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Smoking Prevention Strategies: Identifying Initiation and Cessation Reasons and Intervention Methods

Sigara Kullanımını Önleme Stratejileri: Başlama ve Bırakma Nedenlerinin Tespiti ile Müdahale Yöntemleri

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ABSTRACT

The aim of this study is to gather specific data concerning smoking, elucidate the reasons behind individuals' initiation and cessation of smoking, explore strategies for preventing smoking initiation, and understand how to provide support for individuals who desire to quit. A cross-sectional study was conducted via face-to-face surveys on 309 individuals selected through systematic sampling among 5880 individuals aged 15 and over registered at a family health center in the Kayapınar district of Diyarbakır province in Türkiye between December 2016 and January 2017. The study found that 30.4% of the participants were current smokers, while 14.6% were quitters. Approximately 92% of the participants supported the law banning tobacco use in enclosed spaces. It was determined that before the age of 18, 78% of individuals tried smoking for the first time, and 47.5% of them started smoking regularly. The most common reasons for starting smoking were cited as peer influence, curiosity, and emulation. 66.3% of the participants indicated their support for a government-imposed complete ban, while 65% of smokers stated that they would quit smoking if such a prohibition were in place. The study identified a high prevalence of smoking in the region, and smoking initiation occurs at young ages. A notable proportion of smoking participants expressed a desire to quit; however, there appears to be a lack of support for those seeking to quit.

Keywords: Smoking, Smoking cessation, Smoking prevention, Tobacco control

ÖZ

Bu çalışmanın amacı, sigara içme konusunda belirli verileri toplamak, sigaraya başlama ve bırakma nedenlerini açıklamak, sigara içmeye başlamayı önleme ve sigarayı bırakmak isteyenlere destek sağlama yollarını araştırmaktır. Kesitsel nitelikte olan bu çalışmada, Aralık 2016 ile Ocak 2017 tarihleri arasında, Diyarbakır ilinin Kayapınar ilçesinde bulunan bir aile sağlığı merkezine kayıtlı 15 yaş ve üzeri olan 5880 kişiden sistematik örnekleme yöntemiyle seçilen 309 kişiye yüzyüze anket uygulanmıştır. Çalışmada katılımcıların %30,4'ünün sigara içen, %14,6'sının ise sigarayı bırakan kişilerden oluştuğu belirlenmiştir. Katılımcıların yaklaşık %92'si, kapalı alanlarda tütün kullanımını yasaklayan yasayı desteklemiştir. Katılımcıların %78'inin ilk kez 18 yaşından önce sigarayı denediği ve %47,5'inin yine bu yaşlarda düzenli olarak sigara içmeye başladığı tespit edilmiştir. Sigaraya başlama nedenlerinin en yaygın olanları arkadaş etkisi, merak ve özenti olarak belirtilmiştir. Katılımcıların %66,3'ü, devlet tarafından tütün ürünlerine uygulanacak tam bir yasağa destek vereceklerini belirtirken, sigara içenlerin %65'i böyle bir yasağın olması durumunda sigarayı bırakacaklarını ifade etmiştir. Çalışma, bölgede yüksek sigara kullanım prevelansını ve sigara içmeye genç yaşlarda başlandığını göstermektedir. Sigara içen katılımcıların önemli bir kısmı sigarayı bırakmak istediğini dile getirmekte iken, bırakmak isteyenlere destek sağlanmasında eksiklik olduğu tespit edilmiştir.

Anahtar Kelimeler: Sigara içme, Sigarayı bırakma, Sigarayı önleme, Tütün kontrolü

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INTRODUCTION

The global tobacco epidemic is one of the most important public health problems the world has faced so far, causing the death of approximately 8 million people each year. More than 7 million of these deaths are directly related to tobacco use, while the remainder are due to passive exposure to the smoke of tobacco products.[1]

In 1998, Dr. Gro Harlem Brundtland, the former Director-General of the World Health Organization (WHO), stated that tobacco use is one of the most significant health catastrophes in human history. It is estimated that if preventive measures are not taken, the tobacco epidemic, which caused the deaths of approximately 100 million people in the 20th century, will lead to the deaths of 1 billion people in the 21st century.[2] Therefore the 3.a target of the third goal of the United Nations' (UN) Sustainable Development Goals specifically focuses on tobacco control programs. The indicator for this target is the prevalence of smoking among the population aged 15 years and older.[3]

Tobacco use has not only health-related consequences but also economic and environmental impacts. Among its economic impacts are not only the money spent on purchasing tobacco but also the costs associated with diagnosing and treating health problems resulting from tobacco use, as well as the loss of productivity due to health issues.[4] Additionally, tobacco's environmental effects, which also impact the economy, include pollution caused by smoke and waste, the use of pesticides in tobacco farming, the destruction of forest lands, and forest fires.[5]

In 2008, the WHO initiated the MPOWER policy package for tobacco control. This package includes policies generally aimed at preventing individuals from initiating smoking, assisting smokers in quitting, and reducing accessibility.[2]

In Türkiye, the fight against smoking gained momentum starting from 2008. In this year, all public indoor areas were included in the smoking ban, and the enforcement of penalties was clearly specified. Subsequently, quitline services and cessation clinics were established. Later on, warning messages in Turkish covering at least 65% of each side of cigarette packs were introduced, along with the prohibition of sales to individuals under 18 years of age.[6,7] With these laws and practices, all elements of the MPOWER package prepared by the WHO have been incorporated into domestic legislation and Türkiye has become 3rd "completely smoke-free" country.[7]

In this study, the primary objective was to gather specific data concerning smoking habits, elucidate the reasons behind individuals' initiation and cessation of smoking, explore strategies for preventing smoking initiation, identify the obstacles faced by those wishing to quit, and understand how to provide support for individuals who desire to quit.

MATERIAL AND METHODS

Study Design and Sample Selection

The study was conducted between December 2016 and January 2017 in the region covered by the 17th Family Health Center (FHC) in the Kayapınar district of Diyarbakır, Türkiye. The population of the cross-sectional study consisted of 5,880 individuals aged 15 and over registered with the FHC. Based on the 2012 Global Adult Tobacco Survey (GATS) in Turkey, the required sample size, using an expected smoking prevalence of 27%, a 95% confidence interval, and a 5% margin of error, was calculated to be approximately 289 participants.[4] To account for potential non-responses, a total of 320 individuals were targeted and selected through systematic sampling. Those who did not give consent were not included in the study, resulting in reaching 309 individuals.

Data Collection

The study was conducted through face-to-face interviews, either via home visits or inviting individuals to the FHC via telephone. Individuals who smoke cigarettes daily or regularly are referred to as "current or regular smokers." Those who used to smoke daily or regularly but no longer do so are classified as “former smokers or quitters”.

The research questionnaire consisted of three sections. The first section, administered to all participants, comprised inquiries about sociodemographic data, smoking status, and attitudes toward smoking. The second section, aimed at current smokers, explored reasons for smoking, intentions to quit. The third section targeted quitters, focusing on reasons for initiation and cessation of smoking.

Statistical analysis

Data analysis was conducted using SPSS 21.0 (IBM SPSS Corp., Armonk, NY, USA). Descriptive analyses included calculations of percentages, means, and standard deviations. Categorical data were compared using the chi-square test, while the Mann-Whitney U test was employed for non-parametric comparisons. The Kolmogorov-Smirnov test was used to assess normality. Results were considered statistically significant at $p < 0.05$, with a 95% confidence interval.

Limitations

This study acknowledges the potential for information bias, particularly in the form of recall bias, due to the inclusion of retrospective questions posed to participants. Data acquisition relied on self-reporting by the individuals involved, without employing any measurement techniques or relying on records.

Ethical Considerations

Informed consent was obtained from the participants for the research, and ethical approval was obtained from the Dicle University Medical Faculty Ethics Committee for Non-interventional Studies (Date/Number: 07.10.2016/312) and the necessary institutional permission was also obtained (Date/Number: 17.11.2016/73148353-020-565).

RESULTS AND DISCUSSION

A total of 309 people responded to the questionnaire prepared for the study. Among the participants, 54% were male and 46% were female, with a mean age of 34.4±13.3 years (ranging from 15 to 80). Current smokers constituted 30.4% of the group, 14.6% were quitters, and 55% had never smoked. Among the male participants in this study, 39.5% smoked and 37.7% had never smoked; whereas among females, these proportions were 19.7% and 75.4%, respectively ($p<0.001$). When examined by age groups, the rate never-smokers decreases with increasing age, with the 25-44 age group constituting the highest proportion of smokers at 33.1% ($p<0.001$). When compared by education level, the smoking rate decreases as education level increases, with university graduates exhibiting the lowest rate ($p=0.074$)(Table 1).

Table 1: Smoking status according to some demographic data

		Smoking Status				
		Current Smoker n (%)	Former Smoker n (%)	Never Smoker n (%)	Total n (%)*	p value**
Gender	Men	66(39.5)	38(22.8)	63(37.7)	167(54.0)	<0.001
	Women	28(19.7)	7(4.9)	107(75.4)	142(46.0)	
Age	15-24	23(29.1)	5(6.3)	51(64.6)	79(25.6)	<0.001
	25-44	55(33.1)	19(11.4)	92(55.4)	166(53.7)	
	≥45	16(25.0)	21(32.8)	27(42.2)	64(20.7)	
Education	Primary school graduates at most	35(39.3)	16(18.0)	38(42.7)	89(28.8)	0.074
	Middle or high school graduates	40(28.2)	20(14.1)	82(57.7)	142(46.0)	
	University graduates	19(24.4)	9(11.5)	50(64.1)	78(25.2)	
Total		94(30.4)	45(14.6)	170(55.0)	309(100)	

*: Column percentages are provided in this column, while other percentages represent row percentages.
**: Chi-square test was used in the statistical analysis. p<0.05

With the enactment of the law aimed at preventing the harms of tobacco products in 2008, which prohibited smoking in indoor areas, the prevalence of current smokers decreased from 31.2% in 2008 to 27.1% in 2012.[4,8] However, a notable increase to 32.5% was observed in 2014.[9] This resurgence in smoking prevalence may be attributed to factors such as weakened enforcement of the smoking ban over time, partly due to a loss of enthusiasm among policymakers that was present when the law was initially enacted, increased marketing efforts by the tobacco industry, and the introduction of new tobacco products. Despite these fluctuations, smoking prevalence remains significantly high, as indicated by the current study's finding of 30.4%. Similarly, national surveys report comparable smoking prevalence, including 31.6% in the 2016 Global Adult Tobacco Survey (GATS), 31.5% in the WHO's 2017 National Household Health Survey (NHHS), and 32.1% in the 2022 Turkish Statistical Institute (TURKSTAT) study.[10-12] These findings underscore the need for sustained tobacco control efforts and enhanced support for smoking cessation interventions to achieve lasting reductions in smoking rates.

In the GATS 2008, the smoking and cessation rates among men were reported as 47.9% and 22.1%, respectively, while among women, they were 15.2% and 10%.[8] In 2017, the rates were found to be 43.5% and 14.8% for men, and 19.7% and 6.6% for women, respectively, with an overall prevalence of smoking of 31.5% and cessation of 10.7%.[11] In this study, similar to other research, it was observed that the prevalence of smoking and cessation among women is lower than that among men. Despite the increase in cessation rates, the prevalence of smoking remains similar or higher compared to previous studies, indicating that anti-smoking campaigns in recent years have been effective in quitting smoking to some extent but insufficient in preventing new smokers. Especially among women, the prevalence remains high and cessation rates are lower than in other studies. Thus, it can be concluded that the measures taken after the law enacted in 2008 have not yet yielded the desired results, especially for women.

In terms of regulations regarding smoking within their residences, 38.3% of smokers reported unrestricted indoor smoking. In total, 25.9% of them consider smoking permissible inside their homes, while an additional 24.9% allow smoking indoors in exceptional circumstances. This suggests that, overall, approximately half of households expose their residents or guests to the passive cigarette smoke. Former smokers were most likely to have strict indoor smoking ban, while current smokers were least likely (p=0.004) (Table 2).

Participants were also divided based on whether they had children; among those with children, 23.4% allowed indoor smoking, compared to 33.8% of those without children (p=0.02). Regarding their approval of their children smoking, 98.4% of all participants stated their disapproval. In a study conducted in a primary school in Ankara in 2008, it was

found that smoking did not occur in 42.0% of children's homes.[13] Similarly, in another study conducted in a pediatric pulmonary diseases department of a hospital, 41.7% of families reported no smoking allowed at home.[14] It is understood that individuals with children are more careful about not smoking or not allowing smoking inside the house to protect their children. However, it indicates that children are still exposed to passive smoking to some extent, as nearly a quarter of participants reported that smoking is allowed in their homes despite having children. Additionally, smoking indoors may increase the likelihood of children starting smoking due to factors such as curiosity and emulation. It is interesting that nearly all participants expressed their disapproval of their children smoking; however, smokers still smoke in front of their children, setting a bad example for them.

Furthermore, 91.9% of participants expressed support for the law prohibiting tobacco use in public indoor spaces, with only 5.8% opposing it. Despite being the most opposed group, current smokers still showed significant support at 80.9% ($p<0.001$) (Table 2). In the GATS 2012, these rates were 95.5% for the entire sample, 87.7% for smokers, and 98.5% for non-smokers.[4] In GATS 2016, the rates were 82.1% among smokers and 94.2% among non-smokers.[10] Although support for the law is lower among smokers compared to non-smokers, it remains high, suggesting that even smokers prefer clean air environments. Enforcement of this widely supported law should be closely monitored and expanded as needed to ensure smoke-free environments and protect the community from the passive effects of smoking.

Regarding a potential government-imposed total ban on cigarette sales, 66.3% of participants expressed support, with never smokers showing the highest level of endorsement, while current smokers also demonstrated notable support ($p<0.001$) (Table 2). Additionally, 64.9% of current smokers reported that they would quit smoking if such a ban were implemented. In a study conducted in England, 44.5% of participants supported a total ban on the sale of tobacco products, with the highest support among never smokers, and one-third of current smokers also endorsing the idea.[15] Similarly, a study conducted in Hong Kong found that 64.8% of participants supported a total ban on tobacco sales, including nearly half of current smokers.[16] The significant support from current smokers highlights a growing awareness of tobacco's harms, even among users. Given that other addictive drugs are already prohibited by law, a total ban on tobacco products could serve as a feasible public health intervention, potentially reducing cigarette consumption as well as tobacco-related morbidity and mortality.

When asked about their support for increased taxes on cigarettes, 54.7% of all participants expressed support, with former smokers exhibiting the highest support at 68.9% ($p<0.001$)(Table 2). In the GATS 2012 survey, support for tax increases were 72.5% across all groups, 40.3% among smokers, and 84.4% among non-smokers. Similarly, in the GATS 2016 survey, support for tax increases was 60.6% across all groups, 36.8% among smokers, and 72.2% among non-smokers.[17] In a study conducted on students of Dicle University Faculty of Medicine, 74.5% of the participants supported the increase in tobacco taxes, with 30.4% among smokers and 85.7% among non-smokers.[18]

Many studies, including ours, indicate that non-smokers support increasing tobacco taxes, possibly because higher prices could reduce the affordability of cigarettes. This reduction in affordability may prevent initiation or reinitiation and result in fewer people purchasing cigarettes, thus reducing exposure to passive smoke. The WHO's MPOWER package, especially the "R" component (raise taxes on tobacco), continues to receive significant community support. Even among smokers, nearly one-third of them support higher prices. This could be because they struggle to quit on their own, and higher prices may serve as a deterrent to smoking. Therefore, further increasing taxes can deter the purchase of tobacco, contributing to anti-smoking efforts.

Table 2. The comparison of smoking status with certain attitudes and opinions regarding smoking

Rules for Smoking Inside the House	Smoking Status				
	Current Smoker n (%)	Former Smoker n (%)	Never Smoked n (%)	Total n (%)	p value*
Smoking is allowed indoors.	36(38.3)	4(8.9)	40(23.5)	80(25.9)	0.004
Smoking is not allowed, but exceptions can be made.	22(23.4)	12(26.7)	43(25.3)	77(24.9)	
Smoking is never allowed.	36(38.3)	29(64.4)	87(51.2)	152(49.2)	
Does he/she support the law prohibiting tobacco use in enclosed spaces?					
Yes	76(80.9)	42(93.3)	166(97.6)	284(91.9)	
No	14(14.9)	2(4.4)	2(1.2)	18(5.8)	<0.001
Undecided	4((4.3)	1(2.2)	2(1.2)	7(2.2)	
Do you think cigarette sales should be completely banned by the government?					
Yes	52 (55.3)	31(68.9)	122(71.8)	205(66.3)	0.019
No	33 (35.1)	7(15.6)	34(20)	74(23.9)	
Undecided	9 (9.6)	7(15.6)	14 (8.2)	30(9.7)	
Support for Increasing Taxes on Cigarettes					
Yes	30(31.9)	31(68.9)	108(63.5)	169(54.7)	<0.001
No	61(64.9)	8(17.8)	38(22.4)	107(34.6)	
Undecided	3(3.2)	6(13.3)	24(14.1)	33(10.7)	
Total	94(100)	45(100)	170(100)	309(100)	

*: Chi-square test was used in the statistical analysis. p<0.05

Among smokers or former smokers, 5.8% stated that they first tried smoking before the age of 10, while a cumulative total of 77.7% reported trying smoking before the age of 18. Additionally, 47.5% stated that they started smoking regularly before the age of 18. When comparing by gender, it was found that the median age of first trying smoking among males was nearly 2 years earlier than females (p=0.022), while the median age of starting regular smoking was 0.5 years earlier (p=0.169) (Table 3).

Table 3. Comparison of the age of first trying and starting smoking by gender among smokers and quitters.

	n	Median (min-max)	Mean	Mean*	p value**
Age of first smoking					
Men	104	14 (5-25)	14.3	14.6	
Women	35	16 (10-21)	15.7		0.022
Age of starting to smoke regulary					
Men	104	17.5(7-27)	17.3	17.5	
Women	35	18 (13-25)	18.4		0.169

*: Both men and women
**: Mann whitney u test was used in the statistical analysis. p<0.05

In comparison, the GATS 2012 reported an average starting age of 17.1 years, and in GATS 2016, it was 17.0 years, with males starting approximately 1 year earlier.[4, 10] In 2017 it was revealed that the average age of tobacco product users nationwide was 18.1 years, while in the Southeastern Anatolia region, where this study was conducted, the average starting age was 16.7 years, with males starting approximately 3 years earlier than females.[11] Additionally, in this study, 47.5% of those who started smoking began before the age of 18, compared to 58.7% in GATS 2012 and 57.5% in GATS 2016.[4, 10] For the most significant factor influencing their decision to start smoking, 58.3% indicated peer influence from smoking friends. Curiosity and emulation were also cited as significant reasons by the participants. These three reasons comprised nearly 83% of all reasons provided by the participants. The Turkey Health Surveys conducted by the TURKSTAT in 2014, 2016, and 2019 corroborated these findings, although there were variations in the rankings across the years. In the latest survey conducted in 2019, these reasons were identified as 33.2% for peer influence, 25.1% for emulation, and

19.6% for curiosity.[9] It is evident that the age of first trying smoking often occurs in childhood, and regular smoking often begins at these ages. To reduce the initiation of smoking, it is essential to take measures targeting factors such as peer influence, curiosity, and emulation, which contribute to trying and initiating smoking at a young age. Among the measures to be taken, it is primarily the responsibility of families to refrain from smoking themselves and not set a bad example for their children. Additionally, families should monitor their children's social circles and environments, provide continuous education, and warn them against being in places where smoking occurs. For policymakers, it is crucial to block advertisements, enforce bans targeting children, and ensure the implementation of laws. Additionally, reducing the visibility and accessibility of cigarettes and warning celebrities against smoking publicly are crucial steps to diminish curiosity and emulation among potential smokers.

Regarding quitting smoking, 26.6% stated that they planned to quit within one month from the date of the survey, while a total of 52.1% expressed intentions or were already planning to quit. In GATS 2016, these rates were 7.2% and 32.8%, respectively.[10] In GATS 2012, the proportion of individuals considering quitting smoking was 55.1%, while in a study by G. Yılmazel et al., the rate of those planning to quit smoking was 63.2%.[4,19] Additionally, 47.9% of smokers in this study had attempted to quit smoking in the past year. This rate was 46% in GATS 2012, 24.6% in GATS 2016, and 27.4% in the 2017 WHO's NHHS.[4, 10, 11] Only 28.7% of current smokers in this study indicated that they had never considered quitting, while 19.1% were undecided about whether to quit or not.

Among the 49 current smokers who plan to quit smoking, they were asked about the most significant reasons for wanting and planning to quit. 57.1% stated that they considered quitting smoking due to health issues, 28.6% expressed a desire to quit influenced by anti-smoking campaigns and public service announcements aired in the media, while 8.2% mentioned planning to quit smoking because of family members' encouragement. When asked to former smokers about the most significant reason for successfully quitting smoking, 35.6% mentioned health issues, 20% stated being influenced by anti-smoking campaigns or public service announcements, 15.6% mentioned that their family members wanted them to quit smoking, and 8.9% indicated quitting due to health issues affecting their loved ones. Only one individual mentioned the high cost of cigarettes as the primary reason for quitting. (Table 4).

Table 4. Distribution of reasons for quitting smoking and methods used among current and former smokers

Distribution of reasons for wanting to quit smoking among smokers and completely quitting smoking among former smokers	Current smokers n(%)	Former Smokers n(%)
Self-reported health issues	28(57.1)	16(35.6)
Anti-smoking campaigns or public service announcements	14(28.6)	9(20)
Family members' encouragement	4(8.2)	7(15.6)
Health issues in close relatives	2(4.1)	4(8.9)
Other	1(2)	9(20)
Total	49(100)	45(100)
Distribution of methods used by current smokers who attempted to quit smoking in the last 12 months and by former smokers those who successfully quit smoking		
Not using any method	30(66.6)	42(93.3)
• cold turkey		37(82.2)
• by reducing		5(11.1)
Nicotine replacement therapy	10(22.2)	3(6.7)
Smoking cessation clinic	3(6.6)	0
Prescription medication	2(4.4)	0
Total	45(100)	45(100)

This research and broader studies exhibit similar characteristics regarding the reasons for wanting and planning to quit smoking, with the most significant reason being the presence of health problems in oneself or one's close circle. This rate was 61.2% in our study and 62.4% in GATS 2012.[4] Furthermore, this research revealed that anti-smoking campaigns or public service announcements and the desires of family members play a significant role in smoking cessation.

It was observed that 47.9% of smokers reported attempting to quit smoking within the past 12 months, while approximately 67% had tried to quit smoking at least once in their lifetime. Among those who attempted to quit smoking within the past 12 months, 66.6% indicated that they attempted to quit on their own without using any smoking cessation method. 22.2% attempted to quit using nicotine replacement therapies such as patches or gum, 6.6% sought assistance from a smoking cessation clinic, and 4.4% used prescription medication. Among former smokers, 82.2% stated that they quit smoking abruptly without seeking any assistance, while 11.1% mentioned reducing their daily cigarette consumption before quitting, and 6.7% indicated using nicotine replacement therapy (Table 4).

A considerable portion of those attempting to quit smoking did so without any assistance, and the majority of those who successfully quit smoking reported doing so abruptly and without assistance. According to WHO, professional support and medication usage increase the likelihood of quitting smoking by more than twice, and only 4% of cessation attempts made without any support are successful.[20]

Again, according to some studies, intensive advice from healthcare professionals increases the likelihood of quitting smoking by 84%.[21] Considering that approximately half of smokers in our research area attempted to quit smoking in the last 12 months before the study, and more than half of them also expressed a desire to quit, increasing awareness of Quitline services and smoking cessation clinics, and encouraging more individuals to seek help in quitting smoking from professionals can be effective in increasing cessation rates.

After attempting to quit smoking, it was found that the majority of relapses, accounting for 41.3%, were due to psychological and physical withdrawal symptoms such as irritability, anxiety, and depression. This also suggests that success in quitting may increase with professional assistance. Another significant reason for relapse, at 31.7%, is cited as exposure to smoking within the family and social circle, along with a lack of support for quitting. A study conducted in China found that the most important reason for relapsing was social interaction needs, accounting for 34.5%.[22] This indicates that individuals wishing to quit smoking may not receive sufficient support from their immediate environment. Additionally, 10% mentioned experiencing side effects such as headaches, nausea, or weight gain, leading them to restart smoking.

Open-ended questions were posed to smokers who did not plan to quit smoking, asking them to provide their reasons for not intending to quit. Among the responses, 21.4% indicated "I am stressed," while 16.6% stated "I enjoy smoking," and another 16.6% expressed "I do not believe I can quit." Additionally, 14.2% mentioned "I am addicted," 9.5% cited "habit," and another 9.5% described "cigarette is my friend" as reasons for not planning to quit. Similarly, a study investigating barriers to smoking cessation among vulnerable groups identified stress management, enjoyment of smoking, nicotine addiction, habitual behavior, and lack of support to quit as major barriers. [23] In another study conducted among socially disadvantaged populations, the primary barriers included craving cigarettes, the belief that quitting is too difficult, lack of willingness to quit, habitual smoking, and stress or mood swings. [24] These findings highlight the complex interplay of psychological, social, and physiological factors influencing smokers' reluctance to quit. Addressing these multifaceted barriers through tailored interventions could improve smoking cessation outcomes.

CONCLUSION AND RECOMMENDATIONS

As indicated by other studies, the prevalence of smoking in this study remains significantly high, while cessation rates are lower than expected. The primary reasons for initiation include peer influence, curiosity, and emulation, with both initial experimentation and regular smoking often commencing during teenage years. Moreover, many individuals who attempt to quit lack sufficient support, leading to generally unsuccessful cessation efforts. In conclusion, these findings underscore the necessity for measures targeting children to reduce smoking initiation. Initiatives aimed at decreasing the visibility and accessibility of cigarettes are also crucial. Providing professional support for those wishing to quit and former smokers and educating their immediate environment to prevent relapses are essential strategies. However, completely banning smoking remains a topic of debate due to its radical nature, akin to other addictive substances.

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