dealing with smoking. Schools may order the kit directly from Queensland Health or by downloading it from the web. The kit includes curriculum resources for years 7-9 to allow teachers to address the issues of tobacco usage through school Health and Physical Education (HPE) and Studies of Society and Environment (SOSE) programs.

The Queensland Cancer Fund has just completed the review of its primary intervention resource for schools, the 'Escape' magazine. This resource aims to inform and support school aged smokers to quit smoking. Again, the target group of young women may benefit from this resource where the lower end of the age group is exposed to it through schools.

8.4 MASS MEDIA CAMPAIGNS

In Queensland the Queensland Quit Campaign (a joint collaboration between Queensland Health and the Queensland Cancer Fund) has run a number of mass media campaigns around New Year 2002-2003 and World No Tobacco Day 2003. These have not targeted young women specifically, though the 2002 television campaign "Every cigarette is doing you damage" featured one short advertisement with a young woman as the protagonist. Additionally, in 2003, the Quit Campaign in Queensland ran two radio campaigns which included young women in their target group: the New Year ads targeted women generally, and the May-June releases targeted the under 25 years old group, including young women. The May television campaign "Marshall Menthol" targeted the 18-40 year old blue-collar worker smokers, which again contains some of the target young women 16-28 years old.

Queensland Health has also used mass media television and cinema advertisements as part of the "Cigarette Smoke is Poison" campaign. The "Cigarette Smoke is Poison" ads, like the "Cigarette Smoke is Poison" resource materials, target the 12-17 years group and feature a young female television actor from a popular teen television program as the protagonist. Evaluations of the campaign by a market research company used focus groups, in-depth interviews and self-completion surveys to gauge the extent to which the target group was aware of the ads and their messages as well as the level of acceptance and the impact of the ads of smoking intentions. The campaign was found to be highly successful in informing young people about the chemical content of cigarettes and in presenting the material in an acceptable way. Non-smokers were particularly reinforced in their decision not to smoke and some experimental smokers reported feeling more uncomfortable about smoking as a result of the ads.

8.5 SMOKING CESSATION INTERVENTIONS

Young pregnant women are targeted through smoking cessation initiatives administered by hospitals (see below "Interventions in pregnancy"). The Queensland Cancer Fund targets young people through its "Escape" publication which is a self-help magazine style smoking cessation intervention for high-school students. The harm associated with smoking, the benefits in quitting as well as quiz-style self-assessment tools are included to help teenage smokers to gain control over their smoking habit and encourage quitting attempts.

8.6 BROADER TOBACCO CONTROL INITIATIVES IN QUEENSLAND

Tobacco action groups operate in regional centres of Queensland. Membership usually consists of a Queensland Cancer Fund representative, an Alcohol, Tobacco and Other Drugs representative (ATODS), a representative from the National Heart Foundation (in centres where NHF operates) and a Community Health worker. This group meets regularly and discusses regional tobacco control initiatives.

Smoking Cessation

The Queensland Cancer Fund runs a smoking cessation program called “Fresh Start®” in workplaces and community settings such as community health centres and hospitals. There are 90 trained facilitators who run the program throughout Queensland. Evaluation of each program usually occurs through participants completing questionnaires before and after the course and at 12 months follow-up. Data on the programs have been collected since 1983 when they began. For Queensland, all data are returned to Centre for Behavioural Research in Cancer, Victoria who originated the program. Results published by CBRC in 1993 showed that between 20 and 26% of participants were still smoke free 12 months later.

Interventions in pregnancy

The “Baby and You” publication by Queensland Cancer Fund is a brief intervention book available to anyone who requests it. This publication sets out the arguments for smoking cessation during pregnancy and beyond. It gives suggestions for quitting and information to persuade women to consider the benefits to themselves and their babies or children of quitting now rather than later. “Baby and You” is used by GPs, community health nurses, chemists, hospitals, child health centres and others to inform and encourage pregnant women to stop smoking and remain smoke free.

Most hospital antenatal or maternity units attempt to find out whether women smoke at the time of the first visit and if women admit to smoking then midwives may provide brief interventions in the form of smoking cessation advice, information brochures and short discussions of the health consequences for the baby of continuing to smoke. Many women are then encouraged to try to quit or at least to reduce the amount that they smoke during the pregnancy. Currently, no formal smoking cessation programs are run. However, the Mater Health Service is currently seeking funding from Queensland Health to design and pilot guidelines for smoking cessation interventions in pregnancy targeting antenatal clinics and GP practices. This work is being planned in conjunction with the Three Centres Collaboration (Melbourne’s Royal Women’s Hospital, Monash Medical Centre and the Mercy Hospital for Women). The guidelines will be based on the framework of the “5As” which are: Ask, Advise about health risks, Assess willingness to change, provide Assistance in the form of materials, and Ask again at follow-up while providing additional support and encouragement. Initially, the guidelines will be pilot tested in the Southern Zonal District of Queensland Health for a period of 9 months and then evaluated. It is hoped that following evaluation, the guidelines will be rolled out to the Central and Northern Zonal Districts.

9. EXPERT OPINION ON PRIORITY STRATEGIES: PUBLIC HEALTH ACTION AND RESEARCH TO INFLUENCE YOUNG WOMEN'S SMOKING

Key individuals locally and from other Australian states who work in tobacco control programs, research and policy were interviewed in the latter stages of the Young Women and Smoking Project.

The interviews started with a brief overview on the main findings of the project. With this background, those interviewed were asked about their opinions on what the most productive policy initiatives, interventions, or campaigns would be to influence smoking among young women.

These experts were also asked to identify what they saw to be priority areas for research that would be needed to fill current gaps in the understanding of the factors that might influence young women to adopt smoking, maintain smoking and to quit and the type of research studies that would be most useful in identifying opportunities for public health action.

Focus On Preventing The Consolidation Of 'Addicted' Smoking Patterns In Young Adults

There is a broadly accepted view by tobacco control experts that education and information directed solely at children is not very effective in preventing smoking in early adulthood.

However, there is a strong view that children can be influenced by strategies designed to influence adults and to change community norms and behaviours. Concerted action is particularly needed to change the environmental and social influences that act to drive progression to addicted smoking in a substantial portion young adults, from the experimental, irregular and low-rate smoking that is characteristic of the early teenage years.

The most productive focus will be on preventing progression to the regular, addicted long-term smoking habits that are consolidated during young adult life transitions (particularly in the 18-24 years age group).

Have Truly Smoke-Free Social Environments for Children and Young adults

The greatest impact on preventing uptake and consolidation of smoking habits among young women (and young men) would be if all social venues and facilities that they attended were to be truly smoke-free.

This would be particularly the case for under-age discos.

Eliminate opportunities for 'Nicotine Classroom' Effects

There was a strong view that young women (and equally so young men) 'learn to smoke' in social settings such as pubs and clubs, where the ready availability of cigarettes, smoke in the environment and others smoking are significant

factors that promote the adoption and maintenance of smoking. These environments act to create what has been termed a 'nicotine classroom'.

In addition, there was evidence cited that in nightclub environments and through nightclub advertising, agencies working on behalf of the tobacco industry are providing tobacco-related products and incentives to young adults to recruit new smokers and promote higher levels of tobacco use.

In order to make nightclubs, pubs and other social venues for young women smoke-free, it was seen as vital to encourage young women to 'own' the message that cigarette smoking, and the ready availability of cigarettes in these environments, is not acceptable.

Focus On Social Venue Managers

The importance of venue managers and other 'gatekeepers' in accepting and understanding the importance of regulation and legislation to reduce exposure to environmental smoke and the ready availability of cigarettes was emphasized.

Recent Lessons From The USA

Some Australian experts commented on developments in the USA, particularly in California, where two major factors seem to have been very effective in influencing the behaviours and attitudes of young adults:

- Vilification of the tobacco industry; this may have less application in Australia because of the different climate of litigation that exists in this country compared to the USA.
- Ubiquitous smoke free environments have become accepted and expected by both smokers and non-smokers and are perceived as a very reasonable arrangement.

The Importance Of Linking The Smoke Free Message To Appearance And Health So That Young Women Will 'Own' The Message

There was the view that 'the smoke free message' has significant potential to be linked to good health and appearance, primary concerns for young women. It was argued that many young women are interested in alternative health approaches, including stress reduction and healthy immune function. There may be potential to build on these interests and concerns among some groups of young women.

Suggestions about how to approach this included:

- Investigating promoting and empowering a 'young women's movement' to demand healthy and safe environments in which to socialise. This could involve encouraging significant numbers of young women, or particularly influential groups or young, to say 'no more'. This may have an important impact on attitudes and acceptability of restrictions on smoking and availability of tobacco products.
- The recruitment of advocates or workers in beauty or appearance based industries (such as beauticians, cosmetics sales staff etc) to include "not

smoking” as part of the overall health and beauty advice they offer. This would involve raising a awareness of appearance-related smoking harm.

- Using social marketing methods that might focus on sexual attractiveness and debunk some of the “myths” of smoking (such as smoking as an effective weight control method; smoking helping an easier birth because of a smaller baby)
- Media messages that contain real and immediate images of smoking and its health effects may be likely to have an impact, particularly where young women can identify with them.
- Innovative approaches to using different communications with young women were emphasised. Identifying detailed media use patterns and the demographics of young women’s interaction with media might include considering reality television, Internet websites and the different forms of print media and magazines that are used by young women. Understanding patterns of young women’s media use might be particularly informative.

There was a strong view that where young people are to be affected by legislation it is very important that there is a climate of opinion. Judicious use of relevant media and messages can help to create an environment in which the majority of young people want the legislation and that there is a general willingness to adhere to it.

Understanding The Communication Environments Of Young Adults

The communication environment of young adults was seen to require further research, in order to better understand the range of sources through which messages about smoking are directed and received by children and young adults. This includes television, magazines, films and other forms of print and audiovisual communication.

Focus On The Broader Contextual And Social Influences On Young Women’s Smoking

Experts in tobacco control thought a focus on the broader contextual influences on young women’s smoking behaviour would be more useful than concentrating on psychological attributes and attitudes towards such factors as body image or stress. While these may be important for some young women, they may not act as strong determinants at the population level.

It was felt that greater gains would be made if the more immediate social and environmental determinants of young women smoking were addressed. In particular young women could be encouraged to recognise that there are factors in their environments that can be changed and that the changes would, on balance, be of significant benefit to both smokers and non-smokers.

Take Seriously The Impact Of Adults’ Smoking In And Around Schools

Particular concern was expressed that parents and staff in and around schools are able to smoke on school grounds, as are tradespersons and other who visit schools. If staff, parents and others in and around schools are seen to smoke

smoking in what is primarily a young people's environment this sends an inappropriate message. Children identify a double standard: that staff and other adults smoke in these environments is seen as unreasonable when students are forbidden to smoke and frequently punished if they are caught breaching this ban.

There was a strong feeling that a true 'smoke free school' environment was needed rather than simply smoke free school policies.

Focus On When Smoking Rates Increase Steeply

Identifying exactly when in the teenage years smoking rates increase more steeply was seen to be an important opportunity for research and a basis for informing when particular strategies might be pursued.

In relation to children at high school, the development of smoke-free and anti-smoking norms was seen as a way to influence attitudes and behaviour consistent with the broad idea that 'we don't do that here'.

Focus On The Issue Of Cigarette 'Sales To Children'

Enforcement of legal sanctions relating to sales of cigarettes to minors was seen to be a particularly important issue. It was suggested that this issue be framed explicitly in terms of 'sales to children', which truly reflects the situation as it exists at the moment in all Australian states.

It is clear from the national data from the Australian Secondary Alcohol and Drug Survey that a significant proportion of high school children who do smoke obtain those cigarettes themselves rather than having them obtained by others. There was a strong view among the experts that further research, particularly studies that document how sting operations with retailers might help to very quickly change practices in this area, should be used.

In Queensland, this could be done through test purchases as has been effective in other states.

Reduce The 'Social Supply' Of Cigarettes To Children Under 18 Years Of Age

Reducing the social supply of cigarettes to children under 18 years of age was identified as an important objective. In Victoria there is evidence that many children who obtain cigarettes do so through older brothers or sisters or older peers.

There was a strong view that a focus for public messages and campaigns should be that brothers, sisters, older adolescents, parents, family members and other adults should be encouraged to adopt a more responsible approach to making cigarettes available to children under 18 years of age.

Focus Efforts on Tertiary Education Institutions

Tertiary education institutions (technical and further education colleges, universities and other educational institutions) were seen as being very important settings for creating a smoke free ethos and environment. The sale of cigarettes

on campuses where some students are under 18 years of age needs to be addressed. This is important not only because it may impact on children under the age of 18, but because it promotes the ready availability of tobacco products in settings where young adults are consolidating their smoking habits. This setting was seen as an important element in any strategy to create smoke free environments for young people.

Create A Different ‘Youth Culture’ Around Tobacco Use

The case was made that there are opportunities through judicious media campaigns and well-researched introduction of legislation to create a different ‘youth culture’ around tobacco use, such that the acceptability of smoking is reduced further and the norm of environments being smoke free is strongly reinforced.

Young women (and young men) who smoke and those who do not smoke can be proactively encouraged to develop smoke free attitudes and behaviours.

Social marketing principles and principles related to diffusion of innovation may be useful here. Key opinion leaders could be recruited to help shift social norms towards a smoke-free ethos in local environments (such as specific social venues) where smoking takes places and is normative.

Address Tobacco Promotions That Act To Influence Young People

Clear evidence that nightclubs in Victoria and in NSW have been used as venues where tobacco products are direct-marketed and promoted by young people who are employed by agencies working on behalf of the tobacco industry has been submitted to the review of the Tobacco Advertising and Promotion Act.

There are particular concerns in Victoria about tobacco promotion in and around the Formula One Grand Prix setting where large numbers of children under 18 and young adults are exposed to very direct forms of tobacco advertising and marketing.

The Need For An Overly Gender-Specific Focus Should Be Questioned Seriously

A gender specific focus was seen by some experts as not necessary, given that smoking prevalence and the attitudes and behaviours of young men and young women of comparable ages are not markedly different. Many motives common to both young women and young men were identified. These include the social cachet, feeling as if one is a member of a particular group (either of smokers or of those who smoke a particular brand of cigarettes), being able to use cigarettes and smoking as distractions and social lubricants at a time when many young people may feel anxious, in need of stimulation or may feel the benefit of the tranquillising effects of nicotine in social settings.

While differences in some of the contextual influences and motives of young men and young women to smoke were acknowledged, these were not seen as sufficient to take an exclusively gender specific approach.

There was also the view that a gender specific approach to young women and smoking may well send some inappropriate messages. The early 'Kylie Mole' campaign in Victoria was cited more than once as an example of how a gender-specific approach to campaigns directed specifically at young women can have unintended adverse consequences on attitudes and behaviour.

Cigarette Smoking May Act To Promote Or Exacerbate Socio-Economic Disadvantage

The greater prevalence of cigarette smoking in socio-economically disadvantaged young adults was identified as an important issue.

There is recent evidence from an analysis of national data suggest that, while there are few socio-economic differences in smoking prevalence among children, socio-economic differences in smoking rate rapidly develop as young adults move through the ages in which their smoking behaviour is consolidated.

There was a strong view that nicotine addiction and the associated need for economically disadvantaged people to spend a high proportion of their disposable income on purchase of cigarettes can result in less availability of resources for other life choices and options.

The argument that 'smoking can make you poor' needs to be taken more seriously in public policy and in tobacco-control research.

Understanding The Trajectories Of Smoking Uptake

Trajectories of smoking uptake are likely to be different among different social groups and it was suggested that further research is needed to understand the differences among teenagers and young adults in the way in which smoking habits are adopted and consolidated.

Occasional smokers aged 18 to 24 years were seen as a high priority group to study the influence of social setting such as pubs or clubs.

Research using rigorous methods to recruit and train young adults to observe interactions and activities in social settings could be used to gain insights into the dynamics of smoking in pubs, clubs and other settings.

Cohort studies of high school children who could be tracked through to young adulthood were seen as an important means of obtaining insights into how smoking behaviour is adopted and consolidated.

Exposure To Tobacco Smoke And The Availability Of Cigarettes In Social Environments Can Negatively Impact On Quitting

Young people who have already consolidated smoking habits in their late 20s were seen as potentially being less likely to quit successfully if they were constantly exposed to tobacco smoke and the availability of cigarettes in their environments.

High risk settings and situations that prompt resumption of smoking among smokers who have quit are seen to be an important area for research.

There were strong concerns about ongoing event-marketing by the tobacco industry, including for example, 'Alpine nights' and other less explicit events that promote cigarettes as factors that may both reinforce smoking and promote resumption in young people who have quit.

Possible Unintended Impacts Of Mass Media Promotion Of Nicotine Replacement Products

Mass media promotion of nicotine replacement products (for example the advertisements for Zyban) was seen as an important area for research.

There was a suggestion that exposures to such messages may promote the idea that future quitting may be relatively easy with such technological aids.

The hypothesis that exposure to and stronger recall of this advertising would be associated in young adults with less intentions to quit smoking or a greater likelihood of intention to adopt smoking was identified as an important area for research.

Understanding The Impact Of Point Of Sale Environments

The point of sale was identified as providing opportunities for research that would examine experimentally the effect of different point of sale locations and settings.

It was suggested that this research is likely to identify strong effects on current smokers or future smokers of point of sale cues. Such evidence could strengthen the case for making cigarettes only available on request and having no point of sale visual cues.

Understanding the effects of exposure to point of sale promotions (such as exist in supermarkets and other areas) was seen as another area in which research should be done using participants of the appropriate age to examine the impact of those tobacco related exposures on knowledge and attitudes.

The Need For Generic Cigarette Packs And Not Having Visible Cigarette Displays

Cigarette packs were also identified as important sources of cues and messages about smoking and the need for seriously considering plain generic packaging for cigarettes was identified as an on going issue.

Packaging was seen as the major form of marketing and communication that needs to be addressed. Colours of cigarette packs and the image that is projected by them were seen to be important cues in promoting smoking.

The normative nature of cigarettes that is promoted through visually attractive packs that also form point of sale displays, having cigarettes juxtaposed with soft drinks and sweets in many retail outlets was identified as an on going issue.

Fear Of Addiction As A Potential Motivator

Fear of addiction was seen as an important, potentially protective factor. The use of a risk perception framework to approach how campaigns and communication strategies for young adults would be developed was seen to be potentially promising

The Social Nature Of Smoking In Key Life Transitions

The social nature of smoking was emphasised. This was seen to be a particularly important part of the dynamics in the transition from being at school to young adult roles (either in the work force or in tertiary education or other settings). Smoking for young adults during this time of transition provides 'tension release' and facilitates social interactions. The automatic cueing of smoking where young adults find themselves in the situations where others are smoking and cigarettes are readily available means they may smoke almost without making a deliberate choice. This was seen to be worthy of further research.

Understanding Variations In The Environments In Which Young People Smoke

The variation in bans and restrictions on smoking in pubs and clubs across the different states of Australia was seen to be an opportunity of research on social influences.

Pubs and clubs were seen to be important environments because interventions and changes to those setting would significantly reduce the likelihood of consolidating smoking behaviour. The research on social smokers was identified as being particularly important.

Bans and restrictions on smoking and on the availability of tobacco products in and around environments where young adults are together for work or socializing purposes was seen to provide opportunities to evaluate the impact on the adoption of smoking.

Recent research in California was mentioned on several occasions, identifying the likelihood that uptake of cigarettes took place later among young adults where there were concerted public campaigns and environmental restrictions on smoking.

Changing Settings Is The Most Direct Approach To Changing Behaviour

Children under 18 years of age can be characterised as likely to be curious about smoking and to be highly susceptible to social influences to smoke. There was a strong view that knowledge, attitudes and intentions of young adolescents and young adults, are probably less important than opportunities to smoke, in affecting the uptake of smoking.

The reduction of smoking as a normative behaviour and decreased opportunities to smoke in different settings was seen to be the most effective way to reduce consolidation of smoking.

Build On The Anticipation Of Future Pregnancy

Anticipated future pregnancy was seen as a potentially strong influence on young women, many of whom in interviews cited pregnancy as a time they believed they would definitely quit smoking.

Focus On The Effects Of Smoking On Reproductive Health

The importance of fully communicating the adverse effects of smoking on reproductive health was seen to be important. There are strong messages through qualitative research that young women can discount the deleterious effects of smoking on unborn children, citing factors such as quitting smoking can stress the baby or that pregnancy and child birth will be easier if the baby is smaller as a result of smoking. Methods for countering these myths and for helping women to maintain quitting after the baby is born require further investigation

Focus On Young Women Who Smoke Occasionally And Irregularly

Young women who smoke occasionally and irregularly are potentially strongly susceptible to the influence of more regular smokers who were their friends. Smoking as something that is done together with friends was seen as a significant influence to increase smoking.

Non-smokers were seen as potentially a strong influence on those who were experimenting with smoking. If non-smokers were persuaded to be more confident and assertive about encouraging their friends and acquaintances not to smoke there are opportunities to build a stronger pattern on non-smoking norms among young adults. There was the view that building non-smokers skills and confidence in dealing graciously with smoking as a social issue had potential within integrated interventions for young women.

Experimentation and irregular smoking at school is common and the period after school is seen as a time of 'do or die' in terms of either going on to either not smoke or consolidating a pattern of regular smoking.

The Need For More Restrictive Licensing Of Tobacco Sellers

Making cigarettes available only from licensed shops and legislating against the sale of cigarettes at pubs and clubs was seen to be potentially very important. Where cigarettes are available is an important determinant of how normalized tobacco smoking is among young people. Exposure was seen to be a prime determinant of normalising smoking and cueing young people to smoke.

Parental Smoking Is A Significant Influence On Children And Young Adults.

Parental smoking was identified as a significant influence on children and young adults. Further research on age specific rates of smoking initiation was recommended. Young women may view smoking as being adopted for a short period during a particular life stage. Many do not see smoking as something that they are likely to do for the rest of their lives. This may have implications for campaign messages.

Understanding The National Tobacco Campaign's Impacts On Young Women

The National Tobacco Campaign (in the late 1990s) may have had different impacts on young adults of different ages. For example, those young adults who are 24 years old now would have been 19 at the time of the national campaign. Given the high rates of recall of the campaign advertisements it would be relevant to examine how they may have impacted on young adults of different age groups.

Designing Media Strategies For Young Women

'Buzz' marketing is a new media strategy that is being used by advertising agencies and may have potential for health promotion. Population data suggest that there are not significant differences between young women and young men in smoking prevalence or other attributes, thus the need for good generic marketing strategies was emphasized.

Given that much of the information that adults and young adults in particular obtain is now through media and mass communication, trends in those media were thought to have potential relevance.

Grabbing the attention of young men and young women may be different but the messages that are promoted probably do not need to be different.

The view was expressed that small differences in smoking prevalence and related attributes between young men and young women may be being over emphasised in the context of broader concerns to make smoking a gender issue.

Understand In More Detail The Patterns Of Cigarette Consumption Among Young Women Compared To Young Men

Differences between young men and young women may be in the speed with which they mature socially. There is a common view and some evidence that boys mature more slowly than girls so it could be relevant to examine gender differences in progression from experimentation through to regular smoking between young men and young women.

Focus On Children Who Take Up Smoking Very Early

There are children who take up smoking at a very early age. The characteristics of this group, particularly in terms of coping with life stresses, issues of rebellion, anxiety, depression and minor psychiatric disorder, may be relevant to understanding early adoption of smoking. This sub-group may develop higher rate smoking early in adolescents and during adulthood will find it a lot more difficult to quit. This pattern of smoking may be more the case for young men than for young women.

Research to develop ways of addressing smoking in younger age groups where it may be a maladaptive coping strategy, that should be addressed.

Providing High Technology, Cutting Edge 'Quit' Resources For Young Women.

Australian 'Quit' Services and smoking cessation researchers are at the cutting edge, internationally, in developing innovative services for large numbers of smokers, at an affordable cost.

Innovative use of communication media and service delivery options in Australia have included personalised, tailored mail-outs; enhanced Quitline counseling; a series of high-quality Quit booklets designed for particular groups; and, website and e-mail delivery of cessation services.

For young women who smoke, there is outstanding potential to develop relevant, alternative widely available services using combinations of new information technologies and enhance, tailored versions of existing service modalities. These include websites for young women and innovative uses of mobile phone text messaging, with links to enhanced versions of existing Quitline services and print materials, tailored to the particular needs and interests of young women.

There was a view Queensland has the potential to be a national and international leader in the development of a unique portfolio of high quality, effective and attractive cessation programs for young women. These could provide the leading edge of evidence-based best practice in Australia and could be among the most innovative approaches by any international standards.

Research Priorities And Opportunities

- Several priority areas and issues to pursue through research were suggested:
- Identifying the extent and relevance of gender-specific differences in smoking among young adults.
- Identifying factors that are protective against progressing from experimental smoking to becoming a regular addicted smoker.
- Investigate how nightclubs, pubs and other social venues act as environments that influence the development and maintenance of smoking among young adult female smokers
- There is a need to understand dynamics of social interactions in these environments, the role they play in smoking and their influence over smoking behaviour.
- The role of smoking in work places and in other settings, particularly in relation to going outside to smoke, possible social dimensions of this and possible gender differences in workplace smoking behaviour were seen to be important research issues.
- Rigorous observational studies could provide insights into the dynamics of smoking behaviour and smoking acquisition in pubs, clubs and other settings.

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APPENDIX 1

Length of Appendix - 10 Pages



*THE ROLE OF LIFE-STAGE TRANSITIONS
IN SMOKING BEHAVIOUR AMONG
YOUNG WOMEN*

PRESENTATION BY LIANE McDERMOTT

AT

*35TH ANNUAL CONFERENCE OF THE PUBLIC
HEALTH ASSOCIATION OF AUSTRALIA*

APPENDIX 2

Length of Appendix - 1 Page



***ANALYSIS OF SMOKING BEHAVIOURS
OF YOUNG AUSTRALIAN WOMEN ON A
STATE BY STATE BASIS***

(ALSWH 2000)

APPENDIX 3

Length of Appendix - 2 Pages



*ANALYSIS OF FACTORS ASSOCIATED
WITH CURRENT SMOKING, ADOPTION
OF SMOKING AND SMOKING
CESSATION ACROSS RURAL, REMOTE
AND METROPOLITAN AREAS FOR
YOUNG AUSTRALIAN WOMEN*

APPENDIX 4

Length of Appendix - 6 Pages



SMOKING SURVEY ***(Young Socially Disadvantaged Women)***

APPENDIX 5

Length of Appendix - 9 Pages



YOUNG WOMEN AND SMOKING WEB-BASED SURVEY INSTRUMENT

APPENDIX 6

Length of Appendix - 4 Pages



*TELEPHONE SURVEY INSTRUMENT
FOR
YOUNG WOMEN AND SMOKERS
AND EX-SMOKERS*

Analysis of smoking behaviours for young Australian women on a state by state basis (ALSWH 2000)

Women living in the same state or territory in 1996 and 2000

	Queensland	NSW	Victoria	SA	WA	Tasmania	NT	ACT	All states	Total
Number	1 720	2 144	2 135	633	785	267	44	116	7 844	9 073
Never Smoker	62.7	61.0	57.5	62.4	61.0	55.8	56.8	65.5	60.4	60.4
Never smoker in 1996 & 2000										
Ex-Smoker	7.0	6.2	5.9	6.2	5.9	10.5	4.6	6.0	6.4	6.4
Ex-smoker in 1996 & 2000										
Initiate and quit	1.9	1.7	1.6	1.6	2.2	2.3	4.6	1.7	1.8	1.9
Never smoker in 1996; ex-smoker in 2000										
Quitter	5.0	5.8	6.3	5.7	5.7	4.1	6.8	6.0	5.7	5.7
Smoker in 1996, not smoking in 2000										
Re-starter	3.3	3.5	4.1	3.0	4.0	2.6	2.3	2.6	3.6	3.5
Ex-smoker in 1996, smoker in 2000										
New Adopter	3.2	4.6	3.2	2.1	3.3	2.6	0.0	1.7	3.5	3.4
Never smoker in 1996, smoker in 2000										
Continuing Smoker	16.9	17.2	21.4	19.1	18.0	22.1	25.0	16.4	18.7	18.8
Smoker in 1996 & 2000										

Analysis of factors associated with current smoking, adoption of smoking and smoking cessation across rural, remote and metropolitan areas for young Australian women (ALSWH 2000)

Factors associated with current smoking across rural, remote and metropolitan areas for young Australian women (ALSWH 2000)

	Metropolitan (N = 4937) OR (95% CI)	Large rural (N = 819) OR (95% CI)	Small rural (N = 770) OR (95% CI)	Other rural / remote areas (N = 1581) OR (95% CI)
Illicit drug use				
Never	1	1	1	1
Ex cannabis user	2.7 (2.2, 3.4)	3.3 (2.1, 5.2)	3.2 (2.0, 5.0)	3.5 (2.6, 4.8)
Current cannabis user	5.3 (4.1, 6.7)	6.9 (3.9, 12.3)	2.4 (1.3, 4.6)	5.4 (3.6, 8.2)
Ex multiple drug user	4.2 (3.2, 5.6)	3.9 (1.9, 7.7)	3.0 (1.4, 6.3)	4.0 (2.4, 6.6)
Current multiple drug user	9.9 (8.0, 12.3)	21.2 (11.0, 40.9)	4.8 (2.7, 8.6)	9.0 (6.0, 13.5)
Alcohol consumption				
Low risk drinker, binges less than weekly	1	1	1	1
Non-drinker	0.9 (0.7, 1.2)	0.6 (0.3, 1.2)	0.4 (0.2, 0.8)	0.5 (0.3, 0.8)
Low risk drinker, binge drinks weekly	1.9 (1.5, 2.3)	1.8 (1.0, 3.1)	2.5 (1.4, 4.2)	1.7 (1.2, 2.4)
Risky or high risk drinking	2.9 (2.0, 4.1)	2.9 (1.2, 7.5)	1.3 (0.5, 3.1)	2.6 (1.6, 4.5)
Education				
University	1	1	1	1
Trade / apprenticeship / diploma / certificate	2.0 (1.6, 2.4)	1.4 (0.9, 2.4)	4.5 (2.5, 8.2)	2.2 (1.5, 3.2)
Year 12	2.3 (1.9, 2.8)	1.8 (1.1, 2.9)	3.0 (1.6, 5.5)	2.0 (1.4, 2.9)
Year 10 or less	3.9 (3.0, 5.1)	5.8 (3.1, 9.8)	8.4 (4.5, 15.8)	3.8 (2.6, 5.8)
Marital status				
Married	1	1	1	1
De facto	1.3 (1.0, 1.7)	2.0 (1.1, 3.5)	2.5 (1.5, 4.2)	1.7 (1.2, 2.4)
Not married / separated / divorced / widowed	1.3 (1.0, 1.6)	2.1 (1.3, 3.4)	2.0 (1.3, 3.2)	1.7 (1.2, 2.3)
Active leisure (last week)				
Some	1	1	1	1
None	1.4 (1.2, 1.6)	1.3 (0.8, 1.9)	1.5 (1.0, 2.2)	1.5 (1.1, 2.0)

Factors associated with smoking adoption across rural, remote and metropolitan areas for young Australian women (ALSWH 2000)

	Metropolitan N = 3391 OR (95% CI)	Large rural N = 540 OR (95% CI)	Small rural N = 493 OR (95% CI)	Other rural / remote areas N = 997 OR (95% CI)
Illicit drug use				
Never	1	1	1	1
Ex cannabis user	1.6 (1.0, 2.5)	2.8 (0.9, 8.6)	3.3 (1.3, 8.6)	2.7 (1.2, 5.7)
Current cannabis user	4.6 (3.0, 7.3)	10.4 (3.2, 33.6)	2.4 (0.6, 9.4)	3.4 (1.2, 9.7)
Ex multiple drug user	2.4 (1.2, 4.9)	5.8 (1.1, 30.4)	2.2 (0.3, 18.9)	1.1 (0.2, 8.4)
Current multiple drug user	6.8 (4.6, 10.1)	39.8 (12.3, 128.2)	6.9 (2.2, 22.1)	3.2 (1.0, 10.2)
Marital status				
Married	1	1	1	1
De facto	1.0 (0.5, 2.0)	2.2 (0.6, 8.4)	1.5 (0.4, 5.9)	2.0 (0.7, 5.5)
Not married / separated / divorced / widowed	2.7 (1.6, 4.6)	2.1 (0.6, 6.7)	2.1 (0.7, 6.0)	2.4 (1.1, 5.6)
Active leisure (last week)				
Some	1	1	1	1
None	1.6 (1.2, 2.3)	1.0 (0.4, 2.4)	1.1 (0.4, 2.7)	2.2 (1.1, 4.3)

Factors associated with smoking cessation across rural, remote and metropolitan areas for young Australian women (ALSWH 2000)

	Metropolitan N = 1144 OR (95% CI)	Large rural N = 204 OR (95% CI)	Small rural N = 202 OR (95% CI)	Other rural / remote areas N = 479 OR (95% CI)
Illicit drug use				
Never	1	1	1	1
Ex cannabis user	1.5 (1.0, 2.5)	2.0 (0.7, 5.8)	1.1 (0.4, 2.8)	1.7 (0.9, 3.1)
Current cannabis user	1.1 (0.6, 1.8)	0.7 (0.2, 2.7)	0.6 (0.2, 2.8)	1.0 (0.5, 2.1)
Ex multiple drug user	1.8 (1.0, 3.0)	2.5 (0.7, 8.7)	2.3 (0.6, 8.6)	1.1 (0.4, 2.7)
Current multiple drug user	0.6 (0.4, 1.0)	0.1 (0.0, 1.0)	0.8 (0.3, 2.3)	0.8 (0.4, 1.6)
Pregnancy				
Never	1	1	1	1
Pregnant at survey 1, not at survey 2	0.9 (0.3, 2.8)	0.9 (0.2, 5.2)	0.9 (0.2, 4.9)	0.4 (0.1, 1.8)
Pregnant at survey 2	5.9 (3.3, 10.7)	2.7 (1.0, 7.6)	1.8 (0.5, 6.6)	5.3 (2.7, 10.5)
Feeling lonely even in company				
Never	1	1	1	1
Rarely	1.1 (0.7, 1.7)	1.3 (0.4, 4.5)	2.0 (0.6, 6.4)	0.9 (0.4, 1.6)
Sometimes	0.9 (0.6, 1.3)	1.0 (0.3, 3.2)	1.7 (0.5, 5.4)	0.6 (0.3, 1.1)
Often	1.0 (0.6, 1.6)	1.1 (0.3, 4.1)	0.5 (0.1, 2.6)	1.0 (0.5, 2.2)

Smoking Survey (Young Socially Disadvantaged Women)

INTERVIEWER: _____

DATE: _____ PLACE: _____

START TIME: _____ FINISH TIME: _____

Smoking Survey

Hello, I am a student at the University of Queensland. I'm doing a study on cigarette smoking and women aged between 18 and 30, who currently smoke, live in the area, and are not trying to quit or are using nicotine patches or gum. Is this you?

[IF YES] **Thanks** [PROCEED WITH SURVEY]

[IF NO] **Ok then, Thanks for your time, goodbye.**

It's not about whether smoking is good or bad, but about why people continue to smoke. I'll ask you for some answers to some simple questions, and it should take less than 10 minutes. It's anonymous and completely confidential. You can refuse to answer any questions. We would really appreciate some of your time. It's completely voluntary, and you can ask me to finish up at any time. Is this okay?

[IF YES] **Thanks** [PROCEED WITH SURVEY]

[IF NO] **Ok then, Thanks for your time, goodbye.**

The next few questions are about your household.

1. **What are the rules about smoking in your house?**

Rule

- | | |
|--------------------------|----------------------------|
| Only smoking outside | <input type="checkbox"/> 1 |
| Only smoking inside | <input type="checkbox"/> 2 |
| Smoking allowed anywhere | <input type="checkbox"/> 3 |
| No smoking anywhere | <input type="checkbox"/> 4 |
| Other (Please specify) | <input type="checkbox"/> 5 |

2. **Are visitors usually discouraged from smoking in your house?**

- 1 Yes 2 No

3. **How many of your friends are smokers?**

- ₁ All
- ₂ Most
- ₃ About half
- ₄ Less than half
- ₅ None

4. **When you're around children do you smoke;**

- ₁ About the same amount as usual
- ₂ Less than usual
- ₃ More than usual
- ₄ Not at all

5. **Now I'll give you a card, which has some options on it. Using these, can you please tell me which one suits you regarding the following statements.**

(1-strongly disagree, 2- disagree, 3- slightly disagree, 4- slightly agree, 5- agree, 6-strongly agree) [After each response, confirm answer]

a. Parents living with children should not smoke at all inside the home.

1 2 3 4 5 6

b. Parents living with children should smoke in a separate part of the house.

1 2 3 4 5 6

c. Parents living with children should feel free to smoke in front of them.

1 2 3 4 5 6

The next few questions are about your smoking pattern.

6. **Do you smoke daily** ₁ **or occasionally** ₂

7. **How many cigarettes do you usually smoke per day?**

0-5 ₁ 6-15 ₂ Light 16+ ₃ Heavy

8. **Do you usually smoke at least 1 cigarette every hour throughout the entire day/night?**

₁ Yes ₂ No

9. **How soon after you wake up do you smoke your first cigarette?**
₁ Within 30 min ₂ After 30 min
10. **On occasions when you can't smoke or you haven't any cigarettes on you, do you feel a craving for one.?**
₁ Never ₂ Sometimes ₃ Always
11. **How difficult would you find it to give up smoking altogether if you wanted to?**
₁ Easy ₂ Neither easy or difficult ₃ Difficult
12. **Which cigarette would you most hate to give up?**
₁ The first one in the morning ₂ Any other
 Which One? _____
13. **Do you ever wake up at night to have a cigarette?**
₁ Never ₂ Sometimes ₃ Always
14. **Do you smoke more when you are at a pub/nightclub?**
₁ Yes ₂ No

[If No go to Q 22]

15. **On the days you go to a pub/night club how many cigarettes would you usually have?_____**
16. **How many cigarettes would you usually have on the days you do not go to a pub/night club? _____**

The next few questions are about smoking bans and how you think they would affect your smoking behaviour.

17. **Do you believe that smoking bans in pubs and clubs would:**
- a) Decrease your rate of smoking? ₁ Yes ₂ No ₃ Maybe
- b) Encourage you to quit ₁ Yes ₂ No ₃ Maybe
- c) Result in you giving up smoking all together ₁ Yes ₂ No ₃ Maybe
- d) Have no impact on your smoking ₁ Yes ₂ No ₃ Maybe

18. **Now I will read a list of statements concerning your motivations for smoking. I would like you to tell me to what extent you agree or disagree with the following statements:**

(1 - Strongly Disagree, 2 - Disagree, 3 - Slightly Disagree, 4- Slightly Agree, 5 - Agree, 6 - Strongly Agree) [After each response, confirm answer]

- | | | | | | | |
|--|---|---|---|---|---|---|
| a) Smoking gives a pleasurable experience | 1 | 2 | 3 | 4 | 5 | 6 |
| b) Smoking helps me feel calm | 1 | 2 | 3 | 4 | 5 | 6 |
| c) Smoking helps to reduce stress | 1 | 2 | 3 | 4 | 5 | 6 |
| d) Smoking helps to reduce anxiety | 1 | 2 | 3 | 4 | 5 | 6 |
| e) Smoking helps to prevent urges | 1 | 2 | 3 | 4 | 5 | 6 |
| f) Smoking cigarettes is relaxing | 1 | 2 | 3 | 4 | 5 | 6 |
| g) I smoke with my friends to be part of the crowd | 1 | 2 | 3 | 4 | 5 | 6 |
| h) I find it very unpleasant to be without
cigarettes for some time | 1 | 2 | 3 | 4 | 5 | 6 |
| i) Smoking gives me a lift | 1 | 2 | 3 | 4 | 5 | 6 |
| j) I smoke because people keep offering me cigarettes | 1 | 2 | 3 | 4 | 5 | 6 |
| k) I don't really enjoy smoking | 1 | 2 | 3 | 4 | 5 | 6 |
| l) I only smoke when I'm with other people | 1 | 2 | 3 | 4 | 5 | 6 |
| m) If I didn't go out socialising I would not smoke
for that day | 1 | 2 | 3 | 4 | 5 | 6 |

19. **Now I will read a list of statements concerning the situations in which you smoke. I would like you to tell me the likelihood of you smoking in each of the following situations**

(1-Never, 2 - Almost never, 3 - occasionally, 4- Almost Always, 5 - Always.)
[After each response, confirm answer]

- | | | | | | |
|----------------------------|---|---|---|---|---|
| a) When socializing | 1 | 2 | 3 | 4 | 5 |
| b) When with non-smokers | 1 | 2 | 3 | 4 | 5 |
| c) When alone | 1 | 2 | 3 | 4 | 5 |
| d) When with other smokers | 1 | 2 | 3 | 4 | 5 |
| e) When you are at a party | 1 | 2 | 3 | 4 | 5 |
| f) When in a pub/club | 1 | 2 | 3 | 4 | 5 |

These next few questions relate to smoking and stress.

20. **I will now read a list of situations. Using the card, please tell me which number suits you best. Please imagine yourself in each situation before answering.**

(1-very uncertain, 2- uncertain, 3- slightly uncertain, 4- slightly certain, 5- certain, 6- very certain) [After each response, confirm answer]

(Please read before each statement) **How certain are you that you could refrain from smoking when:**

a) You're at a pub/club and everyone around you is smoking and you **ARE** feeling stressed

1 2 3 4 5 6

b) You're at a pub/club and everyone around you is smoking and you are **NOT** feeling stressed

1 2 3 4 5 6

c) You're at a party and your best friend offers you a cigarette and you **ARE** feeling stressed

1 2 3 4 5 6

d) You're at a party and your best friend offers you a cigarette and you are **NOT** feeling stressed

1 2 3 4 5 6

e) You're chatting with friends and everyone is smoking and you **ARE** feeling stressed

1 2 3 4 5 6

f) You're chatting with friends and everyone is smoking and you are **NOT** feeling stressed

1 2 3 4 5 6

g) You're at home by yourself, (or without partner) you're doing housework and you **ARE** feeling stressed

1 2 3 4 5 6

h) You're at home by yourself, you're doing housework and you are **NOT** feeling stressed

1 2 3 4 5 6

i) You're by yourself at home, you're reading a book or magazine and you **ARE** feeling stressed

1 2 3 4 5 6

j) You're by yourself at home, you're reading a book or magazine and you are **NOT**

feeling stressed

1 2 3 4 5 6

k) You're driving by yourself in the car, and you **ARE** feeling stressed

1 2 3 4 5 6

l) You're driving by yourself in the car, and you are **NOT** feeling stressed

1 2 3 4 5 6

These last questions are just about you in general.

21. **How old were you on your last birthday?** _____ years

₁ Don't know/Not sure

₂ Refuse to answer

22. **What is your current marital status?** ₁ Married / defacto ₂ Single

23. **Do you have any children? [if YES] How many?** _____

- if participant considers themselves the child's parent

Ok. We're finished. Thanks very much, we really appreciate it. To do this study, we have agreed to offer you information about the study and about quit smoking programs. Would you like any of this information? ₁ Yes ₂ No

Thanks again for your time, Goodbye.

Young Women and Smoking Web-based survey instrument

The following survey was posted on the Women's Health Queensland Wide web page (www.womhealth.org.au) during the month of November 2003 with a link that invited visitors to the WHQW page to take our survey on smoking.

Data was collected and stored via a direct link to the University of Queensland server and this occurred in such a way that participants were unaware of the link, though they were informed of the University's involvement.

'Radio buttons' that colour when selected were used for responses to questions and error messages were programmed to appear when respondents had not completed questions fully or had given responses that were invalid (such as letters in postcode sections, numbers out of range etc.)

Information about the survey and the project

The "Young Women and Cigarette Smoking Project" aims to investigate young women's smoking. As part of the project, the following survey is being carried out to ask young women about their awareness of anti-smoking messages and quit smoking advice. We would very much like to find out what YOU think. You can be a smoker or a non-smoker - we want to hear from everyone. The survey is being carried out by The University of Queensland and will be part of a report to Health Promotion Queensland.

The survey will take approximately 10 minutes to complete.

All your answers are anonymous and will only be used for the purposes of the research.

Please complete all questions. If you are unsure of the exact answer, put the one you think is closest to what you think on that question.

This study has been cleared by one of the human ethics committees of The University of Queensland. If you would like to speak to an officer of the University of Queensland not involved in the study, you may contact the Ethics Officer on 3365 3924.

If you want to see the results of the survey and the project, you can check on the Women's Health Queensland Wide website: www.womhealth.org.au early next year (Feb 2004).

Disclaimer

I have read and understood the above information about the "Young Women and Cigarette Smoking Project". I wish to take part in the survey. I have read the information above and I agree to complete the survey.

I agree I disagree (participants chose one of these. Only those indicating agreement were admitted to the survey)

Screening questions to allow extraction of data

How old are you? Under 16 years old 16-28 years old over 28 years

What sex are you? male female

Survey questions

Qu 1. What is your postcode?

Qu 2. Do you currently smoke cigarettes regularly or at least occasionally?

Yes (Go to question 5)

No (Go to question 3)

Qu 3. Have you ever smoked cigarettes regularly or at least occasionally?

Yes (Go to question 4)

No (Go to question 17)

Qu 4. In your entire life, have you smoked at least 100 cigarettes?

Yes (Go to question 13)

No (Go to question 17)

Qu 5. In the list below please tick where you have received anti-smoking or stop smoking messages from (tick all that apply). For each option you ticked, please rate how relevant this message was to you

a) spouse/partner	... 1-----2-----3-----4-----5
	not at all relevant very relevant
b) Your children, parents, other family members	... 1-----2-----3-----4-----5
	not at all relevant very relevant

- | | | |
|---|---|---------------|
| c) Friends | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| d) school-based programs eg. Health lessons, school based health nurse | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| e) Television eg. Marshall Menthols ad; Every cigarette is doing you damage etc. | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| f) Women's Magazines eg. Girlfriend, Dolly, Women's Weekly, Cosmopolitan, Cleo etc. | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| g) Health Magazines eg. Baby and You, Pregnancy, Mother and Child, Good Medicine etc. | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| h) Print mass media eg. Newspapers, Billboards | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| i) Health Professional eg Doctor, nurse, midwife, naturopath etc. | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| j) Cigarette packaging | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| k) Radio ads | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| l) Cinema ads eg. 'Poison' | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| m) Quit smoking brochures and leaflets eg. Quit because you can, Smoking and pregnancy etc. | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |
| n) Other (please tell us where from)
[space to type response] | ... 1-----2-----3-----4-----5
not at all
relevant | very relevant |

(Go to question 6)

Qu 6. Which ONE of those messages above is the MOST relevant to you? ÿ

professional eg nurse, midwife	not at all useful	1-----2-----3-----4-----5	very useful
e) Chemist/pharmacist	not at all useful	1-----2-----3-----4-----5	very useful
f) Friends/ family	not at all useful	1-----2-----3-----4-----5	very useful
g) Other quitters	not at all useful	1-----2-----3-----4-----5	very useful
h) Internet	not at all useful	1-----2-----3-----4-----5	very useful
i) Other (please specify)	not at all useful	1-----2-----3-----4-----5	very useful

(Go to finish)

Qu 13. (ex-smokers) In the list below please tick where you have received anti-smoking or stop smoking messages from (tick all that apply). For each option you ticked, please rate how relevant this message was to you

a) spouse/partner	not at all relevant	... 1-----2-----3-----4-----5	very relevant
b) Your children, parents, other family members	not at all relevant	... 1-----2-----3-----4-----5	very relevant
c) Friends	not at all relevant	... 1-----2-----3-----4-----5	very relevant
d) school-based programs eg. Health lessons, school based health nurse	not at all relevant	... 1-----2-----3-----4-----5	very relevant
e) Television eg. Marshall Menthols ad; Every cigarette is doing you damage etc.	not at all relevant	... 1-----2-----3-----4-----5	very relevant
f) Women's Magazines eg. Girlfriend, Dolly, Women's Weekly, Cosmopolitan, Cleo etc.	not at all relevant	... 1-----2-----3-----4-----5	very relevant
g) Health Magazines eg. Baby and You, Pregnancy, Mother and Child, Good Medicine etc.	not at all relevant	... 1-----2-----3-----4-----5	very relevant

h) Print mass media eg. Newspapers, Billboards	... 1-----2-----3-----4-----5 not at all relevant	very relevant
i) Health Professional eg Doctor, nurse, midwife, naturopath etc.	... 1-----2-----3-----4-----5 not at all relevant	very relevant
j) Cigarette packaging	... 1-----2-----3-----4-----5 not at all relevant	very relevant
k) Radio ads	... 1-----2-----3-----4-----5 not at all relevant	very relevant
l) Cinema ads eg. 'Poison'	... 1-----2-----3-----4-----5 not at all relevant	very relevant
m) Quit smoking brochures and leaflets eg. Quit because you can, Smoking and pregnancy etc.	... 1-----2-----3-----4-----5 not at all relevant	very relevant
n) Other (please tell us where from) [space to type response]	... 1-----2-----3-----4-----5 not at all relevant	very relevant

(Go to qu 13 REL)

Qu 13 REL Which ONE of those messages above is the MOST relevant to you?

(Go to question 14)

Qu 14. How many times had you treid to quit before you succeeded? ÿ
0-5 times ÿ 5-10 times ÿ more than 10 times

(Go to question 15)

Qu 15. How long ago did you finally quit? ÿ 1-3 months ago ÿ 4-6
months ago

ÿ 7-12 months ago ÿ 12-24 months ÿ 2-5 years ago ÿ more than
5 years ago

(Go to question 16)

d) school-based programs eg. Health lessons, school based health nurse	... 1-----2-----3-----4-----5 not at all relevant	very relevant
e) Television eg. Marshall Menthols ad; Every cigarette is doing you damage etc.	... 1-----2-----3-----4-----5 not at all relevant	very relevant
f) Women's Magazines eg. Girlfriend, Dolly, Women's Weekly, Cosmopolitan, Cleo etc.	... 1-----2-----3-----4-----5 not at all relevant	very relevant
g) Health Magazines eg. Baby and You, Pregnancy, Mother and Child, Good Medicine etc.	... 1-----2-----3-----4-----5 not at all relevant	very relevant
h) Print mass media eg. Newspapers, Billboards	... 1-----2-----3-----4-----5 not at all relevant	very relevant
i) Health Professional eg Doctor, nurse, midwife, naturopath etc.	... 1-----2-----3-----4-----5 not at all relevant	very relevant
j) Cigarette packaging	... 1-----2-----3-----4-----5 not at all relevant	very relevant
k) Radio ads	... 1-----2-----3-----4-----5 not at all relevant	very relevant
l) Cinema ads eg. 'Poison'	... 1-----2-----3-----4-----5 not at all relevant	very relevant
m) Quit smoking brochures and leaflets eg. Quit because you can, Smoking and pregnancy etc.	... 1-----2-----3-----4-----5 not at all relevant	very relevant
n) Other (please tell us where from) [space to type response]	... 1-----2-----3-----4-----5 not at all relevant	very relevant

(Go to question 17 REL)

Qu 17 REL Which ONE of those messages above is the MOST relevant to you?

(Go to question 18)

Qu 18. Did you ever experiment with smoking in the past? Yes (Go to question 19) No (Go to question 21)

Qu 19. How did you experiment?

Took a few drags when others were smoking

smoked a few cigarettes (but less than 100 in total)

smoked only when drinking alcohol and partying (but less than 100 cigarettes in total)

still smoke occasionally when around friends who are smoking (but less than 10 cigarettes so far)

(Go to question 20)

Qu 20. If you experimented, what influenced you to experiment?

Space to type response

(Go to question 21)

Qu 21. Why didn't you take up smoking regularly?

Space to type response

(Go to finish)

Finish

Thankyou! You have now finished!

We really appreciate your help and the answers you have given us will help us make our report relevant to young women in Queensland.

If you wish to view the results of this survey and the larger study, they will be posted on the following address some time in early 2004:

<http://www.womhealth.org.au>

Telephone Survey Instrument for Young Women Smokers and Ex-Smokers

Where appropriate, young women callers to the Women's Health Queensland Wide Telephone Information Line were asked whether they would like to participate in a survey on young women and smoking.

The survey and instructions appear below.

Young Women and Smoking Telephone Survey

INTRODUCTION (read to all potential participants)

We are currently running a short survey with the University of Queensland. The aim is to understand what young women think about smoking. Results from the survey will be used to make recommendations to Queensland Health. The questions take about 3 minutes to answer. Any responses you give would be completely anonymous. We would very much appreciate getting your views and experience but you don't have to take part.

Would you like to answer the questions? (Please circle answer)

YES (**Go to Qu 3**) NO (**Go to CLOSE**)

1. Record postcode of caller:
2. Which age group describes you? (Read out each and circle answer; Just record the age if you already know)
Under 16 years (**Go to CLOSE**)
16-18 years (**Continue**)
19-24 years (**Continue**)
24-28 years (**Continue**)
over 28 years (**Go to CLOSE**)

(Please circle answers)

- 3 Do you currently smoke cigarettes regularly or at least occasionally?
YES (**Go to Qu 4**) NO (**Go to Qu 5**)
- 4 In your entire life, have you smoked at least 100 cigarettes?
YES (**Go to SMOKER FORM**) NO (**Go to CLOSE**)
- 5 Have you ever smoked regularly or at least occasionally?
YES (**Go to Qu 6**) NO (**Go to CLOSE**)
- 6 In your entire life, have you smoked 100 cigarettes or more?
YES (**Go to EX-SMOKER FORM**) NO (**Go to CLOSE**)

EX-SMOKER FORM

7. How long ago did you stop smoking? (write in answer)

8. (Read out) The researchers are really interested in where people get messages to stop smoking. What stop smoking messages are you aware of? [Can prompt with examples like family, friends, television, radio, magazines etc] [list all mentioned in Left Hand column below]

9. Thinking back to **when you did smoke**, which of those messages seemed directed at you or relevant to you? [Please tick Right Hand column for each one caller says is relevant]

Source of message	Relevant to me (tick)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

10. Did you ever get help to stop smoking?
 YES (**Go to Qu 11**) NO (**Go to Qu 13**)

11. Where did you get help from? (list all answers in Left Hand column below)

12. On a scale of 1 to 5, where 1 is "not at all useful" and 5 is "very useful", how useful was [say **each** source mentioned in Qu 7 **separately**] to helping you stop smoking? [write in number from 1-5 in Left Hand column corresponding to source]

Source of help useful?	How
1.	
2.	
3.	
4.	
5.	
6.	

7.	
8.	

9. What motivated you to quit? (please write all reasons caller says)

CLOSE

Assure caller that her help has been very valuable. Tell caller that the results from the entire study will be available on-line early in 2004. Give WHQW web address if caller is interested. Thank and terminate call.

SMOKERS FORM

5. (Read out) The researchers are really interested in where people get messages to stop smoking. What stop smoking messages are you aware of? [Can prompt with examples like family, friends, television, radio, magazines etc] [list all mentioned in the Left Hand column below.]

6. When you think about those stop smoking messages, which seem directed at you or relevant to you? (Please tick Right Hand column for each one caller says is relevant)

Source	Relevant to me (tick)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

7. If you were really serious about quitting smoking **NOW** where would you get help from? [List all sources of help mentioned in Left Hand column below]

(If caller says “nowhere” or “cold turkey” or “self” **ONLY go to Qu 9**)

8. On a scale of 1 to 5, where 1 is not at all relevant and 5 is highly relevant how **relevant** do you think the help from [say **each** source from question 7 **separately**] would be to helping you quit? (Write in number in Right Hand column next to corresponding source of help)

Source of help	How relevant?
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Qu 9: Have you ever tried to quit? (Please circle)
 YES (**Go to Qu 10**) NO (**Go to CLOSE**)

Qu 10: About how many times have you tried? (Write in response)

Qu 11: What was your motivation for trying to quit? (List all mentioned)

CLOSE

Assure caller that her help has been very valuable. Tell caller that the results from the entire study will be available on-line early in 2004. Give web address if caller is interested. Thank and terminate call.