

Thesis Prepared for the Degree of
Master of Public Health

Baha'i Institute for Higher Education

May, 2018

The Perception of Tehran Resident Women Aged 20-30 about The Impact of Cigarette Smoking on Their Old Age Health



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ACKNOWLEDGEMENTS

I have taken efforts in this project. However, it would not have been possible without the kind support and help of many individuals.

I would first like to thank my thesis advisor, Dr. Neda Moayad of the Department of Health Behavior and Health Systems at University of North Texas HSC for her immense knowledge, constant supervision, continuous support, and encouragement during my MPH research. Her guidance helped me in all the time of research and writing of this thesis.

I would like to express my sincere gratitude towards my parents, my sisters for their patience, unfailing support, and encouragement throughout my years of study and through the process of researching and writing this thesis and friends who willingly assisted me out with their abilities. This accomplishment would not have been possible without their assistance.

Finally, My thanks and appreciation also go to Department of Public Health for creating such a learning environment with excellent professors.

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INTRODUCTION

The tobacco epidemic is one of the major public health problems which causes 6 million deaths yearly (WHO, 2015a). It is unbelievable that in every six seconds, one of the tobacco consumers dies. Also, one out of ten death among adults is due to this preventable agent in worldwide (WHO, 2008).

In 2010, the WHO claimed that from 5 million death as the result of tobacco use, nearly 1.5 million of this number belonged to women. The majority percentages, around 75%, of these women lived in low and middle-income countries (WHO, 2010a).

Women consisted of about 20% of the world's smokers of the approximately 1 billion total smokers in 2010 (Haglund, 2010). One of the major usages of tobacco is related to cigarette smoking (Yanbaeva, et al., 2007). In 2009, approximately 22 percent of adults who were older than 18 years, were cigarette smokers (WHO, 2015a). According to World Health Organization in 2010, about 22% of men and 1% of women were smokers in Iran (WHO, 2015a).

Almost all the body organs are under attack from cigarette smoking. It can have an adverse impact on the health of smokers in general and causes many smoking-related diseases (National Center for Chronic Disease, et al., 2014). The health consequences causally link to smoking are cancers, such as lung, bladder, and cervix, and chronic diseases, like stroke, coronary heart disease, asthma, and other respiratory diseases (National Center for Chronic Disease, et al., 2014). As evidence of this, it is reported that 90% of all lung cancers are related to any tobacco form, and also it is a significant risk factor for strokes and fatal heart attacks (WHO, 2008). The key point is that diseases rate such as heart disease, stroke, and lung cancer are more prevalent in smokers in comparison with nonsmokers, for instance, it is

estimated that smoking increases the risk of coronary heart disease and strokes by 2 to 4 times (National Center for Chronic Disease, et al., 2014).

Although the prevalence of smoking among men is higher than women, , Women are in danger of tobacco risks as men are (Haglund, 2010). As well as it is mentioned, all smokers in both genders are likely to suffer from cancer, heart disease, and respiratory disease as the result of tobacco smoking. It harms women in different ways in comparison with men like female-specific cancers and compromises pregnancy and reproductive health (Haglund, 2010; WHO, 2010a). As evidence of this, women smokers face infertility, delay in conceiving, and have a higher risk of cancer of cervix more than nonsmokers (WHO, 2010a). It is important to know that premature delivery, stillbirth and newborn death is the result of smoking in the pregnancy period, and also it can cause reduction of breast milk of smoker mothers (WHO, 2010a).

In addition to the effects of smoking consequences on women's health, history shows that women are an important target for tobacco industries. It means that promotions try to encourage women to smoke by using images, themes, features of charming women carry thin cigarette in their packets (Haglund, 2010).

In Iran, however cigarette smoking in women seems to be low, but, there exists probability of lack of accuracy and reliability in Iran statistics. (Sarraf-Zadegan, et al., 2004) Therefore the recognition of perceptions of adult women in Iran about the relationship between cigarette smoking and its consequences on their health in the future is necessary. It can lead to finding the reasons for smoking maintenance among women and to conduct an effective intervention to deal with cigarette smoking among women. This subject is not found in published literature. So the purpose of this study is to explore the perception of cigarette smokers of

adult women aged 20 – 30 about the effects of smoking on their health during their old ages in Tehran, Iran.

OBJECTIVES

General objective

To explore the perception of cigarette smokers of adult women aged 20 – 30 about the effects of smoking on their health during their old ages in Tehran, Iran.

Specific objectives

- To identify the perception of cigarette smokers, women of 20 – 30 years old residing in Tehran about the roles of cigarette smoking in their life.
- To identify the perception of cigarette smokers, women of 20 – 30 years old residing in Tehran, about the consequences of cigarette smoking.
- To determine the belief of cigarette smokers, women of 20 – 30 years old residing in Tehran, about the relationship between disease occurrence and cigarette smoking, and the extent of cigarette smoking to cause the diseases.
- To determine the perception of cigarette smokers, women of 20 – 30 years old residing in Tehran, about catching smoking complication in their old ages.
- To find the perception of cigarette smokers, women of 20-30 years old residing in Tehran, about the benefits of smoking cessation for their health.

BACKGROUND

Prevalence

In the world in 2013, 21% of adults, consisting 950 million men and 177 million women, were current smokers (WHO, 2015b). Despite the increase in the global population during 2007 and 2013, the average of current smokers decreased in the world, 23% in 2007 (WHO, 2015b). It is interesting that the number of current smokers in high-income countries, 25% of the population of adults, is higher than middle-income countries, which is 21% of adults, and only 16% of adults are current smokers in low-income countries (WHO, 2015b). Although usage of tobacco has decreased among men, increase in smoking population especially among women, and young people still seem to be a frightening thread for the developing countries (Yanbaeva, et al., 2007).

Cigarette smoking is still the most used form of tobacco (Yanbaeva, et al., 2007). Apart from the fact that several attempts have taken place to decline the use of tobacco during the past 30 years, the population of cigarette smokers is increasing in the United States (US cigarette prevalence, 2010). Around 46.6 million, 20.6 percent, of adults aged ≥ 18 , were cigarette smokers in the United States, 2009. 21.9%, 10.2 million, out of mentioned number were occasional smokers, and 78.1%, 36.4 million, out of the whole percentage were daily smokers. (US cigarette prevalence, 2010) Due to conventional wisdom, men tend to smoke cigarettes 5.6% more than women (Sarraf-Zadegan, et al., 2004). Moreover, the number of women smokers has risen due to the changes in the dynamic of society after the 20th century (Sarraf-Zadegan, et al., 2004).

Unfortunately, there is no accurate statistics about the prevalence of smoking in Iran, because smoking still is a big stigma especially among women and adolescents. In most cases, they are afraid of their position, family members, and acceptance in society. Therefore, reaching

an exact number of current cigarette smokers is almost impossible. As evidence of this, the prevalence of self-reported and biochemical (by serum levels of cotinine) current smoking among women aged ≥ 19 in a study indicates a significant difference between these two measures; it was estimated 1.3% and 6.7% in women by self-reports and plasma cotinine respectively (Sarraf-Zadegan, et al., 2004).

The prevalence of current smoking increased in both men and women from 1994 to 2000, and this number among women increased by nearly four times (Sarraf-Zadegan, et al., 2004). An analysis in Iran shows that the prevalence of smoking is increasing with 5.3 percent from 1999 to 2005, 11/9% and 17/4% respectively (Mehrabi, et al., 2005). In this research, the prevalence of smoking in three different groups were examined: Active smokers who smoke minimum one cigarette per day, non-active smokers who smoke less than seven cigarettes per week, and ex-smokers who smoke before but not at the time of the interview. The overall prevalence of cigarette among women in three groups was 7%. It means that from 42624 female participants from all parts of countries, approximately 2984 women smoked in 2005. It was concluded from this research that the average of smoking among women was increasing in the world. Iran would not be far from this result, and it is needed to have more consideration on smoking prevalence especially among women. (Mehrabi, et al., 2005)

In a study, the prevalence of women smokers in households of Tehran in 2007, among the 381 people who were current smokers, were 113 (29.7%). The percentage of women among the past and present smokers was 31.8%. Cigarette smoking was significantly less common among women than men, and it may be because of more tolerance for men's smoking in Iran and also the effect of cultural attitude toward smoking of women in society, results in a tendency of women to hide their smoking habit for the sake of social stigmatization. (Eftekhari Ardebili, et al., 2007)

In a cross-sectional study between adult residents of Tehran (aged ≥ 15) in 2009, the prevalence of cigarette smoking was 11.9%, of total population 3195 people (Fotouhi, et al., 2009).

According to WHO report in 2010, about 22% of men and 1% of women smoked in Iran (WHO, 2015a). In 2015 the rate of current cigarette smoking, non-daily and daily use, among adults aged 15 years and over, were 0.6 and 15 percent in female and male in order; And in particular, daily cigarette smoking rate were 0.4 and 10.8 in order in female and male (Global health observatory, 2015).

In the meta-analysis research regarding the prevalence of smoking in Iran in 2013 smoking prevalence varied from 0.6% to 9.8% in women. According to the results of the meta-analysis, one-fifth of Iranian men and 2-3% of women have daily smoking habits (Mahmood Moosazadeh, et al., 2013).

To conclude, although prevalence of smoking among Iranian women is decreased based on WHO and is tangible, this fact is not shown in studies in Iran. As mentioned before, cigarette smoking statistics among women may not be reliable because cigarette consumption is not an acceptable action for women in Iranian culture. Thus, biases may be noticed regarding the true statistics of smoking in females (Meysamie, et al., 2010). Cigarette smoking among women follow camouflage pattern; they do not smoke openly as men do. Therefore, statistics cannot reflect the actual number of smokers because it does not cover the hidden population. Understanding the extent and frequency of smoking among women requires a multidimensional and longitudinal studies. Based on the Fararu news in 2010, Mohammad Reza Masjedi, the head of the Iranian Society against Tobacco Smoking, expressed that smoking among young and educated people especially women was increasing. He continued that studies showed that 25-27% and 4-5.3% of men and women, of adult ages ≥ 15 , were

smokers respectively (Alarming prevalence of smoking among women, 2010). Also, according to Mehr Khane news, women smokers' number is increasing by three times in 2013 (Smoker women in Iran, 2013). If this trend continues, the prevention interventions are needed and it makes this kind of research which emphasizes on the perceptions of women about the effects of smoking on their health valuable.

Mortality

The second major cause of death in the world is tobacco (Yanbaeva, et al., 2007). WHO declares that about 6 million people die due to the tobacco use, smoking and smokeless, across the world annually most of whom are mostly premature and 600,000 people out of this total die from the effects of second-hand smoke (WHO, 2015a). Associated with a disability, ill-health, and non-communicable chronic disease, smoking increases the risk of death from communicable disease among tobacco smokers (WHO, 2015a). Moreover, estimations have shown that if current trends continue, more than 9 million people will die because of tobacco each year (Yanbaeva, et al., 2007).

The leading cause of death in the United States is cigarette smoking which causes approximately 443,000 premature deaths every year and accounts for up to 30% of cancer deaths (US cigarette prevalence, 2010). Based on what World Health Organization has forecasted between 2020 and 2030, 9% of deaths related to cigarette smoking will decrease in developed countries, and the same percentage of deaths will increase in developing countries during the same period (Mathers, et al., 2006).

Consequences

Tobacco is the greatest but the most avoidable risk factor for cancer-related death number that has created 1.6 million of the 7.4 million cancer deaths in 2004 (Oh, et al., 2010).

Cigarette smoking is the most common cause of preventable deaths in the world (M. Moosazadeh, et al., 2014). Besides smoking that is the cause of 70% of lung cancer population, second-hand smoke is known as the cause of lung cancer in non-smokers (WHO). Woman smokers are increasing as total smokers are, anti-smoking considerations have less effect on them (WHO, 2010b).

Manufactured tobacco- cigarette- a combination of tobacco with hundreds of chemical additives, is the most common way of using tobacco. A cigarette which contains 0.5 to 1.0 g of tobacco delivers 10 mg of nicotine to the body. The effect of nicotine is one half after 2 or 3 hours. A cigarette is also the most efficient way to deliver nicotine that is classified as a stimulant drug. However, nicotine is both stimulating and depressing which increases attention, memory, information processing, and learning while tranquilizing anxiety, depression, and pain (WHO, 2010b).

Nicotine reaches the brain in almost 7 seconds of smoking, causing the release of dopamine and neurotransmitters. Dopamine is associated with pleasurable feelings while the release of acetylcholine of blood improves attention, the discreet performance of repetitive tasks, and memory improvements. These pharmacological effects play an important role in addicted ones maintaining their smoking but some of the psychological effects of smoking cause feeling of coping with stress successfully (WHO, 2010b).

Because of the recent decline in smoking in industrialized countries, tobacco companies are targeting developing countries. Consequently, tobacco-related diseases have appeared. The mortality rate of women who smoke is elevated, and premature death of tens of millions of women is doubled by tobacco use factor. Lung cancer is another side effect that is reflected as a reflection of smoking pattern two or three decades earlier while adverse reproductive outcomes is another immediate effect of smoking (WHO, 2010b).

The Effects of Smoking on Women's Health are listed below (WHO, 2010b):

- Effects of Smoking on **the Health of Infants and Children and Reproduction:** The infants of smoker mothers weight around 200 g to 250 g lower than infants born to non-smoking women. Women smokers who become pregnant are at risk of premature rupture of membranes and pre-term delivery.
- Effects of Smoking on **Cardiovascular Disease:** Cardiovascular diseases are the major causes of death among women in the world. Coronary heart diseases (CHD) increases in women smokers whose relative risks are greater for young women in comparison with older ones (Oh, et al., 2010).
- Effects of Smoking on **Chronic Obstructive Pulmonary Disease:** Dying from chronic obstructive pulmonary disease increases in women smokers which are directly related to the number of cigarettes smoked daily.
- Effects of Smoking on **Cancer:** About one-fifth of all cancer cases are attributed to tobacco. Around 6% of women diagnosed with cancer in low and middle-income countries in 2004 were smokers. 25% of women's death in the United States is due to lung cancer that is directly related to duration and amount of smoking. Women smokers are also in danger of oral cancers, and cervical cancer as HPV that is the cause of cervical cancer is prevalent in women smokers.
- Effects of Smoking on **Bone Density and Fractures:** According to studies women smokers have a lower bone density in comparison with nonsmokers.
- **Other Health Effects of Smoking:** Women smokers are in high risk of periodontal disease, gallbladder disease, peptic ulcer, some forms of cataract, and facial wrinkling that are not life-threatening but affects the quality of women's lives.

One of the possible questions is what a threshold of cigarette consumption in a day is that must be exceeded that would result in smoking health issue occurrence. On the one hand, it does not matter what level of cigarette, even an occasional cigarette or secondhand smoke could cause diseases. Any exposure to tobacco is dangerous and hurtful. On the other hand, according to the U.S National Cancer Institute, many factors such as the number of years of smoking, number of cigarette consumption per day, the initiation age of smoking, and ill history have an impact on the chance of developing smoking-related diseases especially cancer. As evidence of this, in a cohort study in the U.S, the risk of death from lung cancer, COPD, and death from any cause among current smokers was higher in the difference between never smokers; and it was related to the number of cigarettes smoked per day and the number of years of smoking (Thun, et al., 2013).

In most studies, however, the lowest consumption group was set at 1–9 or 1–15 cigarettes per day. In a prospective study, it was shown that smoking 1–4 cigarettes per day was significantly related to higher risk of death due to ischemic heart disease in both sexes (Bjartveit, et al., 2005).

A population-based case control study among young women in 2008 indicated that there is a significant dose-response relationship between cigarette smoking and ischemic stroke risk. The results have shown that increasing number of cigarettes per day causes an increase in the risk of stroke. For instance, the stroke will be 2.2 fold in smokers of 1 to 10 cigs/d in contrast to non-smokers. It will be 2.5 fold when cigarette consuming reaches 11 to 20 cigs/d. Therefore, the risk associated with smoking even 1 to 10 cigarettes per day was statistically significant (Bhat, et al., 2008).

In another study, an analysis of the dose-response relationship based on combined data of passive smoking, particulate matter from air pollution, and active light and heavy smoking

directed light smoking (4–7 cig/day) has about 70% of the effect of heavy smoking (≥ 23 cigs/day) . In addition, the risk of ischemic heart disease in smokers ages 35–39 who consume 1–4 cig/day in comparison with a nonsmoker is approximately 3 times. It is also noted that the risk of death from lung cancer is more than 23 and about 13 times higher in daily (> 20 cig/day) smoker's men and women respectively than nonsmokers. Also, the risks for light smokers, while lower, are considerable. As evidence of this, the risk of developing lung cancer in women between the ages of 35 and 49 who smoke 1 – 4 cigs/day is 5 times higher than nonsmokers (Schane, et al., 2010).

It has been proven that occurrence of smoking complications is related to years of consumption and number of cigarettes per day. It is noteworthy that assuming heavy smokers as participants in tobacco prevention intervention is not enough. Because it is shown in studies that low level of consumption like 1-4 cigarette may lead to smoking-related diseases. However, this is the minimum cigarette consumption which it is found to be hazardous, but there may be no safe and secure threshold for cigarette smoking. Therefore, in this study women who are current smokers and smoke minimum 1-4 cigarette per day will be considered.

The last important note is that the health impacts of tobacco consumption, unlike many dangerous substances, are not immediate and it takes years or decades to be revealed after smoking initiation. The full impact of tobacco-related disease and death is already evident in developed countries that early stage of tobacco epidemics has passed, while it takes time to reach this point in developing countries (WHO, 2008).

As prevention is better than cure, there may be still some chances available in Iran, as a developing country, to help people reconsider about smoking. One of the possible ways that

could help prevention campaigns is to find women smokers' perception of the impacts of cigarette smoking on their elderly health.

Definition

Health: World Health Organization defined “Health” as “A state of complete mental, physical and social well-being and not merely the absence of disease or infirmity” (Sartorius, 2006). The American Nurses Association defined health as “a dynamic state of being in which the developmental and behavioral potential (possible) of an individual is realized to the fullest extent possible” (Masters, 2014).

Cigarette Smoker: The US Centers for Disease Control and Prevention have developed and updated the following definitions (Schoenborn, et al., 2010):

- **Never Smokers** – Adults who have never smoked a cigarette or who smoked fewer than 100 cigarettes in their entire lifetime.
- **Former Smokers** – Adults who have smoked at least 100 cigarettes in their lifetime, but say they currently do not smoke.
- **Nonsmokers** – Adults who currently do not smoke cigarettes, including both former smokers and never smokers.
- **Current Smokers** – Adults who have smoked 100 cigarettes in their lifetime and currently smoke cigarettes every day (daily) or some days (nondaily).
 - A daily smoker is a person, who smokes any tobacco product at least once a day (except that people who smoke every day, but not on days of religious fasting, are still classified as daily smokers).
 - An occasional smoker is a person, who smokes, but not every day.

LITERATURE REVIEW

Factors related to smoking

Generally, the prevalence of smoking has a direct association with gender, age, education level, socioeconomic status and marital status (Fotouhi, et al., 2009). For instance, men smoke more cigarettes than women within a day and the amount increases by smokers' age (Meysamie, et al., 2010). Although men tend to start smoking in earlier stages than women, they are the ones who stop smoking first. Furthermore, the risks of abstinence from smoking and the duration of exposure among men are likely to be lesser than women, it is 17.8 years for women vs. 13.2 years for men (Meysamie, et al., 2010).

In a study about Iran, it was indicated that an increase in age had a correlation with the smoking rate. Higher education resulted in a low prevalence of smoking (5% decline for every unit of increase in education), and smoking prevalence was 2 times higher in unemployed in compared with employees (Ebadi, et al., 2011).

In a cross-sectional study in Isfahan, the impact of education level on the occurrence of cardiovascular risk factors was examined. The education levels were categorized based on the educational system in Iran as, illiterate, primary (≤ 5 years), high school (6 – 12 years), and university education (>12 years). The highest smoking rates belong to high school students, yet, it steadily decreased in higher education levels (Gharipour, et al., 2015).

In a study in Finland among the employees of the City of Helsinki aged 40-60 years, it was proven that educational level, occupational status was strongly associated with smoking in both sexes. It means that smoking prevalence was higher among individuals with lower education and income. In women, smoking decreased steadily from manual workers to women with a higher occupational position such as managers or professionals. In this study, education level was divided into three groups: basic (compulsory) education, secondary

education and higher education (university degree). For occupational status, the participants answered to questions about their household income without taxes during a typical month with any welfare benefits, and the number of persons living in the household (Laaksonen, et al., 2005).

Case studies

In order to decrease the prevalence of cigarette smoking and the number of deaths related to that, vital issues are needed to be determined, for instance, motivations for smoking initiation, smokers' visions of why they are smoking, and the rate of their knowledge about smoking-related issues.

A cross-section study among university students aged 20 to 25 in Isfahan, a province in Iran, has shown that there are significant underlying psychological factors that tempt women to start smoking cigarettes and men to start smoking Hubble bubble (Roohafza, et al., 2011).

Another study which took place in 5 European countries reports that the reasons why daily, occasional, and not any more smokers tend to initiate smoking are getting old, being divorced, and having smoker parents or friends. Consequently, having smoking friends (62.7%) and the desire to look "cool" are two of the most fundamental reasons that cause smoking initiation at early ages. Women who start smoking in order to manage their stress and depression are most likely to start smoking at an old age (Oh, et al., 2010). In this project, the participants answered demographic questions, belief about smoking and tobacco background. Demographic questions consisted of age, education, marital status, and income. The education level categorized as 'not complete secondary school,' 'completed secondary school,' 'university,' and 'post-graduate education.' The categories about income status were based on the median annual household income in Ireland, so, the income statuses were 'well below,' 'below,' 'around,' 'above or well above' the median. The participants also answered

an open-ended question about the reasons for smoking initiation (Oh, et al., 2010). In this project, the relationship between socioeconomic status and the smoking rate was not significantly associated. The authors claim that it may be because of biases: first, asking about the age of completing the last grade of education instead of the level of education, second, not correcting the distribution of income levels, and third, variation in the amount of responding in different countries. It was noticeable that education and income status might have less impact on women than men and smoking among women may be more influenced by social factors such as family and friends (Oh, et al., 2010).

In a cross-sectional study in Thailand, the correlation between social behavior and current smokers were examined. The result was that there is a relation between smoking and having a smoker parent or closest peers. It specified that having smoker friends in adolescent age could increase the likelihood of smoking initiation in this age group (Rudatsikira, et al., 2008).

In another cross-sectional study in six states of the European Community-Denmark, Finland, The Netherlands, Portugal, Spain and the UK- parental influences and peer influences were found as a strong relation to onset of smoking in adolescents (de Vries, et al., 2003).

It was also shown among couples in a study in the United States that partners have vice versa influence on their smoking habit, initiating, maintaining or quitting. Women were more susceptible to resume smoking as a result of smoker partner (Homish, et al., 2005).

In a descriptive qualitative study, 36 women lived in Iran in diverse age with a median age of 24 years were questioned about factors related to initiation hookah smoking. It was shown that parents, siblings, and peers who used to smoke hookah or other tobacco products like cigarettes could have an effective role in the initiation of hookah smoking, which normally will happen in family gatherings. It also mentioned that in some participants their enthusiastic

to use hookah was due to not being acceptable cigarette smoking among their family, but they had experience of few puffs in hidden or in front of their family. It was shown that smoker parents are smoother about children in experiencing hookah rather than cigarettes due to the social acceptability of hookah, although they could not criticize their children habit because of poor habits of themselves (Baheiraei, et al., 2015a).

In the other cross-sectional study among adult's ages 18-24 years old in Nepal, perceived health risks and benefits of cigarette smoking were examined between two groups of smokers and non-smokers. The likelihood of becoming current smoker was higher among students who believed that smoking "was enjoyable, would help to deal with problems or stress, would help to feel comfortable with friends, would help to be relaxing, and is something to do when feeling bored" (Aryal, et al., 2015). Moreover, the adults who thought smoking is harmful to their health or made yellow their nail and teeth were at lower risk of becoming a current smoker (Aryal, et al., 2015).

In a systematic review, they found that there is an association between depression or anxiety and smoking. In their point of view, based on self-medication model individuals smoke to alleviate psychiatric symptoms which can lead to the onset of smoking, increasing smoking status, or high dependency (Fluharty, et al., 2017).

In a retrospective cohort, the strong association between smoking behavior and adverse childhood experiences (ACE) is mentioned. They defined ACE including emotional, physical, and sexual abuse; a battered mother; parental separation or divorce; and growing up with a substance-abusing, mentally ill, or incarcerated household member. They argued that individuals who have experienced adverse childhood experience may find cigarette smoking as a psychoactive benefits thing to regulate their mood (Anda, et al., 1999).

Based on a qualitative study which was undertaken with a group of Greek and Australians older male and female, smoking is indicated as a "beneficial" action which helps them manage tiresome and stress. It helps people relax and feel peace, and it empowers their social activities. The majority of participants were not fully aware of the health consequences of smoking except for those who had higher level of education. Eight out of 20 participants suffer from smoking-related diseases and four of them even deny the potential for getting ill. Also among the ones who accept the adverse effects of smoking, there was a belief that the decrease in number of cigarettes and a high quality kind of tobacco will get things under control. Moreover, some of them believed that, there is no use quitting smoking though harmful it may be. Consequently, they justified their claim by the idea that there are lots of people dying from cancer who have never smoked. Four of the participants had a new idea. They believed that smoking cessation may be good for youth but not for the elderly people because the damage has already been done and quitting would not be beneficial (Mohammadnezhad, et al., 2015). In this project, Demographic information were collected such as age, marital status, education level, and employment status. The contents of open-ended question were about participant's history of smoking, personal attitudes, cultural belief and environmental cues towards smoking, participant's understanding about risks associated with smoking, and benefits of cessation. According to the study, the concepts covered in the interview were (Mohammadnezhad, et al., 2015):

- "Smoking antecedents (i.e. kind of smoking, starting age of smoking, reasons for starting, number of years as a smoker, country of starting smoking)
- Relationship between disease occurrence and smoking
- What was good about smoking
- What was bad about smoking , knowledge about benefits of smoking cessation
- Self-confidence and stage of motivation to quit smoking

- Previous quit attempts (i.e. number of attempts, duration of quitting)
- Reasons for relapse in later life and their experience of what led to successful quitting
- Barriers to smoking cessation in later life
- Counselling by health professionals (doctor, psychologist and so on)”

Another research with the aim of detecting smokers’ experiences concerning the initiation and continuation of smoking in a qualitative approach between 12 smokers and 6 non-smokers was implemented in Iran in 2014. In semi-structured interviews, participants were asked about the story of the first attendance to smoking, interactions with other smokers, and initiation and persistence reasons of smoking. The initiation excuse of smokers were irresponsible parents, existence of stressors and crisis in the family, lack of reaction and care, smoking background, and vulnerable social environment such as poverty, magnification of smoking, acceptance of smoking as a norm, convenience of access, and network of cigarette smoking including friends, peers, family members and adolescent role models. Other results of this research declared that some smokers considered the action as something fun, and useful. They also believed that people exaggerate about smoking consequences. For example, they believed that smoking could be safe if the smoker does shallow breath and does not enter the smoke into the lungs. These smokers also thought that smoking cessation is an easy task for them whenever it was needed (Ebrahimi, et al., 2014).

Smokers generally are aware of the risks they undertake. However, they consider themselves as double-standard people and think that the unfortunate consequences will not happen to them. We can find this point of view about other hazards as well. For instance, heavy drinking, unsafe sex, and reckless driving. Sometimes people are quite aware of well-publicized risks and the probability of them for themselves. However, they do not want to believe so, and they construct persuasive arguments to show that the risks are not that

considerable to harm them. As a rule, attempts to reduce optimistic biases are often unsuccessful (Weinstein, 1998).

A qualitative study has shown that current smokers minimize the severity of health consequences of smoking. Smokers believe that future is unknown and unpredictable so why should they lose the immediate good mood that cigarette smoking gives them? Therefore, distant threats about future do not considerably impact decision making in the matter of health. In this research the interview's contents were (Shervington, 1994):

- “Personal health maintenance activities,
- Knowledge of the health consequences of cigarette smoking,
- Attitudes toward smoking,
- Reasons for initiation and maintenance,
- Smoking practices, and
- Feelings about the necessary components of any smoking cessation program”.

In a face-to-face interview with adult smokers and non-smokers in China, never smokers or former smokers were the ones who agreed to the negative health effects of smoking, not the smokers themselves. Over 90% of never and former smokers accepted that smoking causes lung cancer, but only two-thirds of smokers admitted that. Similarly, only half of the current smokers agreed to the fact that secondhand smoke causes lung cancer while 83% of never smokers and 77% of former smokers accepted the idea (Yang, et al., 2010). In this research, demographic questions such as age, gender, education, and income were asked. The subgroups of education level were low (no education and elementary school), middle (junior high school and high school), and high (college and higher). Income status was categorized based on household monthly income threshold. The questions which identified health knowledge and beliefs of participants about smoking are as follows (Yang, et al., 2010):

- “If you think smoking can cause heart disease, stroke, impotence, lung cancer, emphysema, stained teeth, premature aging in smokers and lung cancer in non-smokers;
- If you agree
 - Every cigarette you take damages your health,
 - Tobacco is addictive, and
 - Your cigarette smoke is dangerous to non-smokers;
- How much do you think you would benefit from health and other gains if you were to quit smoking permanently in the next six months;
- To what extent, if at all, has smoking damaged your health; and
- How worried are you, if at all, that smoking will damage your health in the future”.

In 2016, a cross-section study with the goal of determining smokers' knowledge and perception about smoking health risks took place in Iraq. 60.9% of Iraqi smokers confessed that smoking had harmed their health and they were afraid of the dangers of smoking on their health in future. On the other hand, only 7% of the whole thought that smoking is dangerous for the nonsmokers around them. Also, the results indicated that except for lung cancer, there was low awareness about health effects such as stroke, stained teeth, impotence in men, and lung cancer for non-smokers from secondhand smoking (Dawood, et al., 2016). In this project, the questionnaire consisted of three parts (Dawood, et al., 2016):

- “Sociodemographic data,
- Smoking behavior and quitting intentions, and
- Smokers' knowledge and perception of smoking health effects, this section was determined by seven health outcomes such as stroke, lung cancer, stained teeth, and premature aging”.

Over 90% of adult smokers start their smoking habits from adolescence. In particular research intentions and beneficial outcomes of smoking was examined among adolescent smokers and non-smokers in the US. Participants estimated that smokers who started at their adolescence underwent lesser health-related risks and had greater benefits compared to non-smokers. The other important discussion was that although adolescents were aware of long-term consequences of smoking, they believed that they could quit smoking at any time (Halpern-Felsher, et al., 2004).

Based on literature reviews, the snowball sampling, and semi in-depth interview has been used as techniques for gathering information in most of the qualitative studies. As evidence of this, in a qualitative study with the goal of determination psycho-social needs' impact on hookah smoking initiation among women, snowball sampling was used (Baheiraei, et al., 2015b). In the other qualitative research which was mentioned before, the purpose of the project was to find knowledge about Greek-Australian's perspectives on smoking cessation. The snowball sampling was used because of the small size of the target group, hard accessibility and unique attributes of participants like smoking status and age (Mohammadnezhad, et al., 2015). Moreover, semi-structured questions were used because of flexibility to permit participants to describe their life experiences while speaking about their smoking status (Mohammadnezhad, et al., 2015).

METHODOLOGY

In this research, qualitative research was used because it was designed to reveal a target population's perceptions about the risky behavior and its influence on their health. Therefore, the result was more descriptive. In this research, a qualitative approach was implemented via conventional content analysis regarding in-depth and semi-structured interviews. Based on the conventional content analysis, there was no pre-guidance theory for coding categories at the beginning. Therefore, coding categories were derived directly from the text data afterward. Semi-structured interview was used because its flexibility allowed participants to express their life experiences when describing their smoking status and beliefs towards the long-term effects of smoking (Schutt, 2011). The interviews included open-ended questions aimed at exploring participants' knowledge, attitudes, and beliefs about smoking and related matters. Therefore, the smokers' knowledge about smoking cigarette, and its advantages and disadvantages, including health-related risks of smoking, surveyed and examined. It also included demographic questionnaire regarding age, marital status, socioeconomic status, and cigarette smoking status. This information gathered in order to get more reliable perspective and conclusion from the perceptions of the sample group.

Participant Recruitment

In 2007, a study demonstrated the extent of tobacco smoking in Iran based on the information from the third national Surveillance of Risk Factors of Non-Communicable Diseases (Meysamie, et al., 2010). The prevalence of current and daily cigarette smoking were 6.7% and 5.8% between ages 15-24, and 12.4% and 11.3% between ages 25-34, respectively. However, determining the actual number of current cigarette smokers is almost impossible in Iran due to under-reporting (Sarraf-Zadegan, et al., 2004), but even so, the smoking rate between these two age groups almost doubles. Therefore, based on the purposes of this study

to find perceptions of the cigarette smokers about the long-term effects of smoking, it was considered to interview women who were at the early stages of adulthood. Based on this reasoning, the age range of subjects were 20-30, which were the average points between 15-24 and 24-35 age periods.

In this research, the inclusion criteria were adult women between ages 20-30 who were current cigarette smokers. Participants were recruited from different demographic backgrounds, in terms of age, education, marital status, occupation, and geographical region, to ensure that women from diverse demographic backgrounds took part in the interviews.

Recruitment Process

In Iran, there is still a stigma associated with cigarette smoking among Iranian women. Women do not talk about their cigarette experience openly in every condition (Baheiraei, et al., 2015b). They mostly refuse to participate in related discussions because of their parents' or husbands' disagreement, or because they are afraid of their voices being recorded (Baheiraei, et al., 2015b). Thus participants were sampled using a snowballing technique in which each participant introduced to the research her the next person, who was one of friends, colleagues, or acquaintances who smoked cigarettes.

If these women did accept to talk with the researcher, they usually preferred to do it in private rather than a formal gathering such as a focus group discussion (Baheiraei, et al., 2015b). Therefore, at a minimum, only individual interviews were used in order to collect data in this study.

However, the focus group can be an effective qualitative method to gain a broad range of information about events or issues (Kitzinger, 1995). The group interaction includes different forms of communication such as jokes, memories, and arguing which can encourage

participants to explore and state their views which cannot be expressed fully in responses to direct, individual questioning (Kitzinger, 1995). Therefore, participants were also invited to attend a focus group, one 60 minute session conducted to obtain new and enriching insights with six participants who agreed.

After finding volunteer women to participate in the research, interviews conducted one by one. At the very beginning, the researcher explained the purpose of the project and the process of the interview verbally, and a consent form was presented to sign. Then, the in-depth interview, along with a demographic questionnaire, was administered with whom accepted all the rules. The individuals asked to speak openly and freely about their cigarette smoking experiences, and their attitudes towards it. The recruitment process completed with 20 participants.

Data Collection

The participants completed a standardized questionnaire (see [Appendix 1](#)) including demographic questions and questions which helped the researcher define the participants' patterns of cigarette usage and socioeconomic status. These questions were gathered based on the National Adult Tobacco Survey Questionnaire developed in 2009-2010 by the CDC (CDC, 2010). Interviews were continued through a series of broad questions (see [Appendix 2](#)) to explore the participants' experiences of cigarette smoking, perceptions, and beliefs about cigarette smoking and its impact on their health.

Interviews were conducted in Farsi. They conducted for 10 to 55 minutes with an average of 28 minutes. All interviews were audio-taped and transcribed verbatim with participants' permission, and encoded by the researcher.

Data Analysis

The analysis of qualitative research notes began immediately after the time of interview. The data collection and data analysis process took place sequentially. Reading the notes or transcripts was a very important step in the analytic process. The researcher transcribed the data after all interview sessions. Then, the transcriptions read carefully to distinguish the similar concepts and categories which were repeated. To identify important statements and to assess ways of coding the acquired data, a researcher wrote some notes in the margins. In the next stage, the researcher listed the concepts reflected in the notes and found the relationships among concepts. After a while, a pattern emerged, and the findings reported in the results section.

ETHICAL CONSIDERATION

The following participant's rights observed during the research:

- Participation in this study was completely voluntary. Even if the participants decided to take part in the study, and they changed their minds after a while, they could stop the process at any time.
- Participants allowed to avoid answering any questions or refuse taking part in the discussion, interview, and/or the survey if they did not wish to do so. Participants did not have to give any reasons for not responding to a particular question, or for refusing to take part in the interview.
- The participants were free to refuse to continue the interview and to stop at any time, without any ramifications.
- At the beginning of the research, all participants heard verbally the consent form which included the purpose of the research, the methods, and the implementation process so that they could decide whether to participate in the interview or not.
- The information obtained could not be shared with anyone outside the research team and kept private and confidential, and instead of the participants' names, the information had particular numbers.
- The entire interview was tape-recorded. The recorded information kept confidentially. And no one except the interviewer had access to the documentaries during the interviews, and no-one identified by name on the tape.
- The tapes destroyed after the research finished.

FINDING AND ANALYSIS

Twenty women aged 20 to 30, living in Tehran, Iran participated in the qualitative research with per to per interviews and one focus group in summer of 2016; the interviews consisted of demographic questions on the socioeconomic status and smoking status and semi-open questions.

One focus group held consisted of six participants, one interviewer and one observer. All the participants were 20 – 30 years old women who smoked. Two of them were new, and four were volunteers from twenty women who participated in per to per interviews.

Demographic characteristics of participants

Table 1 Demographic information of study participants

Categories	Variables	Number	Percent
Age ranges	20 to 23	3	15%
	24 to 27	11	55%
	28 to 30	6	30%
Marital status	Never Married	15	75%
	Married	4	20%
	Divorce	1	5%
Educational status	High School Graduate	2	10%
	Associate Degree	4	20%
	Bachelor's Degree	11	55%
	Master's Degree	3	15%
Fields of study	Fine Arts	5	25%
	Architecture and Landscape	3	15%
	Management	3	15%
	Literature	2	10%
	Arts and Sciences	2	10%
	Medicine	1	5%

	Social and Behavioral Sciences	1	5%
	Agriculture & Life sciences	1	5%
	Engineering	1	5%
	Others	1	5%
Employment status	Employed for wages	11	55%
	self-employed	6	30%
	out of work for 1 year or more	2	10%
	Student	1	5%
Income status	less than 15000000 IRR ($\cong$ 357\$)	16	80%
	15, 000,001 IRR to 30, 000,000 IRR ($\cong$ 357\$ to 714\$)	4	20%

The average age of participants was approximately 26 years old. The second line of the table shows that the more than half (55%) of participants belonged to age group 24 to 27. For the age group 28 and over there were six persons, representing 30 percent of the sample.

Although the majority of the women (75% or 15 out of 20) were not married, four women were married, and only one woman was divorced.

The majority (90%) of participants had university degrees. The highest educational status was master degree belonging to fifteen percent of whole sample recipients. However, more than half (55% or 11 out of 20) of participants had a bachelor degree. The lowest status was high school graduate with the lowest proportion of 10%. They have been studying in ten various fields such as Fine Arts (25%), Architecture and Landscape (15%), Management (15%), Arts and Sciences (10%), Literature (10%), Medicine (5%), Social and Behavioral Sciences (5%), Engineering (5%), Agriculture & Life Sciences (5%), and Others (5%).

According to a question about the employment status of participants, eleven women of the total population were “employed for wages,” six of them were “self-employed,” two of them

were “out of work for one year or more,” and one was a “student.” The income of the majority of participants (80%) was “less than 15000000 IRR” ($\cong 357\$$) per month from all the resources, and twenty percent had “15,000,001 IRR to 30,000,000 IRR” ($\cong 357\$$ to 714\$) per month as their income.

Table 2 Cigarette smoking status and health status of study participants

Categories	Variables	Number	Percent
Age of the first try of cigarette smoking	11 to 14	2	10%
	15 to 17	4	20%
	18 to 21	13	65%
	22 to up	1	5%
Average number of cigarette smoking per day	1 to 7	8	40%
	8 to 15	8	40%
	16 to upper	4	20%
Time of first cigarettes per day	Within 5 minutes	2	10%
	From 6 to 30 minutes	2	10%
	From more than 30 minutes to 1 hour	1	5%
	After more than 1 hour	15	75%
Number of times of quitting	Never	11	55%
	Once	6	30%
	Twice and more	3	15%
Health status	Excellent	3	15%
	Very good	4	20%
	Good	5	25%
	Fair	6	30%
	Poor	2	10%

The average age of smoking initiation among the participants was eighteen years old. Thirteen women tried their first cigarette smoking between ages 18 to 21, and the rest, two, four, and one of the participants had their first try at ages 11 to 14, 15 to 17, and over than 22 years old respectively. All the participants were daily smokers who had smoked more than a hundred cigarettes in their lives. The average number of cigarettes per day was ten. Forty percent of participants smoked equivalently 1 to 7 and 8 to 15 cigarettes per day, and twenty percent smoked more than 16 cigarettes each day. Sixty percent of participants additionally described their health status as “*excellent*,” “*very good*,” and “*good*,” and thirty percent thought their health condition was “*fair*,” while, only ten percent described “*poor*” as their health status. Five women lit their first cigarette less than one hour after waking up, and the rest have it after one hour in the mornings. Fifty -five percent of the study population had never quit on their smoking, while thirty percent and fifteen percent of participants experienced quitting once and more than twice respectively in their life.

🌈 The perception of study participants regarding the role of cigarette smoking in their lives

Table 3 illustrates the description of women regarding their tempting reasons to smoke their first cigarette. Participants were allowed to select as many as they wanted.

Table 3 Study participants’ reasons regarding smoking initiation

Reasons	Number	Percent
Social networks and role models	15	75%
Emotional problems	8	40%
Curiosity	7	35%
Fun and pleasant	5	25%
To assert independence	3	15%

Social influence had the highest percentage (15 out of 20 or 75%) in this illustration. In most cases, family members, friends, social interactions, images of famous actors, movie stars, and role models tempted the interviewees to start cigarette smoking. They described their experiences as bellows:

Representative Answer 1: *“I used to work in an art place where everyone smoked cigarettes, and a friend who was an old smoker taught me how to smoke,”*

Representative Answer 2: *“I used to work in a bookstore, where the managers were two stylish women, who smoked and aged 50 to 60. They were my role models; I liked their voices, and the artistic atmosphere- the circumstances they smoked, drank coffee and talked,”*

Representative Answer 3: *“I had seen a series named “Red Line.” One of five actors was a smoker, and he was so attractive to me,”*

Representative Answer 4: *“My father was a cigarette smoker; He was so impressive to me. I liked the way he worked and smoked. Also, I liked his smell, the combination of his cologne and cigarettes.”*

Representative Answer 5: *“My fiancé used to smoke a lot. I always wanted him to quit, but since he did not pay attention, I started to smoke as well.”*

The other reasons for initiating cigarette smoking were emotional problems (35% or 7 out of 20) and curiosity (25% or 5 out of 20). The Representative Answers of women in the first category were:

Representative Answer 1: *“I felt grief in my heart because of my father’s death; cigarettes helped me cope with my problem.”*

Representative Answer 2: *“When I started university, I lived alone, and I had no help from my family. Cigarette smoking was a safe place for me.”*

They showed their curiosity with statements like *“I wanted to experience it”* or *“I was always curious about smoking.”* Twenty-five percent (5 out of 25) found smoking pleasant and fun.

They described their reasons saying: *“I like the way smoke comes out of my mouth,” “the style is cool, having a cigarette between my hands,” “I just enjoy even two minutes when I sat and smoked.”*

Based on findings, it seems that the smoking status of participants has highly related to their social network. Table 4 illustrates how many of their nuclear family and friends tended to smoke.

Table 4 Number of family members and percentage of friends of study participants who smoke a cigarette

Social network		Number	Percent
Family members	None	5	25%
	One member or more who smoked and are alive	10	50%
	One member or more who smoked and is deceased	3	15%
	One member or more who is a former smoker	4	20%
Girl friends	90 - 100 %	11	55%
	70 - 89.99 %	6	30%
	50 - 69.99 %	3	15%
Boy friends	90 - 100 %	13	65%
	70 - 89.99 %	4	20%
	50 - 69.99 %	2	10%
	Less than 50%	1	5%

According to Table 4, only twenty-five percent (5 out of 20) of family members “never smoked.” Moreover, it is evident that a high percentage of participants (75%) came from a family that smoked cigarettes. “*When you smoke, you choose smoker friends because you don’t want to be judged. You are comfortable and have things in common,*” some of the participants mentioned. Eighty -five percent of women expressed that more than seventy percent of their friends in both genders were smokers, while only three participants mentioned their smoker friends were less than this number.

Table 5 reveals the variety of reasons and circumstances that can often tempt people to light a cigarette. Participants were allowed to mention as many as they found accurate. It is obvious that the reasons for smoking were mostly psychological.

Table 5 The situations that work as a trigger for study participants to smoke cigarette

Situations	Number	Percent
During social interaction	19	95%
When I have emotional problems	17	85%
When I am happy	13	65%
While working - doing homework	13	65%
After or before having a meal or tea	11	55%
When I am alone	10	50%
During specific times and places	9	45%
When I am tired	8	40%
When having an alcoholic drink	6	30%
After sex	4	20%
While thinking about a problem	4	20%
Hobbies (reading – watching movie or TV)	4	20%
While housekeeping	1	5%

Eighty percent of participants (16 out of 20) expressed that they were craving for a cigarette in all situations. Sample responses include:

Representative Answer 1: *“There are three things that I carry in every situation, cigarettes, my glasses, and my mobile. Cigarette smoking is a part of my character; I smoke always. It is a matter of addiction,”*

Representative Answer 2: *“Cigarette smoking is my habit now. If our interview continues, I will smoke again, and it is not important that I smoked one cigarette 10 minutes ago,”*

Representative Answer 3: *“The cigarette is my best friend, and I like to keep my best friend close. You know the times when you have some words in your chest that you cannot even tell your friends. When I smoke, I feel that those words blow away with the smoke.”*

They brought examples of situations. Social interaction like a gathering with friends or a party were the situations that created the most cravings for a smoker. Ninety -five percent of participants (19 out of 20) claimed that being with a friend is the most powerful trigger, their consumption also increases.

The second reason which tempted eighty –five percent of women (17 out of 20) to smoke was an emotional problem such as “*sadness,*” “*anger,*” “*anxiety,*” “*stress,*” “*boredom,*” “*depression,*” or “*mental pressure.*” They used smoking in order to get calm.

Sixty –five percent of participants (13 out of 20) smoked when they were happy. Also, the same percentage smoked in their workplace or while doing projects. Cigarette smoking was kind of “*break time*” and “*refreshment for their minds.*”

Smoking is a habitual behavior for participants who had some routines in their daily lived. For example, fifty –five percent (11 out of 20) of women said they usually smoked before or

after their meal, or when drinking tea. Also, thirty percent (6 out of 20) expressed they smoke while having an alcoholic drink.

There were also other craving situations such as preferring to smoke when alone (50%), at special times like “*morning*,” “*night*,” “*rainy weather*” or in special places like a “*café*” (45%). Certain situations created craving like when they were tired (40%), after sex with their partner (20%), while they thought about a problem or solution (20%), in their spare time while watching movies, reading a book (20%), or while cleaning (5%).

Table 6 has its focus on the role of cigarette smoking in the life of Iranian women.

Table 6 The social role of cigarette in Iranian culture based on study participants' point of view

Social role	Number	Percent
Smoking is a taboo	20	100%
Women are not as free as men in smoking	11	55%
Smoking's influence over friendships and increasing judgmental behaviors	16	80%
Sign of independence and freedom by breaking norms	12	60%
The sense of pose, prestige, and being attractive	8	40%
A way to manage emotional problems	2	10%

All the participants believed that smoking is a taboo in Iranian culture. They had thoughts such as:

Representative Answer 1: “*Before my addiction to smoking, I loved to use a Hookah. Every night I had to go out to smoke hookah, and my family had not any problem with it. Due to conventional wisdom, smoking cigarettes is considered a mannish activity. People do not ask their boys not to smoke, but they always warn the girls for health consequences,*”

Representative Answer 2: *“Due to conventional wisdom, it is not accepted for a good girl to smoke in the street. It takes some time to help people change their minds, and it is so hard,”*

Representative Answer 3: *“Society does not believe in smoking especially for women in public. This is why woman avoid smoking in public eyes, so they prefer being in more private spaces such as cafes or friends gathering, in other words somewhere that they would not be judged,”*

Representative Answer 4: *“I do believe that women have some limitations in my society and smoking is one of them. Cigarette-smoking is not an appealing or acceptable issue for women in Iran. Conventional wisdom dictates that there is a great difference between males and females who smoke.”*

Eighty percent of participants (16 out of 20) thought cigarette smoking affected their relationship and judgment of others. They expressed their thought with phrases such as:

Representative Answer 1: *“I do not dare smoke in public because people will stare at me,”*

Representative Answer 2: *“Being a smoker women is kind of a bad name,” and “like a prostitute. It is widely believed that there is a probability for a smoker woman to accept any one's proposal and sleep with strangers,”*

Representative Answer 3: *“I have many close friends at work who do not know that I smoke and I do not want to inform them because it affects my image.”*

Fifty –five percent (11 out of 20) thought men are free to smoke a cigarette in public places like streets and parks with no social restriction. And sixty percent (11 out of 20) described cigarette smoking as a sign of freedom and independence for a women who breaks the norms of Iranian society by being a smoker, although eight women (40%) also said that cigarette

smoking for younger smokers is kind of a pose, done for prestige, or to be more attractive.

Here are some of their points:

Representative Answer 1: *“It had high prestige when I held the cigarette between my fingers and the smoke rose to the sky,”*

Representative Answer 2: *“For some women cigarette is some sort of prestige and pose. In the beginning, smokers think they are different, but it will change over time when smoking becomes a part of their lives.”*

Approximately fifty-eight percent (7 out of 12 women) thought that the consequences of tobacco are equal in both genders, although, nearly forty-two percent (5 out of 12) expressed that women are more in danger because of fertility, pregnancy, and weak immune systems.

🌈 The perception of study participants regarding the consequences of cigarette smoking

Participants were asked about the positive consequences of cigarette smoking. Table 7 illustrates the results.

Table 7 Positive consequences of cigarette smoking in study participants lives

Advantages	Number	Percentage
Manage emotional problems	13	65%
Bring pleasure	9	45%
Refresh myself	5	25%
Feels Like a companion	4	20%
Improve personal feelings	5	25%
Helps not stereotype people	1	5%

The highest percentage of positive consequences (65% or 13 out of 20) was that cigarette smoking helped the consumers manage their emotional problems. They expressed that cigarette consumption in times of *anger, stress, sadness, anxiety, loneliness* or *boredom* helped them to “*open up their mind,*” “*be calm,*” “*manage their behavior,*” “*overcome their anger,*” “*concentrate,*” “*become cool and relax,*” “*wash away their anxiety,*” and “*keep them busy*”. Moreover, twenty -five percent (5 out of 20) of interviewees expressed that cigarette smoking refreshed their minds during break times. Also, twenty-five percent (5 out of 20) said that cigarettes give them feelings such as “*self-confidence,*” “*pride,*” and “*power,*” “*a sense of freedom and independence,*” and “*being attractive.*”

Forty –five percent of participants (9 out of 20) thought cigarettes brought them pleasure. They liked tobacco; they described smoking as “*an act of joy and mental satisfaction,*” “*like a celebration,*” “*a lovely habit,*” and “*a positive feeling.*” Twenty percent (4 out of 20) described cigarette smoking as a good companion, friend, and part of their character. A participant described that being a smoker helped her avoid judging other smokers: “*being a smoker helped me not call people names, I used to judge people for being smokers.*”

Table 8 Negative consequences of cigarette smoking in study participants lives

Disadvantages	Number	Percent
Cause of health problems	15	75%
Influences social interaction	4	20%
Turns into a habit	5	25%
Causes stress	1	5%
Bad body smell	1	5%
Change in voice	1	5%

Seventy –five percent of participants (15 out of 20) suffered from health-related problems due to smoking as it is shown in Table 6 and 7. Twenty percent of participants expressed that

cigarettes affect their friendships and social interactions. They said cigarette “constraints their relations,” “changes the attitudes of a family member because of bad smells,” “causes disrespect from others,” and “brings offers of experimenting with other drugs.” A quarter of participants (25%) did not like the cigarette addiction. They said:

Representative Answer 1: *“The worst result of smoking is that it turns into a habit; sometimes I cannot find any reason for it.”*

Representative Answer 2: *“I get terrible headaches when I do not smoke before it was the reverse.”*

Representative Answer 3: *“The negative part is when you get sick of smoking. I don’t eat when I feel sick. Instead, I drink tea, and I only drink tea while I smoke. Imagine smoking with an empty belly. I would tell myself on those days that I will quit. However, when tomorrow comes, I say it is impossible.”*

Causing stress (5%), bad body smell (5%), and change in voice (5%) were three other disadvantages of smoking for participants.

Table 9 Smoking-related diseases in study participants

Health problems in the study population	Number	Percent
Tooth decay	7	35%
Physical weakness	6	30%
Symptoms of emphysema : a dry cough, short of breath	6	30%
Skin damage	4	20%
Esophageal and stomach diseases	2	10%
Hair and nail damage	1	5%
Lung problems	1	5%
Losing muscle	1	5%
Heart issues	1	5%

Sore throat	1	5%
Irregular periods	1	5%

According to Table 7, the largest proportion of the problems (35% or 7 out of 20) belonged to tooth decay. After that, thirty percent (or 6 out of 20) said they feel physical weakness such as “tiredness,” “being sleepy,” “dizzy,” or “too skinny,” others experienced a dry cough or shortening of their breath especially while jogging and exercising. Twenty percent of participants (or 4 out of 20) worried that cigarettes ruined their skin as it used to be fresher and brighter. Two women (10% or 2 out of 20) suffered from stomach aches and peptic ulcer. One expressed that: *“My body suffers from peptic ulcers more and more because of smoking cigarette. For a year and a half, lighting a cigarette was the very first thing I used to do when I woke up. The reason was that I was supposed to go to work early in the mornings and there was no time to have breakfast.”*

Five different participants’ experienced seven problems such as “hair and nail damage,” “muscle loss,” “sore throat,” “irregular period,” “lung problems,” and “heart issues.”

Only five women (25%) could list five or more smoking complications. Seventy – five percent (15 out of 20) named less than five diseases when asked. According to Table 8, participants mentioned sixteen various diseases as a result of cigarette smoking. The majority rate (80% or 16 out of 20) of participants named lung-related diseases. After that forty-five percent of participants (9 out of 20) listed tooth and gum decay. The third issues cardiovascular diseases such as heart attack was mentioned by thirty-five percent of women. Thirty percent and twenty –five percent of participant listed in order: cancer, esophageal and stomach diseases.

Table 10 List of smoking-related diseases based on study participant’s knowledge

List of cigarette smoking hazards	Number	Percent
Lung related diseases	16	80%
Tooth decay, gum decay	9	45%
Cardiovascular disease	7	35%
Cancers	6	30%
Esophageal and stomach diseases	5	25%
Symptoms of emphysema : a dry cough, shortness of breath	4	20%
Skin damage	4	20%
Bone diseases	3	15%
Blood disorder	2	10%
Physical weakness	2	10%
Vitamin C decline	1	5%
Hair and nail damage	1	5%
Hyperlipidemia	1	5%
Alzheimer's disease	1	5%
Liver problems	1	5%
Diabetes	1	5%

The consequences of cigarette smoking are not only related to direct results. One of the side problems is a temptation to experiment with other drugs. On the one hand, fifty – five percent of participants believed that cigarette consumption could not necessarily lead to addiction to other drugs. They claimed that drug usage is a personal choice which they decided not to pursue despite the accessibility because of its adverse consequences like “*overdosing,*” “*delusion,*” “*hallucinated,*” or “*shutting down the brain.*” On the other hand, forty –five percent of the participants assumed that cigarette smoking could be a starting point and a facilitator of addiction to other drugs.

Table 11 If cigarette smoking may cause drug addiction based on the view of study participants

Can cigarette cause addiction to other drugs?		Number	Percent
Yes	Cigarette smoking is a facilitator	6	30%
	Cigarette smoking is the starting point	3	15%
No	Using drugs depends on the person's decision.	8	40%
	Cigarette smoking is not a reason to try another sort of drug.	3	15%

Based on Table 12, only thirty –five percent of participants (7 out of 20) had no experience with drug consumption while the rest tried at least one. They tried different kinds of drugs: marijuana (65%), Hashish (15%), psychedelic drugs such as LSD and mushroom (10%), and Tramadol (5%).

Table 12 Drug experiences of study participants

Drugs experiences	Number	Percent
Nothing	7	35%
Marijuana - cannabis - weed – grass	13	65%
Hashish	3	15%
Psychedelic drugs such as LSD and mushroom	2	10%
Tramadol	1	5%

✚ The perception of study participants regarding the relationship between the extent of cigarette smoking and disease occurrence

The participants were questioned about the time it takes for the health consequences of smoking to appear in the body. Table 13 shows the classification of answers.

Table 13 Statements about the relationship between the extent of cigarette smoking and disease occurrence

Statement	Number	Percent
Linear association	8	40%

Chronic diseases will happen after a long period of time with massive consumption of cigarette	7	35%
Chronic diseases will happen after a long period of time by daily consumption of cigarettes equal to five or less	3	15%
There is no association; it depends only on a person's lifestyle	3	15%

On the one hand, forty percent of participants (8 out of 20) expressed that there is a linear association between the extent of smoking and its consequences, It means the more consumption of cigarettes the more damage it will have. The study population in this group thought that *“every single cigarette can be harmful to the body,”* and *“some problems happen in early years of smoking like shortness of breath, rotting of teeth and changing of voice.”*

On the other hand, fifty percent (10 out of 20) thought that chronic diseases happen after a long-term of consumption, close to forty or fifty years. From this number, seven women (35%) thought massive cigarette consumption more than half of a packet per day has an impotent role in this situation, because of the experience they have had with people in their lives that never had any health issues in regards to smoking. Moreover, these women never agreed with being in a health danger if you smoke less than that threshold. Only three women (15%) believed the scant amount of smoking -one to five cigarettes per day- can cause a problem in the long term.

Three women (15%) noted that occurrence of disease is related to a consumer's lifestyle rather than the number of cigarettes per day. One of them expressed, *“disease occurrence totally depends on personal life. I saw women who smoked for 40 years and were completely healthy, but I know someone else who smoked just for two weeks and her lung was ruined.”*

✚ The perception of study participants regarding catching the smoking-related diseases in their old age

Table 14 Perception of participants about getting diseases in old age

Getting disease in old ages		Due to	Number	Percent
Being concerned	5 out of 20 or 25%	Smoking consequences	2	10%
		Smoking becoming a health issue	3	15%
Not being concerned	15 out of 20 or 75%	Excision of other life-threatening factors	6	30%
		Fate	5	25%
		Having good healthcare and smoking less	9	45%
		Preferring smoking's pleasure	7	35%
		Accepting the suffer	3	15%

Participants were being asked whether they are worried about their health in the long run as a result of smoking. Only twenty-five percent (5 out of 20) answered they are worried. For instance one of the participants which was a professional dancer confessed that she was going out of breath because of smoking in between her classes; another participant talked about how she wants to become healthy again in order to live a longer life.

It was noticeable that seventy –five percent of participants (15 out of 20) had no concerns about catching diseases in their late years. Their explanations are classified into five categories.

Excision of other life-threatening factors: six women (average smoking status: 7 cigarettes per day, 7 years) thought there exists lots of other probable illnesses risk factors in their environment and cigarette smoking is the easiest one, such as “*pollution*,” “*unhealthy foods*,” and “*stress*.”

Fate: five women (average smoking status: 10 cigarettes per day, 10 years) expressed that they are not concerned because of existing chances and believe in fate, *“lots of people smoke their entire life and still make it to 95, and some people never smoke and get a lung cancer, it’s like rolling a dice.”*

Having a good healthcare and smoking less: nine women (average smoking status: 7 cigarettes per day, 7 years) answered that they try to minimize the probability of catching smoking-related diseases in their old ages by reducing consumption, and self-care with alternative options like *“exercising,” “proper diet,”* and *“regular checkups.”*

Preferring smoking’s pleasure: seven women (average smoking status: 9 cigarettes per day, 10 years) expressed that *“joy,” “pleasant feelings,”* and *“moments of life”* are more important than thinking about future and problems that may be caused by cigarette smoking. They found cigarettes *“not such a serious drug.”*

Accepting the suffering: three women (average smoking status: 11 cigarettes per day, 8 years) acknowledged that although they know about the detrimental effects of smoking in their bodies and the possibility of catching diseases, they accept the costs.

Table 15 identifies the result of a question about the study population’s self-image in old age and if they will suffer from any diseases related to cigarette smoking.

Table 15 Participants' self-image in old age

Self-Image in elder age	Number	Percent
A former smoker	2	10%
A smoker who suffers from smoking-related diseases	3	15%
A smoker who does not suffer from any smoking-related diseases	8	40%
A smoker who may have some smoking-related diseases, but it is OK!	7	35%

Ten percent of participants (2 out of 20) described themselves as a former smoker, meaning they want to quite with the aim of being a healthier person before getting old.

On the contrast, ninety percent of participants (18 out of 20) pictured themselves as an old smoker woman with different perceptions of it. The majority (8 out of 20) described themselves as not suffering from any smoking-related disease. Some also imaged themselves being in a state of complete health such as: “cool, attractive grandma who smokes and drinks,” and “a woman who does yoga, walks a lot, and still smokes.”

Seven women (7 out of 20 or 35%) thought about the probability of getting into a health issue but they were not sure if it would be caused by smoking or not, and they rather live their lives as is and accept the consequences. “I know as I get old I will be one of those ladies who walk slowly and breaths heavily. I’m not a physically strong person now, and it might not be due to smoking although it does affect it”, “My skin is not as bright as I wanted it to be. I will probably be getting breathing problems soon too, but I’m sure if I smoke a normal amount, it won’t get that bad.”

Three women (3 out of 20 or 15%) were certain that they would have smoking-related diseases because they experienced health problems in their twenties.

✚ The perception of study participants regarding smoking cessation for their health

The study participants were asked about four main things that may result from quitting cigarettes. The results are shown in Table 16.

Table 16 Reasons for quitting cigarette based on study participants' thoughts

Reasons	Answer	Number	Percent
Relationships	Yes	5	25%
	No	14	70%
Pregnancy and kids	Yes	17	85%

Financial issues	Yes	1	5%
	No	18	90%
Health motivation and knowledge about hazards	Yes	4	20%
	No	16	80%

Only twenty –five percent (5 out of 20) of participants mentioned that their family or their partner could be a motivation to quit smoking. But, seventy percent (14 out of 20) said their family is not an enough of a reason for them to quit.

It was noteworthy that eighty –five percent of the women studied expressed that if someday they became pregnant, they would quit cigarette because “*they do not want to harm the baby,*” “*the baby will be in danger,*” “*they do not want to be a bad role model,*” “*they are responsible for another person’s life.*”

Moreover, the financial issue was only a concern for one participant (5% or 1 out of 20). She said that “*it’s expensive because I need to go to café for cigarette smoking every day because I do not like to smoke in public and my home. Therefore smoking is not just buying a pack of cigarettes; it costs a lot.*” But, the rest of the participants (90% or 18 out of 20) conveyed that “*financial issues are not a problem,*” They also brought reasons that “*cigarettes are cheap enough in Iran,*” or “*you can buy a couple of cigarettes instead of a whole pack.*”

The participants were asked if health motivation and knowledge about hazards statistics and mortality rates would be a motive to quit. Only four people (20%) answered that this information could help them quit because of their experiences. One of them said: “*Yes! It can help if you have had the experience. My father died because of a heart attack which was related to cigarette consumption.*” But most of the participants (80% or 16 out of 20) were

not satisfied with quitting just to have a healthier lifestyle. The replies are classified in three diverse groups:

Minimizing consumption and having good healthcare (5 participants):

Representative Answer 1: *“I will try to reduce the damage, but I will not quit.”*

(Consumption: 3 cigarettes per day, a smoker for 8 years)

Representative Answer 2: *“I prefer to have an annual medical checkup to prevent any possible disease. I won’t quit until I see the symptoms of an illness.”* (Consumption: 5 cigarettes per day, a smoker for 8 years)

Health is not a priority (10 participants):

Representative Answer 1: *“I think about my future, but the financial and spiritual aspects are more important than my body. I know that I will be in complete health if I have inner peace.”*

(Consumption: 7 cigarettes per day, a smoker for 9 years)

Representative Answer 2: *“I know all of this. I may have cancer, a heart attack, or asthma. I even find asthma worse than cancer because you have to live with it for years, but health is not one of my priorities. Even reading books is more important than my health.”*

(Consumption: 3 cigarettes per day, a smoker for 9 years)

Representative Answer 3: *“In my opinion, I am in complete health now so quitting is not necessary. The one and only time I decided to quit did not last more than a week. The reason I quit was the anxiety I had been feeling about my teeth turning yellow. I confess my health is not one of my concerns.”* (Consumption: 8 cigarettes per day, a smoker for 8 years)

There is no logic and guarantee (fate and other health hazards) (10 participants):

Representative Answer 1: *“The statistics have not been helpful up to now. An addicted person does not quit until something real threatens his or her health, because it may happen or not happen.”* (Consumption: 23 cigarettes per day, a smoker for 19 years)

Representative Answer 2: *“Knowing about negative aspects of smoking will not make me quit. I know an old lady who is seventy-one years old, and she has been smoking for twelve years. She is in healthier than anyone else.”* (Consumption: 7 cigarettes per day, a smoker for 9 years)

Representative Answer 3: *“Statistics are not enough a reason because I live in Tehran and pollution may cause cancer without smoking cigarettes. If I put smoking aside, there are still enough destructive things which lead to cancer.”* (Consumption: 19 cigarettes per day, a smoker for 6 years)

When the study population was asked if they are capable of quitting cigarettes whenever they want, seventy percent (14 out of 20) answered YES to this question. And the rest (30% or 6 out of 20) declared that they have not enough will to quit cigarettes whenever they want.

Focus group result

One focus group held consisted of six participants, one interviewer and one observer. All the participants were 20 – 30 years old women who smoked. Two of them were new, and four were volunteers from twenty women who participated in per to per interviews.

Role of cigarette smoking in the participant's lives

The average age of the first try of cigarette smoking was eighteen. The reasons of study participants for starting to smoke the first cigarette were a social network including friends and family members (5 out of 6), emotional problems (1 out of 6) and curiosity (2 out of 6).

From the total participants, four women had at least one smoker in their family.

Representative Answer 1: *"I didn't become a smoker until I was twenty and got married. My husband was a smoker, and we smoked with each other for a few times. He taught me how to smoke though he was against women smoking."*

Representative Answer 2: *"I tried smoking for the first time when I was twenty with two friends of mine who were older than me. It was their first experience as well as me. They bought the cigarette, Esse blue; we smoked together."*

According to the interviewee's thought, the smoker is someone who is addicted to smoke cigarettes every day.

Representative Answer 1: *"I think if someone feels inconvenience after not smoking for two or three days she is a smoker but not someone who smoke occasionally."*

Representative Answer 2: *"In my opinion, you are a smoker if you buy cigarette because it is possible to smoke whenever you want. If you don't buy cigarettes and you just smoke around others, you are not a smoker."*

On the one hand, based on the women's points of view, cigarette smoking is a taboo in Iranian culture especially for women and smoking cigarettes is a sign of independence and breaking social norms. They had thoughts such as:

Representative Answer: *"Smoking is literally a taboo in our culture, and a woman smoking is more disapproved. It's pretty much more accepted for men to smoke. In my opinion, girls who start smoking are more rebellious."*

On the other hand, cigarette brings common sense between smokers which result in trust, friendship and positive feeling, mentioned by half of the participants. They said that:

Representative Answer 1: *“It seems smoking make a colony which we can accept each other within it.”*

Representative Answer 2: *“When you see someone smoking, you can easily start a conversation and even trust him/her. Some ask whether you have a lighter or not; then you start smoking together and talk for a while. It feels terrific. You don’t know that person, but there is a mutual feeling.”*

They were asked about the situations that work as a trigger for the women to smoke a cigarette. One woman expressed that smoking cigarette was a routine in her life, she smoked every thirty minutes without any reasons. While the rests said, their consumption highly related to the situations they are in such as hanging with friends, being in café, rainy weather while watching movies, drinking, having sex, and time of anger.

Representative Answer: *“Smoking itself is not an issue but rather the space in which affects my smoking. For example, when my husband and I are watching a movie, I can’t resist smoking while he is smoking. If he drinks a cup of tea, I will do so. It’s more about space and people rather who I am.”*

Catching the smoking-related diseases in their old age

All the participants in the focus group agreed that knowledge about health hazards of smoking and statistics had no influence on their smoking status. One of them said *“he could not trust the statistics and advertisement against cigarette. There is an obvious connection between health and smoking but not in the way they promote”*. They were no worry about their future and catching smoking-related diseases.

All women expressed that although cigarette is harmful to the health, its effect related to not only consumption but health status of smoker, diet, exercise, and other environment threatens

such as pollution. They said that you could smoke and minimize the chance of catching diseases by having a healthy lifestyle: exercising, being physical fitness and healthy diet. Samples of smokers without any health problems and enjoying the current life were another reasons of lack of worries.

Representative Answer 1: *“Among my friends, those who smoke take excellent care of themselves. They drink milk, go to the gym, eat healthy food, and even some of them has become vegan. We have so many unhealthy habit and smoking is the chosen one at least.”*

Representative Answer 2: *“My husband used to tell me that he knows a 90-year-old man that smoke 2 packs every day; On the other hand, many people die at a very young age. My husband’s cousin died due to lung cancer. She was living in the north in an organic environment, so you can’t say it was for pollution in Tehran. In my opinion, there are other factors that affect our lives.”*

Representative Answer 3: *“I can’t understand what I can’t see. Smoking is such thing for me, as far as I don’t get cancer right away I don’t think about it. When I am working with a knife, I consider a possibility that I may cut my hand but when I smoke nothing pop up in my head this way.”*

They also said some jocks related to smoking:

Representative Answer 1: *“One goes to the doctor and asks how to live up to 80. The doctor asks whether he smokes, drinks, uses drugs or eats unhealthy food and he responds none. The doctor says:” so why you want to live 80 years?”*

Representative Answer 2: *“Someone asks a friend how many he smokes, and he says 2 packs. He does the math and says you can buy a Ferrari if you quit smoking for 10 years and save*

the money instead. His friend replied you don't smoke for 10 years and I don't see you have a Ferrari!"

Representative Answer 3: *"There is printing on "Kent" boxes as did you know 90% of smokers die out of lung cancer, and my husband wrote on that box that did you know 100% of those who do not smoke would eventually die."*

The women were asked about motivation to smoking cessation. Three women said that there was no possibility to quit smoking because of its joy, hard addiction, and its effect on relaxing and coping with problems. Three women brought pregnancy a reason for stopping for a while not permanently; two women also said emotional relationship might result in their cessation.

Representative Answer 1: *"The most interesting thing about smoking is my picture when I am 55, reading and smoking in my house. I can imagine when my nieces and nephews come over, they see a cool aunt who has painted her nails pink. I don't want to have a baby, but if I got pregnant, I would not smoke during my pregnancy period. But when the infant becomes a kid and goes to school, then I might smoke."*

Representative Answer 2: *"I started smoking because of someone whom I loved; I stopped it for the same reason. But it is not the same now. I found that I didn't quit for emotional attachment but because I felt peaceful while I was dating. Now I smoke because I am nervous and have a lot in my mind. I can drop them by smoking and make myself free."*

Health was not a motivation for women to quit cigarettes smoking. Among participants, two women were smoking while they had a lung infection. They brought examples of their fathers who had health problems such as heart surgery and still smoked. This can show that there is no relationship between health and cigarette smoking in smoker's mind. A woman expressed

that “Among us (six women) that are speaking here, health is of least importance in the long-term. The disease is something you cannot understand unless you get one.” According to one other participant, knowing about hazards of cigarette smoking could not help a smoker to quit. She said: “If you are really a smoker then these ads mean nothing to you. You won’t even see the lungs paintings on the box of cigarettes. It might be helping new smokers at most, not us. I personally say if you want me to quit, at least you could print a picture with better quality.”

The relation between cigarette and experience of other drugs

In regards to asking about if cigarette could cause addiction to other drugs, four women answered it is a personal decision. They avoided other drugs because they could cause abnormality and addiction which is hard to quit. Two others agreed that cigarette smoking is a facilitator which increase the risk of trying other drugs.

Two women had never tried other drugs. However, four women tried Marijuana, and one tried Hashish too.

DISCUSSION

The study in hand was conducted by gathering data from 20 women aged 20-30 who lived in Tehran, Iran. The average age among these women was 26 years old, and most of those (75%) were never married. Higher education was a common attribute among the women indicating that the majority (90%) had an associate, bachelor, and master degrees. Fine arts was the most prevalence field of study among the participants. At the time of the study, the majority (85%) were employed, and the monthly income status of most of the participants from all resources was 15000000 IRR (450\$). Characteristics of study participants indicate that this is not a representative sample of women residing in Tehran.

The primary objective was to explore the perceptions regarding the association between smoking cigarette and the health effects of it later on in life.

In Iran, smoking is not an acceptable habit, especially for women. Women do not talk about their experiences freely due to the fear from society and family (Baheiraei, et al., 2015b).

Nearly sixty women were asked to participate in this study but only a quarter accepted the invitation. Smoking as a stigma in Iran confirms that smoking for women is equal to being rebellious against the social norm (100% of women mentioned). Also, there is a “being cool” factor that entices women to reject the social norms and try to be different. Oh, et al. mentioned this factor as one of the fundamental reasons for becoming a smoker at a younger age (Oh, et al., 2010). Being cool had a wide range of meanings in this study, like smoking as a sign of the pose, prestige, independence, and freedom.

The age of the first try of smoking cigarette among participants with the highest frequency (65%) was 18 – 21 years old. Typically age eighteen is when girls experience independence after high school graduation and develop new social interactions. Social interactions were found in this study as a significant factor in initiating and maintaining smoking. The findings

illustrate that the significant factors for initiation of smoking cigarette are social networks and role models (75%). It means that in most cases family members, friends, social interactions and role models like actors were a trigger to start the addiction.

Among the women participants in the study, 75% of them had at least one family member who was a smoker. It has been reported from a survey of five different European countries that friends have a strong influence on a woman's decision to start smoking especially in younger ages and having a smoker parent was significantly associated with ever smoking (Oh, et al., 2010). This correlation was identified in another study between adolescent in Thailand, they mentioned that adolescents with smoker parents or friends have potential to be influenced by smoking (Rudatsikira, et al., 2008). In Iran, there is an association between parents, siblings, and peers smoking hookah or other tobacco products, and the likelihood of young women starting tobacco (Baheiraei, et al., 2015a). In this study, the majority of participants (85%) expressed that more than seventy percent of their friends including both sexes are smokers.

Smoking as a taboo in Iran accompanies by restriction for being a smoker as a woman brings adverse judgment which results in the concealment of being smoker, especially from parents and families. In response to that cigarette plays a social role between smokers, it brings trust between the smoker societies and facilitates their interactions. This finding was represented in a study that smoking is not only a mean for managing stress and exclusions but also a social activity which gives participants a sense of identity and belonging (Mohammadnezhad, et al., 2015). So, this social nature of smoking causes youth to become smokers, and soon by repetition in friend's gatherings it changes to a habit, and then addiction to a cigarette.

From the finding of this study, it can be concluded that family and friends play a crucial role in cigarette smoking onset and continuation which can be mentioned as an obstacle towards

smoking cessation (Mohammadnezhad, et al., 2015). In this study, participants reveal the circumstances which tempt them to smoke a cigarette; social interactions was mentioned by nearly most of the participants (95%) as the most common smoking craving situation. They confirmed that being with smoker friends is not only the most potent trigger but also results in increasing the number of cigarette consumption in that period.

In this study, the majority of participants (85% indicated that they tempted to smoke while they felt sadness, anger, anxiety, stress, boredom, depression or mental pressure. It is noticeable that there is an association between depression or anxiety and smoking (Fluharty, et al., 2017). Smoking is a tool to alleviate -psychological symptoms which can lead to the onset of smoking, increasing smoking status, or high dependency (Fluharty, et al., 2017). Moreover, it has been shown that likelihood of being a smoker is more prevalent among individuals who found smoking as an enjoyable activity, who smoke to manage their stress and boredom, and who would like to be relaxed or get more comfortable (Aryal, et al., 2015). In regards to that, most respondents (65%) expressed smoking has helped them to cope with their problems.

Smoking is the most common cause of preventable deaths in the world (M. Moosazadeh, et al., 2014); and globally current smoking prevalence among adults was approximately twenty-one percent in 2015 (WHO, 2017).

Studies have shown smoking is a major contributory factor to a range of diseases including cancer, cardiovascular disease, chronic obstructive pulmonary disease, bone density loss and fractures among smoker women; and smoking pregnant women are at the risk of the premature rupture of membranes and pre-term delivery (WHO, 2010b). Moreover, smokers are at high risk of periodontal disease, gallbladder disease, peptic ulcer, some forms of cataract, and facial wrinkling that are not life-threatening but affects the quality of women's

lives (WHO, 2010b). In this study, lung-related diseases, tooth and gum decay, cardiovascular disease, cancers, and esophageal and stomach diseases were mentioned by most participants as known smoking complications.

Although smoking is known for the many health issues that it can cause, having this knowledge did not prevent women from this habit. According to the study participants (80%), cigarette plays a crucial role in their lives; they tend to smoke a cigarette in every situation, they named it as a best friend and companion, a habit, or a part of their character.

Additionally, the majority of the participants found smoking as an unhealthy habit that has more positive benefits than negative ones, mostly said that smoking helps them to manage their emotional problems or completing their joy and pleasure.

It is noteworthy that all of the participants agreed on smoking as a risk factor for their health and more than half of the participants experienced health-related problems from smoking, but a high majority of them (75%) did not worry about catching diseases in their old ages. It is essential to answer this question that why people choose to smoke cigarettes while they are aware of the risks and assuming it as unhealthy behavior. Ebrahimi et al. presented that the most frequently reported reasons for initiation and maintenance of cigarette smoking as a harmful behavior include lack of sufficient knowledge, fun, accessibility, opportunity to experiment, social influence, considering it as a low hazardous issue, family history of smoking, existence of stress in social and family environment, and having social benefits due to smoking (Ebrahimi, et al., 2014). Zareiyan et al. added that fact–reality paradox could be the critical factor in choosing lifestyle behavior especially when the border between the fact and reality is not clear (Zareiyan, 2017). Mohammadnezhad et al. revealed that individuals are more motivated in involving in smoking habit as long as they perceive more benefits rather than the risks of smoking (Mohammadnezhad, et al., 2015). Also, R. Aryal et al. found

that between Nepalese adolescents susceptibility to smoking has a direct correlation with gaining positive social benefits regarding smoking (Aryal, et al., 2013). On the other hand, individuals who experienced more risk are more interested in cessation (Mohammadnezhad, et al., 2015).

In this study, although a quarter of participants were worried about catching diseases because of their bad experiences, only two women anticipated they would give up smoking when they get older. On the one hand, it has been shown that smokers are quite aware of well-publicized risks and the probability of them for themselves. However, they do not want to believe so, and they construct persuasive arguments to show that the risks are not that considerable to harm them (Mohammadnezhad, et al., 2015). For instance, Ebrahimi concludes that smokers think that people exaggerate about smoking consequences (Ebrahimi, et al., 2014). On the other hand, youth feels invincible about their health due to a younger age; therefore, it can be difficult for them to prospect the reality that smoking causes health problems and decreases the life expectancy by the matter of time (Chapman, 1999). Shervington reported that smoker women believe mortality and morbidity resulting from tobacco use could not happen to them; they named smoking as a vital function in their life to control emotionally negative situations and a distant threat which do not considerably impact on decision making in the matter of health (Shervington, 1994).

Women in this study did not perceive themselves as having a high risk for future illness due to smoking. They had specific beliefs that lead to accepting smoking risks such as the existence of other life-threatening factors in their lives, being neutralized the complications of smoking through less consumption per day, rich nutrition, or proper health care, finding smoking a more beneficial action, and being unpredictable smoking outcomes. They argued that there are many non-smokers who died because of chronic diseases like cancers due to

other risk factors and on the other hand there are old individuals who smoke for a long time and live without any specific health problems.

A substantial percentage of participants (80%) did not find quitting smoking as a pursuable action regarding having better health in the future. In their point of view, health is unpredictable, and statistics about cigarette smoking consequences are not logical enough to them. They brought reasons that living in the moment is more important, there is no guarantee in catching diseases, and there is a possibility to control the adverse consequences of smoking with less consumption, proper diet, and exercise.

The majority of participants (70%) believe that cigarette smoking was a habit that they are capable of quitting whenever they want.

LIMITATION AND SUGGESTION FOR FUTURE RESEARCH

Although the findings of this study provide valuable information on young female adult's smoking perception, the study is not free from its limitations. First, the results cannot be generalized to all young adults of all parts of Tehran, Iran. Furthermore, the survey was carried out in the city of Tehran, and the results may not reflect the perception for all female smokers in the country. Therefore, it can be recommended that the sample size should include women and men from diverse socio-economic statuses of Iran's society. Second, the sample size of women smokers is not large enough to perform statistical analysis for analyzing if there is a difference in smoking status and perception in relation to socioeconomic status. It is recommended the sample size need to be calculated based on analytic needs of the future study. Third, due to the cultural sensitivity of research issues, some participants may reveal only desirable social experiences rather than their real life's experiences. Hence, it can be suggested more focus groups in the future study that could prevent this bias.

Last but not least, one suggestion for future preventing interventions regarding this target population is to include at least one young individual who has survived from a chronic disease such as cancer in order to give testimony that health issues coming with smoking are not only sensitive to age and could be happening to anyone.

CONCLUSION

In this study, the perception of smoker women, aged 20 to 30 years and living in Tehran, Iran regarding the effect of cigarette consumption on health outcomes later in life, and in old age was explored. The reason mentioned most often for smoking initiation and maintenance among interviewees was smoker family and peers.

Most of the participants found smoking cigarette a beneficial act with more positive than negative consequences. Cigarette played a social role in participant's lives which gave them a sense of identification and belonging. Most of the women in this study use smoking as a tool to alleviate psychological symptoms in their lives; they tempted to smoke while they felt sadness, anger, stress, boredom, depression or mental pressure. Also, Most found smoking cigarettes as an enjoyable habit which completes the joy and pleasure in their lives.

Smoking cigarette may harm the consumer's health was a defined fact to participants. But, this fact was not a persuadable factor to quit the addiction except for whom had experienced smoking-related diseases in their lives. There were four main reasons regarding having the assumption that they are immune from catching diseases in the future and could be not being worry about the smoking's hazards. First, they had this thought that the danger of other life-threatening factors in their lives are more than smoking. Second, they had a fatalistic view of smoking affecting smoker's health means that participants believed that health is unpredictable and there is no guarantee in catching diseases in the future which makes statistics about smoking issues to be unreasonable. Third, they assumed they could handle the adverse impacts of cigarette consumption with less consumption and healthy diet. Four, they mentioned it is worthy to accept smoking's hazards because benefits are more than the negative ones.

APPENDIX 1: DEMOGRAPHIC QUESTIONNAIRE

General Questions	What is your age?	-----
	What is your marital status?	☐ Married ☐ Never married ☐ Divorce ☐ Widowed ☐ Living with partner
Education Status Questions	What is the highest grade or level of school you completed or the highest degree you received?	☐ Less than 9th grade ☐ 9-11th grade (Includes 12th grade with no diploma) ☐ High School Graduate ☐ Associate degree ☐ Bachelor's degree ☐ Master's degree ☐ Professional degree ☐ Doctorate degree
	What is your college/university field?	☐ Agriculture & Life Sciences ☐ Architecture and Landscape Architecture ☐ Arts and Sciences ☐ Literature ☐ Education ☐ Management ☐ Engineering ☐ Fine Arts ☐ Humanities ☐ Medicine ☐ Nursing ☐ Pharmacy ☐ Public Health ☐ Science ☐ Social & Behavioral Sciences ☐ Others
Employment Status Question	Are you currently...?	☐ Employed for wages ☐ Self-employed ☐ Out of work for 1 year or more

		☐ Out of work for less than 1 year ☐ A Homemaker ☐ A Student ☐ Retired
Income level Question	Is your annual household income from all source ...?	☐ Less than 15,000,000 IRR ☐ 15,000,001 IRR to 30,000,000 IRR ☐ 30,000,001 IRR or more ☐ Would rather not say
Smoking Questions	Would you say that in general, your health is...?	☐ excellent ☐ very good ☐ good ☐ fair ☐ poor ☐ don't know/not sure
	What age were you when you started smoking for the first time?	☐ ---- Years.
	Have you smoked at least 100 cigarettes in your entire life?	☐ yes ☐ no
	Do you now smoke cigarettes every day, some days, or not at all?	☐ Every day ☐ Some days
	On the average, about how many cigarettes a day do you now smoke?	☐ __ __ __. number of cigarettes ☐ less than one cigarette a day
If smoke every day?	How soon after you wake up do you usually have your first cigarette...?	☐ within 5 minutes ☐ from 6 to 30 minutes ☐ from more than 30 minutes to 1 hour ☐ after more than 1 hour
	In your whole life, how many times have you stopped smoking for one day or longer because you were trying to quit smoking cigarettes for good?	☐ __ __. number of times ☐ none

APPENDIX 2: IN-DEPTH INTERVIEW QUESTIONS

1. When do you start cigarette smoking? Explain about reasoning.
2. How many members of your family are smokers? What percentages of your friends are smokers (men, women)?
3. What does cigarette mean to you? (The questions below will be asked if not covered in above question's response.)
 - a) What kind of situation tempts you to smoke? (E.g. happiness, workplaces, friends gathering, loneliness, way to work.)
 - b) Why do you smoke in explained situations?
4. From your point of view, what is the role of cigarette on women's social situation? Is there any difference between men and women who are smokers in terms of health and social value?
5. What is the consequences of cigarette smoking for you (adv. and dis-adv.)?
6. Could you list 5 smoking-related diseases?
7. If you know that smoking can cause heart disease, stroke, impotence, lung cancer, emphysema, stained teeth, premature aging in smokers, what is its influences on your smoking status?
8. If you know that smoking can cause lung cancer in non-smokers, what is its influence on your smoking status?
9. How long it is needed for the smoking consequences to appear or how many cigarettes can damage your health?
10. What is your picture of your health in old ages? Is there any relationship between your old age's health and a cigarette?
11. How much are you worry that cigarette smoking can attack your health in the future?
12. Do you use any alternatives to cover the damaging effects of smoking?

13. What will make you quit cigarette smoking

- a) What is your family's reaction to your smoking? Is there any individual whom you do not smoke in front of him or her? Why?
- b) Will financial motivation help you to quit smoking?
- c) If you know that quit smoking in the next 6 months can bring your health and other benefits in the future, will you quit cigarette?
- d) Knowing that lung cancer in women 35 to 49 years who smoke 1 to 4 cigarettes per day continuously is 5 times compared with women who do not smoke, can cause you to quit smoking?

14. Do you think you can quit cigarette smoking whenever you want?

15. Do you agree that smoking can cause addiction to other things?

16. Apart from cigarette smoking, what else have you tried?

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