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Tobacco Use and Related Factors Among Women in Aydın, Turkey: A Mixed Study

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Main Points

- One in three women under the age of 24 uses tobacco. Young and urban women are the target of the tobacco industry.
- Policies that do not take into account gender inequality and the status of women in the fight against tobacco will fail.
- The fight against tobacco is a total struggle. Eliminating inequalities, global struggle, biopsychosocial approach, and ensuring the well-being of the society will strengthen the struggle.

Abstract

Today, one of the most important targets of the tobacco industry is women. Despite the programs implemented so far in the world, the desired success has not been achieved in tobacco use. The aim of our study was to determine the prevalence of tobacco use among women in Aydin and to evaluate the tobacco use experience. The quantitative phase was cross-sectional research design, while the qualitative phase employed a phenomenological design. In the quantitative phase, 1577 people were reached. The qualitative phase was conducted with 45 women smoking tobacco, 2 with their relatives, and 10 public health professionals. The frequency of tobacco use is 23.2%. Smoking status was found to be higher in those aged 44 and under, widowed/divorced, university or higher education level, employed, and living in urban areas. Six main themes related to tobacco use in women were determined in the qualitative phase: "Tobacco control policies," "Starting smoking process," "Individual effect of smoking," "Smoking process," "Smoking cessation process," and "Root causes and holistic approach." In the fight against tobacco use in women, it is important to eliminate gender inequality, empower women, increase social welfare, global struggle, and ensure the well-being of society.

Keywords: Aydın, nicotine addiction, qualitative research, tobacco control, tobacco use, tobacco use cessation, women' status

This study was derived from the medical specialty thesis conducted by the first author under the supervision of the second author.

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Introduction

Tobacco use, one of the leading preventable causes of death, is still a serious public health problem. However, in 2021, the World Health Organization (WHO) reported that tobacco use caused more than 8 million deaths yearly (World Health Organization [WHO], 2021). The WHO has highlighted that one of the most important target groups of the tobacco industry is women (WHO, 2021). World Health Organization estimated in 2018 that 244 million women worldwide smoke tobacco (WHO, 2019). Tobacco use is the leading risk factor for many noncommunicable diseases, especially cancer. Especially in women, the risk of infertility and preterm birth increases due to reproductive health. Therefore, tobacco use in women affects not only the woman's health but also the health of society (WHO, 2003).

Türkiye was the first country to fulfill all the strategies in the MPOWER policy package in 2013 (WHO, 2013). Data from the Global Adult Tobacco Survey (GATS) from Türkiye showed a decrease in tobacco use from 2008 to 2012, followed by an increase from

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2012 to 2016. In the second period, the group with the most significant increase in the proportion of smoking was women (38.9%) (Turkish Public Health Institution, 2010; Turkish Public Health Institution, 2012; WHO 2017).

Women are an essential component of tobacco control. However, special efforts are needed to protect women, as they have become a key target market for the tobacco industry (WHO, 2021). Despite national tobacco control measures in Türkiye, a meaningful reduction in tobacco use, especially among women, has not been achieved (Cakir et al., 2013). Despite many studies on tobacco, the desired success has not been completed at the international and national levels. There are two main ways to reduce tobacco use. The first of these is not to start using tobacco, and the second is to stop using it. Therefore, a holistic evaluation of the tobacco use process is important (Calikoglu et al., 2019). Most of the studies are representative of the whole society and are quantitative studies. Clarifying factors underlying the tobacco use process in women will increase the success of tobacco control policies and programs. Our study aims to determine the prevalence of tobacco use among women and related factors in Aydin province in western Türkiye and to in-depth evaluate the tobacco use experience from start to finish.

Methods

This study used a mixed methods approach. One of the most important advantages of mixed methods research is that it combines the existence and importance of the physical and natural world with the influence of human experience and creates a new synthesis (Östland et al., 2011; Johnson et al., 2004). In our study, quantitative method was used as the first phase and qualitative method was used as the second phase. The reason for this is to reach the target population in the qualitative phase through the quantitative phase. In the quantitative phase of the study, we evaluated the frequency of tobacco use in women and the affecting factors. In the qualitative phase, we aimed to develop a theoretical and conceptual framework for the reasons for women to start, continue, and quit tobacco use. The quantitative phase was carried out using a cross-sectional research design, while the qualitative phase employed a phenomenological design, performing focus group discussions (FGD), in-depth interviews (IDI), and observation (O). The study was carried out in Aydin, a province of western Türkiye, between May 2018 and December 2020. Permission was obtained from Aydın Adnan Menderes University, Medical Faculty Non-Invasive Clinical Research Ethics Committee (May 23, 2019, approval number 2018/1420) and Aydın Provincial Health Directorate.

In the quantitative phase, the population of the study consisted of women over the age of 18 living in Aydın. Sampling, including sample size ($n = 2237$) and three-stage cluster sampling, was overseen by the Turkish Statistical Institute (TURKSTAT). The study population includes all districts and population of Aydın province. Two separate services were obtained from TURKSTAT for sample size calculation and determination of households. Sample size using the general tobacco use rate according to Global Adult Tobacco Research (GATS) 2016 results [q: 1−p, (0.818)], d: sensitivity level (0.0273) 15% of the variable of interest, Deff: design effect (2 was taken as design effect in the calculations), ko: loss rate was calculated as 2237 based on 0.30 (total loss rate was used as 0.30, taking into account the household and individual loss rates in household surveys conducted by TURKSTAT) (Annex-1). In the first stage of the three-stage sampling, clustering was made to contain approximately 100 addresses for urban and rural settlements, and a total of 224 clusters were selected. Clusters were selected using the proportional probability selection method. The number of addresses in each cluster formed the cluster size. In the second step, 10 addresses were selected systematically from each selected cluster. In the third stage, the sample unit is individuals, and after the listing study conducted in the field, one suitable individual was selected randomly among 18+ years old women. Individual selection was made using the birthday method (the person with the nearest birthday based on the later period of the travel date). Then, we applied a questionnaire during face-to-face interviews by visiting homes from a catchment area of 1582 km^2.

With the concepts of "non-smoker, smoker, former smoker," the state of never using cigarettes, currently using it irregularly/regularly, and having used it in the past are defined, respectively. In the quantitative phase, the participants were asked, "What is your smoking status throughout your life?" I have never smoked, I used to smoke, but now I smoke regularly and irregularly, and other options are presented. Analyses were made according to three categories since there were no participants who chose the option "Other."

In the qualitative phase, the participant groups were divided into three: women who smoke tobacco (WST); relatives of women who smoke (RWS) from households containing WSTs; and public health professionals (PHP) who had an interest in tobacco issues. Participants joined the study by using a purposeful sampling method. Of the 330 smokers who were involved in the quantitative phase for the WSTs, the women who accepted the qualitative phase and shared their phone number were contacted. Detailed information was provided for the qualitative stage, and the participation status was confirmed. Totally 45 participants were included in the study by sampling according to the purpose, the volunteers, and availability of time. For RWSs, 2 of the 45 participants in the household who were willing to participate in the study were interviewed. For PHPs, experts were contacted, whose researchers know that they work in this field either in Aydın or in Turkey. Figure 1 shows the sampling strategy in the quantitative and qualitative phases of the study.

We performed pilot trials for the questionnaires, and then, the data collection form was given its final form as a result of the discussions. We used a voice recorder in all interviews. All interviews with PHP and RWS were conducted as in-depth interviews. Eight of the interviews with WSTs were made as focus group interviews and eight of them were IDI. Two observation sessions to evaluate WST and RWS were carried out at the participants' own homes by two different researchers, present simultaneously. Each FGD consisted of four to six interviewees. Women who smoke tobacco were interviewed in the department meeting room, and we performed online interviews with eight of the PHPs and both RWS. The remaining two PHPs were interviewed at work by one of the researchers. The participants gave written and/or verbal permission to participate in the qualitative phase of the study. The voice recordings obtained from the qualitative phase were stored in encrypted form, and all tapes

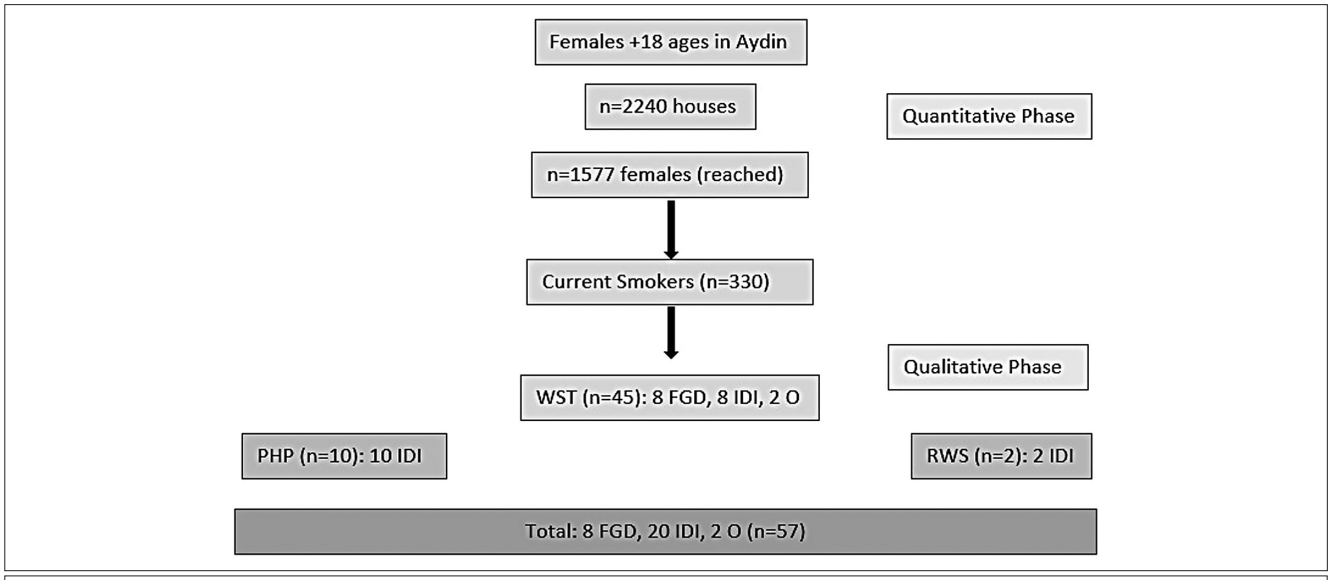

Figure 1. Sampling strategy in the quantitative and qualitative phases of the study. WST, women who smoke tobacco; RWS, relatives of women who smoke; PHP, public health professionals; FGD, focus group discussions; IDI, in-depth interview; O, observation.

were anonymized. The semi-structured form was piloted with four female research assistants from Aydın Adnan Menderes University, Faculty of Medicine, Department of Public Health. The total interviewing time was 36 hours and 20 minutes.

By using three data collection methods, three subject groups, and an analysis performed by two separate researchers, we tried to maximize the reliability and validity of the study.

As a data collection method, a structured form in the quantitative phase (55 questions), semi-structured form (7 main questions, 27 sub-questions) in the interviews in the qualitative phase (Annex-2), and an observation form in the observations were used. The questions used in the quantitative phase were based on GATS Türkiye questions. The researchers prepared the questions in the qualitative phase based on critical findings or research questions from the existing literature.

Statistical Analyses

The quantitative analysis was conducted using the Statistical Package for Social Science, version 21.0 (IBM SPSS Corp., Armonk, NY, USA). Kolmogorov – Smirnov test, histogram, and skewness – kurtosis coefficients were used to evaluate conformity to normal distribution. Pearson's chi-square test was used to compare groups by categorical data. Multinominal logistic regression was performed with sociodemographic variables that affected the current cigarette consumption status in the analyses. Significant variables included in the model were age, gender, labor force status, education level, income level, and the most extended place of residence. Non-smokers, former smokers, and current smokers were the dependent variables. Type 1 error level was taken as $\alpha = .05$.

The qualitative analysis process was conducted with Nvivo-12 (QSR International, Chadstone, Victoria, Australia) using thematic content analysis and cluster analysis methods. Before analysis, audio recordings were copied to another device and then transcribed by one researcher, resulting in 1140 pages of text. The second researcher assessed the validity of transcription in a 250-page sample. The researchers reached a consensus on the sub and main themes. Next, all the data were encoded by reading it four times, and a final total of 88 codes were obtained. Subsequently, we created the coding tree and table, resulting in sub and main themes (6 main themes and 17 sub-themes).

Results

Quantitative Results

A total of 1577 of the eligible population of 2240 (70.4%) participated in the study. The participants' median (range) age was 45 (18 – 86) years. Table 1 shows the sociodemographic characteristics of the participants by smoking status.

The frequency of tobacco use among the sample was 23.2% (95% CI: 21.1 – 25.3), and 8.3% of women use tobacco products other than cigarettes. About a fifth (20.9%) of the participants were currently smoking, and 19.2% smoked daily. Less than a tenth (7.4%) of the sample were former smokers.

Nearly half (49.3%) of current or former smokers had their first cigarette before the age of 18, and 25.3% were daily smokers before the age of 18. Figure 2 shows the smoking status of women by age group.

The smoking risk of women was assessed by age and most extended place of residence. Women aged 44 and under (odds ratio (OR): 2.153, 95% CI: 1.609 – 2.882) or living in urban (OR: 3.946, 95% CI: 2.627 – 5.927) or suburban (OR: 3.259, 95% CI: 2.262 – 4.696) were more likely to be smokers than those aged 45 and over or women living in a village (R2: Cox-Snell: 0.117, Nagelkerke: 0.150; Model χ^2: 196.600; $p < .001$).

The rate of smoking cessation was 26.2%. Among women who had stopped and then started again or were former smokers, 22.4% had used some method to help quit smoking, and 4.3% had received support from a smoking cessation clinic. Only half (44.6%) of current smokers have considered stopping, but

Table 1.
Relationship Between Sociodemographic Characteristics of the Participants and Smoking Status

		Total		Non-smokers		Former Smokers		Current Smokers			
		n	%	*n*	%	*n*	%	*n*	%	χ^2	*p*
Age	≤44	767	48.6	491	64.0	57	7.4	219	28.6	53.674	<.001
	≥45	810	51.4	639	78.9	60	7.4	111	13.7		
Marital status	Married	1069	67.8	776	72.6	78	7.3	215	20.1	31.677	<.001
	Widow/divorced	265	16.8	155	63.8	10	4.1	78	32.1		
	Single	243	15.4	199	75.1	29	10.9	37	14.0		
Education status	High school≤	1306	82.8	969	74.2	89	6.8	248	19.0	24.210	<.001
	≥University	271	17.2	161	59.4	28	10.3	82	30.3		
Working status	Not working[a]	852	54.0	647	75.9	60	7.0	145	17.1	18.620	<.001
	Working	725	46.0	483	66.6	57	7.9	185	25.5		
Income status	Income<expense	631	40.0	479	75.9	36	5.7	116	18.4	11.753	.019
	Income=expense	830	52.6	567	68.3	70	8.4	193	23.3		
	Income>expense	116	7.4	84	72.4	11	9.5	21	18.1		
Longest inhabited region	Urban (city)	395	25.0	231	58.5	49	12.4	115	29.1	118.660	<.001
	Suburban (small city)	692	43.9	462	66.8	59	8.5	171	24.7		
	Rural (village)	490	31.1	437	89.2	9	1.8	44	9.0		

[a]Housewife, [b]Bold values represent statistical significance.

48.5% of the women who managed to quit smoking started again afterward.

More than four-fifths (83.2%) of women reported that they have information about the harms of smoking, 60.8% of the sample thought that formal smoking prohibitions were insufficient, and 66.5% thought that bans were not sufficiently enforced. In addition, most of those questioned (69.1%) thought that public service adverts had no effect on cigarette consumption, and even more (71.7%) felt that pictures and slogans on cigarette packs were ineffective.

Qualitative Results

Six main themes emerged from the data obtained in the qualitative phase. These themes were "Tobacco control policies," "The process of starting smoking," "The effect of smoking on the individual," "The smoking process," "The smoking cessation process," and "Root causes and holistic approach" (Figure 3).

Tobacco Control Policies

Participants stated that control of the use of tobacco in indoor and outdoor areas continued. Participants felt that the existing prohibitions should be enforced more effectively, rather than

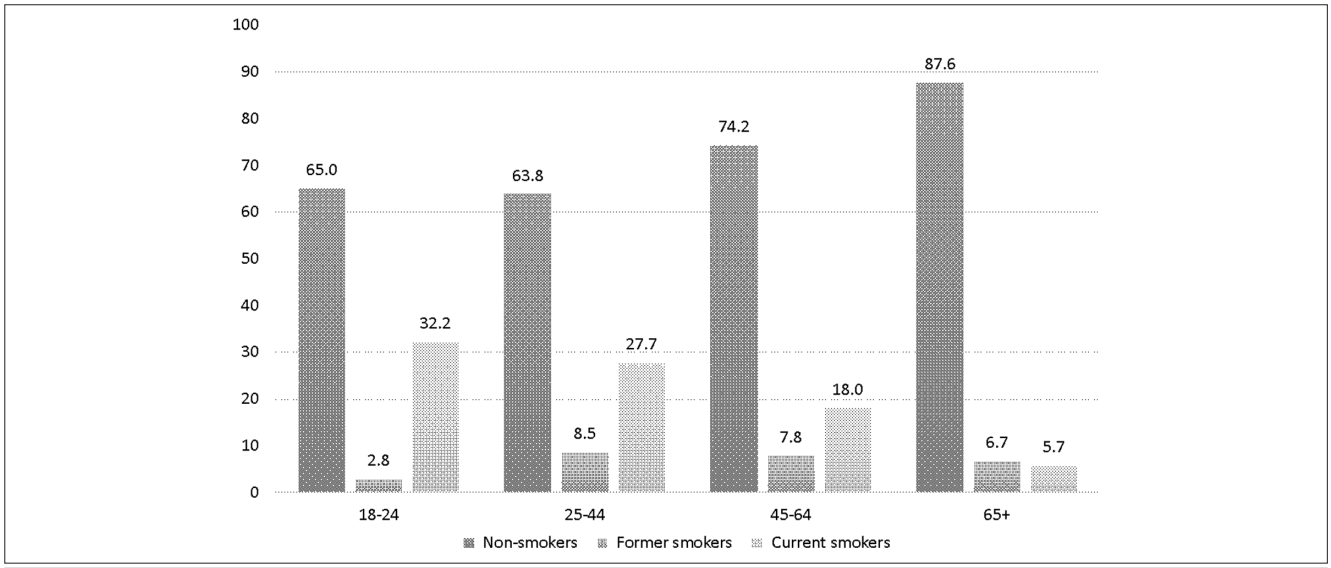

Figure 2. Smoking status of women by age group. Age group is given on the x-axis and percentage on the y-axis.

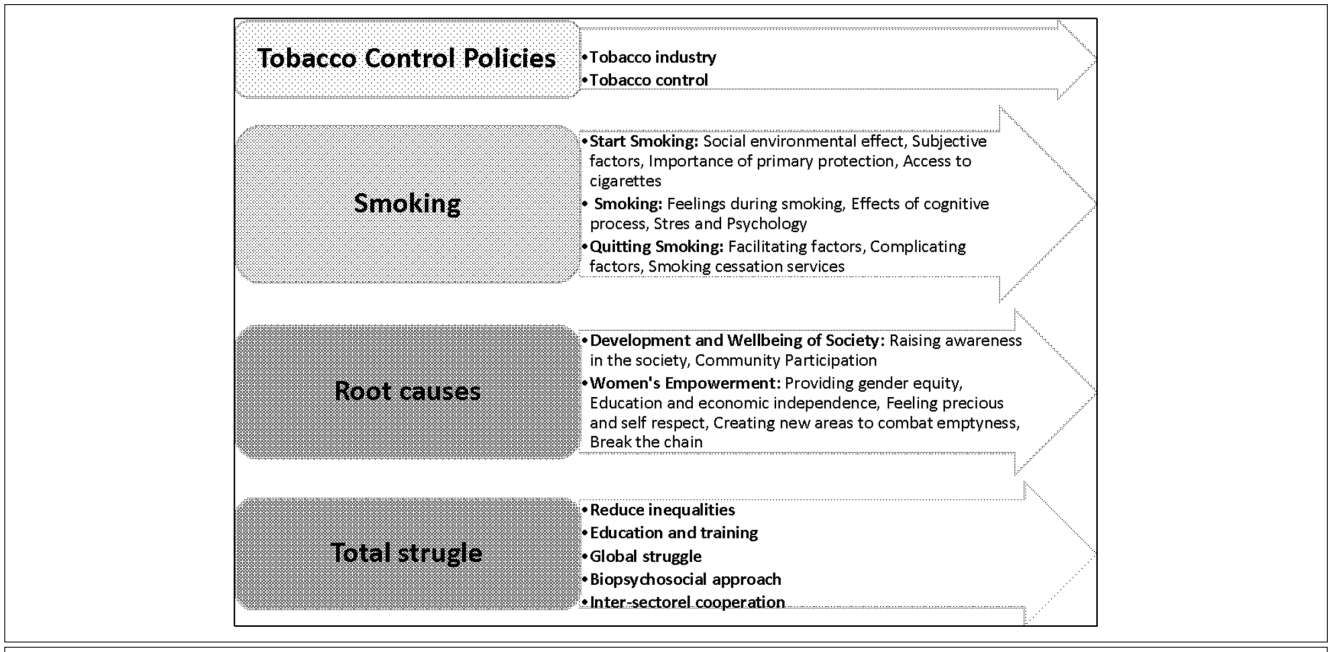

Figure 3. Conceptual framework.

adding more prohibitions, and control mechanisms were not independent. They mentioned that new solution-oriented approaches are needed in public information and warning messages. In addition, they said that they can easily reach tobacco even if they are under the age of 18 and that they can buy cigarettes one by one from some grocery stores.

According to the participants, the primary methods used by the tobacco industry to attract women were media and product diversity, such as slim and flavored cigarettes. In addition, they stated that electronic cigarettes attract women because of their smoke-free and odorless nature.

"Why are women targeted? The men's market in Türkiye is saturated, and women are a significant market. The people that the industry can hold the most in this market are middle class, urban women, women who have the power to buy cigarettes and have the economic power." (PHP, Male)

The Process of Starting Smoking

Women who smoke tobacco stated that they were curious when they started to smoke; they felt more confident by smoking and "proven" themselves. Almost all participants stated that environmental influence, especially friends, played a major role in the starting process. However, they drew attention to the fact that their curiosity and desire to prove themselves at the beginning turned into action by reaching for cigarettes.

"… In other words, the most important reason for the increase in women is that I am also an individual, and I am a person, as they gain power in the hands of women, and their economic power rises." (WST, 39 age, high school, married, 10 cigarettes/day)

"Everyone was smoking, there was a temptation. I was saying no, I won't smoke; but they were saying smoke. Because of the environment we were in, I wasn't offended. Then I looked and I started, I couldn't understand how it happened during that process." (WST, 21 age, high school, not married, 15 cigarettes/day)

"I started out of curiosity. The fact that it was secret and forbidden caught my attention and I wondered. For example, you see a colorful drink and wonder about its taste. It was something like that. It affected me differently. They did not react differently when they drank a juice, they did not say that they will drink it tomorrow, but when they smoked, they smoked constantly. I was thinking how could they want so much." (WST, 22 age, high school, not married, 25 cigarettes/day)

The Effect of Smoking on the Individual

Women who smoke tobacco stated that while smoking, they reported feeling enjoyment, sound and happy, free, relaxed, rested, rewarded, and having the best day. They also said that smoking time was "me time," and they felt more beautiful, they were thankful for their existence and that cigarettes were indispensable. One participant also described smoking as an antidepressant. Some participants said that smoking had a place in their routine at home and that they saw it as a reward for housework. Smokers also stated that they sometimes take shelter in cigarettes and see them as their friends with whom they share their problems. Public health professionals, on the other hand, associated this issue with women's inability to spare time for themselves and their hunger for love.

"When I smoke, I get above the clouds. Butterflies fly inside me. There is nothing more beautiful than that." (WST, 37 age, primary school, married, 25 cigarettes/day)

"After my housework is done, I look for a pleasant cigarette. There is something routine for smokers. You get up in the morning, prepare your breakfast, clean the house, finish the work, and finally sit down and smoke. This is my whole life. I'm not rushing it, I'm just trying to enjoy it." (WST, 39 age, high school, married, 10 cigarettes/day)

"As if you are dealing with a cigarette as a secret friend, as if you are taking shelter in it. Even if you have a friend, you can't tell everyone everything. Is that a cigarette? You see cigarettes as a friend, you carry it with you." (WST, 35 age, middle school, married, 20 cigarettes/day)

"From the point of view of women, loneliness is too much. It takes shelter in it, something like a port. I say, 'Are you sure this surrounds you? There are those who say, 'Of course, it doesn't hug, but that smoke surrounds me' or something. The image is a cigarette, but in its essence, it is a hunger for love." (PHP, female)

Smoking Process

It was notable that, concerning the smoking process, different groups expressed different concepts about smoking. Women who smoke tobacco emphasized problems and stress relief, RWS emphasized the financial cost, and PHP emphasized the social aspects. Cluster analysis confirmed that participants frequently mentioned "stress" and "problems" in periods when smoking increased. In addition, PHPs reported smoking by women was used as a substitute for professional support for psychological problems. Women who smoke tobacco stated that they were not addicted to smoking and that because they were not addicted, they would not be harmed by smoking. Some even considered themselves as not smoking. Younger respondents thought smoking would not affect their health because they were young. Some participants were more fatalistic, reporting that smoking is an individual choice and everyone dies of something.

"Women smoke secretly in stressful situations at home. Housework, pressure from her husband, children, mother-in-law, etc. In some families, the woman has no say, and I think there is stress because of this." (WST, 20 age, high school, not married, three cigarettes/day)

"A woman can start smoking instead of going to a psychiatrist. However, if you have an economic problem, it is not solved, if there are personal problems, it is not solved, they just live a deception of the nicotine of cigarettes. But the problems remain where they are." (PHP, male)

"Sounds like it doesn't hurt. You're fooling yourself. People are smoking, look, they are 80 years old, I say they do not have a disease. So you're making excuses not to let it go. I know them all. But I don't want it to get out of my life." (WST, 39 age, high school, married, 10 cigarettes/day)

The Smoking Cessation Process

Participants emphasized social support as the most critical factor in facilitating smoking cessation, including family and friends' support and the importance of the correct approach to the smoker. Participants with smoking cessation experience stated that they replaced cigarettes with coffee, through employment or housework, or with sports. Participants indicated that they experienced deprivation and lack of will. At the same time, broad acceptance and normalization of tobacco use made quitting harder, and the presence of people still smoking made the cessation process harder. Most of the WSTs were not knowledgeable concerning smoking cessation services and methods. Distillation of the participants' views on smoking cessation services led to identifying key components of a smoking cessation service (Figure 4).

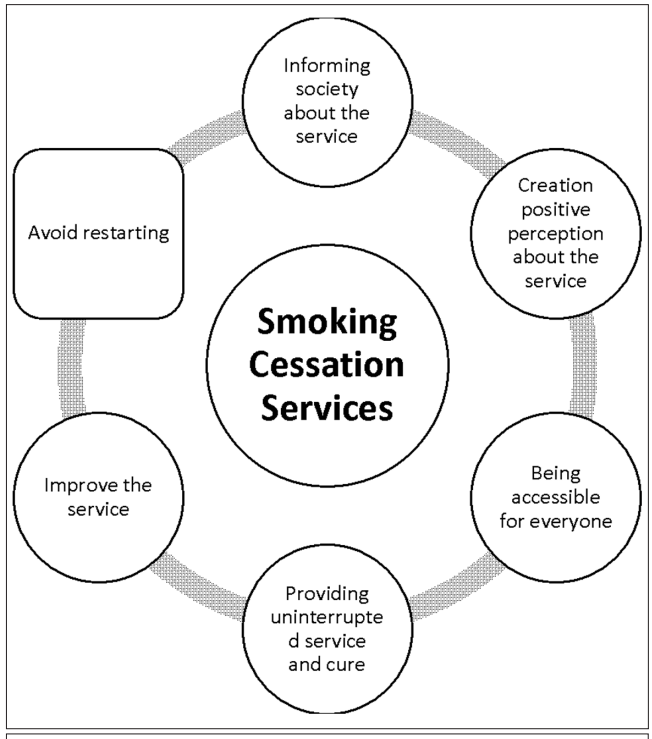

Figure 4. Components of the smoking cessation service.

Root Causes and Holistic Approach

This broad topic has been divided into several sub-themes: the status of women, total struggle, and empowerment of society and well-being. Again, the different groups had different ideas about this topic. For example, WSTs were mainly concerned with gender inequalities, RWSs addressed public awareness, and PHPs emphasized women's empowerment but were also concerned about disparities. Given these views, the concepts of women's empowerment, gender inequality, and societal awareness were grouped in the cluster analysis. In addition, inequalities, the biopsychosocial approach, and society's general societal mental well-being were also grouped.

Women who smoke tobacco stated that smoking helped relieve stress and increased societal visibility. Thus, PHPs also referred to women as the "second gender" in society and noted an increase in smoking among educated women and women in more traditional societal environments. In addition, PHPs reported that smoking was a status symbol, regardless of women's education or socioeconomic status.

Public health professionals said that even after successfully stopping smoking, women would be in the same environment with the same triggers that initiated tobacco in the first place. To prevent this, they suggested that women's empowerment should be improved (Figure 5).

"… For women, environments outside the home in which they can take care of themselves should be developed. Their social life needs to be strengthened." (PHP, female)

Participants stated that women regard smoking as their closest friend, are lonely enough to see smoking as their closest friend, and have nothing to replace smoking with. In addition, WST stated that women are undervalued in society.

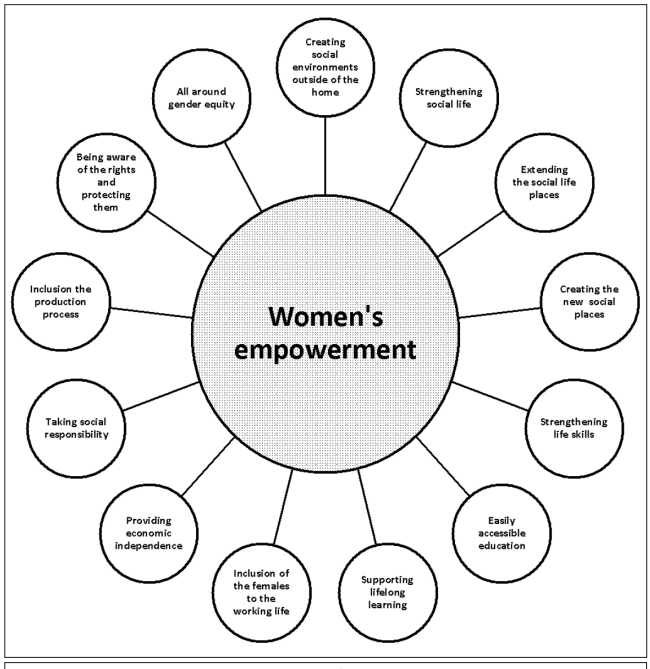

Figure 5. Key factors for women's empowerment.

"This is my only pleasure in life, and there is no other choice. I am completely devoted to the children, and my husband. I have no other social life. I only have a cigarette in my life." (WST, 26 age, high school, married, 30 cigarettes/day)

"The woman knows that she has to quit smoking, but when you take her cigarette from her, you take her self-respect, her self-love... She thinks she will lose herself when she quits, so she doesn't want to do that." 57 (PHP, female)

The participants stated that as public awareness increases, general health literacy and community participation increase, resulting in healthier living. They suggested when all individuals in society were recognized as equal, many of the stimuli for female smoking would be removed. The participants also emphasized the importance of upbringing in tobacco use and that education of the woman/mother was vital, with both formal and family education having an important role.

Discussion

One of the most critical findings is that one in three women under 24 use tobacco. In addition, in our research, we found tobacco use to be higher in women under the age of 45 than in women over the age of 45 and in women living in urban areas compared to women living in rural areas.

In our study, the root causes of tobacco use in women were reached, and the individual, social, and global causes of tobacco use were revealed by women who use tobacco, their relatives, and public health professionals working on smoking. Although there are common causes and roadmaps at the global and national levels in the fight against tobacco, there are also specific reasons and different solutions for women. It has been determined that women have a tendency to increase their status in society in the process of starting, maintaining, and quitting tobacco use, and they see tobacco use as a method of increasing their status. In our study, we have observed that women turn to tobacco products due to root reasons such as not being sufficiently included in social life, their production power being mostly limited to domestic work and childcare, and lack of gender equality.

Many studies have been conducted on tobacco use, which is still the leading cause of death worldwide. The global prevalence of tobacco use among women is lower than among men, but tobacco is increasingly being used by women in developing countries (Amos et al., 2012). Consistent with other studies, in our study, it was determined that as the education level of women increased, tobacco use also increased (Elbek et al., 2021). For example, in recent Turkish studies, the prevalence of tobacco use in women was reported to be between 14.9% and 19.7% (Centers for Diseases Control and Prevention [CDC], 2019; Hitchman et al., 2011; WHO, 2018). While the rate of tobacco use in Türkiye was 41.5% for men and 13.1% for women according to the 2012 GATS, the rate of tobacco use increased to 43.7% for men and 18.2% for women, according to the 2016 GATS (Turkish Public Health Institution, 2012; WHO 2017).

We found that the smoking rate was approximately twice as high in the younger group ($\leq$44 years) compared to women aged $\geq$45. Although the increase in tobacco use among young women in recent national studies is striking, our study's prevalence was particularly notable in the 18 – 24 age group (Centers for Diseases Control and Prevention [CDC], 2019; Hitchman et al., 2011; WHO, 2018). The problem of adolescents and young people smoking was highlighted by the WHO recently (WHO, 2020). In Turkiye, the minimum age limit to buy cigarettes is 18 years. Despite this, participants reported that a significant portion of daily smokers starts smoking before this age. Consistent with these findings, in our qualitative phase, women said that they had easy access to cigarettes before the age of 18 and that they could even buy a single cigarette from some grocery stores. It is very important that tobacco control policies are implemented holistically, especially by focusing on the age of 18 and under. It is also important to protect the young population, especially against new-generation tobacco products (Kurtulus et al., 2022).

In our study, WSTs exhibited poor knowledge of available smoking cessation services. The drugs used in smoking cessation treatment are not routinely available through the social security system in Türkiye. It is known that the success of quitting smoking is higher in people with high income (Elbek et al., 2021). Depending on the current anti-smoking campaign, these drugs are sometimes free and need to be paid for at other times. This lack of continuity has been reported to reduce success (Simsek et al., 2014; Celik et al., 2015). It has been reported that the success rate of those who try to quit smoking alone is <5% (WHO, 2020). Relapse rates may be higher among women than among men (Hitchman et al., 2011; Aslan D, 2016). This suggests that stressors, which led to smoking initiation in the first place, continue to exist, leading to these high relapse rates. In the qualitative phase, the causes of the problems related to the smoking cessation process in women were discussed in detail, and a six-step cycle was obtained, ranging from insufficient information about the smoking cessation service to avoiding starting again (Figure 4). The application of this circular approach obtained in our study of smoking cessation service delivery can be considered.

The tobacco industry increasingly targets women, associated with increased female smoking rates (Hitchman et al., 2011). Tobacco products are promoted with concepts such as free, prosperous, funny, romantic, and pleasing that appeal to women who feel trapped by the societal constraints they live with (Sieminska et al., 2014). In the qualitative phase of our study, women also mentioned that they felt well and safer and also become proven themselves by starting tobacco use. In a survey on waterpipe tobacco use among women in Iran, attention was drawn to the tobacco industry's influence. The tobacco industry's tactics have been mentioned, and the importance of policies in tobacco control has been pointed out. Makvandi et al. (2021) reported that the tobacco industry uses decorations and lighting for women. In our study, we also mentioned the relationship between tobacco use, tobacco control, and the tobacco industry. Although the struggle against the tobacco industry is tried to be implemented at the social and global level, the participants shared that additional efforts should be made for women. Our findings indicated that women living in urban areas and having economic income were on target. Yıldız F's study, which examined cigarette consumption between 1960 and 2016 in Turkey, determined that there was a linear relationship between income level and urbanization and cigarette consumption (Yıldız, 2020). The results of our study are also compatible with these long-term data.

Our study has confirmed that the fight against tobacco use should be a total, global struggle, inter-sectoral cooperation is essential and that a biopsychosocial approach, especially to eliminate inequalities, will have a marked impact. It was suggested that the fight against tobacco would be facilitated by both strengthening society and increasing individual well-being. In this context, the importance of raising societal awareness, community participation, and increased mental well-being was mentioned. Community participation and motivation should have a priority on the whole. Public information channels, health literacy and related concepts, and practices should be accessible and widely recognized (Turkish Statistical Institute [TURKSTAT], 2019). Within the scope of improving health, tobacco control measures should be supported by new research, especially in light of the global pandemic and the possible increased risk factors for COVID-19 in smokers (Aslan, 2020).

An approach that lacks a gender equality-based perspective in tobacco control will prioritize practices that do not consider the differences in social roles and responsibilities between women and men. This situation may create more complex issues instead of solving problems (WHO, 2013). Although the form of tobacco consumed is a status indicator, the knowledge and practice of how it will be consumed, which brand, where, with whom, and in what way are closely related to smokers' social status and cultural capital (Graves et al., 2006; Robinson et al., 2013). We found that women used smoking as a status-enhancing factor, regardless of their education level or socioeconomic status.

In conclusion, tobacco use's prevalence in women is particularly worrying at younger ages. Therefore, there is a need for programs that focus on root causes and employ a holistic approach, especially concerning the status of women and gender equality, and how to empower women.

Limitations and Directions/Suggestions for Future Research

The current study is the only mixed-method study in the literature that examines tobacco use among Turkish women and its affecting factors. The study's strengths were cooperating with TURKSTAT, which provided a Turkish GATS sampling service in the quantitative phase and ensured data validity through cross-referencing sample opinions and answers in the qualitative phase. However, a weakness of the study was that, because of the COVID-19 pandemic, the RWS sample was small.

When evaluating the fight against tobacco in future studies, a perspective that considers both biological and gender differences between men and women may be useful. It is important that priority interventions are aimed at women aged 18 – 24.

Ethics Committee Approval: Ethical committee approval was received from the Non-Invasive Clinical Research Ethics Committee of Aydın Adnan Menderes University Medical Faculty (May 23, 2019, approval number 2018/1420).

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