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Men's business, women's work: gender influences and fathers' smoking

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Abstract To further understand men's continued smoking during their partner's pregnancy and the postpartum period, a study was undertaken to explore women's perspectives of men's smoking. Using a gender lens, a thematic analysis of transcribed interviews with 27 women was completed. Women's constructions of men's smoking and linkages to masculine and feminine ideals are described. The findings highlight the ways women position themselves both as defenders and regulators of men's smoking. Femininities that aligned women with hegemonic masculine principles underpinned their roles in relation to men's smoking and presented challenges in influencing their partner's tobacco reduction. By positioning the decision to quit smoking as a man's solitary pursuit, women reduced potential relationship conflict and managed to maintain their identity as a supportive partner. Insights from this study provide direction for developing gender-specific tobacco reduction initiatives targeting expectant and new fathers. Indeed, a lack of intervention aimed at encouraging men's tobacco reduction has the potential to increase relationship tensions, and inadvertently maintain pressure on women to regulate fathers' smoking. This study illustrates how gender-based analyses can provide new directions for men's health promotion programmes and policies.

Keywords: smoking, gender relations, fathers, mothers, harm reduction

Introduction

The majority of expectant fathers who smoke do not successfully quit by the birth of their child (Blackburn *et al.* 2005, Everett *et al.* 2005, Everett *et al.* 2007); hence, there have been recent calls for a better understanding of men's smoking to reduce the adverse effects of pre- and post-natal smoke exposure related to parental smoking (Pattenden *et al.* 2006). Explorations of gender influences on health behaviour have described how masculinities

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contribute to men's health risk behaviours and poor health outcomes (Galdas *et al.* 2005, O'Brien *et al.* 2005), as well as women's roles in promoting men's health (Lee and Owens 2002). Because women are known to influence men's health (Brown 2001, Robertson 2007, Westmaas *et al.* 2002), we endeavoured to learn if and how they interpret and respond to their male partners' continued smoking during pregnancy and after the birth of their child to help determine ways to support smoke-free families.

Review of literature

A social constructionist perspective positions health practices as a means of enacting gender (Courtenay 2000). The accumulated evidence that many men jeopardise their health in high-risk activities and ignore positive health behaviours has been theorised as evidence for how men interact socially and culturally in the reproduction of traditional masculinities (Courtenay 2000, Mahalik *et al.* 2007). Masculinities have been theorised as multiple constructions in a gender order that comprise, form alliance with, or protest the manifestation of idealised and hegemonic masculinity. Since gender is relational, theorists have proposed an idealised form, as well as plural expressions of femininities, and a socially idealised relation between masculinities and femininities (Howson 2006). Howson suggests three types of femininities that function within a model of dominative hegemonic masculinity: emphasising, ambivalent and protest femininities. *Emphasising femininities* refer to an idealised gender type that accepts and co-operates with the social and power principles of hegemonic masculinity without issue. *Ambivalent femininities* represent a gender type that questions the social order and gender configurations operative within hegemonic masculinity, but is unable to condone or reject conditions and so responds tactically to either co-operate or resist. *Protest femininities* challenge the foundation of gender relations and the gender order, and represent a severing or disconnect from hegemonic masculinities while upholding the best interests of femininities and masculinities as the goal.

Fatherhood has been described as a life stage that challenges traditional masculine norms because contemporary societies demand nurturing skills in addition to traditional breadwinner and protector roles (Lamb 2000). A qualitative study with working class men in the UK examined men's health experiences within the context of family life, fathering and masculinities to reveal how cigarettes and alcohol were used by men to offset the domestic constraints of fathering, and the pressures and obligations of work and employment (Williams 2007). Traditional masculinities were reflected in the fathers' perceived needs to exhibit 'strength' and to engage in 'solitary practices,' and supported men's resistance to emotional disclosure and the management of feelings of vulnerability and difficulties in personal relationships.

Although becoming a father is often associated with a desire to curtail or change patterns of alcohol and tobacco use (Everett *et al.* 2005, Williams 2007, Bottorff *et al.* 2009), few men quit or substantially change their tobacco consumption by the time of the birth of their child (Blackburn *et al.* 2005, Everett *et al.* 2007). Fathers who smoke have been reported to rationalise and defend their continued smoking by linking it to masculine characteristics of invulnerability and risk-taking (Bottorff *et al.* 2006). But, alignment with masculine norms is often complex and contradictory for fathers, whose relationship with tobacco is challenged after the birth of their child, as they respond to the competing demands of domestic and child care responsibilities and their desire to smoke.

To date, women's domestic partners/husbands have been ignored in theory and practice in relation to how to promote smoke-free families (Gage *et al.* 2007). In one of the few studies that investigated gender dynamics and partner influence during a quit attempt, the authors

found that men responded positively to the social influence of women partners or spouses to remain, quit or reduce, whereas for women, increased partner influence produced inverse results and was associated with lower reductions in cigarettes smoked (Westmaas *et al.* 2002). In other areas, researchers have established evidence for the positive influence of women partners on men's health habits, including improved dietary practices (Kemmer *et al.* 1998, Sellaeg and Chapman 2008, Sobal 2005), and reduced substance use (Homish and Leonard 2007, Leonard and Homish 2005). For example, a longitudinal study of 471 couples during the first two years of marriage concluded that gender relations explained how spouses' marijuana use influenced the other's initiation and cessation of marijuana. Specifically, at years one and two assessments, men were more likely to stop using marijuana if their wives did not use it. These findings are not consistent with investigations of pregnancy and postpartum-related smoking cessation patterns where there is evidence that male partners' continued smoking negatively influences smoking relapse among pregnant and post-partum women (Ratner *et al.* 2000, Severson *et al.* 1995), and that having a partner who smokes has a more negative impact on women than men during an attempt to quit (Manchon Walsh *et al.* 2007).

While researchers have studied and commented on men's smoking in terms of cultural constructions of manliness (Bottorff *et al.* 2006, Dutta and Boyd 2007, Johnson *et al.* 2009), and men have described their own experience of smoking reduction and cessation (Bottorff *et al.* 2009), we do not know how women with male partners who smoke perceive their smoking, and the extent to which they may or may not rely on the construction of traditional masculinities to interpret smoking behaviour in their partners. Hence, the research questions guiding this study were: (1) What masculine ideals inform women's constructions of men's/fathers' smoking? and (2) What femininities do mothers align with when describing their roles in the smoking patterns of their male partners?

Methods

The findings presented in this paper result from a secondary analysis of data from two components of a multi-phased programme of research to explore the micro-social context of smoking patterns and cessation efforts in new families during pregnancy, post partum, and early childhood through a gender lens (Bottorff *et al.* 2009, Johnson *et al.* 2009, Oliffe *et al.* 2008). The ethnographic component investigated the social context of smoking among men during their partner's pregnancy and postpartum period, while the grounded theory component explored familial contributions to tobacco reduction from pregnancy through early childhood following maternal smoking reduction.

Study participants

Following university and health authority ethics approval, study participants were recruited from prenatal and postpartum units of a hospital in Vancouver, British Columbia, Canada and through advertisements in a local newspaper. Participants signed an informed consent and were offered a $20 honorarium per interview to recognise their contribution to the research project. This analysis included 27 new mothers recruited to the study whose partners smoked during pregnancy, postpartum, and early childhood. The characteristics of the study sample are shown in Table 1.

Data collection

Digitally recorded, semi-structured interviews were the primary data collection method. Interviews were conducted by female interviewers at locations chosen by each participant,

Table 1 *Demographics and smoking history information of participants*

	Women (n = 27)	*Partners (n = 27)*
Age (years)		
20–29	13	6
30–39	14	15
40–49	-	6
Education		
Less than high school	3	5
High school	8	6
Post-secondary	16	16
Ethnicity		
Anglo-Canadian	16	18
Asian	8	5
Aboriginal/First Nations	1	2
Latino	1	-
Middle-Eastern	1	1
Multi-ethnic	-	1
Smoking status (before pregnancy)		
Daily smoker	16	26
Occasional smoker (10 ≥ a week)	2	1
Nonsmoker	8	-
Ex-smoker	1	-
Smoking patterns from pregnancy to early childhood		
Nonsmoker/Ex-smoker	9	-
Quit and remain quit:		
During pregnancy/ postpartum	5	3
At year 1	-	1
At year 2	-	1
Quit with occasional slips	5	-
Quit and resume	2	1
Reduce	3	4
Reduce and resume	3	-
Smoker	-	17
Number of years smoked		
Never smoked	8	-
Less than 1 year	-	-
1–5 years	-	-
6–10 years	8	4
11–15 years	5	6
16–20 years	4	5
21 years +	1	12
Unknown (ex-smoker unreported)	1	-

most often the participant's home, and varied in length from 45 to 90 minutes. Field notes were used to record logistical details about the interview, general impressions of the interview process and content, and ideas for data analysis.

Ten of the interviews were conducted with female partners of men involved in the ethnography study, while the other 17 interviews were completed with mothers participating in the grounded theory study. Ethnographic interviews were designed specifically to understand women's perceptions of their partners' smoking. The grounded theory interviews focused on smoking reduction in the couple and family more broadly by exploring how the parents who sought to protect their child from secondhand smoke (SHS) negotiated their tobacco reduction and/or control. Table 2 provides examples of the interview questions.

During analysis of early grounded theory interviews, we realised that the women with smoking partners were echoing information that women shared in the ethnography interviews, particularly in terms of how the women drew on gendered identities to describe and make sense of men's smoking during pregnancy, postpartum, and early childhood. To

Table 2 *Interview Questions*

Ethnographic Study	Grounded Theory Study
How has becoming a father changed your partner's smoking patterns?	What changes, if any, occurred in the way your partner smoked during your pregnancy and in the first few months after the baby was born?
What types of things can partners of expectant fathers who smoke do with regard to men's smoking during this period?	Have you noticed a change in the way you and your partner deal with smoking issues during the past year?
We have learned that some women want their partners to reduce or stop smoking or to change their smoking in other ways–such as smoking away from them or at different times. Did you try to get your husband/partner to change his smoking in any way during your pregnancy? If so how? What was his response?	How are the expectations related to smoking different for mothers and fathers?
How did the issue of smoking come up between the two of you when you found out you were pregnant? Tell me what I would have heard if I had been there. What was the end result?	Do you have any rules about smoking (for yourself, partner, or other people in your immediate circle of friends and family) in your home and/or car? What are they and why are they important to you? Are the rules different for you and your partner? Or for other people in your immediate circle of friends and family? (Probe - is one of you more strict or relaxed with the rules than the other?) Can you give me an example? How would you describe the roles you and your partner each play in creating and maintaining rules about smoking in your family?
What advice do you have for new fathers who want to quit smoking?	What advice would you give other couples who are dealing with smoking issues or their child's exposure to secondhand smoke?

explore this in more depth, subsequent grounded theory interviews included more focused questions on men's smoking. The two data sources were combined as the basis for the secondary analysis reported in this article (Thorne 1994).

Data analysis

Verbatim transcriptions of the interviews and the field notes were analysed focusing on segments of the interviews where women addressed men's smoking. Independent close readings of the initial ethnographic interviews and detailed discussions of the data were used to identify analytical categories that could be used to represent the data. Through this process, a coding framework was developed, and the data coded. The qualitative analysis software program N-Vivo was used as a tool to code and retrieve these data. Data coded to each category were reviewed in detail, comparing and contrasting data from all participants to identify patterns in women's constructions of men's smoking. In addition, the data were explored for representations of masculinities and femininities.

Findings

Discourses related to the good father and to masculine ideals were strongly reflected in a tension underlying women's constructions of smoking as something that, on the one hand, 'good fathers' shouldn't do, but, on the other hand, as something that men deserve. We interpreted the combinations of compliance, resistance and co-operation with dominant hegemonic principles as representing ambivalent femininity (Howson 2006). Specifically, there was compliance in accepting and affirming men's breadwinner and protector status underpinning constructions of men's needs to smoke, but resistance and questioning about how men who smoked might best embody their roles as fathers. In addition, the deep concerns women expressed about the effect of smoking on their partner's health and the health of their children evoked evidence of traditional femininities that prescribe women's roles in taking care of the health of the men and children in their lives. In terms of Howson's (2006) model, this concern can also be interpreted as women responding with compliance and accommodation to men's lack of interest in self-health. This tacit agreement was further evidenced by women who recognised that smoking was a traditional masculine activity and part of their partner's identity. As one woman, a former pack-a-day smoker who quit during pregnancy, stated: 'Smoking to him, it's like chocolate to a girl'. Although many women accepted men's smoking prior to the birth of their child, there was general agreement that fatherhood was a compelling reason to quit. The women's responses to men's continued smoking are discussed in relation to three themes: (a) 'It's his little thing': defending men's smoking, (b) 'He just smokes without thinking': the work of regulating men's smoking, (c) 'It has to be his decision to quit': the power of men's autonomy. In each of these themes there is evidence that the women relied on discourses of emphasised femininity as they contrasted their role in the family with that of their husband.

'It's his little thing': defending men's smoking

Twenty-two of the 27 women in this study candidly defended men's smoking. They did this in three distinct ways that reflected contemporary social discourses about smoking, as well as traditional discourses of gender. One woman's comment stood out as a strong reflection of this general stance, when she described her partner's smoking as 'his little thing'. This defence is interesting in light of 1980s qualitative research in which mother's smoking was interpreted as a means by which women in poverty coped with the full-time daily responsibilities of

caring for young children (Graham 1987). While this may appear to be a parallel situation with fathers' smoking, we reflected that in contrast, more than 20 years later, we cannot imagine any equivalence to her 'little thing' in connection with mothers' smoking. Contemporary social discourses in connection with parental smoking are gendered, more forgiving of fathers' smoking (Bottorff *et al.* 2006) and are reflected in this woman's defence.

Throughout their narratives, the women positioned men's smoking as an individual right and personal choice over which they held no influence. The legitimacy of choosing to smoke was framed as a collective social value that should be respected, and explained in part why some mothers possessed so little agency in regard to fathers' smoking. A 29-year-old mother, who had quit smoking several years earlier with her first pregnancy, stated the 'argument':

> Because I think it's a personal choice, I don't think it's like, if it's not personal then why is it not banned, like why is it allowed for people to smoke? You know, that's sort of my thinking to it. No one can tell you, you can or cannot smoke – you can if you want.

Despite respecting individual smoking rights, some women expressed helplessness with this situation. A 29-year-old mother who relapsed after quitting for her pregnancy indicated the limitations of this philosophy saying, 'I mean he's his own person I can't stop him, I can't prevent [him], I can't, you know, so I'm kind of at a loss for what to do'. These comments reveal the challenges when women bought into dominant discourses about smoking as a right and choice because their partner's smoking effectively operated outside their jurisdiction.

The second way women defended men's smoking was by minimising its impact on their domestic lives by framing smoking as an activity men did privately or when out of the house; in either instance smoking was portrayed as a gendered activity removed from home and family life. As a 35-year-old mother and hairdresser affirmed, 'If he wanted to smoke then it would be kind of very secretive, go and hide it… like I never saw him…he never would smoke around me and the kids'. Because men often ensured their smoking was not visible, and did more smoking when out with buddies or at work, many women accepted this discrete smoking as something men do when away from the home, thereby polarising men's public smoking as a masculine activity separate and in contrast to domestic feminine activities. For example, a 38-year-old mother defended her husband's smoking saying, 'It's separate from me, it's a separate life, a separate thing that he does, and I'm not involved in it at all'. Some women had no idea how much their husband smoked, as a 32-year-old mother and non-smoker explained, 'I don't know [how much he smokes], he won't tell me the truth' (laughing). These women's acceptance of their partner's alignment to a 'different' set of masculine performances in the public sphere, illustrates characteristics of emphasised femininities.

The third way women defended men's smoking was by describing their partner as a good father who accepted domestic responsibilities, provided for and protected the family, and therefore 'deserved' to smoke. While the relationship of masculinity to smoking went unchallenged, the relationship of fathering to smoking was expressed in qualified terms. Some women emphasised how men were 'really good' and 'protect us' by never smoking around themselves and their children, by ensuring children were not exposed to SHS, and by maintaining vehicles that did not smell of smoke. A 35-year-old mother, who had quit and smoked occasionally, remarked how her pack-a-day husband, 'really tries hard to make a smoke-free environment' in their car. Because he only smoked in the vehicle when alone, she stated, 'we're lucky as a family, lucky'. This woman cited her man's smoking practices, not as a health risk, but as yet another example of his commitment to protecting the family.

Similarly, a 38-year-old non-smoking mother who experienced complications after a caesarean section and whose husband stayed at home with her after her surgery, stated, 'that

man deserves everything, if he wanted to smoke four times as much, that would be his prerogative and, you know, as much as I really want him not to, he deserves that'. Others described the stress of new fathering responsibilities or stressful circumstances at work to explain why their partners deserved to smoke. In these ways some women valorised their man's strength by linking cigarettes to reward whilst affirming their femininity as caring about, rather than controlling, a supportive father who smoked.

By defending fathers' smoking, women positioned themselves as responsible for maintaining harmony in their relationships, a stance that could be interpreted as reflecting emphasised femininity. For example, a 26-year-old mother who quit smoking and whose husband reduced, but did not quit, reflected an emphasised femininity when she said, 'you know, I've just come to the decision that it is a personal choice and it's not gonna help our relationship any to nag at him'. In this scenario she extends her acceptance of her partner's self-reliance to include the assertion that contesting that position would render her a pest and impact negatively on the relationship. Among the 10 mothers who continued to smoke, father's smoking was portrayed as an element of enjoyment within these relationships and, therefore, something of value to the couple. Women kept men company while they smoked and supported their smoking rituals (*e.g.* making exceptions for smoking inside when it was raining or cold). For these women, smoking represented an aspect of shared intimacy, with strong nostalgic connections to their earlier courting days.

'He just smokes without thinking' – the work of regulating men's smoking

Women's roles related to protecting and maintaining family health, and masculinities that position men as not caring much about health often placed women in the trying position of regulating their partner's continued smoking. This stance was evident in interviews with 20 women. In their narratives, a disconnection between men's smoking and their health and the health of others was evident as the women implicitly and sometimes explicitly positioned smoking men as not knowing any better, or as people who were unaware of the effect that their smoking was having on those around them. Similarly, unequal gender relations and the assumption that men's health is the responsibility of women has been identified in other constructivist-based empirical research (Lyons and Willott 1999). Lyons and Willott identified a prominent health discourse that positions 'men as infants' in need of women's care to receive good health. This representation of men as ignorant and child-like in regard to their own health was mirrored in accounts from women in our study. They described how, at times, men lapsed into unthinking smokers who were completely unaware of others' needs and required reminding:

> I think whenever I kind of did something like tried to wave it [smoke] out of my face or move or something, then he'd become more aware of it [smoking] and he'd feel bad because like he would apologise and I think it made him feel kind of guilty, you know. But I think for the most part, he wasn't even really thinking about it, he was just sitting there smoking and that's all he cared about.

Under the weight of the responsibility of safeguarding their children and fulfilling their role as good mothers, the women engaged in a variety of strategies to regulate men's smoking. Complicating these efforts was their need to preserve their relationships, a reflection of their gendered role in the dyad. Women's strategies for regulating men's smoking included educating them about the effects of SHS, setting rules to control when and where they could smoke, monitoring their smoking, cajoling them to make changes, making sure men's lighters and cigarettes were not left in reach of children, and providing continual reminders. In these

instances there was acceptance of an essentialised maleness, in that being men, fathers were positioned as not knowing any better. Yet embedded here also were ambivalent femininities that questioned men's practices and were dedicated to influencing men's behaviours, ideally without ongoing conflict:

> Whenever I used to tell him not to smoke he would like get pissed off, he'll tell me not to tell him not to smoke. And now like after we have so like so many times we just sit and talk about our child and how like the effects, the bad effects on our baby and so now like we've been talking about it and talking about quitting and making a smoke-free environment for our kids and for everyone else. So now whenever I tell him not to smoke he's not frustrated, he'll take it, he'll say okay, I'll do it, I'll do it.

Some women used language aimed at making men feel guilty about being fathers who smoked. For example, women drew attention to child health problems when men 'forgot' to smoke outside or put off trying to quit. One woman who admitted she 'hated cigarettes' cried in front her husband telling him she was worried he would die of lung cancer leaving her 'alone' with their baby. Others reminded men about their responsibilities as fathers and role models by letting them know that the kids were 'watching' them smoke. Others, frustrated with men's 'stubbornness', broken promises to quit, and in a few instances, increases in smoking, resorted to 'nagging':

> Just like telling him all the time…telling him…you've got to do this. And he doesn't like to hear me nag and it's like, I know…I know…I've got to do this and that… And yeah it's just basically nagging.

A few women conceded that it was impossible to change their partner's smoking, and that they couldn't push any further. As one woman stated, 'the more I nagged him about it the more irate he'd get'. Another suggested her nagging 'aggravated' her partner into smoking extra cigarettes. These comments reveal how nagging could contribute to increased conflict and even worsen the situation. These women were at a loss about what to do.

The women found the role of regulator difficult and unsatisfying, and many were left feeling frustrated, tired of fighting, and tired of this seemingly endless job. 'He's like in one ear out the other kind of guy…I just have to keep on telling him what the rules are and stuff'. They did not want to be a 'nagging wife', or to 'fight every time' about the cigarettes. Yet balancing competing needs when their partners smoked made life difficult and left women frustrated. One woman who quit, but whose husband was smoking a pack a day, often indoors, when she became pregnant stated:

> I didn't want to be mean and I was trying not to be like this bitchy pregnant woman because then he'd have to tell me about how my hormones are all getting in the way and I didn't want to hear that so it was very frustrating. I had to bite my tongue a lot, I was trying very hard to be nice and respect him but I was also trying not to be around the cigarette smoke, you know, it was kind of hard.

Reluctantly then, women were often put in the position of making concessions and compromising their own needs to accommodate their partners' smoking, preserve relationships, and minimise potential conflict. Even in these situations they tried their best to regulate men's smoking practices to protect their children from SHS. For example, ambivalent femininities were displayed by this woman who described how she juggled dual

needs to be kind-hearted to her husband and yet maintain domestic control and protect her infant from SHS:

> When it's freezing, freezing cold…I allow him to smoke in the spare room if he has the window open and he stands by the window and he has to have the door to that room closed and he has to make sure he leaves the window open to air it out. But that's just because I feel bad for him that he has to go outside and when it's really cold that just seems kind of mean, you know. Like I don't want my baby getting sick but I don't really want him freezing his butt off either so, you know. I am slightly lenient. But there's like he can never have the smoke around the baby and anywhere if it is inside it needs to be aired out, you know. You can't be just smoking anywhere in the house if he's, if he's there so.

'It has to be his decision to quit': the power of men's autonomy

Consistent with their position that smoking is an individual choice, the women were adamant that quitting required a personal decision and commitment to quit. A 27-year-old mother who desperately wanted her husband to quit explained, 'When they [partners] are ready and they decide to quit, I think that's the only way'. This position was also reinforced by their lack of success in persuading their husbands to quit smoking, and the fact that fatherhood did not prompt most of the men to make this decision. The women provided a range of explanations about why their partners were not taking this step. The central explanation women offered aligned to dominant masculine ideals about autonomy and individualism, and emphasised femininities dedicated to embodying supportive and caring characteristics. For example, a 32-year-old stay-at-home mother, who had never smoked, retreated from diplomatic attempts to influence her partner's smoking and reframed her requests in ways that might mobilise masculine ideals (*e.g.* strength and decisiveness to put mind over matter and quit) while assuming a supportive stance:

> What I say to him now is, you need to quit because you want to, not because I'm telling you, or I'm asking you…I asked him at the beginning [of pregnancy] about smoking, but I don't ask any more…he doesn't like it, like he doesn't feel good, I don't want to remind him.

By concluding that a decision to quit was a man's solitary process, women managed both to reduce relationship conflict and maintain a self-identity as a supportive wife. As one woman explained, 'He'd be like, 'You can't do anything, I've got to do this on my own'.

The gendered nature of spousal decision making also supported this position. A 32-year-old mother married to a taxi driver who had smoked for over 20 years provides an interesting example. Despite shared decision making related to finances, she acknowledges the patriarchal power that explicitly exists around smoking and accepts the confines of an *emphasised* feminine skill set:

> About taking care of our child, I would say, I'm the one who's making decisions. Well, to tell you the truth, I'm the one who's always seeing the doctor, the nutritionist, and always reading about stuff and always with the baby, always – well, he has to listen to me, right? ….And about the finance, we kind of – we kind of negotiate… And about smoking (laughing) he's the dominant one, I would say.

Yet, several women suggested their husbands were unable to decisively quit smoking due to the addictive nature of nicotine. A 21-year-old mother, who also smoked, emphasised the

nicotine dependence of her husband who had reduced from two packs a day to a pack and a half following the birth of their child:

> He wants to quit, he doesn't like smoking, he doesn't enjoy it, he's constantly, he's like, 'I've got to quit. I don't like the taste of it'. He doesn't enjoy it at all. It's not even the habit, it's the addiction of it, and partial habit, like he's used to going out for a cigarette after dinner, as am I right, it's just a habit kind of like part of your routine.… But he has no enjoyment in it anymore. The only thing he feels is it reduces his stress…Yeah, he's at the point of disgust over it, he doesn't want to smoke any more.

Despite the addictive power of nicotine, most of the women placed more emphasis on a man's inherent decision-making power, and dismissed the notion that external aids might increase the chances of a successful quit. Failed attempts to quit were also interpreted within this framework as evidence that 'I just don't think he wants it bad enough'. A woman whose husband had used nicotine patches valorised his current abstinence insisting that, 'before, he used the patch…he tried Zyban as well, but in the end, it was just determination…the only reason [husband] quit is through will power'. The women's emphasis on sheer will and determination as the key ingredient for a man quitting smoking successfully underlines the traditional gendered perspective operating in their understanding of nicotine dependence and smoking behaviour. This perspective on the need for autonomy in quitting smoking has also been identified in men's own narratives (Bottorff *et al.* 2009, Robertson and Williams 2007).

Discussion

The findings of this study provide new understandings of women's responses to fathers' smoking practices in the context of new fatherhood, and add to a growing body of literature on the social factors influencing tobacco reduction in family life. In women's constructions of men's smoking, and in their descriptions of how they defend and regulate men's smoking, we find significant influences of emphasised and ambivalent femininities, and traditional masculinities. For example, identification with emphasised femininities buoyed women's self-identity as a supportive wife and partner, and complemented their defence of men's smoking from the perspective of individual rights, traditional masculinities and the good father and husband. Reconstruction of dominant masculine ideals related to male autonomy and individualism, and feminine ideals related to support and caring were also reflected in women's position as regulators of men's smoking. In addition, they constructed fathers' smoking cessation as largely dependent on the men's decisions to stop.

Women's awareness of the potential for tensions and conflict in their intimate relationships as a result of their efforts to regulate men's smoking was clearly evident. This resulted in muted actions and reflected ambivalent femininity where women assessed relationship harmony as the most important thing. This sensitivity to maintaining good relationships was critical to women's self-protection in domestic relations, where various constructions of power may rest more power with men than with women (Greaves 1996). Not only do these women demonstrate this dynamic related to tobacco use, but also illustrate their responsibility for it and their sensitivity to balancing their comments and interventions. In short, women accommodated men's smoking and calibrated the marital dynamic in the context of both rationalising and intervening on men's smoking. This balance and its relationship to elements of power and control have been observed in the context of tobacco reduction during pregnancy in earlier phases of our research programme (Greaves *et al.* 2007).

Protest femininities (*i.e.* those that challenge the foundation of gender relations and the gender order) are missing in the data from these 27 women, perhaps because such approaches would have upset the marital balance at a vulnerable time in a woman's life, when she is in sequence pregnant, recovering from childbirth, caring for a newborn and feeling responsible for the protection of an infant. Protest femininities have been identified in women smokers during pregnancy when they rejected social norms for women's compelled tobacco cessation that were monitored by their male partners (Greaves *et al.* 2007). It is possible that the types of responses available to women at this life stage are limited, and that women may be actively maintaining harmony in relationships where fathers smoke as a means of protection and reduction of vulnerability.

While sex and gender differences in health practices and outcomes are often reported, rarely do we delve into why these differences occur, or how gender specifically shapes health outcomes. The application of a specific gender lens, as used in this study, is a valuable analytic tool. The findings of this study move us beyond comparisons by showing how gender relations are shaped by societal ideals of what it means to be a man or a woman, and therefore influence the smoking practices of new fathers. The heartening aspect of these findings is that these relations are socially constructed and therefore modifiable. For example we have seen tremendous shifts in fathering roles over the past several decades. These shifts have come about because of policy changes and cultural shifts that have enabled men to consider how they can approach fatherhood and take on different roles.

Health professionals need to consider ways to help shift the gender dynamics that place so much responsibility for smoking cessation on women. Robertson and Williams (2007) highlighted the problem that relying on female partners to promote men's health may afford men opportunities to advance their own wellbeing while preserving their masculine identities. However, this situation is problematic, reproducing unequal gender dynamics by placing the responsibility solely on women. In the context of fathers who smoke, and the findings drawn from this study, women's self-labelled 'nagging' seems, at least in part, effective in reducing exposure to SHS but it is clearly not without risk both in terms of intimate partner safety and relationship functionality. In addition, it is noteworthy that both men and women perceived and labelled women's requests for their partner to quit as 'nagging'; this use of language might also be interpreted as an example of how gender relations and gender discourses are co-constructed, co-maintained, and in this instance, protect the continuance of male smoking. The acuity that typically mobilises men's actions in seeking help rarely emerges in smoking to foster changes to benefit men's and their families' health. Instead, we suggest re-thinking reliance on emphasised and ambivalent femininities for men's health programmes in which women are targeted because of their influence on men's health practices. As Robertson (2007) has revealed, and our findings confirm, there is potential for intimate relations to be generative of both positive and negative health outcomes, and it is naïve to assume the efficacy or continuation of women's home interventions in governing the smoking of new fathers. In assuming that men need to be taught and reminded about the health risks of smoking, as the women in this study play out, we locate masculine ideals as the potential 'problem' and ignore the complicity of femininities and the influence of gender relations. Rather, professional smoking cessation interventions that 'talk' directly to men might both effectively address the masculine ideals that permeate men's smoking as well as relieve women of this responsibility at a very vulnerable time in their lives.

In conclusion, this study extends our understanding of how idealised gender types, gender relations, and alignments with femininities and masculinities influence the health practices of women and men, and illustrates the limitations of health behaviour discourse and intervention that focuses on individual choice and responsibility. The findings provide

direction for developing gender-specific tobacco reduction initiatives targeting expectant and new fathers. Indeed, a lack of intervention aimed at encouraging men's tobacco reduction has the clear potential to increase relationship tensions, and inadvertently maintain pressure on women to be responsible for regulating fathers' smoking. This study illustrates how gender-based analyses can provide new directions for men's health promotion programmes and policies, address root gender-specific issues underlying health behaviours, and promote and preserve family health.

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