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Smoking cessation advice after cervical screening:

a qualitative interview study of acceptability in Dutch primary care

Abstract

Background

Cervical cancer screening in general practice could be a routine and opportune moment to advise females who smoke to stop smoking.

Aim

The aims of this study were to investigate the attitudes of females who smoke to receiving advice about stopping smoking after cervical screening and to identify factors associated with the acceptability of this advice.

Design and setting

This qualitative interview study was conducted with Dutch females who smoked, had undergone cervical screening, and were aged 30 to 60 years. Interviews were performed between December 2016 and September 2017.

Method

In this study 15 participants were interviewed and transcripts were analysed using thematic analysis.

Results

Females who smoke were ambivalent (positive or sceptical) about being advised to stop smoking after they had undergone cervical screening. An explanation of why smoking behaviour is addressed by the practice assistant performing the smear, and making females feel at ease during the smear test, were found to be factors that might influence acceptability of such advice. Although a personal and non-judgemental approach to discussing smoking was considered essential, participants expressed different preferences regarding the form and content of cessation support. This was reflected by the variations in knowledge about smoking cessation support, previous experiences of cessation attempts, and received cessation advice or support.

Conclusion

Study participants had mixed opinions about being given advice about smoking cessation after their cervical smear test and differed in their preferences for the type of support for smoking cessation. An interactive approach might improve how well a smoking cessation intervention is received by females who smoke and cater to their individual needs and preferences.

Keywords

attitude; cancer screening; female; general practice; qualitative research; smoking cessation.

INTRODUCTION

The increase in smoking among females has increased the incidence of tobacco-related mortality, with tobacco consumption being responsible for two-thirds of deaths among females aged 50 to 70 years.¹ Despite the overall impact of anti-tobacco policies on the prevalence of smoking in developed countries, tobacco use has declined more in males than in females. Stopping smoking is beneficial for individuals who smoke at any time in life² but its preventive impact is greater at younger ages. To optimise the preventive effects of smoking cessation in females who smoke, it is important to achieve higher cessation rates, preferably at an age when the prevalence of smoking-related disease is still low.

Cervical screening programmes aim to detect cancer at an early stage. As 11% of new cancer cases in females are attributable to smoking,³ screening could provide the opportunity to inform relatively young females who smoke about the benefits of stopping smoking. Smoking is a risk factor for continued high-risk human papillomavirus (hrHPV) infection of the cervix, carcinoma in situ (CIN), and cervical cancer.^{4–8} In addition to the effect of smoking on hrHPV infection, evidence suggests that tobacco and nicotine promote oncogenic mechanisms in cervical cells.^{9–13}

In the Netherlands, females aged 30 to 60 years are offered cervical cancer screening in general practice every 5 years

(participation rate 64% to 66%, equalling 485 000 yearly participants). In this age category, approximately 1 in 5 females smoke daily.¹⁴ The majority of European countries have a cervical cancer screening programme for females, usually aged from 25 to 65 years and with screening intervals of 1, 3, or 5 years. Beside the Netherlands, countries where the cervical smear test takes place in general practice include Belgium, Denmark, Norway, and the UK.

Despite clear guidelines, only 8% of Dutch individuals who smoke receive smoking cessation advice when consulting a clinician^{15,16} and even fewer when individuals who smoke do not have tobacco-related symptoms. Asking about smoking after females have undergone cervical screening could help identify females who smoke who still have a relatively low prevalence of tobacco-related disease and enable staff in general practice to give them advice and support about stopping smoking.

Before carrying out a trial in which a smoking cessation intervention will be given by general practice assistants after females have had a cervical smear taken, the researchers performed a qualitative study, presented in this article, to investigate the experiences and expectations of females who smoke about being given smoking cessation advice after cervical screening, and to investigate determinants of a positive attitude to such advice.

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How this fits in

The combination of early cancer detection with primary prevention via smoking cessation has the potential to significantly improve health outcomes, as illustrated by studies reporting the positive effect of behaviour change or lifestyle interventions after routine cancer screening. Cervical screening is performed in general practice and could therefore create an opportunity to routinely provide females who smoke (who have a relatively low prevalence of smoking-related disease and would therefore benefit from smoking cessation) with quit advice and cessation support in primary care. When combining cervical cancer screening and smoking cessation it is necessary to understand the perceptions of females who smoke about smoking cessation advice after having a cervical smear test and how to best approach these females, especially because taking a smear test can be a delicate time. This qualitative study provides relevant insights for GPs on how to best provide cessation advice to female smokers after they have taken the smear.

METHOD

Study design and participants

This qualitative study involved females who smoke and who had undergone cervical cancer screening. Purposive sampling ensured a variation in age, socioeconomic status, nicotine dependence, and motivation to stop smoking. Recruitment took place via 15 general practices throughout the Netherlands. After cervical cancer screening and after assessing their smoking status, the GP assistant invited females

who smoke to participate in an interview study. Out of 10 participants invited for an interview, eight consented to participate. The other participants were recruited via social media: 11 eligible participants signed up, of whom seven consented to participate. All participants were Dutch and aged 30 to 60 years (the eligible age for cervical cancer screening in the Netherlands). Written consent was obtained. Interviewees received a gift voucher of €25 as compensation for their time.

Data collection

In total, 15 semi-structured in-depth interviews were conducted from December 2016 to September 2017. An interview guide was developed to stimulate an open conversation and to obtain a thorough narrative, with a view to investigating the attitudes of females who smoke to being given advice to stop smoking after cervical screening in general practice. All participants were interviewed about their views of a conversation about smoking (assessing smoking status and receiving quit advice) after the smear, as well as their preferences and needs regarding cessation support. Expertise within the research team and the literature was used to develop the interview guide. Box 1 shows the topics used. Interviews were performed face-to-face by one trained female researcher and lasted 30 to 70 minutes. Participants completed a questionnaire to collect demographic and basic characteristics, such as smoking history, GP visits over the last year, and history of cervical abnormalities. Data were collected until no new themes emerged or data saturation had occurred.

Analysis

Interviews were audiotaped, transcribed verbatim, reviewed for accuracy, and imported into MAXQDA 12. Thematic analysis was used for data analysis, going from open to analytical coding. Three members of the research team coded the first five interviews independently; one of them then coded the next 10 interviews. An inductive approach was adopted, meaning that the transcripts were coded without specifically relating them to the themes of the topic list. An iterative process of data collection and analysis was used. The same three researchers as before frequently discussed the codes and categories of the interviews in detail. Discrepancies were discussed until consensus was reached. A thematic analysis methodology called the Framework Method¹⁷ was used to

Box 1. Topics for semi-structured interviews

Topic	Example of questions
1. Opening of interview	Can you tell me about your smoking? How would you describe yourself as a smoker, for example, are you a heavy, moderate, or light smoker?
2. Views about a conversation about smoking (assessing smoking status, receiving smoking cessation advice) after having had a cervical smear test	How did you experience the cervical smear? What do you think about being given smoking cessation advice after the cervical smear?
3. Views about a conversation about smoking (assessing smoking status, receiving quit advice) in general practice	How do you want to be approached about smoking (cessation)?
4. Views about smoking cessation support in general practice (experiences, preferences, and needs)	What is your experience about receiving smoking cessation advice/support? What are your preferences for cessation support given by your general practice?

Table 1. Patient characteristics, N = 15

Characteristic	n
Sex	
Female	15
Age^a range, years	
30–44	10
50–60	5
Geographical location^b	
Major city	5
Urbanised region	9
Remote area	1
Have children^c	
Yes	13
No	2
Socioeconomic status^d	
Low	3
Moderate	7
High	5
Comorbidity^e	
Yes	2
Smoking history	
FTND score, mean (SD)	3.9 (2.8)
Cigarettes per day	
<10	4
>10	11
Intention to quit	
Within 1 month	1
Within 6 months	2
Within 1 year	2
Within 5 years	2
No intention	8
Number of GP visits over the last 12 months^f	
1	4
2–5	6
>5	5
Use of assistance to quit^g	
Used assistance	6
Unassisted	9
Wish for help via GP for future quit attempt	
Yes	3
No	5
Don't know	7
History of aberrant Pap smear/cervical cytological aberrations	
Yes	3

^aAccording to age categories to participate in cervical cancer screening in the Netherlands (all women aged 30–60 years are invited once every 5 years; women at 60 with an aberrant smear undergo a follow-up smear at age 65 years). ^bResidency of females who smoke (residency of participants recruited via general practice matched with geographical location of their practice). ^cNo participants were pregnant at the time of interview. ^dSocioeconomic status was measured as the highest completed level of education. ^eParticipants were asked about tobacco-related disease: chronic airway disease, diabetes, cardiovascular disease, or cancer. The two participants with comorbidity had cardiovascular disease. ^fIf applicable: including consultations for their children. ^gAll participants had performed ≥1 serious quit attempts (>24 hours of abstinence) in their lifetime; participants were asked about quit assistance for any of their previous quit attempts. FTND = Fagerström Test for Nicotine Dependence.

enable a comprehensive analysis between interviewees and codes. The researchers' final coding tree was charted into a matrix, enabling further data analysis and gradually leading to the generation of relevant themes.

The study was reported in accordance with the 32-item checklist of Consolidated Criteria for Reporting Qualitative Research (COREQ).¹⁸

RESULTS

Participant characteristics are shown in Table 1. Ten of the 15 participants were aged 30 to 44 years and eight were not motivated to stop smoking. All had visited their general practice at least once in the last year, mainly for children's health problems or minor complaints. All participants had attempted to stop smoking at least once, six of whom had used cessation support that was not necessarily evidence based or via the GP. Triggers for smoking cessation were related to health risks or to the social context, mostly pregnancy, children's health, or their own health. Other triggers included starting oral contraception, surgery, and pregnancy. All participants who had tried to stop smoking for health reasons had done so after a clinician had pointed out the effects of smoking on their health.

Results are presented under two major themes: acceptability of smoking cessation advice after the cervical smear; and preferences and needs regarding cessation counselling and support.

Acceptability of smoking cessation advice after the cervical smear

Participants were ambivalent (positive or sceptical) about such advice. Explaining the association between smoking and the cervical smear, and the attitude of the assistant who took the smear and initiated the conversation, were identified as factors that could influence the acceptability of smoking cessation advice given at this time. See also Figure 1.

Positive attitude. Most participants thought it logical to be asked about their smoking status after the cervical smear; they related smoking to cancer or expected to be regularly confronted with the fact that they smoke. That a conversation about smoking was considered as acceptable or necessary was underlined by the participants' wish to be made aware of the health risks of tobacco and the perception that it is the GP's role to inform their patients about these risks. A participant with previous aberrant smears, and the only one with knowledge of the effects of smoking on continued hrHPV infection of the cervix, underlined the need to be informed:

'I think that you need a good doctor who tells you about the dangers when there

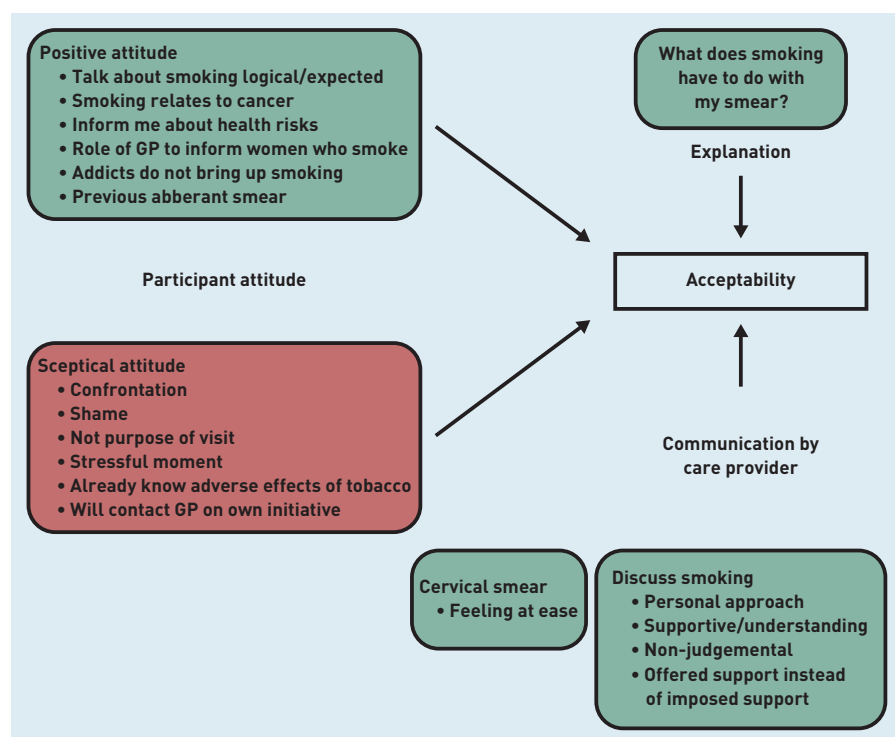


Figure 1. Factors influencing the acceptability of female who smokes receiving smoking cessation advice after cervical screening in general practice. Participant attitude = attitude of female smoker participating in cervical screening to smoking cessation advice given after a smear. Explanation = explanation from care provider to female who smokes about why smoking is discussed. Care provider = care provider performing the cervical smear and initiating the discussion about smoking; in Dutch general practice this usually is the practice assistant. Red: negative impact on acceptability. Green: positive impact on acceptability.

is nothing wrong. Subconsciously, you know what the dangers are, but at that moment you are triggered in a different way.' (Participant [P] 5, 35 years).

Participants described individuals who smoke as addicts who do not bring up the subject on their own initiative. Some argued that the GP should record the smoking status preventively, to help individuals who smoke in case of other health issues.

Sceptical attitude. Although sceptical participants stated it was fine to enquire about their smoking status, they were not in favour of a conversation about smoking. Sceptical participants were predominantly not motivated to stop smoking. They expressed feelings of stigmatisation or shame — the advice to stop smoking served only to confront them yet again with their habit. Some stated that they already knew that smoking was bad for their health, thus making it unnecessary to inform them about health risks:

'I think that you are more likely to elicit guilt feelings than encourage the feeling, "perhaps I should ask for help".' (P1, 50 years)

These participants stated that females in general might not expect to talk about smoking after cervical screening because this was not the purpose of their visit or that the

stress of undergoing a smear might make them unreceptive to such advice. Two females who smoked argued that knowing the GP is available for cessation support meant that they could contact the general practice on their own initiative if they wanted help.

Explanation. Females who smoked from both groups deemed it legitimate to address smoking behaviour if the reason for the encounter was related to smoking. Participants stated that they would want to know what smoking has to do with the cervical smear. Apart from one participant, the females were not aware of the possible effect of smoking on the cervix, and many were not aware of risk factors for cervical cancer:

'And, what has this to do with my smear?' (P2, 50 years)

An explanation by the care provider (usually known as the practice assistant) of why smoking should be assessed after a smear test was considered acceptable, and thus after the actual cervical smear would be a suitable moment to give advice on smoking cessation

For example, females could be told that smoking is a risk factor for developing cervical cancer:

'I don't know much about it and the percentages etc., but if smoking influences the development of cervical cancer, then of course this is a very appropriate moment.' (P6, 30 years)

Communication by care provider. Participants from both groups described the cervical smear as something they had to get done. Some females found it burdensome, but the benefits outweighed the burden:

'Let your mind go blank; just get it over and done with.' (P3, 30 years)

It was important for females to feel at ease during the smear, which depended on the practice assistant's attitude:

'For a start, you need to feel at ease, relaxed, for this investigation.' (P4, 35 years)

How the assistant broached the subject of smoking also determined how willing participants would be to discuss smoking. In general, a personal, non-judgemental approach would be best, with the assistant offering understanding and support to

individuals who smoke instead of lecturing them about smoking. Females from both groups felt stigmatised and ashamed of their smoking (ashamed with regard to their children or colleagues, experiencing smoking as socially unacceptable, being constantly judged). Females who smoke described smoking as an addiction, for which they needed understanding:

'The reprimanding finger is wagged as soon as I see the GP. It's a pity, because whatever the GP does or organises, you have the feeling that it's only done because you are a statistic that's no good rather than that you are seen as an individual.' (P1, 50 years)

Preferences and needs regarding cessation counselling and support

Participants expressed a number of preferences on how to talk about smoking and their needs for cessation support provided by the general practice, preferences that were not necessarily consistent with their attitudes to a conversation about smoking after the smear:

Do/do not discuss health risks. The females with a positive attitude to post-smear advice preferred to be made aware of the health risks of smoking and of the help the general practice could provide. Others preferred emphasis to be put on the health benefits of stopping instead of the health risks of smoking. This last point was also made by the females in the sceptical group, who considered being told about the health risks of smoking patronising and that making people afraid was ineffective. The difference between informing individuals who smoke about the risks of smoking and being patronising was not always clear cut. Although the females who had previously had aberrant smears and who knew about the effects of smoking on cervical health wanted to be made aware of the health risks of smoking, the researchers did not observe differences in the awareness of tobacco-related disease among females who did or did not want to be told about the risks of smoking. A few participants with a positive attitude to post-smear advice felt constantly stigmatised by health warnings or public campaigns and lamented the availability of support for smoking cessation:

'I mean, people say "it's not good for you, it's not good for you", but do something about it. It's much easier said than done.' (P9, 35 years)

Do/do not offer support proactively. Of the females with a positive attitude, a number

were highly motivated to stop smoking and wanted the GP to give them firm advice and to proactively guide them throughout the process, because they might otherwise relapse:

'I had to go to the GP for the pill. She said, in a very stern voice, "Do you smoke? If you do, then I'm not going to give it to you." I found her very strict and severe, but then I thought why not take it seriously. The day I start the pill is a good day to stop smoking. And that's what happened.' (P10, 35 years)

They also stated that the GP should take the initiative to schedule support if a female who smokes indicates she considers stopping smoking because otherwise nothing will come from it:

'I know how I react, that if the GP says somewhat half-heartedly, "You smoke, you should think about stopping." As soon as I'm out the door, that [advice] will be forgotten. They won't notice that I don't phone.' (P6, 30 years)

Not all females in the positive group were in favour of a proactive approach for cessation support. Some feared that they might feel obliged to accept smoking cessation support and that they would feel negative about themselves if they failed to stop smoking. Although the females in the sceptical group were less open to an unsolicited conversation about smoking, one female who argued that smoking should only be discussed at the individual smoker's initiative also said that, if a person wants smoking cessation support, the GP should guide her proactively.

Wanting/not wanting/not sure about smoking cessation support. Females considered the personal approach to stopping smoking with the support of the GP as a benefit to individuals who smoke in general:

'Because he/she knows about you, about your body.' (P2, 50 years)

Participants believed that the GP could help individuals who smoke who are not able to quit on their own. Although many females stated that the GP should be easily accessible if an individual who smokes asks for help, they varied in their views about wanting smoking cessation support — some wanted support, some did not want support, and some were unsure. There were also differences in knowledge of smoking

cessation support and its availability, experience of previous attempts to stop smoking, and advice or support received.

Individuals who smoked who wanted support in a future attempt to stop smoking were not necessarily more motivated to stop smoking but rather they recognised that they might not succeed without support — they wanted to maximise their likelihood of succeeding — or they wanted to avoid weight gain:

'I could go to the GP and say: listen, I want to stop smoking or I'm stopping smoking, but I don't want to weigh more than 85 to 90 kg.' (P15, 60 years)

These females tended to have a better knowledge of evidence-based smoking cessation support and its availability via the GP (requesting varenicline or support from the practice nurse), and were positive about receiving smoking cessation advice after cervical screening. A few females wanted smoking cessation support, but did not know or believe help was available via their GP:

'I think I'll be told the usual things — and I know about them myself.' (P4, 35 years)

Participants who did not want support or advice thought that smoking cessation was a question of willpower, which would make cessation support redundant. Or they were individuals with low self-efficacy and little faith in the effectiveness of smoking cessation support via the GP after many failed attempts to stop smoking despite receiving support. These females were sceptical about receiving smoking cessation advice at the time of cervical screening. A different argument for unwanted support came from females who were confident that they could stop smoking without support as they had stopped without support during previous periods of abstinence from smoking. These females were positive about receiving smoking cessation support and advice after cervical cancer screening.

Certain individuals who smoke who were 'not sure' about wanting smoking cessation support either did not know what the general practice could offer them; or had had a negative experience of smoking cessation support and advice in general practice, such as feeling judged or that support was not made readily available when requested.

DISCUSSION

Summary

Females who smoke were ambivalent

(positive or sceptical) about receiving smoking cessation advice after they had had a cervical smear. Explaining why it was important to stop smoking, and the attitude of the practice assistant who took the smear and provided the support, were factors that influenced the females' attitude to discussing smoking at that time. The females preferred a personal and non-judgemental approach to smoking cessation. Various preferences were expressed for counselling and smoking cessation support, depending on participants' knowledge about smoking cessation support and its availability, previous experiences of quit attempts, and previously received advice or smoking cessation support. Preferences for cessation support did not necessarily coincide with the females' attitude to discussing smoking after cervical screening.

Strengths and limitations

This study provides information about the receptiveness of females who smoke to smoking cessation interventions after they have had a cervical smear test. To the authors' knowledge, this is the first qualitative study assessing the attitude of females who smoke aged 30 to 60 years to smoking cessation advice after cervical screening in general practice.¹⁹ A few studies have reported on the effects of smoking cessation interventions after routine cervical screening.^{19–21} According to one pilot study, concise advice about stopping smoking given by a practice nurse during routine cervical smear tests could be acceptable and feasible.¹⁹ Two studies were either not performed in a general practice setting²⁰ or did not include a face-to-face interaction between care provider and patient.²¹

The participants disclosed their expectations about a scenario of smoking cessation advice after the smear test. Eight participants talked briefly about smoking and their experiences with the practice assistant who recruited them to the study; however, these practice assistants were not trained in smoking cessation advice.

Purposive sampling ensured a heterogeneous sample of females who smoked. Although data saturation was obtained in this study, some females who smoked and were invited for an interview might have been reluctant to participate and share their attitudes. Although variability in the attitudes of study participants was observed, answers could have been subject to social desirability. Individuals who had smoked previously but had now stopped and who participated in cervical screening were not interviewed; views on smoking

cessation among long-term abstinent individuals who smoked were thus not included. The researchers did not interview participants with a migrant background (all participants were Dutch nationals), which is a possible shortcoming because tobacco use and attitudes may vary in some of these groups and cervical screening attendance rates can be lower. The views of primary care professionals about giving smoking cessation advice after cervical screening have been studied by the present research group and will be published separately.

Comparison with existing literature

This qualitative study explored the prospective acceptability of smoking cessation advice after cervical screening in females who smoked. The recently proposed Theoretical Framework of Acceptability (TFA) describes seven constructs to assess if a healthcare intervention is appropriate for people delivering or receiving the intervention based on their emotional and cognitive responses.^{22,23} The ambivalence in attitudes of females who smoked towards the proposed intervention and their perceived self-efficacy in quitting or their expected effects of cessation support were closely related to several of the TFA constructs, such as, 'affective attitude' (individual feelings about the intervention), 'ethicality' (the fit of the intervention with an individual's value system), 'perceived effectiveness' (perceived likelihood to achieve its purpose), and 'self-efficacy' (confidence to perform the required behaviour).^{22,23} The present findings add to the TFA constructs that the expected interaction between the person delivering and the person receiving the intervention was perceived as also influencing acceptability, for example, the quality of communication by the care provider (feeling at ease during the smear test, how to broach the subject of smoking).

Ambivalence to smoking cessation advice has been described previously. Butler *et al* identified individuals who smoked in general practice who were sceptical about smoking cessation advice and individuals who smoked who believed it was reasonable for doctors to discuss smoking.²⁴ Ulbricht *et al* reported that half of individuals who smoked expected their GP to address the issue of smoking, although females might have reservations about a discussion of their lifestyle initiated by the GP.²⁵ In the present study, females who were positive about receiving smoking cessation advice/support after cervical screening described it as logical or expected.

However, many females did not expect to

talk about smoking after a smear test. Only one of the participants knew of the potential effects of smoking on the cervix. Females who smoked from both groups wanted to know why their smoking history should be assessed after cervical screening, but considered it acceptable to have a conversation about smoking if the reason for the visit to the practice encounter was related to smoking. The authors, therefore, hypothesise that explaining the importance of stopping smoking has a positive impact on the willingness of females to receive smoking cessation advice after having a cervical smear test. Cleland *et al* reported that individuals who smoke prefer to create a link between symptoms and smoking when cessation advice is provided in general practice.²⁶ According to Marteau *et al*, improving the knowledge of individuals who smoke and providing an explanatory model to individuals who smoke might have a positive impact on how well the information is received by cervical screening participants.^{27,28}

Irrespective of their attitude, the participants wanted to feel at ease during the smear test. The importance of feeling at ease in this context can be underlined by the fact that feeling anxious during a cervical examination can prevent females from understanding what is being said.²⁹

The females who were sceptical about receiving smoking cessation advice were predominantly unmotivated to stop smoking. This could influence their willingness to discuss smoking. However, some of these females also expressed feelings of stigmatisation and shame about their smoking. Some females with a positive attitude to the intervention described feelings of stigmatisation as well. This is probably reflected by the fact that the participants considered a non-judgemental approach to be essential when addressing smoking behaviour. Stigmatisation has been described as problematic for females with a lower socioeconomic status,³⁰ for mothers with a low income who smoke, and for pregnant females. Stigmatisation can lead to avoidance of stigmatising situations, such as a visit to a health professional.³¹

A lack of knowledge of evidence-based smoking cessation support and its availability was evidenced by the intention to seek support for future attempts to stop smoking. Informing females about evidence-based smoking cessation support and its availability via general practice should be stimulated. Indeed, not knowing about the availability of such support in general practice has been described as a

barrier to receiving support.³² There were differences in the preferred type of cessation support. Females have more difficulties in maintaining long-term abstinence than males,³³ therefore adopting female-specific cessation programmes or treatment based on the personal needs and preferences might help support females who attempt to stop smoking.^{34,35}

Implications for research and practice

When it comes to providing smoking cessation advice after cervical screening in general practice, a personal and interactive approach would increase the acceptability of receiving such advice and cater to the individual female's needs. Practice assistants should assess smoking behaviour in a non-judgemental manner, provide an explanation of why smoking behaviour is addressed, and make females feel at ease during the smear test, while leaving room for questions from females who smoke and their preferences.

This study focused on the prospective acceptability of smoking cessation advice given after a cervical smear. The effect of a smoking cessation intervention initiated after cervical screening on smoking

behaviour and take-up of cessation support via general practice will be studied in a future intervention study by the present authors, which will include a process evaluation to explore why females who smoke do or do not respond to the intervention, including the retrospective acceptability of the intervention, and to assess the impact on intention for future screening attendance.

Practice assistants participating in the upcoming trial, to be carried out by the present authors, will provide brief advice according to the guideline for smoking cessation for Dutch GPs¹⁶ using the ask–advice–connect method.³⁶ For this purpose they will receive training in interviewing techniques and results from this qualitative study are incorporated in the training. Females who smoke and are interested in cessation support will be referred within their practice to the practice nurse or GP who is qualified to guide the actual stop smoking support. The trial does not interfere with this support. Stop smoking support that adheres to the Dutch smoking cessation guidelines is comparable with the training provided by the National Centre for Smoking Cessation and Training (NCSCT).^{16,37}

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Ethical approval

Official approval of this study was waived by the Medical Ethics Review Committee of the Academic Medical Centre in Amsterdam, the Netherlands (reference: W16_312 # 16.367).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

All authors have declared no competing interests.

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