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In the Name of Modernity: Smoking Away Health, Wealth, and Womanhood in Gecekondu

Hülya Yüksel[1]*, Mansoureh Tajik*[2]

ABSTRACT

We explore factors that affect smoking behavior and perception of women who have lived in gecekondu ("built-over-night") neighborhoods. We conducted semi-structured in-depth interviews with a convenience sample fifty (50) women who were married, smoked, lived in gecekondu neighborhoods in Yukseltepe near Ankara, from 2007 to 2008. Women were ages 20 to 60 years and had lived in gecekondu for at least 15 years. Data were analyzed using content analysis techniques and open coding followed by axial coding. Multiple themes emerged that were coded and classified. We highlight four classes of "smoking as an affective response, "social ties as safeguard, " "social isolation as risk," and "media influence" themes and discuss their influence on gecekondu women's smoking behavior. We conclude that effective health promotion programs to address smoking among these women must be rooted in socio-ecological principles have dimensions that go well beyond individual-based behavior change interventions.

Key Words: Smoking and Turkish women, gecekondu, modernization, ecological principals, health promotion.

[1] *Dumlupınar University, Kutahya*

[2] *University of Massachusetts, Lowell*

BACKGROUND

Two thirds of the world's smokers live in 10 countries according to the World Health Organization (WHO) report on the global tobacco epidemic, published in 2008. In the same report, Turkey ranked 10th among 192 countries with 16 million smokers (out of a population of 73 million people) (TUİK, 2008). Of the total number of smokers in Turkey, 4 million (15.2%) are women. In terms of adverse economic impacts, 20 billion dollars is spent on tobacco products each year in Turkey. At the same time, 30 billion dollars is spent on treatments for tobacco related diseases (Kılınç, 2012). Based on the most recent report from Turkish Statistical Institute (2008), of the approximately 16 million smokers ages 15 and older, 4 million were women. This is about 15.2% of the total population of women aged 15 and older. While the prevalence of smoking among women (15 and older) is much less than men (12 million or 47.9% of the males ages 15 and older), this is still an alarmingly high prevalence. Reports from earlier studies, too, indicate that, among women 15 years and older, 15.2-19.2% were smokers (Mackay et al., 2006; Official Gazette, 2006). According to Shafey et. al.'s study report in 2003, 10.9% of women ages 20 years and older were smokers. Smoking prevalence among women living in urban areas is more than double that in rural areas—18.7% and 7.2% respectively (Government Press, 2006).

While smoking has not been traditionally a socially acceptable behavior for women in Turkey (Dagli, 1999), recent studies indicate that this attitude is changing. Historically, urban professional women were more likely to smoke than women in rural areas (Bilir and Onder, 2000; Fırat , 1996). For example, 41% of female physicians in Antalya (Dedeoglu *et al.*, 1994) use tobacco. Compared to 10.9% of women in the general population, 34.9% of female final-year medical students are smokers (Kocabas et al., 1994). Among teachers, the prevalence of smoking was even higher: 44.3% (Bilir et al., 2000). A 1996 study of 538 randomly selected women in İstanbul found an overall smoking prevalence of 48% among women (Daglı, 1999). A recent study in Burhaniye found that 22.7% of Turkish mothers under 20 years of age smoked and 74.1% were daily smokers (Ergin *et al.*, 2008).

Worldwide, tobacco kills more than 5 million people annually. It is projected to kill more than 8 million people each year by the year 2030, with 80% of the deaths occurring in low- and middle-income countries typified by Turkey (WHO, 2009). In addition, multiple chronic diseases with

costly treatment plans are attributed to smoking. Given the important roles women play not only in the public sphere as professionals, workers, and public workers but also as mothers and caregivers, their health and health behavior (including smoking behavior) have profound effects on the society as a whole. Most smoking-related investigations have focused on smoking behavior among either rural or urban women. Studies that examine the smoking behavior of women living in *gecekondu* areas are sorely lacking. In these neighborhoods, women in transition from traditional, rural life to modern, urban life exhibit significant changes in smoking behaviors. This paper describes and discusses some of the findings from a series of in-depth interviews with a sample of women smokers who live in *gecekondu* in Ankara, Turkey.

METHODS

Sampling. The IRB approval was obtained from the Dumlupınar University Ethics Committee in 2007 prior to data collection. Participants were adult women (18 and older) from among 6,839 married women living in Yükseltepe *gecekondu* neighborhood in Ankara, Turkey. Access to the local residential rolls was provided by the *Muhtar Kayıtları* [the Neighborhood Magistrate Office]. Two trained female interviewers went door-to-door during the day, introduced themselves, and asked for permission to interview the woman of the house. Participants were selected if they: 1) were married; 2) had children; and 3) had lived in the *gecekondu* for at least 15 years. We chose these criteria on the basis of: a) cultural restrictions that only married women--not unmarried girls--could speak freely about their smoking behavior; b) high prevalence of smoking among pregnant women and mothers around their children, especially those with low education and rural-to-urban immigrants (Ergin et. al., 2008); and c) fifteen-year residency length based on findings that differences between rural and urban lifestyles are clearly noticeable after 15 years (Çakır, 2007, p.28).

Data. Sixty (60) women were contacted, of whom fifty (50) were interviewed. (Ten of those approached did not meet the study criteria.) Each interview was given a code number and no identifying marks were collected. Informed consent and permission to tape- record were obtained and participants were informed they could opt out of the interviews at any time. Interviews lasting 30 to 90 minutes were audio taped, except when the participant chose not to be recorded, in which case extensive notes were taken by hand. Audio taped interviews were transcribed and iterative analysis was performed. A saturation point was reached at around forty (40) interviews.

Ten additional interviews were conducted to ensure the saturation remained constant. In addition to in-depth interviews, field observations were conducted and the women's social and physical environments documented.

Study Instrument. Interview guide included questions about the impacts of urbanization, socio-cultural factors, smoking knowledge and attitudes about smoking. Questions regarding age, income, education, home towns as well as the participants' personal, interpersonal, and social experiences were also included. Table 1 has a summary of categories and sample questions.

Table 1: Question categories with sample examples

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Category	Purpose	Questions
Context	Explore social/physical environment	Describe your life in village. Describe your life here; likes/dislikes. Others around you who smoke; Access to information about smoking (What/where).
Smoking Behavior	Explore smoking behaviors/ habits	How often do you smoke? When/how started smoking?
Smoking Experiences/ Meanings	Explore beliefs and attitudes toward smoking	Why do women smoke? How do other people react to your smoking? What do you think about smoking?
Health Impacts	Explore potential health impacts of smoking	Any health problems from smoking? Smoked while pregnant or around children?

The questions were derived from prior tobacco research. After an iterative analysis of the first few interviews, several questions were added. For example, in the initial semi-structured interview guide, we did not ask whether women worked from home, which revealed the researchers' bias that "real work" occurs outside of the home. It emerged, however, that most women were generating income through domestic handicraft such as crocheting and knitting. Therefore, appropriate prompts were added to the questions.

Data Analysis. Content analysis techniques were used to analyze the data. During the initial analysis, interview transcripts were thoroughly read and passages were open coded and an evolving list of codes

was developed by two research team members. Initial codes were categorized according to the research questions to create a code book. Open coding involves forming initial categories of information and assigning codes by segmenting the text. Axial coding involves assembly of data based on specific coding paradigms. We returned to six of the original participants who were the most forthcoming and agreed to discuss the formulated descriptions and categories of themes for initial validation. The six women were presented with the codes and the transcription of their statements that corresponded with those codes. They were then asked to verify whether or not the codes accurately depicted what they had said during their in-depth interviews. The codes were reviewed again and finalized after the validation step.

RESULTS

Demographics. Yukseltepe Gecekondu near Ankara has a population of approximately 24,468 people (12,987 male; 11,481 female) according to the neighborhood magistrate office (Muhtar Kayıtları, 2007) and is one of nearly 3,600 *gecekondus* in the area. Most of the men worked in seasonal jobs such as construction, but were otherwise unemployed. Approximately 6% of the women in our study worked outside the home doing housecleaning or childcare for professional women. Some generated income creating handicrafts. About 65% had migrated to the *gecekondus* with their husbands right after marriage. Table 2 summarizes the participants' socioeconomic and demographic characteristics.

Table 2: Participants' Socio-demographic Characteristics

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		No	%
Age			
	Mean	34(yrs.)	
	Minimum	20(yrs.)	
	Maximum	60(yrs.)	
Education			
	No Schooling	6	12
	Less than 5th Grade	15	30
	Completed 5th-Less than 9th Grade	21	42
	Completed 9th-Less than 12th	6	12
	12th Grade and Above	2	4

Table2. continued

Income		
$140 to $340/month	32	64
$341 to $680/month	17	34
Over $681/month	1	2
Origin		
Central Anatolia	18	36
Eastern Anatolia	16	32
Southeastern Anatolia	9	18
Other areas	7	14

Field Observations. Interviews and local neighborhood records attested that sections of the *gecekondu* had been sold to real estate developers to build apartment complexes. Public health and utility infrastructures were inadequate, and access to natural gas, fuels, and public transportation was limited. Quite a few houses appeared dilapidated and unsafe. Open sewers were observed running on the sides of some streets. Some residents were raising chickens in the yard. Women were forthcoming about their preference to live in the newly developed apartments if affordable. Many continued their rural tradition of preparing "winter food" (e.g., fruit preserves, dried fruits and vegetables, pickles, homemade tomato paste and noodles) many of them baked bread from scratch. While they still covered their hair, they began wearing trousers instead of the more traditional *shalvars* (large baggy pants) and skirts worn in villages. Women also shared other (personal/non-research related) information quite freely, were welcoming and hospitable, and seemed pleased that someone listens to what they had to say. They offered tea and snacks and were more welcoming than ordinary urbanized women who usually do not open their doors to strangers and researchers.

Themes. Several critical themes emerged from which four (4) classes of themes are highlighted and their influence on *gecekondu* women's smoking behavior are discussed in depth in this paper. The four classes are: *"**smoking as an affective response**," "**social ties as safeguards" & "social isolation as risk**," and "**media influence** ".**Smoking as an affective response**.* Affective responses are often used interchangeably with mood, emotion, and attitude. They usually manifest themselves in the form of facial expressions, vocal expressions, gestures, and body language. Some women indicated that whenever social pressures were put on them, *"it created a feeling to get back at them by smoking. "* A few believe that when they smoked, they are *"doing something against them and this somehow comforted"* them. A participant

explained, *"I smoke when I have a fight with my mother in law. My mother in law gets upset when I smoke. Then, I smoke even more. When I do something she doesn't like, I feel I am getting revenge. "* Another participant recalled: *"My father caught me while I was smoking. He was very upset beat me up. He made me swear to go that I will not smoke again. But I smoked in secret. When I lost my husband though, I smoked in front of my father and he couldn't say anything."* A participant explained, *cigarettes are instant pleasure they take away the anger and rage. They lessen nervousness and sadness. "* Another said, *"I cannot have a child I smoke because of that anxiety."*

Social ties & Social Isolation as Safeguards and/or Risks. Existence and absence of social safeguards could serve as mechanisms that affect the smoking behavior either positively or negatively. With respect to participants in our study, the following were coded as social safeguards as they appeared to serve as an obstacle to smoking: *"In the village everyone is nosy. Here no one cares that's why smoking increase."* Or, *"In the past men even wouldn't smoke around their elders."* And, *"I don't smoke around my elders butnow kids smoke on the streets. There is no respect to elders."* A participant stated, *"if my grandpa saw me at the door he would shout at me. I never opened my hair, never wore short sleeve cloths, never smoked cigarettes in front of my father.* "Another woman contrasted the social environment's impacts and stated, *"since there are so many more female smoker in the city smoking is very well received. However, in the village everyone knows each other so you have to hide your smoking. Because they condemn you."* A participant explained, *"Now times are different there is no discrimination between women and men. So women smoke like men do."*

For some participants, their social ties appeared to be a negative factor with respect to their smoking behavior. For example, some women spoke of their spouses' attitude and impact toward their smoking. A participant stated: *"I was smoking one or two cigarettes. After I got married I increased the amount because I could smoke with my husband freely."* Another participant recalled, *"I started when i was 30. My brother fell of a roof and killed. I start eating dirt from sadness. My husband got upset with me and gave me cigarettes instead. He said this is less harmful to you. Whenever I cried he gave me cigarettes."* A woman explained that, "my *husband hooked me up to smoking. He would give me one to light up. He would say come and smoke with me. He was so understanding he wouldn't be upset with my smoking. I would call him to buy me cigarettes he would bring it. "*

Most participants reported economic hardship and claimed they would get support in the form of food from their families still living in the village. Some were also receiving food supplied and delivered by the mayor's office. At the same time, some women indicated that they spent as much as $170 for cigarettes monthly even though their families lived on severely limited budgets and some were unemployed.

" People who live here smoke because they are so poor. Stress, life troubles. When they move to the city they realize women can smoke too. Also they dream better life in the city. And when they cannot find that better life. They feel empty and start smoking. Smoker women make it look like they are more relaxed no one can bother me. I can buy cigarettes. For instance in the work place when women opens her bag and take out cigarette pack seems so cool. She looks more knowledgeable and big. So other women envy this."

Many women expressed loneliness and a sense of isolation and disconnect in the *Gecekondu* compared to their lives in the village. Examples of statements alluding to isolation include: *"Everything is with money here. Even stepping out of your house means money."* And, *"we make our own bread so we don't pay money for it. But we don't do it with the neighbors,"* or, *"I don't have guests over...in the village everyone would visit each other....we would eat together, work together. "* A participant stated, *"When my husband goes to work I feel lonely and I smoke even more."* Another stated, *"in the village we would work in the garden whole day...Here we feel empty and get bored."* One woman explained, *"when people move to the city they expect better lives. When they face difficulties and economic hardship, they start smoking."*

Media influence. Evidence of direct media influence (i.e. direct commercial marketing of tobacco products via media outlets) and indirect media influence (i.e. through social influence and social marketing) emerged from the statements of the participants. Indirect media messages exited through TV film series, songs, and movies. Some women stated having been exposed to media messages about harmful effects of smoking (i.e. public service announcements). Subtle and indirect media messages that encouraged smoking through movies were also reported by women. Some participants made statements like: *"in the TV serials and movies, women who smoke seem powerful, beautiful, self-confident, sophisticated, and smart. "* Or, *"It seems like only powerful people with money and free people smoke."*

Participants' statements about the two facets of the media influence (direct and indirect messages) and contradictory nature of the two types of messages were also extracted. Themes that were classified under this category emerged from statements similar to *"They show smoking women on TV and then they ban*

smoking," and *"They say it is forbidden to smoke at the hospital but doctors' offices are filthy with the smoke."* Additionally, statements that rationalized smoking behavior were included in this category. Some women, for example, expressed that *"air pollution"* or *"additives in food"* were *"far more harmful than smoking."*

DISCUSSION

We explored factors that affect smoking behavior and perception of women who have lived in *gecekondu* neighborhoods. We highlighted four classes of themes that emerged from our data. They were: *"smoking as an affective response," "social ties as safeguard," "social isolation as risk,"* and *"media influence"*. Our findings indicate that some participants were using smoking as an affective response that served as a proxy to demonstrate anger, sadness, defiance, and the like. That is, they sometimes smoked not to relieve stress or due to addiction but as a response to "get back at" a family member (e.g., father, grandfather, mother-in-law) who, based on their perception, would be upset with the smoking. This emerged from participants' statements like, *"I smoke when I have a fight with my mother in law. My mother in law gets upset when I smoke. Then, I smoke even more. When I do something she doesn't like, I feel I am getting revenge."* Or, *"when I lost my husband though, I smoked in front of my father and he couldn't say anything."* While there are studies that have examined the affective responses to smoking cues, like those conducted by Payne et al. (2007), no study has explored the actual act of smoking *as an* affective response itself. For example, Payne and his colleagues found that smokers having withdrawal symptoms and those most motivated to smoke showed favorable emotional responses to smoking cues, but those with no withdrawal or low motivation to smoke showed negative responses. However, their findings and those previously cited in the literature has not explored how smoking itself could be an affective response. Given that our sample size is quite small and our participants were from a socially and geographically select group, we could not extrapolate and generalize this theme, smoking as an affective response, to the general population. Additional research with participants from diverse backgrounds and larger sample sizes are needed to explore more deeply this finding.

Our findings also highlighted the importance of social ties and interpersonal relations and their influence on women's smoking behavior. Social ties are interpersonal connections among people in their social environment. They could serve as sources of information to help one avoid stressful or high-risk situations, offer positive behavioral role models, increase feelings of self-esteem, self-identity and control over one's

environment, and lead to better health outcomes (Mittelmark, 1999). Social ties could also subject an individual to social regulation and social controls, and define normative behavior. They can be sources of tangible support in the form of financial assistance and of emotional support in the form of a confidant in a time of need, for example. In times of acute stress (e.g. the death of a loved one), the resulting stress responses may be buffered to a degree by the actions of others, such as the providing of emotional support, companionship, sympathetic listening and practical support (Mittelmark 1999; Wills 1985; Cassel 1976). The social ties could therefore be a constructive method of stress reduction which would diminish the need for unhealthy coping mechanisms such as smoking. In our participants, the role of social environment appeared quite significant.

In regards to media influence theme, while direct media influence (i.e. direct commercial marketing of tobacco products via media outlets) is not supported by our data, indirect media influence (i.e. through social influence and social marketing) emerged from the statements of the participants. Media appear to play an important role in influencing women's smoking behavior through indirect messages prevalent through TV series, songs, and movies. Some women stated having been exposed to media messages about harmful effects of smoking (i.e. public service announcements). However, subtle and indirect media messages that encouraged smoking through movies and songs appeared more influential in shaping women's perception about smoking. Some participants made statements like: *"in the TV serials and movies, women who smoke seem powerful, beautiful, self-confident, sophisticated, and smart."* Or, *"It seems like only powerful people with money and free people smoke."*

Given the significant role the social environment and the media play in shaping women's smoking behavior, we therefore recommend that effective health promotion programs to address smoking among these women be rooted in socio-ecological principles. By design, these principles have dimensions that go well beyond individual-based behavior change interventions and offer a well-rounded and comprehensive approach to reduce the prevalence of smoking among a vulnerable population, the *gecekondu* women.

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