SMOKING, WOMEN AND LOW INCOME PROJECT

A European Project from 15 September 2000 to 14 September 2001

Final Report

This is a project of the
EUROPEAN NETWORK FOR SMOKING PREVENTION
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1040 Bruxelles
Belgium

Supporting organisations: Ulster Cancer Foundation (U.K.) Institute of Equality (Greece)
Province de Namur, Service Promotion de la Sante (Belgium)
Eastern Regional Health Authority (Ireland)

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Executive Summary

Each partner project identified and established target groups to work with, during the past year. Each partner city considered that the programme within each of the groups that they worked with delivered the objectives of the European project and achieved the desired outcomes.

The approaches to different elements of the programme have varied from country to country. For example recruitment of trainers and participants has varied depending on the circumstances. Participants were recruited using a variety of methods. Each city chose the method that best worked for itself.

The implementation of elements of the programme also differed from city to city. A very successful initiative that other cities felt that they should absorb into their own programme was motivational interviewing. This particular technique was initially implemented in Northern Ireland where health workers and other professionals were contacted and trained in motivational interviewing. They worked with women on the ground.

The exchange and dissemination of information from city to city allowed each city to integrate other elements of other cities programmes into their own programmes. In this regard the business meetings were particularly important, but ongoing contact with each city was maintained throughout the duration of the project.

The innovative nature of the project was particularly attractive to other voluntary and statutory bodies within each country. Each partner has been able to use their involvement with the project to network and develop links with voluntary and statutory organisations and groups in their region. This has been a valuable project and has helped to not only raise awareness of the issues at hand, but also to create a space for the possible continuation and sustaining of the initiatives in the longer term, although the format might change.

Each city carried out an internal evaluation. This included contributions from both professionals and participants. Both groups within each city felt that the programme had proved itself to be effective, with the result that while this project is now finished, each of the cities has expressed interest in continuing and mainstreaming this work and has set in motion the mechanisms to realise this objective.

The four cities have tested successfully this programme with many different groups in many different cultural and social environments and we consider that this programme can be replicated in other cultural and social environments throughout Europe.
TABLE OF CONTENTS

Executive Summary

Overall Project report

Partner reports

   Belgium
   Greece
   Ireland
   Northern Ireland

Appendix

This report has been compiled by Angela King. For further information, please contact Dublin Healthy Cities at 8722278
Overall Project Report

The Framework Project (FWP) 1999, Smoking, Women and Low Income Pilot project examined smoking in relation to smokers who are women in areas where low income was an issue. We consulted women and drew up appropriate initiatives including peer led programmes, to bring tobacco onto the health agenda of women, raise awareness and develop practical strategies for supporting women who are trying to change their smoking behaviour. In Framework Project 2000, we developed the work of Framework Project 1999 and tested the initiatives with a wider group.

The aims of Smoking, Women and Low Income project in the Framework Project (FWP) 2000, were:

- To demonstrate the universal application of the initiatives developed under the pilot project, Smoking Women and Low Income. The programme will be tested with women in five countries and will involve all major target groups.
- To train sufficient women as trainers to allow the initiatives to continue after the project ends
- To evaluate, report and disseminate the findings to hundreds of organisations and cities throughout Europe
- To test the effectiveness of the initiatives in the area of smoking reduction in the short and long term
- To collate the resources and programme initiatives and distribute to organisations and cities throughout Europe

Description of Tasks and work – including methodology and evaluation

Our tasks and work in order to realise the aims of FWP 2000 included:

- Establishment of criteria for critical evaluation of the programme including the programme and process, relating to each target group. This was to be done through meetings and consultation with relevant parties.
- Identification of women in the target groups, through contact with local groups, health professionals and advertising. Participants from identified target groups were to be recruited to participate in project initiatives.
- Initiation of initiatives with target groups. The initiatives were to be run on a groupwork or on an individual basis, over a six-month period. The leaders would be women who have taken part in the first programme. Methods to be used would include group discussion, presentations, one to one work, computers and creative arts, in a non-judgemental and supportive environment. Initial and closing questionnaires would be completed in order to evaluate change.
- Holding an international conference in Namur, between the partners where we would report on experiences to date, examine the success and difficulties experienced and draw out possible ways forward. This would help to refine the programme where necessary.
This would be done through meeting of the workers and women involved in the programme development. This included workshops; presentations, discussions and social get togethers.

Also the co-ordinators would meet to ensure administrative, financial, technical and scientific structures and processes are established to ensure successful completion.

Training of women in each of the initiatives would be conducted so that there are a body of trained women in each country. This would be done through a specific training programme, which would be developed in conjunction with women who have taken part in both the first and second year training. It would draw on experiences and expertise and use a variety of methods.

As in FWP 1999, the following approaches and processes continued to provide the framework for our work throughout FWP 2000. Each partner used a variety of these.

The common threads of the project interventions included:

- Recruitment of women through networks involved with the project partners organisations and one to one contact with women
- Where necessary and appropriate, one to one contact with women was maintained either through individual time made through phone calls, brief meetings separate from groups activities or home visits.
- Time is vital to create the group through fostering good relations and building trust.
- Common groups included unemployed women, women over 45, immigrant women/ethnic minorities, pregnant women and young women.
- Some groups were mixed between smokers and a few non-smokers.

Common elements of the programmes run included:

- Health
- Tobacco
- Disease – accurate information – opening with tobacco generally and move to other issues and return to tobacco in a more personalised way – this contributed to building trust and ensuring that women did feel judged
- Cycle of Change
- Covering impact of tobacco on parents and children
- Empowerment
- Inclusion of smokers and non-smokers in groups
- Methods used included: Photolanguage
  Motivation – internal and external motivaters
  Blocks and successes
  NRT and support alternatives
  Stress management
  Food and nutrition
The common elements of the project intervention included:

- Making contact with women – Self-selection
- Voluntary participation
- Specific to women
- Non-judgemental approach
- Quitting is not an obligatory end result

- Group work and one to one work and support
- Reflective listening
- Motivational interviewing and brief interventions
- Support positive lifestyle practices
- Empowering
- Flexible but focussed approach
- Approach used encourages tolerance and support
- Training other women to work with initiatives

- Understanding context of smoking in women’s lives
- Understanding the nature of addiction in relation to nicotine
- Cycle of change/ behaviour change
- Positive benefits of quitting, highlighted
- Look at positives and drawbacks of smoking/ quitting
- Managing change
- Dealing with relapse
- Dealing with consequences of being a smoker
- Planning strategy for change
- Support develop positive lifestyle behaviours
- Information on alternatives – i.e. NRT, Zyban etc
- Nutrition/weight management
- Stress management – breathing exercises, exercise, relaxation
- Assertiveness
- Conflict resolution
- Ongoing method/process evaluation
- Collate resources

**Outcomes**

- Some women quit smoking during the duration of the programme
- Some women reduced the number of cigarettes smoked per day
o Increased awareness of passive smoking and its impact on children resulting in non-smoking around children and smoke free rooms and not smoking around babies.

- Introduction of smoking policies in organisations/group settings e.g. hotel maternal and Dublin group also.
- Changes in smoking areas in the domestic environment – requesting friends to confine smoking to particular rooms.
- Support group developed by women who had quit.
- Increased sense of confidence and wellbeing through support offered and reduction in guilt in relation to being a smoker.
- Acknowledgement of influence of parents in relation to their own children.
- Acknowledgement of reality of priority of smoking issues in terms of women and change – many expressed that it was low on their list of priorities as other needs and issues were more pressing.
- Training opportunities were provided and taken up by a variety of groups including General Practitioners (doctors) and professionals working with women on the ground.

**Learning from FWP 1999/2000 includes:**

- Programme was worthwhile overall.
- Programme needs to be adaptable and flexible to work with various cultures and groups.
- Option of one to one work (individual) and groupwork.
- Programmes should include motivation and decision making.
- Need for option of ongoing support.
- Recognition of women being active regarding their own health.
- Programme serves to open doors e.g. psychology, alternative medicine, homeopathy, general health.
- Programme provided resources and materials, approaches.
- Programme can be stand alone or integrated into other programmes and can also accommodate other aspects of health in it.
- There are different elements that need to be considered in terms of preparing the components to the programme – cultural context, policy, target group, programme available for professionals or voluntary leaders.
- Need for recognition of the limitations of a total of about 24 hours exposure to the programme through the sessions and successes achieved e.g. Quitting versus behaviour change.
- Finding/raining trainers and established structures to work in issues in organisations proved difficult in some partners.
- Context of smoking in a given country is central to potential integration and ease of development of similar programmes e.g. Sense of southern Europe including Greece being more tolerant of smoking that northern Europe.
- Smoking may not be a sustainable issue to continue indefinitely on its own and could benefit by its integration with other issues.
Value in using professionals opportunities for interventions with individuals through brief intervention training and use of same on the ground. However there can be some resistance from professionals too.

While one to one work is beneficial, need to review available resources to do this.

Time available to people working with women is limited, but has also other implications

Training – in relation to community work and health work, there is a split and difficulty of prioritising health and tobacco on either’s agenda.

Motivational interviewing is beneficial in working with women – as it is non-aggressive

Value of training trainers – specially professionals who are willing and able to take on the work and they also have exposure to women in the target group

Value of work needs to be shared with distribution of resources created by each country

Supportive environment for good engagement with women

Having a format and tapping into the whole person and wider tobacco issues with the programme is very beneficial.

Issue regarding doctors and teachers as trainers and their professional power. Dentists and pharmacists would be seen to have a different approach and agenda

Use of the cycle of change and its impact on moving people through a structured format has been beneficial

Process of relationship building needed for successful engagement of women in the process and development of progress

In community context, relationships take time to build.

The following report from each city shows in greater detail how each city introduced and implemented the project.
Country reports:
INSTITUT PROVINCIAL D'HYGIENE SOCIALE DE NAMUR - PROMOTION HEALTH CENTRE

Rusingizandekwe Bénédicte
INTRODUCTION

Overall approach to nicotine addiction and health among women from areas where low income is an issue.

The European programme began in January 1999 and the first stage consisted of building up our knowledge and skills in the following fields: social precariousness (low income), women’s health, risks or morbidity/mortality due to nicotine addiction among women.

Before presenting the different activities carried out up to now, we will look at the general approach that we used. The approach that we have developed is based on key concepts: health promotion, participative management, empowerment and appropriation and community. By these we mean:

- **Health promotion** – giving priority to a positive and empowering approach to health
- **Participative and appropriate management** – involvement of workers in the field, in the project development and active participation in some stages of the project.
- **Empowerment** – Individuals and/or community is given ability to exercise a power, to make choices, to make decisions etc.
- **Community approach** – Involving various professionals and non-professionals from a community in realising our objectives.

For the second phase of the project, we set up five groups of women to talk about tobacco. We created a programme of 8 sessions. This one is leaded with the local partners in each group. To build this program we selected educational tools (to talk about health and tobacco). There is also training sessions and supervision for the local partners.
**EPIDEMIOLOGIC CONTEXT**

This the epidemiological situation in Belgium, which comes from the Crioc (situation of tobacco in Belgium, CRIOC’s investigation - 1999)

**Graphic 1: Percentage of daily smokers in Belgium (18 years old and more)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982</td>
<td>53%</td>
<td>28%</td>
<td>40%</td>
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<tr>
<td>1983</td>
<td>47%</td>
<td>27%</td>
<td>37%</td>
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<tr>
<td>1984</td>
<td>47%</td>
<td>26%</td>
<td>36%</td>
</tr>
<tr>
<td>1985</td>
<td>45%</td>
<td>27%</td>
<td>35%</td>
</tr>
<tr>
<td>1986</td>
<td>46%</td>
<td>26%</td>
<td>35%</td>
</tr>
<tr>
<td>1987</td>
<td>42%</td>
<td>26%</td>
<td>32%</td>
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<tr>
<td>1988</td>
<td>42%</td>
<td>24%</td>
<td>32%</td>
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<td>1989</td>
<td>39%</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>1990</td>
<td>38%</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>1991</td>
<td>33%</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>1992</td>
<td>31%</td>
<td>21%</td>
<td>26%</td>
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<td>1993</td>
<td>31%</td>
<td>19%</td>
<td>25%</td>
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<td>1996</td>
<td>34%</td>
<td>27%</td>
<td>30%</td>
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<td>1997</td>
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<td>27%</td>
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<tr>
<td>1999</td>
<td>31%</td>
<td>26%</td>
<td>29%</td>
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</table>

Source: CRIOC – SOBEMAP
Graphic 2: Percentage of daily smokers, occasional smokers, and no smokers in relation with age and sex (N= 2374)

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-64</th>
<th>65 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAN</td>
<td>N = 1,153</td>
<td>N = 193</td>
<td>N = 216</td>
<td>N = 261</td>
<td>N = 341</td>
<td>N = 187</td>
</tr>
<tr>
<td>Daily</td>
<td>31%</td>
<td>29%</td>
<td>39%</td>
<td>36%</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>Occasional Smoker</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>No-smoker</td>
<td>65%</td>
<td>69%</td>
<td>57%</td>
<td>60%</td>
<td>63%</td>
<td>82%</td>
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</table>

WOMEN

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<tr>
<th></th>
<th>Total</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-64</th>
<th>65 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOMEN</td>
<td>N = 1,221</td>
<td>N = 182</td>
<td>N = 228</td>
<td>N = 226</td>
<td>N = 345</td>
<td>N = 240</td>
</tr>
<tr>
<td>Daily</td>
<td>25%</td>
<td>38%</td>
<td>29%</td>
<td>33%</td>
<td>23%</td>
<td>10%</td>
</tr>
<tr>
<td>Occasional Smoker</td>
<td>4%</td>
<td>6%</td>
<td>5%</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>No-smoker</td>
<td>71%</td>
<td>56%</td>
<td>66%</td>
<td>65%</td>
<td>73%</td>
<td>87%</td>
</tr>
</tbody>
</table>

Source: CRIOC – SOBEMAP
Graphic 3: Spending for advertising from 1993 to 1999 (millions €b))
Sources: Belgian association of advertising agencies

<table>
<thead>
<tr>
<th>Year</th>
<th>Spending (€b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>40 100</td>
</tr>
<tr>
<td>1994</td>
<td>42 140</td>
</tr>
<tr>
<td>1995</td>
<td>45 075</td>
</tr>
<tr>
<td>1996</td>
<td>47 249</td>
</tr>
<tr>
<td>1997</td>
<td>53 628</td>
</tr>
<tr>
<td>1998</td>
<td>61 718</td>
</tr>
<tr>
<td>1999</td>
<td>67 446</td>
</tr>
</tbody>
</table>

Graphic 4: Selling of tobacco in Belgium during 1986 till 1999
(milliards of cigarettes)

<table>
<thead>
<tr>
<th>Year</th>
<th>Selling (milliard)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>18,9</td>
</tr>
<tr>
<td>1987</td>
<td>17,9</td>
</tr>
<tr>
<td>1988</td>
<td>18,2</td>
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<tr>
<td>1989</td>
<td>17,6</td>
</tr>
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<td>1990</td>
<td>17,5</td>
</tr>
<tr>
<td>1991</td>
<td>17,9</td>
</tr>
<tr>
<td>1992</td>
<td>17,7</td>
</tr>
<tr>
<td>1993</td>
<td>16,7</td>
</tr>
<tr>
<td>1994</td>
<td>16,2</td>
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<td>1995</td>
<td>16,1</td>
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<td>16,0</td>
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<tr>
<td>1997</td>
<td>16,7</td>
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<tr>
<td>1998</td>
<td>17,3</td>
</tr>
<tr>
<td>1999</td>
<td>19,0</td>
</tr>
</tbody>
</table>
Graphic 5: Selling of loose tobacco (people make themselves the cigarettes with sheet of paper and loose tobacco) during 1990-1999

<table>
<thead>
<tr>
<th>Year</th>
<th>Selling (en tonnes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>4.904</td>
</tr>
<tr>
<td>1991</td>
<td>4.899</td>
</tr>
<tr>
<td>1992</td>
<td>5.181</td>
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<tr>
<td>1993</td>
<td>5.129</td>
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<tr>
<td>1994</td>
<td>5.616</td>
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<td>1995</td>
<td>7.294</td>
</tr>
<tr>
<td>1996</td>
<td>8.300</td>
</tr>
<tr>
<td>1997</td>
<td>9.569</td>
</tr>
<tr>
<td>1998</td>
<td>10.479</td>
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<tr>
<td>1999</td>
<td>11.949</td>
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</table>

Graphic 6: The cost of a packet of 25 cigarettes (till 1\textsuperscript{er} janvier 2000)

<table>
<thead>
<tr>
<th>Year</th>
<th>Prix (FB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>68</td>
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<tr>
<td>1987</td>
<td>73</td>
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<tr>
<td>1994</td>
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<td>1996</td>
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<td>1999</td>
<td>135</td>
</tr>
<tr>
<td>2000</td>
<td>138</td>
</tr>
</tbody>
</table>
**GEOGRAPHIC CONTEXT:**

In Namur, **people with low incomes are geographically identified** (the darkest part), this people receive a financial help of the city, the « Minimex ». The **offices of the local partners** who are working with us **are localised in same areas.**


NAMUR’S PROJECT
The project’s poster

We created a poster to promote the project. The conceptualize our ideas and the philosophy of our project we ask to a local drawer (Aurélien Tirtiaux) to realise the poster.

There’s no cigarette or smog on, because we want something positive and peaceful. All the partners signed this one with logos.

Aims of the Namur program

A. General objectives:

- encourage women from low income groups to reduce or stop smoking
- using local resources (social, medical, paramedical) to address the problem of smoking
- adopt a non judgmental approach
- develop participative strategies

B. Health objectives

- sensitise women with low income to global health issues in the perspective to reduce tobacco use
- sensitise people working in the social and paramedical sectors to the problems of nicotine addiction
C. Education objectives

- identify the needs and desires of women regarding health and tobacco
- facilitate the involvement of women in creating local actions
- identify the needs and desires of local social partners
- facilitate the involvement of social workers in creating local project

D. Operational objectives

- create a place where women can speak, meet and dialogue with professionals (in a non judgmental way) [health workshops]
- create a practical (stop smoking kit) with the women [workshops to prepare to quit smoking]
- set up training workshops for local professionals

Approaches and processes we use

The approaches and processes we use in our project include:

Group work
One to one support
Non-judgemental approach
Long term
Quitting is not obligatory end result
Support positive lifestyle practices
Empowering
Reflective listening (listening and feeding back to check)
Flexible but focused approach
Voluntary participation
Access
Visibility
Setting up a network of local partners
The content included:

Understanding context of smoking in women’s lives
Understanding addiction
Cycle of Change/behaviour change
Positive benefits of quitting
Dealing with relapse
Social competence training
Information on positive aspects of quitting
Support/develop positive lifestyle behaviours
Information on Nicotine Replacement Therapies
Nutrition/weight management
Stress management
Relaxation
Complementary practices i.e., massage and storytelling

Other areas include

Health workshops
Training of resource people
Building up skills in the target group

Methodological principles

Participation of the professionals concerned by the precariousness
Awareness about the self image of the target group about health and tobacco
Improved status of the target group
Development of local community services
Network and involvement of the local partners
Long term approach

Educational tools

We build a program session for the target group who include the using of some educational tools At first to talk about health (we choose an overall approach about nicotine and health), and after to talk about tobacco

Some people of the target group are unable to read or write, so the majority of the tools except the tests, doesn’t necessity those abilities (reading, writing).
To talk about health

-Photolanguage (we presented this one at the Valence’s conference-2000)
-Sac ado (we presented this one at the Namur’s conference-2001)

Sac ado is composed of 7 bags of different colours, each one has a name and a theme
Theme 1: To search identity
Theme 2: Overcome obstacles
Theme 3: To be in relationship
Theme 4: To have big dreams
Theme 5: To manage the time
Theme 6: To escape from routine
Theme 7: To build the own space

Sac ado suggest to the participant to search the solution and give arguments to defend their opinions. Sac ado facilitate communication and interactions in the group.
With sac ado we can work on the physical and the mental dimensions of health.
Like the Photolanguage, it doesn’t matter if people can’t read or write.

-Comprendre son corps

« Comprendre son corps » give the possibility to explain the respiration with posters. We adapt it to speak about the effects of nicotine

-Anatomically accurate modelkit

We include this modelkit in the session program for the target group. It’s very important to show the different part of the body (and to answer at the question « whatever’s got into him?)

To talk about tobacco

-Cycle of change (we discovered this tool at the Dublin’s conference)

The cycle of change is necessary to explain the different stage of someone who wants stop smoking.

-Test de Fageström
This one let to know the level of dependance of the smokers to nicotine. We use also other tests:

- **Test de Horn**
- **Test de Demaria/Grimaldi**
- **Test de Had**

- **Tournicotine**

This is a photolanguage to speak about tobacco (conceptors: Cdes - Pas de Calais, CPAM de Boulogne sur Mer)

- **Film: le pari (the bet)**

This is a movie who related the story of two men who want to stop smoking.

- **Poster « The harmful effects of tobacco**

This poster present the effects of tobacco on different part of the body. We discovered this one in Dublin.

(« Bruce Algra’s Fitnus chart series from BODYCARE PRODUCTS, England)

**THE LOCAL PARTNERS**:

**Recruitment of the local partners**

We looked for the associations who welcomed people in difficulties in Namur. There is 26 associations. Seven of them took inscription in the european project. At present five associations have signed a convention for the second phase of the EC program.
Network of the local partners

In 1999-2000
The Cpas and the Lst are no more in the project
In 2000-2001

<table>
<thead>
<tr>
<th>Groupe d’Animations de la Basse-Sambre (GAbs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Professional and social insertion for unemployed people)</td>
</tr>
<tr>
<td>Espace communautaire des Balances</td>
</tr>
<tr>
<td>Femmes Prévoyantes Socialistes</td>
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<tr>
<td>Service Promotion Santé</td>
</tr>
<tr>
<td>Asbl Forma Balances</td>
</tr>
<tr>
<td>Alpha 5000</td>
</tr>
<tr>
<td>Hôtel Maternel</td>
</tr>
<tr>
<td>Other association: Siep (Professional training)</td>
</tr>
</tbody>
</table>

**Training sessions for the local partners**

Before the implantation of the program for the target group, we met the local partners for training sessions.

*Workshops H.C.I. (Health, Communication, Interactions)*

- The content of the workshops about **health** is about:
  - Self image about health and tobacco
  - Information about mortality and morbidity of tobacco (in Europe, in Belgium)
  - Information about the effects of tobacco particularly for Women

- The content of the workshops about **communication** is about:
  - The way to talk about tobacco with people living precariousness
  - The way to manage and implicate people who can’t read and write
  - The selection of educational’s tools adapted to the target group

The content of the workshops about **interactions** is about:

- The identification of each association (public, needs, type of activities, resources)
- The exchange about experiences about health in each association
The possibility to help each other (creation of interactions) to build the program.

<table>
<thead>
<tr>
<th>Dates</th>
<th>Content</th>
<th>Places</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 January</td>
<td>Participation of the local partners to the international conference</td>
<td>Mess provincial</td>
</tr>
<tr>
<td>15 February</td>
<td>Presentation and explanation of the program of prevention about tobacco. Identification of the public in each association and the way to start the project</td>
<td>Campus provincial</td>
</tr>
<tr>
<td>23 February</td>
<td>Information about the roles of each others (co-ordinators, leaders, resource persons) Methodology and process of the action Training about the epidemiologic situation, the harmful effects of smoking, the dependencies (types of), the cycle of change</td>
<td>Espace Communautaire des Balances</td>
</tr>
<tr>
<td>28 February</td>
<td>Training about the key concepts: Health promotion, participation, network, empowerment, evaluation</td>
<td>Espace communautaire des Balances</td>
</tr>
</tbody>
</table>
Training about the educational’s tools and supervisions

Each local partner receive a training to use the educational’s tools. A follow-up of the actions is organised. In fact, we set up supervisions (one per month)

Planning of training, supervisions sessions

<table>
<thead>
<tr>
<th>Dates</th>
<th>Educational tools</th>
<th>Places</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/22 february</td>
<td>Comprendre son corps</td>
<td>Mess provincial</td>
</tr>
<tr>
<td>23/28 february</td>
<td>Photolanguage</td>
<td>Espace Communautaire des Balances</td>
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<tr>
<td></td>
<td>Sac ado</td>
<td></td>
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<tr>
<td></td>
<td>Tournicotine</td>
<td></td>
</tr>
<tr>
<td>15 march</td>
<td>Le pari</td>
<td>Institut Provincial d’Hygiène sociale (IPHS)</td>
</tr>
<tr>
<td>21 march</td>
<td>Supervision of the local partners</td>
<td>IPHS</td>
</tr>
<tr>
<td>18 avril</td>
<td>Idem supra</td>
<td>IPHS</td>
</tr>
<tr>
<td>26 april</td>
<td>Comprendre son corps (adaptation to talk about tobacco)</td>
<td>Idem supra</td>
</tr>
<tr>
<td>17 mai</td>
<td>Comprendre son corps</td>
<td>Mess provincial</td>
</tr>
<tr>
<td></td>
<td>Sudden infant death syndrome (effect of tobacco-pregnant women)</td>
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</tr>
<tr>
<td>18 mai</td>
<td>Supervision of the local partners</td>
<td>IPHS</td>
</tr>
<tr>
<td>8 juin</td>
<td>Idem supra</td>
<td></td>
</tr>
<tr>
<td>21 juin</td>
<td>Initiation about massage</td>
<td>IPHS</td>
</tr>
<tr>
<td>29 juin</td>
<td>Supervision of the local partners</td>
<td></td>
</tr>
</tbody>
</table>

Evaluation tools

After each session we make an evaluation

- **After the training session**, we evaluate de satisfactions/dissatisfactions and the expectations of the participants

- **For the supervisions**, we pay attention to the expectations and identify the resources (human, material ...) and also the constraints and the way to go through.

- We set up **individual meeting to identify the needs of the leader of the group**
Recruitment of the resources persons

The leader of each group need to have help of medical or paramedical professionals to manage some workshops (about tobacco, stress management, food, ..)

Network of resource persons

At present, we have a local network of professionals

<table>
<thead>
<tr>
<th>THEMES</th>
<th>RESOURCES PERSONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco</strong></td>
<td>Axel Roucloux (physiotherapist, bachelor’s degree in public health)</td>
</tr>
<tr>
<td></td>
<td>Jacques Dumont (nurse, bachelor’s degree in public health)</td>
</tr>
<tr>
<td><strong>Stress management</strong></td>
<td>Danielle Hacardiau (social worker)</td>
</tr>
<tr>
<td></td>
<td>Martine Hennuy (psychologist in a medical centre)</td>
</tr>
<tr>
<td></td>
<td>Annick Penson: massage (nurse, bachelor’s degree in public health)</td>
</tr>
<tr>
<td><strong>Food</strong></td>
<td>Delphine Riez (dietetician)</td>
</tr>
<tr>
<td></td>
<td>Beatrix Vansina (dietetician)</td>
</tr>
<tr>
<td></td>
<td>Sophie Boudart (dietetician)</td>
</tr>
<tr>
<td><strong>Drugs - dependencies</strong></td>
<td>Françoise Laboureur (doctor in a multidisciplinary health service)</td>
</tr>
<tr>
<td><strong>Sudden infant death Syndrom</strong></td>
<td>Jean-Luc Collignon (bachelor’s degree in public health)</td>
</tr>
<tr>
<td></td>
<td>Nathalie Martin (psychologist)</td>
</tr>
<tr>
<td></td>
<td>«Centre for patient’s education»</td>
</tr>
<tr>
<td><strong>Anatomic modelkit</strong></td>
<td>Véronique Meert (social worker in an association: «Culture and health»)</td>
</tr>
<tr>
<td><strong>Esthetic</strong></td>
<td>School ‘Henri Maus and Cenam’</td>
</tr>
</tbody>
</table>
THE TARGET GROUP:

Recruitment

The recruitment is not the same for each association. There is two kind of recruitment:

<table>
<thead>
<tr>
<th>Intern recruitment</th>
<th>Extern recruitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha 5000 (people come to have training - literacy)</td>
<td>Espace communautaire des Balances (it’s a meeting place, for the recruitment we send message on radio, we put some poster in different place, ...)</td>
</tr>
<tr>
<td>Asbl forma (people come for professional’s training) it’s the same for Gabs</td>
<td></td>
</tr>
<tr>
<td>Hôtel maternel (women are in this association for a long period (9 months))</td>
<td></td>
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</tbody>
</table>
Evaluation tools
We create documents to evaluate the satisfaction/dissatisfaction and expectation of the target group

THE WORKSHOPS ABOUT HEALTH AND TOBACCO
The commune program : training sessions

2 SESSIONS
1) Self image about health
2) Sensibilisation to an overall approach to nicotine and health
3) To collect the expectations about health's themes

1 SESSION
Exchange 'expériences about tobacco
Tips
Level of dependance to nicotine

1 SESSION
Motivations to stop smoking (identification)
Difficulties to stop (Pro and cons)

2 SESSIONS
Effects of nicotine on health
Substitutions tips

2 SESSIONS
To stop smoking : a planning ?
- Tobacco and stress
- Tobacco and weight (gain)

1 SESSION
Follow up of people who decide to stop smoking
(MAY, JUNE 2001)

1 SESSION
1) Photolanguage
2) Sac ado
3) Group's interview

1 SESSION
Tournicotine
Group interview
Test de Fageström

6 SESSIONS
Le pari (movie)
Cycle of change (Charon)
« Comprendre son corps »

1 SESSION
Le pari (film)
Workshop : management of the stress : relaxation
Workshop about food
The development of the program in each group

**SERVICE DE PROMOTION DE LA SANTE**
(Namur)

**NETWORK OF LOCAL PARTNERS**

**ALPHA 5000**
Directrice : Nathalie Donnet

**ASBL FORMA**
Directrice : Marie-Claude Nijskens

**HOTEL MATERNEL**
Directeur : Pierre Meunier

**ESPACE COMMUNAUTAIRE DES BALANCES**
Coordinateur : Guérino Saporosi

**GABS**
(Groupe d’animation de la Basse-Sambre)

**Coordination - animations**
Marie Delcominette (Educational)
Bénédicte Rusingi (Bachelor degree’s in public health)

**Coordination**
Sylvie Marin (social worker)
Animations
Delphine Riez (diététicien)

**(Coordination)**
Robert Baillon
Animations
Veronique, éducational

**(Coordination)**
Guérino Saporosi
Animations
Marie Dessaint, Evelyne, éducational

Coordination et animations
Marie-Claire Lambotte (éducatrional) et Anne – Sophie Piette (graduée en communication)
## Planning of the workshops

### JANUARY - FEBRUARY 2001

<table>
<thead>
<tr>
<th>DATE</th>
<th>SITES</th>
<th>HOURS</th>
<th>PLACES OF THE ACTIONS</th>
<th>RESSOURCE PERSONS</th>
<th>WORKSHOPS THEMES</th>
<th>EDUCATIONAL’S TOOLS</th>
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</thead>
<tbody>
<tr>
<td>16/01</td>
<td>Asbl Forma n=6</td>
<td>13h30-15h30</td>
<td>Asbl Forma</td>
<td>Delphine Riez</td>
<td>Self image about health</td>
<td>Photolanguage</td>
</tr>
<tr>
<td>30/01</td>
<td>Alpha 5000 n=6</td>
<td>14h16h</td>
<td>Alpha 5000</td>
<td>Marie Delcominette Rusingizandekwe</td>
<td>presentation of the results of (evaluation) of workshops -1999</td>
<td>Photolanguage</td>
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<tr>
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<td>Asbl Forma</td>
<td>13h30-15h30</td>
<td>Asbl Forma</td>
<td>Delphine Riez</td>
<td>Self image about health</td>
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<td>Presentation of the second phase (future workshops)</td>
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<td>Feedback of the precedent session + identification of needs of the group</td>
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<tr>
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<td>Alpha 5000 n=12</td>
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<td>Alpha 5000</td>
<td>Robert Goret (psychologist) Jacques Dumont</td>
<td>Depression</td>
<td>Tournicotine</td>
</tr>
<tr>
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<td>Asbl Forma</td>
<td>13h30-15h30</td>
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<td>14h-16h</td>
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<td>Marie Delcominette Bénédicte</td>
<td>Self image about health (feedback)</td>
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<td>Espace communautaire</td>
<td>Danielle Hacardiau</td>
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<td>Alpha 5000</td>
<td>Frédéric Brichau Jacques Dumont</td>
<td>Gynaecology Realife experiences about tobacco</td>
<td>Discussions-exchanges</td>
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<td>Stress management</td>
<td>Relaxation</td>
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<td>14h16h</td>
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<td>Bénédicte Rusingizandekwe</td>
<td>Preparation to stop smoking</td>
<td>Cycle of change</td>
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<td>DATES</td>
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<td>RESSOURCE PERSONS</td>
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<td>Speaker(s)</td>
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## APRIL 2001

<table>
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<th>SITES</th>
<th>HOURS</th>
<th>PLACES OF THE ACTIONS</th>
<th>RESSOURCE PERSONS</th>
<th>WORKSHOPS THEMES</th>
<th>EDUCATIONAL’S TOOLS</th>
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<tr>
<td>3</td>
<td>Asbl Forma</td>
<td>13h30-15h30</td>
<td>Asbl Forma</td>
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<td>Stress management</td>
<td>Relaxation Test</td>
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<td>13h30-16h30</td>
<td>Service Promotion santé</td>
<td>Axel Roucloux</td>
<td>Self esteem</td>
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<td>Stress management</td>
<td>Sophrology (relaxation)</td>
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<td>Interview to identify the needs</td>
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<tr>
<td>24</td>
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<td>Alpha 5000</td>
<td>Bénédicte Rusingizandekwe</td>
<td>Effects of tobacco Substitutions means</td>
<td>Cycle of change Anatomically accurate modelkit Poster (the</td>
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<tr>
<td></td>
<td>Balances: Espace communautaire des Balances</td>
<td>Balances: Espace communautaire</td>
<td>Sabrina Stocquart, Bénédicte Rusingizandekwe</td>
<td>the team</td>
<td>harmless effects of smoking</td>
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<tr>
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<td>13h30-16h</td>
<td>Anne Boudart</td>
<td>Food</td>
<td>Responses to the questions of the precedent session</td>
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<td>Bénédicte Rusingizandekwe</td>
<td>Tobacco-dependencies</td>
<td>Focus group</td>
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<td>14h-16h</td>
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EVALUATION CRITERIA

To evaluate our program we have identify criteria:

Criteria about the program (activities: evolution, appropriateness with the needs of the target group, unexpected events/effects)

Criteria about the professionals (local partners) (numbers, competences, kind of implications..)

Criteria about the communities (target groups, participation’s degree, (in)satisfaction, needs)

Criteria about the resources we needed (availability, management) and difficulties

Appendix

Listing of the local partners and ressource persons
Presentation of the project to the local partner (in french)
**LISTING OF LOCAL PARTNERS AND RESSOURCE PERSONS - PHASE II**

COORDINATORS OF THE EUROPEAN PROGRAM EUROPEEN IN NAMUR:

<table>
<thead>
<tr>
<th>Names / Surnames</th>
<th>Institution</th>
<th>Phone numbers</th>
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<tbody>
<tr>
<td>Roucloux Axel</td>
<td>Service de Promotion de la santé de l’IPHIS (Institut Provincial d’Hygiène Sociale de Namur) rue Château des Balances, 3 5000 NAMUR</td>
<td>081/723 786\n081/723 787</td>
</tr>
<tr>
<td>Rusingizandekwe Bénédicte</td>
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OTHER MEMBERS OF THE TEAM

<table>
<thead>
<tr>
<th>Names / Surnames</th>
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<tr>
<td>Blanpain Véronique</td>
<td>Illustrations, video’s project</td>
<td>081/723 787</td>
</tr>
<tr>
<td>Charlier Dominique</td>
<td>Documentalist</td>
<td>081/723 781</td>
</tr>
<tr>
<td>Penson Annick</td>
<td>Massage (workshops)</td>
<td>081/723 784</td>
</tr>
<tr>
<td>Mauguit Frédéric</td>
<td>Design</td>
<td>081/723 785</td>
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<tr>
<td>Loutz Nathalie</td>
<td>Co-animator for the one group (Gabs) Diffusion of the poster</td>
<td>081/723 782</td>
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<tr>
<td>Reginster Bénédicte</td>
<td>Adaptation of educational’s tool (comprendre son corps) Diffusion of the poster</td>
<td>081/723 780</td>
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<tr>
<td>Faucon Colette</td>
<td>Secretary</td>
<td>081/723 783</td>
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**CONCEPTOR OF THE POSTER**

Aurélien Tirtiaux 0498/82 53 80

**LOCAL PARTNERS**

<table>
<thead>
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<th>Noms / prénoms</th>
<th>Institutions</th>
<th>Téléphones</th>
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<tr>
<td>Marie Delcominette</td>
<td>Alpha 5000 rue cardinal mercier, 51 5000 NAMUR</td>
<td>081/74 60 96</td>
</tr>
<tr>
<td>Sylvie Marin, Virginie Perraut</td>
<td>Asbl Forma rue Pépin, 48 5000 NAMUR</td>
<td>081/22 68 62</td>
</tr>
<tr>
<td>Delphine Riez</td>
<td>rue Petite Chenèvière, 139 6001 Marcinelle</td>
<td>0497 146 046</td>
</tr>
<tr>
<td>Marie Claire Lambotte, Anne, Sophie Piette</td>
<td>Groupe d’animation de la Basse Sambre rue Haute, 8</td>
<td>071/78 42 71</td>
</tr>
<tr>
<td>Nom</td>
<td>Contact</td>
<td>Tél.</td>
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<tr>
<td>Cécile Arnold</td>
<td>Jemeppe sur sambre</td>
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<tr>
<td>Claudio Pescarollo</td>
<td>( directeur)</td>
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<tr>
<td>Nathalie Loutz</td>
<td>Service Promotion santé</td>
<td>081/723 782</td>
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<tr>
<td>( Aide à la mise en place du projet au Gabs)</td>
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<td>Bénédicte Reginster</td>
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<tr>
<td>Robert Baillon</td>
<td>Hôtel Maternel</td>
<td>081/22 70 83</td>
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<tr>
<td>Véronique Léonard</td>
<td>rue des Brasseurs ,170 5000 Namur</td>
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<tr>
<td>Danielle Hacardiau</td>
<td>FPS</td>
<td>081/ 72 93 48</td>
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<tr>
<td>( Personnes ressources pour l’atelier gestion du stress )</td>
<td>Ch de Waterloo, 182 5002 St Servais</td>
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<tr>
<td>Guérino Saporosi</td>
<td>Espace Communautaire des Balances, rue des Bosquets, 38 5000 Namur</td>
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## Ressources Personnes

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<td>Axel Roucloux</td>
<td>Service de Promotion de la santé</td>
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<tr>
<td>Jean-Luc Collignon, Nathalie Martin</td>
<td>Centre d’éducation du patient&lt;br&gt;5530 Godinne</td>
<td>Sudden infant death</td>
</tr>
<tr>
<td>Dr Pierre Brasseur, Dr Françoise Laboureur</td>
<td>rue St Nicolas, 5000 Namur</td>
<td>Médicaments</td>
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<tr>
<td>Xavier Rassel</td>
<td>Rue du Travail, 35 5000 Namur</td>
<td>Supervision</td>
</tr>
<tr>
<td>Jacques Dumont</td>
<td>Hôpital Erasme (CAF)&lt;br&gt;1070 Bruxelles</td>
<td>Tabac&lt;br&gt;Aide à l’arrêt du tabac</td>
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<tr>
<td>Véronique Meert</td>
<td>Culture et Santé</td>
<td>Éducation&lt;br&gt;Outil d’animation&lt;br&gt;Approche globale de la santé</td>
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<tr>
<td>Martine Hennuy</td>
<td>Centre de Santé de Namur&lt;br&gt;Rue Cardinal Mercier 5000 Namur</td>
<td>Relaxation&lt;br&gt;Sophrologie</td>
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<tr>
<td>Dr Duchâtel</td>
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<td>Médicaments</td>
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<tr>
<td>Véronique Perpinien</td>
<td>Asbl Alpha 5000&lt;br&gt;Rue Cardinal Mercier 5000 Namur</td>
<td>Esthétique&lt;br&gt;Aide aux premiers soins&lt;br&gt;Aide aux premiers soins à événements professionnels</td>
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<tr>
<td>Annick Penson</td>
<td>Service Promotion santé&lt;br&gt;5000 Namur</td>
<td>Relaxation&lt;br&gt;Masseur</td>
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<tr>
<td>Béatrix Vincina</td>
<td>IPHS -Centre diététique</td>
<td>Alimentation&lt;br&gt;Aide aux personnes diététiciennes</td>
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<td>Anne Boudart</td>
<td>Independant dietitian association</td>
<td>Alimentation&lt;br&gt;Aide aux personnes diététiciennes</td>
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<td>Robert Goret</td>
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<td>Centre de guidance</td>
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<tr>
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<td>Esthétique&lt;br&gt;Aide aux coiffures</td>
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<td>Institut Technique Henri Maus</td>
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<td>Evelyne Christophe</td>
<td>rue Julien Colson, 44/25</td>
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<td>Marie Dessaint</td>
<td>rue St Roch, 29a</td>
<td>Organizer for the workshops</td>
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**PRESENTATION OF THE PROJECT TO THE LOCAL PARTNERS THE 15 FEBRUARY (in french)**
Irish Report
Compiled by Angela King
Context of smoking in Ireland

Tobacco use is the single most important, preventable risk to human health and its social and economic effects are well documented. A cigarette is the only consumer product which when consumed as described, kills half of its regular customers. All of these deaths are preventable. - Regional Tobacco Control Strategy (2001-2005), Action plan for Dublin, Wicklow and Kildare (ECAHB, NAHB, SWHB 2001)

In Ireland, there have been restrictions on sales and advertising in relation to cigarettes since 1985. 1986 saw the introduction of controls of advertising, sponsorship and sales promotion concerning advertising restrictions, health warning on packages, sponsorship or support of cultural/sports events and fiscal measures. The advertisements can not contain misleading claims or recommendations, or show people smoking. No events can be sponsored by the tobacco industry. Cigarettes must be in packets of 10 or more.

In 1988, restrictions on sales to minors, under 16s, smokeless tobacco and levels of toxic constituents, were introduced and in 1990, restrictions of smoking in public places were implemented. The complete legal prohibition of smoking in public places including, libraries, cinemas, railway and bus stations, taxis, public areas in banks, hairdressers, doctor’s waiting rooms etc. was operative from 1995 and restrictions on smoking in other named public places with specific regulations in relation to the rights of non-smokers.

Although smoking by women in developed countries was not socially acceptable for many years, by the 1950s, smoking among women had taken off and has increased rapidly. With the growth in information relating to the dangers and health risks associated with tobacco, the prevalence of smoking among men declined in some developed countries. However, smoking rates among women did not begin to go down until later and in Ireland the two rates, for men and women are currently converging. In Ireland, as in many other developed countries, smoking is predominantly a practice of young women, women with limited education and women in the lower socio-economic groups.

In the past, cultural norms would have acted as a powerful influence in stopping women from smoking in developed countries. Interestingly from our work, this may still provide a protective effect in relation to a particular ethnic group in Ireland, Travellers, however, with the onset of responsibilities of married life and 'adulthood',

Women and Tobacco use: Patterns and trends in Ireland

The reduction of tobacco consumption in Ireland is central to our cardiovascular strategy 'Building Healthier Hearts' and the National Health Promotion Strategy 2000 - 2005. The Regional tobacco control Strategy Action Plans for Dublin, Wicklow and Kildare, 2001-2005 aim to reduce the incidence and prevalence of smoking in the region through work with young people helping them not to start, helping smokers to quit through a multi-strategy approach with policy, education and service development.
smoking behaviour changes, with many of these women starting to smoke as a sign of independence and being 'grown up'.

Smoking was not always socially acceptable for men, and even less so for women and children. Smoking was considered unfeminine but with the onset of the second world war, smoking amongst women became an indicator of women’s emancipation.

There are some interesting findings in relation to smoking and general health from the National Health and Lifestyle surveys, SLAN (1999). This is a baseline survey of health related behaviours among adults and was carried out across the Republic of Ireland in 1998.

The report shows that the rate of smoking is slightly higher among men than women. However, when different age groups and social categories are considered, the highest rates of smoking are amongst the 18 to 34 age group of women, at 40%, with 45% of women in the lowest socio-economic group smoking. Interestingly, only older males and females are at the target level for the population as a whole.

The rate of smoking amongst women aged 55+ ranges from 17% to 19% throughout all the social classes. This compares to a range from 36% to 45% in women aged 18 – 34 and 22% - 38% in the 35 – 54 age groups with the higher rates amongst women in the lower socio economic groups SLAN (1999). The mean number of cigarettes smoked by women ranges from 11.8 in the 18 – 34 age group in the highest socio economic group to 17.8 among 35-54 age group in the lowest socio economic group.

Also, when asked to report on their perception of their own health, smokers tended to rate their health slightly less well than non smokers generally Slan (1999).

The Slan report does not contain specific information in relation to pregnant women and women Travellers.

**Recruitment of women**

The initial target groups identified by the Dublin project included young and older women, pregnant women and women with children and women from urban and rural areas and Traveller women. Travellers are a small indigenous minority in Ireland, with a separate and distinct history and characteristics and traditions.

Each of these groups was selected for a number of different reasons including:

- Recorded levels of smoking among the group (Slan report 2000)
- Health concerns in the particular target group
- Accessing of healthcare of the women
- Potential impact of changes in health behaviour in relation to tobacco consumption
Methodology

The programme developed in Framework Project 1999 was further developed in Framework Project 2000. The settings were opened up further and included, Travellers in a Travellers’ Centre and also in a youth Training programme. Young women and pregnant women in a young women's training programme and also a community training/arts programme as well as a group of older women in an urban and more rural setting. The facilities were provided by each of these groups for the groupwork. One to one work, as also presented as an option, as not everyone wanted to take part in group work.

In the course of the project, it emerged in some of the initiatives, that women with particular issues, including pregnancy and being the only smoker wanting to look at smoking issues, wanted to opt for one to one support work, which was available. The venue for this varied from centre-based support sessions to home based and telephone support, depending on the need and resources available at a given time.

Initial contact was made with individuals and organisations working with women in the target groups, including networking organisations. Letters were forwarded to these contacts and these were followed up. Contact was made with groups that had been contacted under FWP 1999 and also new groups. Individual women were contacted through leaflet distribution during International Women’s Day in the local shopping centre.

Contact was made with women in the target groups through the Community Arts Factory, Ballymun Community training Workshop, St Margaret's Travellers' Centre, the Dark Horse venture and the Swords Day Activity Centre for Older people. Personal communication with these groups through meetings, proved to be very effective in terms of bringing them on board for the project interventions. In terms of recruiting, leaflet drops and generalised letters to organisations were less successful, perhaps due to the random nature of the intervention, poor literacy levels among those receiving the leaflet, lack of personal explanation of the project and lack of prior experience of such an initiative not requiring the women to cease smoking.

It is suggested that one to one contact may be more effective together with personal recommendations by friends previously involved in the group, as it ensures that there is a clear understanding of the nature of the intervention and the importance of the role of the participant in providing direction for same.

In relation to the older women, contact was made through the Dark Horse Venture, which is an Award Scheme for older people operated on a networking basis throughout Ireland. Through this, a number of groups that worked with women, were contacted. Introductory meetings were held with two groups, one urban and one more rural based. From one group, two women out of twenty were current smokers, while up to ten of the women had previously smoked and quit. The meetings explored the role that the women in the group might take in relation to their being mothers and grandmothers in families. They all expressed concern about smoking behaviour of family members particularly young women and teenagers.
A number of different possibilities were discussed but in the end the women reflected and make contact with the project to indicate that they did not wish to pursue it at this time. Some of the women believed that they could not influence their children and grandchildren for fear of perceptions and subsequent relationships. However, one of the women was interested in individual work in relation to her own smoking.

Another group of older women, were involved in a more rural area through a community based senior citizens centre. An initial introductory meeting was held following an informal meeting at a Senior Citizens open day in the area and a follow up letter and phone call. The women agreed to take part in a programme.

Young women, young mothers and pregnant women were contacted through a number of local groups working with these women. In view of the temporary nature of pregnancy and concerns regarding identification of women in this group separately, it was agreed that it would be more appropriate to include these women in other groups. Women in these groups were contacted through a local youth training/education scheme and pre-employment training scheme. Two of the women in the Training Centre were Travellers. While other groups were also contacted, they chose not to take up the programme.

Some women who attended initial meetings at the Centre also chose not to pursue the programme at that time and opted out. This ensured that the majority of those attending did so on a voluntary basis. It is suggested however, that having a programme such as the women and smoking one, in a structured environment, such as a training or employment based centre, may by its very nature, send out messages to potential participants and participants about the exact nature of the 'voluntary' involvement. This needs to be borne in mind when considering where such a programme might be run.

Only a small number of women in the groups chosen were pregnant however, individual contact was made with other women who were pregnant and they subsequently engaged in individual work. Contact was made through the local Public Health Nurses.

Travellers were contacted through the local Travellers’ Centre. This group had been involved in previous focus groups.

How trainers were identified

Our approach to trainers was adapted from our experience in the first year and also from our experiences during the second year of the project.

Initially, we had proposed training up women who had taken part in the project initiatives during the first year. However, despite ongoing support and training development opportunities, most of these women expressed concerns and reservations
about their potential involvement as co-facilitators or peer leaders. Reasons given included perceived lack of confidence and relevant experience, work, family or training commitments and time constraints.

From further informal discussions with some of the women, concerns were raised about how they thought they would be perceived within their community as ‘health’ workers that were not deemed to be professionally trained nurses. Issues were also raised in relation to remuneration and recognition of their work.

Despite this, a group of women did take part in training during the first year of the project. Women from the local Lifestart Programme took part in the training programme. Lifestart is a home visitation, educational programme, which focuses on the birth, to five age group and their parents in each community. The programme is facilitated by Family Visitors, who on a monthly visit, bring materials to the participating family and spend discuss the material and the child’s development with the parent(s). The materials are left with the family as a resource. The family visitors also facilitate parent group sessions, which act as a forum for discussions of issues related to child education, and possible community development activities. The women, who took part in the training, incorporated their training into their visits with the families.

Contact was made with the women who had trained in FWP 1999. Unfortunately, only two of the women who had taken part were still part of the programme. The Lifestart programme was in the process of reorganisation and would not be working directly with women on the ground. However, the two women were interested in maintaining involvement and employing the part of their work, when they recommenced work with families.

Contact was made with groups working with women on the ground. In the course of these it became evident that the expectation of those involved at an organisational level was that the programme was really a ‘quit smoking’ programme, despite the initial correspondence both written and verbal, outlining the programme. It was decided at this point to try to target those currently working with women in the target groups and conduct some training with them to run alongside work with the women in the groups themselves. This group therefore included professionals working in relevant fields.

The initial groups identified were the community arts factory, which is an education/training programme for young women aged 18 to 25, who have not completed school and have found it difficult to gain access to mainstream employment. There was one main trainer working with this group and a few part-time trainers.

Another influential group was the public health nursing staff. These would work directly in the community, primarily with women and young children and those who are long term sick in the community. Training workshops were held with five of the nursing staff. Through this process, there was an increased understanding of the
approaches used and their potential effectiveness in working with women within the community. Many of the women through FWP 1999 and FWP 2000 cited medical personnel as having very negative attitudes towards their smoking without offering much support or practical advice. This group was therefore an important target group for training and awareness raising.

In relation to work with the Traveller women, training was provided through one key worker with the women.

**Groups Selected**

One of the aims of FWP 2000 was to demonstrate the universal application of the initiatives developed under the pilot project by testing it out with a variety of target groups. In order to do this; contact was made with groups that engaged with women in the target groups. These included women from the geographical area of FWP 1999 and outside the area. Following initial consultations with organisers of these groups, introductory meetings were held with women.

One of the essential features of FWP 1999’s initiative was that participation was on a voluntary basis. To ensure this, initial introductory meetings were held with groups. As part of the evaluation process and monitoring, each group completed initial and closing assessment forms.

**Travellers**

Travellers are a small indigenous minority in Ireland. They have a long shared history and value system, which make them a distinct group, with their own language, customs and traditions. Traveller lifestyle and culture is based on a nomadic tradition, which makes it very distinct from the sedentary population or ‘settled people’.

Although Irish Travellers are native to Ireland, there are similarities between European Travellers and Gypsies. In the past, there have been attempts to absorb them into the settled population, which has been met with resistance from the Travellers who have striven to retain their identity.

The population of Travellers in Ireland in 2000 was estimated to be 25,000. However, there are a relatively large number of infants and children and few older people. There is a high birth rate and low life expectancy. Traveller life expectancy is low, with only 5% of Travellers living to be 50 years old and only 1% live to be 65 years of age.

There is a low uptake among Travellers in the formal education sector with few Traveller children completing full schooling. Also, parents and teachers from the settled community were hostile toward Traveller children and settled children being educated together and this led to segregated provision for Traveller children. There
was also a serious lack of recognition of Traveller culture in the formal education system. This lack of inclusion of Traveller children in the formal education system, has also had impact in terms of health information and programmes and other aspects of health provision through the education system.

Traveller women play an important part in the immediate family and the wider Traveller community. They have home, family and child responsibilities. Traveller women play a key role in the Traveller movement and articulate the issues for the Traveller Community.

Issues for Traveller women include racism, sexism and violence against women. Racism is evident in both obvious ways and more subtle ways in terms of how public institutions operated. In reality, many public services are designed by ‘settled’ people for ‘settled’ people mean that health, education and social welfare services, do not meet the specific need of Travellers and other minority groups.

Traveller health is significantly worse than the health of the settled community. As a response to the desperate need for health care improvement, Pavee Point and members of the Travelling community set up with Travellers, a primary health care project to train Traveller women to work as health care workers in their own communities. Other Traveller support groups around the country are currently replicating it.

In relation to smoking and Traveller women, no specific information is available. In the course of the project, meetings were held with Traveller women on one site and different patterns of smoking behaviour emerged from settled women. It is suggested that smoking among young Traveller women is not approved of, along with alcohol consumption.

With close family ties and respect for family, many women do not smoke until they are married. This was confirmed by a number of women who went on to say that it was a mark of a 'coming of age' and 'independence'. Interestingly, one woman commented that despite being married and not smoking for eight years, she still does not smoke in front of her parents.

**General programme elements and evaluation**

One of the aims of the FWP 2000, was to demonstrate the universal application of the initiatives developed under the pilot project by testing it out with a variety of target groups. In order to do this, contact was made with groups that engaged with women in the target groups. This included women from the geographical area of FWP 1999 and outside the area. Following initial consultations with organisers of these groups, introductory meetings were held with women.
Generally, much of the resources used in FWP 1999, were re-used in FWP 2000. The approach adopted in the work, aimed to provide a balance between factual information and support which would enable women to act, to raise awareness and empower women.

From a health psychology perspective, we looked not only at the individual's behaviour, the issues and concerns, but viewed this and their health beliefs and decisions and behaviour in a much wider context including culture, class and life.

Initial assessment form were used and developed from those of the first pilot project with further questions covering some of those asked in the focus groups of FWP 1999. The groups’ facilitators administered the assessment forms. The reason for this was that it meant that there was a consistency of recording. Also, a high percentage of the women would have reading and writing difficulties and administering the form would reduce risk of embarrassment. Copies of the completed forms were made available to any of the women who wanted them. About half of the women took the copies.

Although a carbon monoxide monitor, for measuring the level of carbon monoxide in the lungs, was not used during FWP 1999, this was introduced in FWP 2000 on a trial basis following a suggestion from one of the management committee.

For many of the women the concept of a group in relation to smoking that tried to raise awareness of the impact of smoking without ‘forcing’ or ‘pressurising’ women to quit, seemed quite alien. In order to look at this, the background to the initiative was presented and discussed. For some of the women, who had initially engaged however, they opted out of the initiative.

In order to help with the initial assessment of knowledge of the impact of smoking, further ideas were developed with the women, including body outlines with internal organs drawn on them. Each group was invited to identify the organs and the impact of smoking on this particular organ or body part. Factual information was provided where necessary and as the activity was completed in groups, it was very safe for the women, as they were not put on the spot. As the initiative was tested on further groups, an anatomical body kit was used. This allowed a very physical picture of the internal organs of the body and function of each part and impact of smoking on it.

During the course of the development of the initiatives with the groups, programmes were adapted to allow for differences within the needs expressed by these groups. One group expressed the need for very specific input in relation to cessation and support for women during the programme who quit.
Evaluation - Older Women's intervention

The starting point with this group was very different. When we did the initial assessment forms with the women, the women who smoked did not express any real desire to quit smoking, unlike the other age groups. Reasons given included thinking that they were ‘too old’ to quit and ‘the damage is done at this stage’. In order to make the programme more relevant, a slightly different approach was adopted in that we looked initially at the possibility of becoming a ‘healthier smoker’.

This seemed to capture the imagination of the women and also provided a space for the whole group to engage, as it seemed to be more broad based. The concept of being a ‘healthier smoker’ is based on work of Dr Jim Scala, who looked at smokers who were not interested in quitting.

The materials from the first year were initially used with this group, with adaptations where necessary. We also looked at issues relating to the 'concept of health' and how healthy the women perceived themselves to be. Despite obvious disabilities and physical limitations experienced by the women, they generally reported themselves as healthy. They reported eating well, taking 'a bit' of exercise and friendship and getting out, as important.

The women who smoked were in a minority and had decided that it was 'too late' for them to quit. Other women in the group had previously quit 'cold turkey' and successfully remained smoke free. Throughout the group the women engaged and the group was kept informal with round table directed 'chats' and informal presentations.

The evaluation with this group highlighted a number of issues regarding older women and smoking. These included a major concern with young people smoking, particularly young women and the health impact. Other issues raised related to the length of time that the women had been smoking, the perceived barriers to quitting and the perceived benefits to quitting. Interestingly, some of the women suggested that the doctor advising them to quit smoking would have had an effect in the past in terms of their successfully quitting, but now, they thought that it was too late and required too much effort.

Women in the 55+ age group who were invited to introductory meetings as part of the smoking and women project, and those who took part in the initiatives all raised concerns about the level of young women smoking. They voiced concern about the visibility of young women ‘smoking on the street’.

As a response to their concern regarding younger women, we looked at ways that these women might act as role models and role played potential situations they might meet and how they might deal with them. Unfortunately, many of the women expressed concern about how they might be perceived as 'interfering old Biddies' with no notion of what was going on in 'real life'.

The women who took part in this group and were current smokers, did not quit smoking during the course of the group however, there were changes in relation to
where they would smoke within their homes with the introduction of smoke free areas and specific smoking areas. They also made minor changes such as eating breakfast before the first cigarette and agreeing to not offer them around to other people in their company as a way of monitoring their own smoking behaviour.

In relation to the actual intervention with this group, while the women said that they enjoyed the sessions and learned some new information, they knew most of it. Equally, for those that did smoke, behaviour changes were very minor and a more long term review needs to be made to assess any more long term change. Also, in relation to the non-smokers, it is suggested that a more structured programme might be introduced for older people in view of their role in family health and their sphere of influence.

**Learning from Older Women's intervention**

The level of interest in the women and smoking initiative in relation to groups working with older women that were contacted was relatively low. There was a general sense that ‘at my age, I’ve done the damage’ and ‘you should be looking at young ones and stopping them from smoking’. Also, the general level of smoking among older women, 55+, is lower than that of young women and this is across the socio economic groups.

**Younger women/pregnant women's intervention**

Smoking is deemed to be a major preventable risk factor in relation to coronary heart disease and cancers, especially lung cancer and osteoporosis.

One of the recommendations in relation to smoking and women, arising from the Saffron Report on Women’s Lifetime Health Needs, relates to having a specific campaign, targeted at younger women, implemented by the Health Promotion Unit of the Department of Health.

Women in the younger age groups were contacted through a number of locally based education/training and pre-employment facilities. These groups also had young Traveller women and young women who had children and also some women who were pregnant.

Contact was also made with organisations and agencies working with young women and women who were pregnant. Initial meetings were held with two groups of young women, including a young women’s creative arts training group and two pre-employment training/education programmes. Attempts were also made to specifically target pregnant women through the public health nurses however; success in this group was limited. The women who had trained through Lifestart also worked with women who were pregnant.

In view of the difficulty of isolating pregnant women and not replicating another pilot programme specifically working with women during pregnancy in conjunction with the health services, pregnant women were part of the mainstream group with young
women. Three other women, one of who smoked and two where their partners smoked made personal contact with the project and wanted involvement.

The worker initially met with trainers from the groups to go through the programme including methodology and support that might be provided through the centres. We also looked at training aimed at those who would be working with the young people and the environment in which the smoking takes place including cultural norms, smoking policy, general policies within the centre. This staff training ensured that there was more of a context in which the programme was placed and helped to provide support for not only the programme at the centres, but also for the women.

This group looked at much of the same issues as the other groups, with activities in relation to current smoking behaviour; impact of smoking on health and financial implications; perceived benefits of smoking and benefits of quitting; general health; diet and nutrition; personal histories in relation to smoking and for those that had quit, quitting. Also, we looked at the possibilities and potential of the women influencing family and friends in terms of gaining support for potential change and also to reduce the incidence of subsequent smoking amongst their children.

Another big aspect of work directly with this group involved the context in which they smoked. In the training centres, smoking was a 'social' activity, associated with breaks and 'time out', particularly useful when the women did not want to 'engage' with what was taking place at a given time. In one centre, there were no designated 'smoking' areas and this meant that everywhere was considered to be a smoking area. We worked with the women on the development of a policy at the centre. This provided a good reflection ground for the women to look at their smoking behaviour in the context of their work, and also the manner in which they shared cigarettes etc.

**Younger women/pregnant women's evaluation**

In relation to the pregnant women where partners smoked, they wanted increased knowledge and information in order to address issues relating to passive smoking and their partners. However, they wanted to find positive and supportive ways of addressing the issues and we did this through individual work specifically targeted at these women. Interestingly, these women, following the birth of their babies, commented on the change in smoking behaviour of their partners, with both reductions in smoking and also ensuring that they did not smoke in the environment of the child.

One of the women quit smoking during her pregnancy and was very keen on staying off cigarettes during the pregnancy and also in the long term. In order to facilitate the erratic work hours of this woman, a combination of a small amount of groups sessions together with individual meetings and home visits as well as telephone support, were adopted. The baby has been born and the woman has stayed off cigarettes and has reported high levels of self esteem also. Her older child has also been involved in the process and has been very supportive.
For the woman involved in the group, advice had been given by her health advisor during her pre-natal visits. Unfortunately, while she had been advised to quit smoking, no practical measures were offered to assist her in the process. In fact, during some group discussions in relation to smoking and pregnancy, many of the women in the group, who had children, commented on the ‘negative’ attitude of health professionals towards them and their smoking during pregnancy. The women made reference to the fact that a supportive environment offering positive support and encouragement and also addressing the women’s reasons for smoking could be more beneficial rather than only focusing on the dangers of smoking to the unborn child.

**Overall Evaluation of the programme**

In view of the fact that no group had only one specific target group and the value of having integrated groups, women from different target groups joined together in previously existing groups. This enriched the experiences shared in the groups.

The specific needs and requests of each group and the ground rules for the operation of the groups were set down from the onset of each group and particular to the group. This ensured that the content and process were kept as relevant as possible to the women and remained flexible and responsive.

Generally, much of the resources used in FWP 1999, were re-used in FWP 2000. The initial assessment form was administered to ensure consistency of recording and manage issues relating to literacy. Copies of the completed forms were made available to any of the women who wanted them. Some of the women took the copied forms and referred back to them later on completion of the intervention, indicating their satisfaction about changes in awareness, knowledge and behaviour regarding their smoking. This proved to be empowering for the women involved.

Although a carbon monoxide monitor, for measuring the level of carbon monoxide in the lungs, was introduced in FWP 2000 on a trial basis following a suggestion from one of the management committee. It gave a very clear picture to the women of the level of carbon monoxide in their lungs and the level of their smoking. In one group, one woman claimed to be a light smoker and that she did not inhale. When she used the carbon monoxide monitor, the alarm sounded. The woman was very surprised at this and this helped her to look at her smoking behaviour in a different light, particularly in relation to inhaling.

The use of the carbon monoxide monitor should not be over emphasised. Some women did not want to use it. Also there are some concerns about the accuracy about the use of this method of monitoring carbon monoxide, so consideration needs to be given prior to its introduction.

For many of the women the concept of a group in relation to smoking that tried to raise awareness of the impact of smoking without ‘forcing’ or ‘pressurising’ women to quit, seemed quite alien. In order to look at this, the background to the initiative
was presented and discussed. For some of the women, who had initially engaged however, they opted out of the initiative. This however, was important as it ensured that although the groups would be smaller, they had women who wanted to be there, as opposed to those who were ‘coerced’ into being there.

The benefits of a multi-faceted approach to looking at the issues relating to smoking was useful, with the introduction of visual activities, such as mounting used cigarette boxes for costing a desired item or the body parts and internal organs and smoking impact of smoking, as a 3-dimensional body. These gave very visual support to the impact of smoking, but also helped to support visual learners.

Flexible approaches to the development of the initiatives with the groups was important as it allowed for differences within the needs expressed by these groups. One group expressed the need for very specific input in relation to cessation and support for women during the programme who quit. This was provided.

Another issue, which arose, was the availability of the drug Zyban on the general medical services during the year. This drug, which had been cited as being beneficial in helping people trying to quit smoking, had become available in the Republic of Ireland on prescription through the General medical services. Much media attention had been given to the drug. Some of the women in the groups wanted information on this drug and this was provided.

Interestingly, a number of the local General Practitioners would not prescribe it for the women who had asked. They brought this back to the wider group and we looked at this issue in conjunction with the local public health nurses and local pharmacist, who were both, very supportive. We also did role plays with the women in relation to raising the issue again with their gaps. We were aware of the need not to antagonise the local general practitioners yet, also aware of the rights of the women to take an active role in gaining all the support and information that was available to support their attempts to quit smoking.

Sadly however, many of the women became disillusioned with Zyban over the following few months. Much media attention had been given to isolated examples of sudden deaths in people taking Zyban and the perceived safety of the drug was diminished.

In the case of the groups with older women, their seemed to be two categories of women who engaged. The first, women who had at some stage been advised by medical personnel to quit smoking and the second, women who reckoned that they had done the damage and quitting now would not have a particularly positive impact.

A number of responses were developed to meet the needs of these groups. For those that had been advised to quit smoking, activities from the original programme were used to look at the issues and approaches to support a move toward quitting.
Individual programmes were used when individuals within the group requested this, with home support visits used.

However, soon it became clear that the women had no real intention of quitting and the programme was adapted to look at ways of developing and enriching other current positive health behaviours. While some of the material was adapted and used with the women in relation to ensuring the maximisation of healthy eating to try to minimise the negative impacts of smoking, including general healthy eating and identifying antioxidant vitamin sources and other heart health and cancer risk reduction approaches. The programme also looked at other measures to maximise health. The materials and activities previously developed were also integrated into the programme to increase awareness of the benefits of quitting even in older women.

The group with older women also focused on their role as matriarchs within family systems and their field of influence in relation to children and grandchildren. Some of the women felt that they had an influence in relation to their children and grandchildren and were interested in looking at how they might positively influence them in relation to their stopping or preventing them from smoking.

**Did the programme achieve its explicit objectives**

The programme did meet its explicit objectives in that we did apply the initiatives in a variety of target groups, as described, and tested in target groups. The degree of success varied from group to group with younger women from 18 - 35 perhaps more receptive to the intervention, than older women and Traveller women.

It is suggested that older women are already clear whether they want to quit and have done so or not, as they see fit. However, they were open to being healthier generally. They did not identify their role as matriarch or family leader and influencing but they were open to it.

**Recommendations**

Interventions need to be flexible as groups present with very different needs according to their living circumstances and lifestyles. Both formal and informal responses to their needs should take their cultural and varying needs into consideration.

Building self esteem is vital to equipping women to make behaviour change. There is a need to assist in the development of the individual and collective self-esteem through services, which are based on standards of excellence, are non-judgemental, accepting, culturally appropriate, encouraging and yet challenging.

Where possible, women and smoking interventions should be placed into a wider planned intervention with a group to ensure maximum effectiveness. Another alternative might be to have a lead in period with general health topics. This ensures
that supportive relationships are built up, which will enhance the effectiveness of the intervention.

Provide advance, detailed information about the content and approaches used in the intervention to those involved in organising the potential group. This is most effectively done through advance meetings with organisers of the potential group, and also holding an initial introductory meeting with the potential group itself. Training of staff/trainers should also be done to ensure that they can support and encourage the participants through the programme by creating a supportive environment.

During the initial introductory meeting with the organisers, check out relevant information such as literacy levels, ages, communication and behavioural style. This can help with planning and preparing the sessions with the group.

If the group is a pre-existing group in an organised environment, consider the possibility of some of the trainers or current smoking staff present. This however, should be negotiated. This provides an opportunity for professional development and relationship building through co-facilitating.

The area health boards of the Eastern Region, where the pilot and follow up programme were based, have developed posts for health promotion officers with responsibility for tobacco in their areas. Part of their work would be to work specifically with groups which the project has previously targeted and to use the resource pack developed in FWP 1999, together with the learning from FWP 2000, including that of our European partners. Also the resource packs developed in FWP 1999 have been distributed to the health boards and voluntary groups working with health issues throughout Ireland, where they will be employed as part of their health promotion and tobacco programmes.

Equally, many of the staff that have been involved in the initial training programmes have taken on board the continuation and maintenance of the smoking policies with an increased understanding of the complexity of the issues in relation to women and smoking.

In relation to the Traveller group, the particular group are now part of a wider funded project which focusses on building skills and training in relation to a health needs assessment, which it is hoped will include tobacco usage among Travellers on the site. Also, from their training it is hoped that they will undertake a health training programme, which will be multi faceted and specific to their needs. It is envisaged that issues including sanitation on sites, nutrition, housing, together with preventive measures will be explored in relation to health.
Greek Report

Executive Summary

The 2000-2001 project “Low income women and smoke” came as a continuation of the previous year’s project, which was successfully completed.

The results of the 1st year included:
- The development of an extended group of friends-supporters of the project aims among the beneficiary group, with different degrees of involvement (trainers, trainees, participants in the open days and coming-together sessions etc.)
- The development of a methodology
- The creation of informational material

During the 2nd year, we aimed at the following objectives:

- To demonstrate the universal application of the initiatives developed under the pilot project, Smoking Women and Low Income. The programme will be tested with women in five countries and will involve all major target groups.
- To train sufficient women as trainers to allow the initiatives to continue after the project ends
- To evaluate, report and disseminate the findings to hundreds of organisations and cities throughout Europe
- To test the effectiveness of the initiatives in the area of smoking reduction in the short and long term
- To collate the resources and programme initiatives and distribute to organisations and cities throughout Europe

To these aims:
- We contacted all the participants of the 1st year project, to renew their interest on the issues of low-income women and smoke
- We formed 4 segmented groups of trainees from the beneficiary group (who were trained by the 1st year’s trainees)
- We formed 1 group of professionals working closely with low income women smokers
- We created and adapted training tools, according to the findings of the 1st year project for the 4 groups
- We (within the 5th group) worked on the development of a “manual” with guidelines for professionals
- We continued our contacts with community groups, women’s organizations, hospitals etc. for information dissemination and creation of awareness of the products (training material and guidelines) and methodology of the project
We supported voluntary groups that were created in the country, who undertook the duplication of the training programme in areas of Greece other than Athens.

We incorporated the feedback of criticism from the 1st year project, namely opportunities for one-to-one support, socializing (building on the relationships of the group outside the strict contours of the training sessions, contributing towards overcoming the absence of a more structured framework for smoking cessation support within the public services, creating a framework for continuation of the personal and/or group efforts against tobacco et.al.)

We incorporated an on-going evaluation process of the project.

The results of the 2nd year project:

- The successful completion of the work of the 5 groups
- The extended work in groups that took place in the country
- The creation of training material
- The creation of a “manual” with guidelines for professionals working with low-income women smokers
- The dissemination of information material and the project’s results to organizations and groups working with low-income women.

Evaluation

- There was noted a pronounced behavioural change among all participants from the beneficiary group (in terms of self-image, goal setting, healthy living, as well as with respect to smoking).
- The participants appreciated the methodology of empowerment and the non-judgmental attitude of the project, as well as the peripheral (to smoking) support the got.
- The training material seems to work better in urban areas, among younger and older women. Young mothers and immigrant women smokers showed less propensity to change.
- Rural areas showed a bigger propensity to keeping the relationship that was formed among the group, whereas urban areas to keeping one-to-one relationships between specific participants or trainers/lecturers etc.
- The professionals involved in the 5th group needed primary “training” on being persuaded on the methodology used, which was achieved through sessions whereby the professionals worked on their own experiences w.r.t. change.

The issue of putting tobacco on the agenda of low income women smokers seems to move constantly between 2 poles: group work and individual work. Another 2 poles exist w.r.t. to the level of behavioural change achieved: focus and expansion. Both are indispensable during the various stages of the “Cycle of change” and depend a lot on the specific individuals’ needs.
Note: This report is complimentary to the report of last year, where the fundamental principles, the philosophy, as it were, of this initiative are thoroughly presented and discussed.

Contacts with participants from previous project

The teachers, the steering committee and the work group of the Institute contacted all the participants in the previous project, namely:
- The participants in the training sessions
- The participants in the open days and the coming together sessions
- The organizations we had contacted for the purposes of recruiting participants and gaining support

The purpose of the contacts was:
- To inform them on the continuation of the project
- To recruit participants for the new project
- To get feedback on previous project, so as to incorporate suggestions in new project
- To get feedback on possible segmentation of the new groups of trainees

Development of the new training programme

It was decided to follow the same outline and the “curriculum” developed in the previous project with the following differentiations:
- Segmentation of the beneficiaries in more homogenous groups
- Providing supplementary one-to-one support once a week throughout the duration of training for those participants that needed it
- Incorporating social activities once every fortnight (parties, visits to museums, walks etc)

One of the major concerns of our planning was that the outcoming trainees of this new programme should be in a position to become trainers themselves. However, in Greece smoking cessation is not incorporated in social support/ work, thus making it almost impossible for our trainers-to-be to become involved in social work and put their newly acquired skills into practice.
Furthermore, it is an inherent problem of the programme that underprivileged-low income women have not the overall prerequisites for such type of employment, i.e. as social workers, teachers, nurses et.al.

Under these circumstances and after consultation of the other partners and the project leader during the Namur meeting, it was decided that we should continue to develop
the skills of low income women, that will be in a position to influence and help other women within their own community, by mere interaction, through our encouragement towards them to develop their own initiatives.
Furthermore, we decided that one of the 5 groups of trainees should be recruited from areas of social workers, teachers and nurses. This way, we would try and test out the possibilities of their intervening in the areas of their own work, by their own initiative in cases when they work with low income women smokers.

As far as the methodology used for training as well as its contents, we were to follow the same as those of the previous project. The same held for the print material.

**Recruitment**

From the initial contacts with the previous participants, we encountered a low intention for further participation. The reasons by order of importance were:
They felt that they had closed a circle and that there was not much more to be done.

They felt that now they had been informed as well as empowered and that it relied on them to work on their smoking problem. They said they would come back to us, should they feel they need further support.
The circumstances of their lives had changed in the meantime (found a job, gotten married, had a child, illness within the family etc)

The majority of the participants would be eager to keep in touch with us, be informed in our work, participate in comings together, meet their friends again etc.

Thus, mainly through our previous participants, 5 groups were formed:
- Young women (15-22)
- Mothers of young children and/ or mothers to be
- Women immigrants
- A mixed group with unemployed women and women 45+ (due to lack of women to form 2 separate groups)
- Teachers, nurses, social workers. This group was formed mainly through existing contacts of the Institute. Most of the participants are “friends” of IN.IS with a keen interest in women’s issues.
Methodology - The contents of training

The first 4 groups of trainees

For the implementation of the training sessions, we followed the methodology developed last year, fine-tuned by the feedback of the participants and our European partners. More specifically, the attitude, the scope and the content may be briefly summarized as follows:

- Making contact with women – Self-selection
- Voluntary participation
- Specific to women
- Non-judgemental approach
- Quitting is not an obligatory end result
- Group work and one to one work and support
- Reflective listening
- Motivational interviewing and brief interventions
- Support positive lifestyle practices
- Empowering
- Flexible but focussed approach
- Approach used encourages tolerance and support
- Training other women to work with initiatives
- Understanding context of smoking in women’s lives
- Understanding the nature of addiction in relation to nicotine
- Cycle of change/ behaviour change
- Positive benefits of quitting, highlighted
- Look at positives and drawbacks of smoking/ quitting
- Managing change
- Dealing with relapse
- Dealing with consequences of being a smoker
- Planning strategy for change
- Support develop positive lifestyle behaviours
- Nutrition/weight management information
- Stress management information

The same basic training outline was followed as last year.

We took into account the feedback from last year’s participants in the training sessions as well as in the open days, coming together sessions etc.

3 new elements were added:
- Invitation of doctors, psychologists, teachers, lawyers to discuss health, stress, children upbringing, legal maters (immigration, unemployment, divorce) to all 4
groups of trainees. The participants were given the opportunity to have one private session with the professionals, if they so wanted.

• Incorporation of social events at a fortnight basis (visiting museums, galleries, going to the cinema, dining out together, getting together at each others houses.
• Provide one-to-one counselling to those who needed it, by trained psychologists. The psychologists offered their work for free for up to 3 sessions with each participant.

This time, we produced a leaflet to assist training and we also used adapted material from our European partners.

Below is the outline of the training sessions structure.

<table>
<thead>
<tr>
<th>SESSION</th>
<th>AIM 1</th>
<th>AIM 2</th>
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<tbody>
<tr>
<td></td>
<td>CONTEMPLATION PROCESS</td>
<td>SUPPORTING MECHANISM</td>
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<tr>
<td></td>
<td>LEADING TO ACTION</td>
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<tr>
<td>SESSION 1</td>
<td>Smoking history. In pairs. Finding our common themes/patterns Homework: creating a smoking diary</td>
<td>Presentation of the basic principles of the project and training Recapitulation from the focus groups</td>
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<tr>
<td>SESSION 2</td>
<td>Pros and cons of smoking (what’s good about smoking, what’s annoying). Nightmare session (what are your fears w.r.t. smoking/ health)</td>
<td>Stress management - basic principles</td>
</tr>
<tr>
<td>SESSION 3</td>
<td>Emotional addiction. Brainstorming. Presentation of how dependence works.</td>
<td>Cycle of change. Presentation</td>
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<tr>
<td>SESSION 5</td>
<td>Presentation of the smoking diary. Group discussion and comments on each diary. Finding the common patterns.</td>
<td>Presentation of homework “a portrait of myself”. Comments by the group.</td>
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<tr>
<td>SESSION 6</td>
<td>“A portrait of myself” cnt’d</td>
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<tr>
<td>SESSION 7</td>
<td>Continuation of smoking diaries.</td>
<td>Discussing children or partners. How to be affirmative about one’s needs/attitudes. Where to look for inexpensive/free of charge recreation/hobbies etc.</td>
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<tr>
<td>SESSION 8</td>
<td>How would your life change, if you were to give up smoking. In pairs – each one for her partner. Group work: write down all changes.</td>
<td>Stress management revisited.</td>
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<tr>
<td>SESSION 9</td>
<td>Dependence revisited after the insight of previous session. Presentation on emotional addiction.</td>
<td>Healthy living.</td>
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<tr>
<td>SESSION 10</td>
<td>Quitting methods. Presentation and discussion. Fears and methodology. Where to look for help.</td>
<td>How can we influence others to quit</td>
</tr>
<tr>
<td>SESSION 11</td>
<td>Making a check list for change. Each one for herself. Assessment of relapsing.</td>
<td>How can we influence others to quit</td>
</tr>
<tr>
<td>SESSION 12</td>
<td>Evaluation of each participant’s status. Evaluation of training sessions.</td>
<td>How can we influence others to quit. Quitting may be incorporated into the better life that the participants want to build for themselves. Let’s start changing our life to the better.</td>
</tr>
</tbody>
</table>
Group work included some other aspects that had been given as feedback during the last year’s project: social activities and external visitors who discussed relevant issues.

The social activities took place every fortnight and included:

- Visits to museums and galleries.
- Small excursions in the Athenian countryside.
- Going to the cinema together.
- Going out for lunch/dinner.
- Having parties at the participants’ houses.

The project ended formally with a celebration dinner where around 40 people participated from all over Greece (trainees, trainers, friends of the Institute from outside Athens who had worked on voluntary groups, project workers...).

The outside visitors included doctors, social workers, psychologists, dieticians etc.
The structure of the training in this instant was much less structured. It was very much being adapted to the needs of the group.

| Session 1 | getting to know each other  
Presentation of the project and methodology |
|-----------|----------------------------------------------------------------------------------|
| Session 2 | putting smoking into the context of low income women’s lives  
Evaluating last years results |
| Session 3 | the cycle of change  
Presentation of participant’s own experiences w.r.t. change/ smoking |
| Session 4 | visiting the groups |
| Session 5 | points of possible intervention during the professionals’ contact with clients – description of their overall job procedures |
| Session 6 | motivational interviewing |
| Session 7 | making up a schedule for intervention live in the participants work environment |
| Session 8 | feedback from the experience |
| Session 9 | drafting guidelines |
| Session 10 | more feedback from experience |
| Session 11 | visiting groups |
| Session 12 | guidelines revisited/ finalized |
Throughout the duration of the project so far, the steering committee as well as the working group on the project contacted doctors, nurses, social workers, immigrants organisations, social municipalities et.al, in order to disseminate information and familiarize them on the project’s methodology and findings.

As there is a limited structure social support against tobacco in Greece, we continued bridge building with other organisations involved in community work, women’s issues, health networks et.al. Our main partner in this effort was the Research Centre of Women’s Affairs.

We established a working and information exchange relationship with the following organisations. This relationship included:

- Presentation of the context of our work
- Distribution of material (newsletter, sticker, training material, articles etc.), that they in turn distributed to their members and co-operating organisations
- Organisation of meetings for opinion exchange
- Recruiting participants for training

The organisations we worked closely with include:
- Telessila network
- Kilkis hospital
- Immigrants groups
- Groups of women in Giannena, Thessaloniki, Pylos

Towards the same goal we organised a press conference, inviting journalists as well as community workers, teachers, nurses, representatives of women’s groups. The participation from the part of the press in the very event was not very great. 4 journalists were present. However, 22 representatives from the other target groups participated.

We also sent out a complete press kit to all national newspapers, TV stations and radio stations, as well as to selected local media.
Group 1: Young women (15-22) – 10 participants

Demographics
4 participants pupils (15-18 years old)
6 participants age 18+, out of whom:
1 unemployed, 2 get professional training, 2 get college training, 1 University student
Only 3 of them work as part-timers occasionally
All participants live on their parents, except from the unemployed one and the University student who live with relatives, as they come from the country (their parents support them financially).

Overall group description - Major concerns
The participants in the young group share the following pre-occupations, as well as attitudes:
• They do not think of smoking as a problem. They think that they are too young, they claim not to have noticed health problems deriving from smoking. Now smoking is a peer thing, an emancipation thing. They can always give up in the future, if needed – so far they do not recognise addiction in themselves.
• Relationships are a major topic of discussion among them. They want meaningful, stable relationships. They want to make a family.
• Finding work is an important concern. However, the group seems to have an untested, in the sense that only three of them have actively tried to find a job, notion of reality: they are afraid of unemployment and have also got an a priori pessimism as to their future job options. Opinions like: “We know who find good jobs, only those with connections” or “Women have to make sexual concessions to be promoted” are stated very often by the participants. At the same time, the participants fantasise a lot of glamour and money. Their role models seem to come primarily through TV. Their motto could easily be “we want quick and effortless success”. The ideals of their parents “no pain, no gain”, “no matter what, get a University education, become a better person”, do not seem to strike home with this generation, that combines cynicism, demanding attitude and pessimism.
• The participants want to consume. They are well aware of everything trendy, shopping (or at least window shopping) is an important pastime for them. Their dreams are illustrated through brands. Their lack of disposable income can be extremely frustrating, indeed to such that it undermines their self-image.
• The participants want to take their life in their hands, they are, however, at a permanent state of adolescence, whereby their family not only supports them (often at an extend higher to the family’s actual financial ability), but also interferes into their lives. The participants resent such an involvement, although they welcome the support.
• Looks and weight play an extremely important role in the participants life. It is interesting to note that although they are aware of the importance of healthy eating and of exercise, smoking was not considered part of this effort for healthy living.
The group’s evaluation of the training programme

They liked
- The opportunity for discussion (the element of structure in the discussion combined with the freedom of expression that was given to them),
- The fact that they were treated as adults
- The opportunity to think about themselves and their life.

Concerns
- “Now I have no excuse for not being responsible.” The participants realized the responsibility involved in making choices, in taking their life in their hands, something that they lacked due to their continued adolescence.
- The empowerment that they undoubtedly gained was often coupled with fear of not being able to keep up with what they found out they should be doing (not only w.r.t. smoking, but also w.r.t. their studies, looking for a job, breaking up relationships etc)
- “It’s lonely out there”. Peer pressure came up very often. Not everybody could find the inner strength to become an opinion leader among her friends. All admitted to feeling intimidated by the lack of acceptance from their friends, who are more important to them than their family.

Behavioural change
2 of the pupils gave up (1 relapsed)
4 reduced

The trainers feedback
- This is a group very easy to work with, once the trainer manages to establish contact. The girls were eager to get support. They welcomed the structure of the discussion, which eventually led them to conclusions and decisions. They welcomed the feeling of respect and freedom.
- The girls found the manual offered to them as a tool for working during the training very helpful. They regarded it as a personal diary and almost all took up this “girlish” habit of writing down their thoughts – a method of expressing themselves most of them had never used.
- Discussing the effects of smoking was another good part of the training, since the girls had been never given the actual facts of the dangers of tobacco. This group did not find this information threatening. On the contrary, it helped them a lot to put smoking in a different context. Till then, they had only encountered their parents negative attitude to the fact that they smoked, which was never justified. A lot of the participants smoked without their parents knowing it, thinking that this was an act of rebellion.
- The concern of the younger women with their body (on a diet, eating healthy, going to the gym etc.) provides a good background for discussion.
- Follow-up is important for this group, who is never encouraged to think for itself in school, within the family, even among peers.
- An adaptation of this programme could be used successfully in schools, outside the curriculum, in the career support sessions (should such sessions be available – they are in certain schools, not in all though).
Group 2: Mothers of young children and mothers to be - 7 participants

Demographics
5 participants between 28-35: 2 pregnant, 3 with children between 6months and 6 years of age, 2 employed, 1 divorced.
2 at the age of 24: 1 pregnant, 1 mother of a 3 year old child, both working.

Overall group description - Major concerns

With respect to their overall life
- Obviously the main issue in their life is their child
- The work load they are faced with w.r.t. their house, their child, their job. The sense of responsibility, the fact that they feel they were not prepared for so much pressure.
- Relationships – especially with their husbands, who is perhaps the only contact besides the child and their parents/ in-laws they have. They no longer seem to have time for going out and seeing friends.
- Initially, the participants seem satisfied with their life. They claim to have no personal ambitions – it is enough for them to have a husband who brings home money.
- Most would dream of not working – they do not find work fulfilling.
- The participants seem to rely to traditional roles – they are tired of trying to keep up with everything, life is too demanding. Their role as mothers is very important – “isn’t it what they had been always told, anyway?”- “why should they be required to do so much more?” and “anyway, what are men for?”
- The child has brought them in front of the importance of money very seriously. The cost of living, everyday budgeting is frustrating, having enough money for today as well as for the future is a big concern.

With respect to pregnancy and their role as mothers
- During and after pregnancy, the participants experience an alienation from husband and doctor, as well as, or perhaps more importantly from themselves.
- They experience pregnancy with a certain fear, they do not know what to expect – everybody told them that pregnancy and motherhood had an aura of sweetness about it – but, they do are very often treated (or indeed feel) as sick, ugly and unimportant. They are important insofar as they are bearers of the child, not in themselves.
- They do not like their bodies. They feel fat, not sexy, not liked. Will they remain fat after pregnancy?
- As mothers, they experience a frustration by constantly having to look after or their children. It is as if their own life has ended – now somebody else comes first. Always running around to cope. In certain cases, the respondents admit that they do not do as much as they should, however the feeling of this huge responsibility remains, as well as that of guilt.
- Life is full of obligations, no freedom, no entertainment.
- The participants’ behaviour towards their children seems to be over-protective and not always consistent in terms of “do’s and don’t’s”. The grandparents, when
around, have an active role in the upbringing, as well as in the very relationship of the young couple. Often, neurotic attitudes towards the children are manifested, even violence, especially in cases of intense financial difficulties.

*With respect to pregnancy, children and smoking*
- All tried to give up during pregnancy. In the first months all said they did not want to smoke. After the 5th month some started to smoke occasionally. One went on smoking throughout her pregnancy. Pressure from their surroundings was great against their smoking. If it were not for this, some women said they would have taken up smoking again.
- After the baby came, all went back to smoking gradually. For some it was a way of feeling that they were back to their old selves, others said that they felt they needed it more, as a way of having a moment of relaxation, of having a break, of dealing with stress.
- All smoke in front of the children.

*The group’s evaluation of the training programme*

*They liked*
- The support, the information, the encouragement
- The opportunity to get away from home for a while.
- The fact that they felt much less isolated in their problems. Other women in similar circumstances shared their fears, problems, concerns. They felt more empowered by the sheer realization that it was not just them.
- Two claimed that they had become much more sensitised about their own needs
- Most liked the information on how to deal with responsibility and stress, the advice that specialized people gave them about children up-bringing.

*Concerns*
- What to do with the children during the training.
- Some women experienced a sense of further responsibility, which they could not take up. “It’s not as if I did not have enough to do, now I have to become a better person, too. Even this is a must for me.”
- The surroundings did not seem very supportive to the women changing attitudes and coming to the meetings. Some husbands and in-laws would either ridicule or criticise the training as a waste of time.
- A lot of women said that for them to either reconsider their life or to reduce/ give up smoking, more support from their partners was needed. And the partners were not prepared to offer support. Trying to discuss with them would just produce problems.

*Behavioural change*
1 pregnant smoker reduced smoking and smoked at a lower rate after childbirth
2 participants quitted, 1 relapsed but smoked a smaller quantity and less regularly
The trainers feedback

- The group was hard to work with. The participants were isolated in their circumstances, motherhood overwhelmingly important.
- Less constant participation. Children were allowed to be brought in, but then the focus shifted towards the children.
- Need for adapting the training material. Self-fulfilment and longer term empowerment did not seem to work so well with these women, who had specific problems to solve. Thus, focus was shifted towards health and children upbringing. This was particularly welcome. Specific solutions to specific problems were required by this group.
- Another alternative would be working with the couples, instead of just with the women, as the women themselves admitted to be in need of support from their partners. However, the partners did not seem very willing to participate.
- Pregnant women and young mothers are extremely susceptible to the advice of doctors, especially if the latter are willing to explain. At this stage, their help would be of high importance, should they adopt a different attitude.
Group 3: Immigrants – 5 participants

Demographics
3 Greek citizens, 2 in Greece for more than 5 years.
A mixed age group (18-55)
All work as domestic help.
4 married.

Constant participation, although with difficulty. Feeling of belonging, being accepted.

Overall group description - Major concerns

With respect to their overall life
• Difficult family situation. More often than not women are the salary earners of the family, as it is easier for them to find jobs as domestic help.
• In 2 cases domestic violence from husbands has been admitted to, as well as from boyfriends who exploit the women.
• Trying to make a new life is the major concern of these women, who experience a deep trauma of changing both country and circumstances. Back home they were housewives and had a qualified job (teachers, blue collar workers, higher education etc.). Having to start all over again, as well as feeling and/or being treated as second class citizens creates bitterness in them.
• The group experiences high insecurity – to keep their job, to create a sustainable income for their children’s future, often to have to provide for their relatives who have been left behind to their home country, to have to deal with their partners’ depression and violence.
• Their work is hard and often insecure.
• “I have to look after so many things, I can’t cope, I try to have dignity for myself and my family sometimes I crack.”
• Most can communicate well in the Greek language. Expressing themselves de profundis, as it were, is not as easy for them in a foreign language (in certain cases, an interpreter was needed).

With respect to health and smoking
• The participants have a deep but not expressed concern about their health, especially the older women, who often adapt an attitude of feeling sorry for themselves. Very seldom and only in acute cases do they go to hospitals.
• It is the family’s health that comes first though. However, the participants have noted the difficulty of access to public health services, as well as their own lack of knowledge on health issues.
• Smoking is very much part of the culture in the countries of the participants’ origin. Women very seldom stop to think about it. Some have already realized they suffer from the bad effects of tobacco (throat problems, respiration difficulties, heart problems etc.). Some regard it as the only “joy” they can afford, some others fear tobacco will kill them, but have a passive attitude (“Oh well, my health is ruined anyway”, “I’m not so important, anyway”)
• Most do not want their children to smoke, because “it is a bad habit”.
The group’s evaluation of the training programme

They liked
The feeling of participation and support that the group offered to them.
The fact that these training sessions were perhaps the first time they were not treated as second class citizens.
The overall support offered to them, on such issues as the legal system, the public services, health, psychological support etc.

Concerns
- “Smoking cannot become a priority. My life is such a mess, so hectic, so insecure…”
- Fear of not keeping up to the promise they made to reduce smoking.
- Need further support from their family in a variety of issues, before they be in a position to focus more on themselves and their smoking.

Behavioural changes
Smoking was indeed put in their agenda.
3 reduced.

The trainers feedback
- The group was not consistent in their participation.
- A lot of help was needed on peripheral, practical issues (legal, health, violence, work, Greek language et.al.)
- There were pros and cons in this specific ways of segmentation. It was a good thing that the immigrants shared their common concerns. However, young immigrant women tend to share the same mentality with the Greek women, more than they do with their mothers, for example. By the same token, the group would often shift the focus of the discussion towards the specific to the immigrants’ problems.
- The participants were much more introvert than the Greek women, perhaps due to their lack of fluent knowledge of Greek.
Group 4: Mixed (unemployed, 45+) – 9 participants

Demographics
5 participants are 45+ (4 over 55), out of whom: 2 employed, 1 retired, 2 housewives (all have children)
4 unemployed (30-45). 2 unqualified, 2 qualified. 2 married no children

Overall group description - Major concerns
• Obviously this was not a homogenous group, unified due to lack of higher numbers which would allow the development of 2 groups.
• Within the group each of the 2 internal groups had a lot in common. However, both shared a feeling discouragement from life.
• Children are always a concern. The group faces serious money problems (as only 2 have got a job), often coupled with a feeling of being useless, not having achieved anything in life. In certain cases where a partner is present, the participants struggle with blaming him of being a loser and having remorses for being so hard on him.
• The older age segment faces health problems of parents and in-laws, the responsibility of looking after them has been undertaken by the participants. The same women are always busy, always worried. On top of that, they do not feel important. All have used minor tranquillisers at certain periods in their life, without prescription.
• The group of the unemployed often feel at a dead-end and having failed in their life. They are at a loss as to what to do.

The group’s evaluation of the training programme

They liked
• The support offered to them, the fact they came together with other women. A certain feeling of isolation that the participants had shifted through these regular meetings. The fact that they felt that alternatives were indeed available for them.

Concerns
• “Am I really capable of change?” (women 45+)
• “O.K. But first I have to find a job. After that I can more easily consider other aspects of my life” (unemployed)

Behavioural changes
All tried to give up.
4 successfully.

The trainers feedback
• Constant participation.
• The less homogenous group.
• Interested in discussion, more eloquent than other groups – their situation (feeling isolated or marginalized) had given them a chance to think things over
• This group seemed initially less easy to change drastically. However, they wanted to do something good for themselves, willing to try.
• The training material proved very helpful.
3 intuitive groups

By the initiative of the participants in the open days and the coming together sessions in various areas in Greece other than Athens, 3 groups were formed as a follow-up of the second year project. More specifically:

- In Kilkis – started with 20, ended with 6
- In Giannena – started with 13, ended with 5
- In Pylos – started with 5, ended with 4

Methodology

The women who took the initiative had participated in the coming together sessions. They were given the training material, together with guidelines. Constant contact with them was developed, through telephone calls once a week. The Athenian trainers and project workers visited often.

Due to the fact that the peer leaders of the group had not had a “formal” training during the 1st year, the new groups that were formed worked a lot ad hoc, according to the participants’ needs and the “trainers” personality and skills.

Group description

The groups were mixed. It so happened that the majority of the participants were women up to 35 years old, i.e. more open-minded women with less family obligations. Also a strong participation in terms of involvement was noted by women around 45, with a background of dynamic involvement in community matters.

The participants’ feedback

Due to the lack of homogeneity and constant participation, it is not possible to give a coherent outline of the groups.

The following aspects should be noted:

- Low income women in the country are to a large extent dependent totally on either their parents (if single) or their husbands (if married), especially those occupied in agriculture. They offer their work without being paid or being eligible for a pension.
- It is difficult to distinguish who are unemployed, as the trend is for women to stay at home or contribute to the family income by working at the family small farm, shop etc. In both cases, this situation may not be voluntary unemployment. The women may be forced not to work, according to their family’s attitude.
- Especially young women, have very few opportunities for developing themselves in terms of a further education or a career. They are obliged to move to a bigger urban area, very often to Athens or Thessaloniki, the 2 big Greek cities that amount for more than half of the Greek population.
- Low income women are much less isolated in the rural areas, where community bonds are much more tight than in big cities. However, the pressure to conform, the obstacles to developing an independent personality are equally high.
Men in general and also low income men in the country have many more opportunities for socializing (going to the village “kafeneion”-coffee shop), whereas women are supposed to stay at home.

Smoking patterns, however, are very similar to those in Athens.

As far as the training is concerned the participants feedback was very favourable.

They liked:
- The aspect of socializing
- The concept of re-considering their lives in terms that they themselves develop (not what anybody says and thinks, but what the women themselves wish and need)
- The feeling of belonging to a group with similar aspirations
- The fact that they had the chance to discuss family, children, relationships, health, work opportunities, within a context that considered them worthy and important.

Their concerns focused mostly on the fact that
Their family and peers made fun of their participation in many occasions (“this is a women’s think, like gossiping or shopping or grumbling”, “don’t you have anything more serious to do?”)

Behavioural change
All in all 5 gave up, 10 reduced.

Trainers’ feedback
- The women did not have constant participation.
- The training material was helpful, but the women were not as ready to respond and open up as in urban areas. The fact that the women knew each other in advance replicated the group dynamics of the community.
- The participants in many instances became themselves opinion leaders in their family and peers, not only about smoking, but also about healthy eating, children upbringing etc.
The Professionals’ group

Rationale

Mainly through the network of the Institute and also with the help of the Research Centre of Women’s Affairs, a women’s group that we co-operate very closely with, the Institute invited professionals that have the opportunity to work with low income women in various occasions, to work together in order to develop guidelines for their own use.

The lack of organised structures that deal, consult, support on the issue of smoking in the health, education and community social sectors in Greece does not mean that professionals may not bring forth the issue of smoking when dealing with patients, customers, community members, students. Even more so, as they tend to have repeated contacts with them, building thus a relationship of trust.

Participants

The participants included doctors in public hospitals, dentists, social and community workers, nurses, teachers.

The group was mixed (both smokers and non-smokers)

Methodology

- The participants were presented the scope of the project as well as the work/results that was done so far. Emphasis was given on the non-judgemental approach.
- Elements of Motivational interviewing were selected so as to form a methodology of establishing contact with low income women smokers and putting gradually smoking in their agenda.
- The participants were asked to go back to work and start using this method, to share their feedback with their group, in an on-going process of getting better themselves and learning from the implementation of the process.

Feedback

- There was initially high inertia w.r.t. the non-judgemental approach. Inherent to this group is the attitude that their role is to tell others what to do.
- The professional participants tend to think that their “clients” should make decisions rationally. A lot of effort was needed to show the complexity of making choices and establishing a behavioural change, mainly through asking the participants to analyse their own behaviour.
- Smokers were more responsive to this.
Training material works better in urban areas, with younger women (not mothers) and 35+. Helps with finding a job, dealing with relationships, dealing with stress.
The evaluation process

Two questionnaires were created and were given to the participants. The first one with the title “Personal needs”, with the aim to monitor their propensity to change, was distributed to the participants 3 times: before the beginning of the project, at the 6th session and after the completion of the project. The second one with the title “Programme evaluation questionnaire” was distributed to them twice: after the 6th session and after the completion of the project.

The questionnaires were also distributed among the participants of the less structured sessions in the country. Their response is similar to the response of the trainees. When we present the questionnaire results, they refer to the overall participants, although focus is given to the answers of the trainees. When a differentiating point between the respondents from Athens and those in the country arises, we shall make a special note.

In the 2 following pages the two questionnaires are presented.
PERSONAL NEEDS

This questionnaire has been formed so that we learn what your needs are, so that we may be in a position to make the group sessions as relevant for you as possible. Please take a little while to complete it. Thank you for your help.

1. How would you describe your smoking situation:
   - You never think of quitting
   - You sometimes consider quitting
   - You are planning to quit
   - You have quit

2. How would you describe your life
   Healthy    unhealthy    don’t know

3. Do you smoke in front of non-smokers (inclusive of your colleagues at work, your children, etc.)
   Always    never    after asking for their permission

4. How would you describe your situation w.r.t:
   neutral
   Satisfactory    unsatisfactory
   Work
   finances
   parents
   partner
   children
   social circle
   your health
   yourself

5. How many cigarettes do you smoke daily?
   - less than half a pack
   - less than a pack
   - one pack
   - one and a half pack
   - two packs
   - more than two packs
This is a questionnaire meant to evaluate the sessions you are participating at. Please take not more than 5 minutes to complete it. We will appreciate it, if you are sincere and demanding. Your help is very important for the development of this programme, but also for future use throughout Europe. Thank you for your time.

1. Which group do you belong to?
Group A  Group B  Group C  Group D

2. Which of the following elements of the group sessions would you describe as positive and which as negative (please tick accordingly):

+   -

The trainer
The training material
Your fellow participants
The content
The lectures and presentations from outside professionals
The opportunity for one-to-one counselling
The social activities every 15 days

3. Do you find the interaction among the group participants:
Indispensable  helpful  irrelevant  annoying  negative  absent

4. Which of the elements of the “philosophy” of the sessions do you find positive, which negative and which absent (please tick accordingly):

Positive  negative  absent

We are here to help you help yourself
You are the one who knows best
Take a closer look at yourself
Don’t ignore your needs
Change is an on-going process

5. Which of the following activities/ events did you (please tick accordingly):

Like  dislike  neither like nor dislike

Presentation on women’s health
Presentation on stress management
Presentation on children
Presentation on education, employment
Presentation on legal issues
Going out for dinner
<table>
<thead>
<tr>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Going to galleries/ museums</td>
</tr>
<tr>
<td>Going to the cinema/ theatre</td>
</tr>
<tr>
<td>The party</td>
</tr>
</tbody>
</table>
The compared results of the 3 questionnaires are as follows:

**PERSONAL NEEDS QUESTIONNAIRE**

1. **How would you describe your smoking situation?**

   Before the beginning of the training sessions, 6 out of 10 participants claimed never to have considered quitting, 3 to sometimes consider it and one to be planning to.

   One would have expected that to have decided to participate in the project, the participants would be at least considering to give up smoking, but this is not the case. Apparently, their reasons for participating in the project are more general, like wanting to do something good for themselves, but mostly trying to socialize, find friends, support.

   It is interesting to note the development of this attitude throughout the duration of the project. After the 6th session, only 1 out of the 6 participants that had claimed never to have thought of quitting, persisted in her attitude, whereas 4 now sometimes think of quitting and 1 was at that point planning to quit. By the completion of the sessions, the remaining 1 out of the “never thinking of quitting” group, had shifted towards thinking of quitting and all but one out of the “sometimes thinking of quitting” group had shifted to the planning to quit group.

   The same shifting procedure was noted among the initial group of those who sometimes thought of giving up.

   By monitoring the propensity to change (quitting in this instant), we have proven that the sessions worked successfully in terms of the cycle of change, by triggering (not in an explicit way) sensitization on smoking cessation and by helping/empowering participants with vague considerations to articulate their wish and/or determination to quit.

2. **How would you describe your life?**

   It is interesting to note that almost half of the participants did not know initially how to comment on their health/unhealthy living. Apparently, they had never considered the issue or they did not actually know what could be considered healthy and unhealthy. This lack of information combined with a general idea that modern living is unhealthy came up very often during the sessions.

   It is interesting to note that after the 6th session, an overwhelming 70% of the participants characterized their way of living as unhealthy, an opinion that shifted yet again after the 12th session. The reason for this harsh self-criticism was perhaps due to the information the participants gained during the sessions, that led them to compare what they had learned with how they lived. Such an attitude was noted for a variety of issues, especially after the participation of invited professionals to talk about matters of interest. Sometimes the women despaired through accumulation of information and that had the risk of their giving up the effort to change. The sessions then focused
... more closely on the nature of change (gradual) and the empowerment effort (love yourself, you can do it, you are in control).

The completion questionnaire reflects the efforts of the participants to make their life more healthy. Only 10% do not know how to characterize their way of life and 50% consider it healthy.

3. **Do you smoke in the presence of non-smokers?**

The vast majority of the participants do not respect non-smokers at the initial phase of the questionnaire. This attitude changed drastically at the second phase, whereby 4 out of 10 claim not to smoke in front of their children and to try and compromise at work. By the completion of the project 6 out of 10 participants claim to respect non-smokers and the remaining ones, argue that they should have better help to do this (e.g. smoking rooms and/or a smoking break at work and in other public places, some help at home with the children et.al.)

4. **How would you describe yourself w.r.t. work, finances, parents, children etc.?**

This is a question difficult to assess. The response of the different groups varies. For example, the young women tend to be initially more satisfied and much less neutral, compared to, say, the immigrants who are more dissatisfied and neutral initially. The older women are much more neutral and the unemployed much more dissatisfied than the other groups and the young mothers are initially more satisfied.

As an overall conclusion, we should note the same trend spotted in the second question, whereby women shift towards increased dissatisfaction, as part of their internal and group process of spotting out the real issues in their lives.

One thing is certain: neutrality retreats as the sessions proceed. The participants become actors in their lives, but the transition may be traumatic initially.

Taking life in their hands does not necessarily mean that the actual circumstances of the participants’ lives change. However, some of the participants will regard them with a more optimistic perspective – thus describing them as satisfactory by the end of the project. Satisfactory means that “I am in control and that gives me the opportunity to make them actually more satisfactory”. Some of the participants tend to regard the circumstances of their life, after the completion of the project less satisfactory than at the beginning. Not satisfactory means “I will no longer pretend I like my life or that I do not care. I am in a position to face the truth. I want to do something about changing my life for the better”.

5. **How many cigarettes do you smoke daily?**

Initially the vast majority of the participants smoked between one and two packs daily.

The trend throughout the sessions was diminishing the quantity of cigarette consumption, not dramatically during the first 6 sessions, but by the end of the project, the vast majority had managed to achieve 1 pack and less. It is interesting to
note that after the completion of the project 3 out of 4 participants of the training sessions claimed they had either reduced or were planning to reduce smoking.
2. Which of the following elements would you describe as positive or negative?

The trainers, the outsiders (professionals as lecturers) and the social activities gained positive comments by the majority of the participants throughout the duration of the project.

The contribution of the fellow-participants was positive for 60%.

As far as the training material and the content of training was concerned, after the 6th session there was negative response from 46% of the participants (especially young mothers, immigrants and certain unemployed women). They claimed frustration because they could not see the point of the approach: “If we are here to discuss smoking, why do we have to talk about our whole lives?” They seemed not to understand the process and also they felt threatened. Some of them even asked the trainers to tell them what they should do. Getting in control, re-evaluating seemed a premature process for them. The negative response to the training material and the content of training retreated to 17% by the end of the project.

Since this negative feeling was in a position to undermine the successful development of the project, the trainers and the project workers initiated discussions on the issue, wherefrom we have the above comments. Important reasons for this attitude are that low-income women are not accustomed to making free choices, they are used to being told what to do and they also have a low self-esteem. In a sense, the ones that responded negatively did not actually believe that their lives could change and they also lacked support from the ones nearest to them (husbands, peers).

3. How do you find the interaction among the group participants?

The majority of the participants find the interaction helpful. 1 out of 4, however, find it negative, especially those from the country, where the group dynamics reflect very closely the established relationships within community.

Negative interaction is also due to the group dynamics as perceived by certain participants, who either fail to integrate or regard criticism (and in many cases, there was heavy criticism by the members of the group) as negative. Apparently, in some cases, sharing was primarily viewed through a judging lens, both for oneself and for others. This was an aspect, a frame of mind, an approach which was difficult to overcome, but was indeed overcome in the majority of the groups.

4. Which of the elements of the “philosophy” of the sessions do you find positive, which negative and which absent?

5. Which of the following activities/events did you like, dislike?
All of the elements and activities were considered positive throughout the duration of the project.
An attempt towards an integrated framework for working with low income women smokers against tobacco

Two seem to be the paremeters of working on the issue of putting tobacco on the agenda of low income women and working with the them on the issue of smoking cessation:

Focus and expansion on the one hand
Individual and group work

Both are indispensable if we are to tackle the issue holistically.

Expansion is needed, as smoking is not an isolated issue within the overall framework of low-income women’s lives. Indeed empowerment is an attitude that requires an overall behavioural modification from the part of the individuals involved. According to this principle smoking has to become part of a new way of looking at health and every day well being.

Focus is needed at the stages of decision to change. By the same token, smoking cessation is a very specific issue and we should not wait for the moment where women are utterly ready to take life in their hands (which is a purely theoretical moment indeed). Change and emancipation are a process. In this context, smoking reduction and/ or cessation are a goal in themselves, as well as means of achieving emancipation and well being overall.

In the specific context of this project, expansion is needed to explain the nature of dependence, the process of change and also of supporting the women after cessation, whereas focus is needed to give women the tools of evaluating smoking, finding their own ways of quitting, as well to support them in their specific decision.

On the other hand, group work can provide invaluable assistance in triggering women to enter the decision to change process, as the group can contribute to their understanding the nature of their dependence, to their modifying their self-image, to their feeling of belonging to a group with similar problems, acting as a mirror.

Individual work may help on specific issues individuals may be having as well as it may support women who are reluctant to work in groups. It is also relevant in cases of providing additional support on all stages of the decision to change process.
It is clear that group work should be available in organized structures where public and community services would be in a position both to fund it and to guide those in need to take advantage of it. Individual work could be offered more easily perhaps, but is more costly, especially in countries like Greece, where anti-smoking support is absent.

Expansion practically means that smoking could be incorporated in all public and community services for the public health and well being. But, this is but a prelude to changing smoking behaviour, so focused assistance should be available as well.

Group and individual work in the context of Greece could take place by the professionals’ initiatives. Those professionals working with low-income women smokers can incorporate the expanded or the focused approach, especially in the early stages of the decision to change process. From their part, they as well may work individually and also as a group. For example, in a hospital, a specific nurse could motivate a patient towards putting smoking in her agenda, but her work would be much more efficient, if the doctor was to support her, as well as the hospital’s policies. The same would hold for schools, where teachers, sports teachers, the parents’ association etc. could work in a complementary way to help girls against tobacco.
Introduction

The work carried out by the Ulster Cancer Foundation in Year One of the Women Smoking and Low Income project highlighted the need for interventions that took an indirect and holistic approach to smoking cessation.

The one to one nature of the intervention in Year One proved preferable for many women. Namely women who felt that they had reacted negatively to public health campaigns and for those who felt that group sessions on smoking cessation were ineffective for them. This particular group of women described themselves as ‘stuck’ in their own thinking. On the one hand they were aware of the dangers associated with continuing to smoke, yet, they were also very concerned about issues such as rising stress levels and weight gain if they should quit. Without third party assistance this circular thinking was likely to continue indefinitely.

Year One therefore focused on testing whether women in this situation would react positively to Motivational Interviewing and whether it would move them further along the cycle of change. The experiences from Year One directed the programme for Year Two. Year Two subsequently focused on introducing the skills of Motivational Interviewing (M.I.) to key people within communities of low income so that more women would have opportunities to raise the issue of tobacco in a non-threatening way.

The objectives of Year Two were:

1) To create opportunities for communities to gain the skills of Motivational Interviewing for use in new or established community based cessation programmes.

2) To train suitable individuals in the skills of Motivational Interviewing with a view to working in the community with women who are resistant to participating in cessation programmes but who are interested in exploring ways of changing other areas in their lives. This would be viewed as agenda setting for any future interest they might have in tackling cessation.

3) To increase the number of trained people in the community who can run smoking cessation sessions.

The purpose of the project was to involve local people, community workers and health professionals in the development of a resource that could be used to raise the awareness of tobacco issues and the influences on the individual and the community.
This resource took the form of:

1) A number of key community workers acquiring the skills of Motivational Interviewing and smoking cessation.

2) A resource pack and support network for those trained in the skills, which would enhance the sustainability of the intervention.

The emphasis in Year Two was therefore on creating a network of skilled people within communities who could use the skills of Motivational Interviewing to assist women to initiate and manage change in their lives.

The Process

Partnerships

Similar to studies carried out in Scotland, which also address women, smoking and low income (1234), the UCF recognised the need to work collaboratively with partners who had already established links in the community. In Year Two the UCF worked with the South and East Belfast Health and Social Services Trust to consult with key people within the community in the areas of South and East Belfast and Castlereagh about the feasibility and interest in training people with the skills of M.I. and smoking cessation.

Consultation

A number of meetings were held in local community centres to which community workers and health professionals were invited. The project was discussed in full on two levels:

1) The philosophy behind the intervention.

2) The practicalities of implementation.

The idea of the project was well received and participants agreed to identify at least two members of their communities who would be suitable and available for training. The specific nature of the skills required for M.I. were addressed and it was agreed that a selection criteria should be drawn up and distributed. This would assist the participants in selecting people who would most benefit from training of this sort.

Criteria

The following criteria were drawn up as guidelines for selection:

1) Respect for the smoker and their freedom of choice and self direction.

2) Empathy for the difficulties associated with an addiction to tobacco.

3) A good listener.

4) A preparedness to work outside of the ‘expert’ role.
5) A good knowledge of the community and its support networks.
6) A willingness to receive feedback.
7) A willingness to practice with feedback.
8) An openness to learn.

It was also suggested that a useful background for those undertaking Motivational Interviewing training would have:

a) Experience of working one to one or in small groups, with a proven record of having a natural rapport with people.

b) An understanding of the principles of good health promotion practice.

**Motivational Interviewing training**

Two days were chosen for training in Motivational Interviewing skills. The participants were a selection of community workers and volunteers, practice nurses attached to GP surgeries, counselors and health visitors working in the community. An experienced motivational interviewer whose background was in addiction, social work and health promotion carried out the training. The aim of the training was to equip the participants with a basic knowledge of the principles and skills of M.I. as they relate to interventions in smoking cessation. The participants explored the Stages of Change model (5) and the principles and spirit of M.I. They had opportunities to practice basic skills and to explore strategies for dealing with resistance.

**Feedback**

The training was well received by all the participants with all of them claiming it met their expectations. Some participants recognised that they were already using Motivational Interviewing skills in their work but in an unstructured way.

“I would use a lot of the skills required for motivational interviewing, but my technique would not always be so directive…. this (training) will make me more aware of trying to structure my interviews”

Most of the participants however said that they would not normally use M.I. skills in their work but that the course had highlighted the value of the skills and felt that they would try to incorporate them in the future.

“I would not normally be as directive in my work… I feel I will be able to apply the use of ‘more selective reflection’ to elicit self motivating statements.”

“It made me think more about what I was saying to the person”

The most common reason given as a difference in how they normally worked was in advice giving roles.

“I am more inclined to give advice to patients…. However I will now be more inclined to involve them in the decision making.”
Most people said the course had prompted them to try to delay advice-giving and reflect on their conversations to ascertain what ideas the person might have to resolve their own situation. The main obstacle anticipated by the participants was time.

“I went away from the training thinking I would love to use the techniques, but where am I going to get the time”

Most felt that they already had huge workloads and this seemed like another task and also one that would require considerable practice.

From an organisers point of view our disappointment was the low attendance of community workers in comparison to the health workers. Further discussion revealed that some of this was due to an administrative error and unsuitability of dates. However, one other factor highlighted was the need to follow up letters with personal phone calls and/or meetings to consolidate commitment. This imbalance elicited interesting reactions in the participants. One of the community workers felt that the imbalance meant that the health workers got more from the course. The health workers on the other hand were disappointed that more community people were not there as they had come with the expectation of training together and consequently to work alongside them in the community. These perceptions highlighted for us the significance of the differences in practice and interpretations of roles between the voluntary/community sector and the health sector.

To address the imbalance between the number of community workers and health professionals additional training was arranged for later in the year.

Follow up/support

The first of the follow up/support meetings took place three weeks after the training. The participants were tasked to come back having consciously used M.I. skills on at least one occasion and to take brief notes. The trainer and the project worker facilitated the morning. Unfortunately, the participants from the community centres were not at this meeting. Two because of a diary mix up in their centre and another because of illness in the family. The response from those who were able to attend the support meeting was encouraging.

As anticipated, the issue of time was a major theme. The facilitator addressed this by relating to individual circumstances and illustrating how this skill could be incorporated into current practice rather than being viewed as an extra piece of work.

The experiences of the participants varied. Some had positive stories to relate reporting that they felt they had listened to their clients more and as a result they felt they got new and more information than usual. Consequently they reported that they responded differently and went down different avenues of advice. They also reported that their clients seemed to enjoy the conversation better and were more open and responsive. Everyone agreed that using the skills required more mental energy and felt tired at the end of the discussions.

Others reported that using the skills highlighted for them how little they actually listened to people’s conversations and how using the skills meant that they delayed their advice giving. The pressure to give advice was very strong for the health
professionals. They felt that they were trained to think of themselves as advice givers and that the public also had that expectation.

Linked with the issue of time was confidence. Feeling inexperienced led some people to underestimate the impact they might have had. Retelling their experiences and accepting the positive feedback that was offered from other group members and the facilitator altered their perceptions of their ability to incorporate these skills. The supportive element of the morning was very important.

**Resource Pack**

As part of the training the participants were given a draft resource pack. The pack covered the theory and principles behind M.I., the core and micro skills and strategies for handling resistance.

The overall response to the pack was that it was useful, particularly for revising the skills before a situation where they anticipated using them. They also reported that it helped them to clarify their understanding of the approach. Those who responded asked for references for further reading on the subject of Motivational Interviewing and an outline of information about support agencies for smoking cessation and related subjects. It was felt that these would be useful in circumstances where issues arose which they felt they were unqualified to advise on.

**Smoking Cessation Training**

Those who were trained in Motivational Interviewing were also offered free training in smoking cessation. This was a two-day course, which was conducted by a member of staff from the Ulster Cancer Foundation. It was intended to give participants an understanding of the smoking habit, the process of stopping and guidelines on setting up a stop smoking group for those who chose to take that route.

One of the aspects of the course that the participants cited as the most valuable for them was, the information on the effects of smoking. They appreciated the opportunity to ask questions and get information clarified directly from ‘the experts’ (an organization which is directly concerned with cancer). They acknowledged their own lack of confidence about their level of knowledge when it came to some of the misinformation they hear in the process of their work with smokers. Also, the opportunity to attend both courses helped the participants to focus the skills of Motivational Interviewing on tobacco and related issues.

**Conclusion**

The process

To integrate skills into the community requires a lot of groundwork in order to establish commitment. The intervention in the second year could best be described as
a process that was slow to establish and one that could not be rushed. For success in this intervention there were a number of necessary elements:

- patience
- awareness of how systems operate in the community as opposed to the health care settings
- understanding of the perceptions of roles in the community
- dedicated time and resources for someone to follow up activities and sustain momentum

In these circumstances it is easy to interpret slow progress, administrative errors and initial low attendance as setbacks. But viewed positively as part and parcel of working in the community these difficulties were viewed as the fabric of our learning process and fundamental lessons were learnt about how to progress in the future.

Lessons learned

There were many benefits to working in partnership with another organisation.

- The combined community networks and contacts of the two organisations meant that there was greater access to key community workers.
- Tapping into existing networks speeded up the process since working relationships had already been built up.
- The advantages of combining financial and administrative resources were that more training and support could be offered throughout the programme.
- Working in partnership meant that two organisations worked together with similar objectives sharing expertise and knowledge thus avoiding the duplication of work and the consequent waste of valuable resources.

The experience from Year One of the project was reflected in the response from those trained in Year Two. There was a very positive reaction from those who used the skills after their initial training. Those who were trained spoke of better relationships with smokers:

“I found I got more information from her and as result I went down a very different avenue than I would have before this”

“I got much more of a response from my client and I honestly think she enjoyed talking to me more.”

Some felt that they were able to bring up the subject of smoking without the person getting defensive.

“Before when I brought up the subject about smoking she just didn’t want to know, but this time she actually talked to me!”

Many mentioned that this technique allowed more opportunity to talk about smoking indirectly. However, just as many spoke of how much harder it was to listen rather than give straight advice or information.

“Boy it was hard work, I was exhausted after it. It made me realise how little I actually listen to people”
There was a strong desire expressed for opportunities to practice the skills and to have access to feedback and support from the trainer or others experienced in Motivational Interviewing skills.

The prime objective of Year Two was to introduce the skills of Motivational Interviewing to key people who worked in the community. By increasing the number trained in Motivational Interviewing skills women who smoked would have access to skilled people who could address the issues of smoking with them in a non-judgmental and non-clinical setting.

We had success in attracting community health workers to attend courses and practice the skills. However, despite our efforts we were disappointed with the number of community workers who attended the training.

The community health workers define their role as facilitators of behaviour change in relation to health. Traditionally they do this through advice and information giving. The community development workers on the other hand do not have such a clearly defined role. It is also not specifically health, thus other priorities can easily take over. The reasons for the low attendance figures included, illness, family commitments or unsuitable dates. In one of the community areas political disturbances the weekend before the training meant that their focus shifted onto more immediate community concerns.

**Recommendations**

The following recommendations are made in light of the lessons learnt over the duration of the Smoking, Women and Low Income Project. They have been made with the underlying tenet that, using the skills of Motivational Interviewing with people who are unable to move themselves along the Cycle of Change, is a successful intervention.

**Specific recommendations from Year Two**

1. The work begun in the Smoking, Women and Low Income should continue beyond the life of the project.
2. Motivational Interviewing skills are acquired through practice. In practical terms this can start to be addressed when planning training. By spreading the training over a longer period of time with shorter sessions will extend the amount of contact time with the trainers thus encouraging more practice and feedback. It will also allow more time for participants to assimilate the knowledge and skills.
3. Specific targeting of community groups or groups of interest will result in more skilled people in one area. This will offer more peer support for trained individuals and encourage a more integrated approach to smoking cessation throughout that community.
4. Plans for the future will need to involve our partners and ourselves taking on a more direct advocacy role. There is a great need for joint working between community development bodies and smoking cessation groups to set the tobacco agenda higher among groups who have direct access to smokers in the community.

5. Support is the most important resource that can be offered to the practitioner of Motivational Interviewing skills. If the skills are to survive there is a great need for a support network for practitioners to be established in Northern Ireland. It would be worth investigating the feasibility of a multidisciplinary group where experiences and perspectives could be usefully shared. Alternatively or in tandem with, small groups could be established to offer more immediate support to new learners.

7. Motivational Interviewing is not a technique that should be viewed in isolation from, or instead of, other health education interventions. It needs to be fully supported by other programmes within the community and offered as an ongoing resource that is easily accessible to women.

General recommendations

1. For many women smoking is a strategy for coping with other issues. Women raise many serious life issues and stresses as they go through the process of Motivational Interviewing. Consequently it is recommended that health promoters strengthen their links with agencies responsible for mental health with a view to building community based preventative mental health programmes.

2. Further research is needed on the effects of health education/promotion campaigns on smokers. The indications from the pilot research are that many health promotion campaigns may be counterproductive. It may well be that for many women every message that points out the reasons why they should not smoke reinforces their sense of failure.

3. The pilot research also highlighted some poignant comments from women about how they react to their children worrying or trying to get them to stop smoking. Knowledge of how women react and feel about pressure from family and in particular children could be incorporated into other health promotion programmes. The most obvious one being the schools education programmes as these are the most likely to have a direct impact on the women. Elements in these programmes that empower young people to communicate their opinions and perhaps fears in a sensitive way, could have far reaching effects in terms of their role as health promoters for their parents.


