Tobacco and England’s Ethnic Minorities
A research report
# Contents

Foreword  
Key findings and recommendations  
Introduction  
Methodology  
- Research methodology and design  
- Focus groups and sampling  
- Interviews with key informants  
Definitions  
Literature review  
- Overview of existing research  
  - Levels of smoking  
  - Levels of regular smoking by gender and age  
  - Giving up smoking  
  - Constituents of chewing mixture  
  - Levels of chewing tobacco  
  - Chewing and health  
  - Health beliefs, attitudes and behaviour  
  - Beliefs related to health and smoking  
  - Health promotion  
Tobacco related behaviour—research findings  
- Initial experiences with tobacco  
  - Smoking  
  - Chewing  
- Current reasons for smoking  
  - Smoking as a social activity  
  - Social pressure  
  - Stress: smoking as a coping mechanism  
  - Stress: smoking as a calming mechanism  
  - Boredom and inactivity  
  - Addiction  
  - Habit  
  - Digestion aids  
  - Weight control
<table>
<thead>
<tr>
<th>Reasons for chewing</th>
<th>26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture and tradition</td>
<td>26</td>
</tr>
<tr>
<td>Social activity</td>
<td>26</td>
</tr>
<tr>
<td>Stress and boredom</td>
<td>26</td>
</tr>
<tr>
<td>Social and cultural attitudes to smoking</td>
<td>27</td>
</tr>
<tr>
<td>General attitudes towards smoking</td>
<td>27</td>
</tr>
<tr>
<td>Women smoking</td>
<td>27</td>
</tr>
<tr>
<td>Smoking with the family</td>
<td>28</td>
</tr>
<tr>
<td>Relationships between smoking, chewing and other drugs</td>
<td>28</td>
</tr>
</tbody>
</table>

| Health knowledge – research findings | 30 |
| General health knowledge and practice | 30 |
| Health perceptions in relation to tobacco use | 31 |
| Perceived state of health in relation to smoking | 32 |
| Perceived state of health in relation to chewing | 32 |
| Perceived future health in relation to smoking | 33 |
| Smoking and pregnancy | 34 |
| Perceived future health in relation to chewing | 34 |

| Giving up smoking – research findings | 35 |
| The experience of giving up smoking | 35 |
| Influencing factors in giving up | 36 |
| The threat of health problems | 36 |
| Religious and cultural factors | 36 |
| Influence of friends, family and partners | 37 |
| Giving up during pregnancy | 38 |
| Cost | 38 |
| Deterrents to giving up | 39 |

| Information about tobacco use and health – research findings | 40 |
| Sources of information | 40 |
| Broadcast media: television and radio | 40 |
| Printed media: magazines and books | 41 |
| GPs and health information leaflets | 41 |
| Advertising campaigns | 42 |
| Information sharing in the community | 42 |
| Reactions to sharing information | 43 |

| Summary of findings | 46 |
| Appendix A: Details of focus groups | 48 |
| Appendix B: Recruitment questionnaire | 49 |
| Appendix C: Focus group topic guide | 52 |
| Bibliography | 53 |
Foreword

The research described in this report was originally commissioned by the Health Education Authority (HEA) as part of its smoking research programme.

Other projects from the programme included surveys of adults, pregnant women and teenagers to provide:

- Intelligence on smoking behaviour and attitudes
- Process evaluations of national and local alliances to determine characteristics associated with successful alliance working
- Consumer research to examine what smokers know and think about different types of cessation products and services
- Evaluations of Quitline, the UK helpline.

By March 2000, the findings from much of this work had already been published. However, a number of important studies were still outstanding.

On 1 April 2000 the Health Development Agency (HDA) was established in accordance with the government white paper Saving Lives: Our Healthier Nation, following on from the closure of the HEA.

- Turning the evidence into action by building up the skills and capacity of those working to improve the public’s health
- Advising on the setting of standards for public health planning and practice.

In keeping with its remit, the HDA aims to publish the outstanding reports from the HEA’s smoking research programme and to continue to disseminate the findings from these and other studies as widely as possible.

The results from the study described in this report clearly have value to the public health field and will help inform the work of all those working in this priority area.

Acknowledgments

The HDA would like to thank everyone who contributed to the research, including the authors of this report Sarah Maltby, Rosemarie Simmons, Salma Choudry, Michael Warrant and Claire Haggett at Surrey Social and Market Research, University of Surrey.

The Health Development Agency

The HDA is a special health authority with a remit to improve the health of people in England – in particular, to reduce inequalities in health between those who are well off and those on low incomes or reliant on state benefits. It achieves this by:

- Working with key statutory and non-statutory organisations at national, regional and local level
- Finding out what works and maintaining this evidence base
The primary objective of this qualitative research was to ascertain appropriate methods of intervention for reduction of tobacco use among black and other minority ethnic groups. This research was intended to inform the development of national and local interventions around tobacco use for black and minority ethnic groups. As such, the research sought to explore the diversity of tobacco use, and its role, within and between minority ethnic groups.

Additionally, the research sought to examine the levels of knowledge regarding tobacco use among minority ethnic groups and to assess responses to health promotion initiatives. The overview of the literature conducted was based on these findings. A total of 36 focus groups were conducted: 22 with South Asian participants and 14 with African-Caribbean groups. Participants reflected a diverse range of religion, educational attainment, employment status, gender, age, language and place of birth.

The data collected in this study has provided valuable information with which to recommend appropriate methods of intervention for the reduction of tobacco use among black and minority ethnic groups. The following recommendations are based on these findings.

Information provision

Participants' knowledge of the health risks of smoking and chewing tobacco, and the relationships between their knowledge sources and their reactions to information, have highlighted a need for a number of interventions. Where the data revealed consistent findings between all ethnic groups, more nationally based recommendations applying to the whole UK population may be more applicable. All of these are discussed below.

**Health campaigning in Asian media**

- The findings from this study show that the primary source of health information for the majority of South Asians was from Asian broadcast media.
- As such, effective health promotion should include an increase in the dissemination of information on Asian television and radio about the health risks of tobacco.
- Such information provision will not only overcome some of the linguistic and cultural boundaries associated with print based information, but will ultimately reach a greater South Asian audience, particularly among older members who rely solely on Asian media for information.
- Furthermore, findings indicate that there is currently a dearth of health information regarding the risks of chewing tobacco and paan and as such, broadcast information should specifically highlight the health risks associated with this type of tobacco behaviour.
- In terms of printed media, while younger South Asian participants tended to use Asian magazines as an information source about health issues, older participants were more reliant on Asian newspapers. This would suggest that these forms of printed media are also a good resource for health promotion within this community.

**Multi-language and culturally familiar printed information**

- The majority of participants in this study stressed that printed health information, such as leaflets and posters were inaccessible. This was particularly so among South Asians, who tended to be culturally unfamiliar with the information and also encountered language difficulties.
- It is therefore recommended that information leaflets be printed in all languages to reach each target group effectively. Additionally, leaflets should be...
written in a style that is simplistic and more ‘culturally familiar’

• One means with which to devise ‘culturally familiar’ text is to draw upon the experiences of members of these groups and to use ‘vignettes’ based on these experiences to highlight specific aspects of the health risks associated with tobacco use.

• Findings from this study indicate that participants tend to draw upon their own experiences and those of others in building their knowledge of the risks of tobacco. Consequently, using people’s real experiences of the health risks of smoking as ‘stories’ in leaflets, including their own advice on cutting down or giving up, is an effective way of making the information more accessible at a cultural level.

Consistent health information

• This study found overwhelmingly that participants thought information about the health risks of smoking was inconsistent and, consequently, unreliable. It is perhaps because of this that participants consider the link between smoking and ill health to be unpredictable.

• Such a finding would suggest a need for a nationally coordinated public information resource, including a national smoking helpline providing facts and giving advice on giving up smoking.

• The service should have the scope to deal with a multi-language population.

• A national agency can provide an authoritative source of information regarding the risks of smoking (and tobacco use), and attempt to regulate, through endorsement, the consistency of other tobacco information that is available to the public.

Smoking cessation campaign aimed at young people

• While the younger participants in this study, from all ethnic groups, appeared to be aware of, and concerned with, the harmful effects of smoking on their future health, there was an overriding reluctance to act upon this information ‘now’. Most believed that their smoking behaviour would change later in life.

• Additionally, findings from the study showed that young people believe that healthy practice in other areas, such as exercise and diet, offset the detrimental effects of smoking. Such views would suggest a national smoking cessation campaign targeting these specific aspects of smoking behaviour in young people.

• This report suggests that this campaign could contain explicit ‘why wait?’ messages that explain the effect and risk of smoking on both current and future health. The campaign should highlight the predictable link between smoking and ill health, demonstrating that a procrastinating attitude towards giving up smoking is more damaging than is currently supposed by this generation. For example, this study has shown that coughing and wheezing is considered an acceptable part of a smoking habit with little consideration of the short and long term effects.

• It is important therefore that the campaign should encourage young people to consider their future health in the here and now and, sympathetically, argue for a more proactive attitude towards giving up smoking.

• Any advertising must reflect the lifestyles and interests of the young target population.

Smoking cessation campaign aimed at parents

• Findings from this study have shown that the vast majority of participants, from all ethnic groups, believe that it is essential for women to give up smoking during their pregnancy to protect the health of the unborn child.

• Furthermore, a large number of the parents who took part in the study were also reluctant to smoke in front of their children. Conversely, other findings demonstrated that some participants had started to smoke primarily because they had witnessed their parents smoking.

• This would suggest that promoting smoking cessation messages among parents has a three-fold benefit: First, parents can be encouraged to give up smoking to protect the health of their children, both during pregnancy and from passive smoking once the child is born; second, children will be less likely to be encouraged to smoke as a result of being raised in non-smoking homes; and third, the ex-smoker will also gain by improvements in their own health.

• This report suggests that appropriate methods with which to promote such smoking cessation messages would be ante- and post-natal care where the benefits to the child’s and the parents’ health can be stressed. Health visitors and other staff who have contact with parents, should be encouraged to pass on anti-smoking messages either verbally and/or with appropriate literature.
Promotion of alternative methods for indigestion relief among South Asians

- The findings show that tobacco use is often used as an indigestion reliever among South Asians. While this finding raises questions regarding the possible high levels of indigestion within these groups’ diets, it also stresses the need to recommend alternatives to relieve the discomfort of indigestion.
- Although this study has also shown that members of these groups are often distrustful of pharmaceutical drugs, particularly Bangladeshis, other, more natural remedies could be promoted as a substitute for using tobacco or paan for relieving indigestion, for example, mint, ginger or fennel.
- Concurrently, the promotion of these products should also run alongside information campaigns that highlight the harmful effects of tobacco chewing.

Community based work

While the demand for information based strategies appeared to be the most important aspect in encouraging tobacco cessation, the acceptance of such culturally unfamiliar information among minority ethnic groups is a crucial aspect to consider in the promotion of healthy living. Findings from this study indicate that the relationships between tobacco related behaviour and culture, tradition and religion are particularly strong.

Consequently, this needs to be integrated into any successful tobacco cessation campaign. The following recommendations are founded upon this premise.

- The findings indicate that the greatest response to health information, particularly within the South Asian communities, derives from face to face contact with community members.
- Conversely, interviews with key informants revealed very little community health support specifically for tobacco users in most areas.
- This would suggest an opportunity for community based work targeted at tobacco users thereby involving the community at grass roots level to become involved in smoking cessation strategies.
- Community based strategies should involve community members conducting support groups and workshops in a culturally familiar manner. In particular, community and religious leaders could play an important role in health promotion.
- The use of peer group members to communicate health promotion messages is a valuable strategy; for example, Age Concern has trained a number of older people to encourage members of their own older community to improve their diet and exercise, with positive results.
- In the same manner in which drug users and alcohol users have access to specific resources and health professionals who encourage cessation, smokers should have access to this type of service provision.
- As such, a community-based tobacco ‘surgery’ or ‘clinic’ would offer local members of the community an opportunity to become involved, and be supported by, the community in a familiar setting where members can avoid feelings of isolation and alienation.
- Doctors’ surgeries and health centres could be an information source and provide services that will aid smoking cessation. For example, the study highlighted the relationship between smoking and stress among many South Asian participants, so alternative practices (such as acupuncture and yoga sessions) that help relieve stress could be provided, and subsidised.
- Reward incentives and the sharing of information [like Weight Watchers] could also form an integral part of the community approach to tobacco education and cessation.
- Community based strategies can have positive results, for example, lectures on the importance of breast screening held in a Woking mosque increased the uptake among South Asian women.

Future research

While the current study provides useful information and ways in which appropriate tobacco cessation interventions can be devised, it also raises more detailed questions about the relationship between tobacco use and minority ethnic groups.

The following recommendations are suggestions for future research into this area.

Community based action research

- Because of the cultural and traditional aspects associated with tobacco use among ethnic groups, particularly South Asians, the most appropriate form of future research would appear to be action research, which would allow for a participant centred approach to both data collection and promoting tobacco cessation.
Action research involves community representatives, commissioning organisations, researchers and relevant agencies working together on small projects to find solutions to problems. For example, those participants who have taken part in this study could be re-invited to work in small action research groups to help suggest solutions to the problems previously raised, subsequently, when some measures have been implemented, groups would assist with evaluation.

These action research groups should ideally meet regularly over the duration of the project (usually three to six months).

The coordinating research agency would then be one of facilitation and training – training relevant staff and members of the community in the techniques of action research, and facilitating each meeting to keep projects on track. This would be adding value to the existing consultation process by creating an inter-relationship between agencies and the community to bring about real change.

Further research into the influence of religious and cultural practices associated with tobacco use

A number of findings surfaced in this study that were directly related to the religious and cultural practices of minority ethnic groups but whose relationship to smoking was less clear.

For example, the cultural unacceptability of smoking among women for both South Asians and African-Caribbeans is an area that could be further explored to bring forth fruitful issues that may be used to promote culturally familiar tobacco cessation campaigns. Related to this was the high number of South Asian women who cited that chewing tobacco was preferable to smoking, even during pregnancy, because it was deemed more culturally acceptable.

Furthermore a number of participants highlighted that the strong religious influence in their lives encouraged them to consider giving up smoking; however, very few had actually acted on this.

While this demonstrates the divergence between opinion and action (manifest in many types of research), it also highlights a need to identify specific religious influences so that they may be encouraged.

Issues to consider would be what types of religion are influential and in what way and why is it that so few – while aware of this influence – do not act upon it?

Lastly, findings from this study's key informant interviews have highlighted a gap in service provision for smokers in minority ethnic communities. Future research should consider the full extent of this gap nationally so that new recommendations are consistent with current health initiatives that overlap in services is avoided.
Introduction

This report summarises research commissioned by the Health Education Authority (HEA) and conducted by Surrey Social and Market Research, at the University of Surrey, examining the role of tobacco use in black and minority ethnic groups. Research was conducted between June 1999 and February 2000, comprising:

- 16 interviews with key informants from local health authority health promotion units, community health educators and community leaders
- 36 focus groups of between eight to 10 participants (316 individuals) inclusive of some ‘mini groups’ with 16 to 19 year olds (38 individuals).

The main research aims were to:

- Explore the diversity of tobacco use, and its role, within and among minority ethnic groups
- Explore beliefs and attitudes towards tobacco use among minority ethnic groups
- Explore attitudes towards health and self-perceived wellbeing both in general, and with regard to tobacco use and health
- Examine levels of knowledge and identify concerns with regard to tobacco use and health
- Examine the experiences, and levels of motivation, of ceasing tobacco use
- Assess responses to health promotion initiatives such as information and recommendations for improving health, and in particular not smoking
- Investigate appropriate targeting of intervention for reduction of tobacco use among black and minority ethnic groups

Structure of this report

The findings from the focus groups are presented in two parts, a literature review and research findings.

The literature review is an overview of existing research on tobacco use among ethnic minorities.

The research findings are presented in the following sections:

- Tobacco related behaviour focuses on the role of tobacco in participants’ lives and their attitudes towards smoking and tobacco use. As such it examines the age at which participants started to use tobacco and why, and the social acceptability of smoking and tobacco use within the community. To allow for a more comprehensive analysis of the differences between smoking and tobacco use (such as chewing), these topics are discussed separately throughout this section.

- Health knowledge examines participants’ smoking in relation to their health. As such, this section outlines participants’ health knowledge with regard to the perceived risks of tobacco use on both their current and future health.

- Giving up smoking details findings relating to participants’ attempts to give up smoking including motivating and deterring factors.

- Information about tobacco use and health then explores participants’ knowledge of tobacco use, their primary sources of information and their reactions to information.

Finally, the report concludes with a summary of the main findings of the research.
Methodology

Research methodology and design

This study employed a qualitative methodology through the use of focus groups and indepth interviews. Focus groups are a particularly appropriate method of collecting data rapidly and effectively as they allow for indepth examination of the experiences, circumstances and attitudes that underpin specific behaviours and the social meaning that individuals bring to bear on their own behaviour (Jarrett, 1993, Lee, 1993). As such, they often bring to the fore issues that have been relatively unexplored in more quantitative studies.

In particular, focus groups are advantageous for researching culturally sensitive issues because the company of others from a similar cultural setting allows for spontaneous expression that may be unobtainable in an interview (Maclver, 1993). Such interaction enhances the richness of the data and stimulates participants to consider themselves more as 'consultants' than 'respondents' (Lee, 1993: 160), thereby engaging participants in difficult to access and potentially mistrustful subjects.

While qualitative research allows for an examination of the diversity of experiences and attitudes, it does not permit measurement of the extent to which a particular attitude is held. As such, findings cannot be considered statistically representative of a particular population. While, therefore, this report explores the range of views and behaviours held by specific populations, it does not consider the proportion of people that may hold those views.

Key issues informing the design

The rationale for the design of the project was informed by previous quantitative research on smoking among black and minority ethnic groups and information pertaining to the breakdown of ethnic groups among the UK population. The two largest groups of ethnic minority communities in the UK population comprise South Asians at 2.7% and black people at 1.6% (OPCS 1991 census).

In the 1991 census classification, the main communities among South Asians are identified as Indian, Pakistani and Bangladeshi. Among black people, the African-Caribbean and African (mainly West African) communities comprise the main groups. Nearly 47% of all people from minority ethnic groups are born in the UK with some variations between different ethnic populations.

The design of this study was based upon a number of principles:

- To reflect the diversity among black and other minority ethnic groups in the UK and to allow an examination of the differences among these groups regarding attitudes and behaviour in relation to tobacco use.
- To enable uninhibited and open discussion to take place among group participants in each group.

The first stage of the research was undertaken between July 1999 and January 2000 and comprised:

- 28 focus groups of between eight and 10 participants (250 individuals in total) inclusive of some mini groups with 16-19 year olds (30 individuals in total).
- 16 interviews with key informants from local health authority health promotion units, community educators and community leaders.

This initial study produced a number of important and interesting findings on which the rationale for the second stage of the research was founded. The two key issues were first, the initial study conducted focus groups that included a mixture of black Africans and Caribbeans in...
the same group. As such, it was difficult to ascertain any differences in smoking behaviour between the two ethnic groups. Second, the initial study found that smoking rates among Bangladeshi men were very low, which contrasts strongly with previous research into smoking in the community. On the basis of these key points, additional research was undertaken between January and February 2000 comprising:

- Four focus groups of eight Bangladeshi male participants over the age of 16 years
- One focus group of eight African male and female participants over the age of 16
- Three focus groups of eight Caribbean male and female participants over the age of 16.

The main aims of this second study were.

- A more detailed study of Bangladeshi men to examine their smoking behaviour and to examine the findings in relation to other research suggesting that Bangladeshi males have a high incidence of smoking
- To investigate whether there are significant differences among and within African-Caribbean groups; in particular, whether island/country of origin has an influence on smoking behaviour.

Focus groups and sampling

A total of 36 focus groups were conducted to ascertain the role of tobacco usage in black and minority ethnic groups. The selection criteria used for recruitment of participants was based upon the following three principles:

- To ensure participants reflected the South Asian and black communities including: Pakistani, Indian, Bangladeshi, African and Caribbean individuals
- To ensure participants reflected a variety of different life stages, thereby reflecting the range of attitudes and behaviours associated with smoking in different age groups
- To ensure participants reflected a variety of characteristics including gender, religion, socio-economic group, level of education, employment status and marital/family status.

In addition, and in relation to the specific topic of research, the following criteria ensured a balanced mix of:

- Individuals who smoked and individuals who lived in a household where one or more members of the household smoked
- Individuals who had tried to give up smoking and had been unsuccessful
- Individuals who had given up smoking and had been successful
- Individuals who used tobacco in other forms, for example paan, biries (roll-ups) and hooka
- Individuals with differing levels of fluency in English, educational attainment and literacy.

The African-Caribbean participants were recruited through a fieldwork recruitment agency based upon the selection criteria (see Appendix B for the recruitment questionnaire). Some of the Pakistani, Indian and Bangladeshi participants were recruited with the help of key informants and through community networking.

Once an initial sample was established the remainder of the Indian, Pakistani and Bangladeshi participants were recruited using the snowballing method. This method used an existing participant’s contacts in the community to recruit another participant. The snowballing method is a particularly useful way of recruiting participants who are difficult to locate. Although the initial hypothesis was based upon the assumption that men smoke more than women, early findings from the Pakistani and Indian communities proved otherwise. Due to this, an equal number of female and male focus groups within the Pakistani community were carried out.

A white, middle-aged, male moderator conducted the African-Caribbean focus groups, whose skills and experience as a moderator outweighed any racial considerations. Additionally, because he was unable to follow the ‘shared experience’ approach the groups were more exploratory and therefore more informative.

The Pakistani, Indian and Bangladeshi groups were conducted by a multilingual, middle-aged, South Asian, female moderator whose experience of conducting focus groups among this community enabled participants to freely discuss experiences in depth in the knowledge that they were culturally familiar to the moderator. All focus groups deliberately avoided recruiting more than one participant from each existing participant to avoid the sample comprising groups of people that know each other well. While friendship groups can be useful in some settings they were not appropriate for this study. Each participant recruited must also fulfill the selection criteria.

It is noteworthy that employing African-Caribbean moderators is difficult because of their scarcity.
group discussions were facilitated by means of a free-flowing discussion guide that covered the following areas:

- Background
- Tobacco related topics
- Perceptions of health
- Health promotion
- Sources of information about tobacco use and health
- Life stages
- Relative importance of other factors to smoking
- People who give up smoking.

These flexible guidelines enabled participants to raise their own concerns and to discuss their experiences with other members of the group. The moderator led an open-ended discussion using a topic guide (see Appendix C). Each group discussion was tape-recorded and lasted approximately an hour and a half. Transcripts of the group discussions were produced and a detailed analysis carried out by each moderator.

**Pakistani and Indian focus groups**

Data was collected from 12 focus group discussions with Pakistani and Indian participants. The Pakistani group discussions were carried out in Urdu and the Indian group discussions were carried out in Hindi. The data from each group was translated into English and analysed by the moderator.

The focus groups were held in Bradford, Leeds, Leicester and Southall and took place in a number of locations including a recruiter's house, mosques, community centres and school halls.

Selection of these geographic locations was primarily based upon their strong composition of Pakistani and Indian ethnic groups. Additionally, the moderator's connections in these areas enabled ease of access to these communities, and the acquisition of venues, in each locality. The focus groups were divided by the following categories (see Appendix A for a more comprehensive breakdown).

- Ethnic origin and religion
- Gender
- Age (16-29/30-49/50-64)

**African-Caribbean focus groups**

Data was initially collected from 10 focus group discussions within the African-Caribbean groups. The focus groups were held in Birmingham, South London and North London.

Additional data was then collected from three focus groups with Caribbean men and women and one focus group with African men and women, both of which were conducted in the London Borough of Lewisham.

All focus groups were conducted in the home of an African-Caribbean recruiter where it was felt participants would feel comfortable, secure and relaxed. They were conducted in English and therefore no translation was needed.

All focus groups were divided by the following categories (see Appendix A for a comprehensive breakdown of all the focus groups):

- By gender
- By age (16-29/30-49/50-64)

**Bangladeshi focus groups**

Data was collected from six focus groups carried out with female and male participants from the Bangladeshi community, within the age range of 16-64. Four of these focus groups were conducted in the London Borough of Tower Hamlets, due to the high population of resident Bangladeshis in this area, and two focus groups were conducted in the London Borough of Newham.

Additional data was then collected from four focus groups with Bangladeshi men. Two of the additional focus groups were conducted in the London Borough of Newham, one in the London Borough of Tower Hamlets and the remaining group in Surrey.

One group was conducted in English with some Urdu (the 16-22 year group), while remaining groups were conducted in Urdu and Bengali. Each group was translated into English and analysed by the moderator.

The focus groups were divided by the following categories (see Appendix A for a comprehensive breakdown of all focus groups):

- By gender
- By age (16-29/30-49/50-64).

---

*Bradford and Leeds are often referred to as 'Little Pakistan' due to the strong composition of Pakistani Muslims resident in these areas. Similarly Southall is referred to as 'Little India' due to the fact that the majority community are from the Indian Punjab and are Sikhs by religion.*
Interviews with key informants

The study also included 16 interviews with key informants including health professionals, community educators and community leaders. Local branches of Action for Smoking and Health (ASH) assisted in the recruitment of interviewees by highlighting the relevant health promotion units to contact in local health authority areas known for their relatively high proportions of ethnic residents. As such, professionals at health promotion units in Halifax, Southampton, Bradford, Wakefield, Leeds Southall and Leicester were interviewed.

In addition, community educators and leaders were also interviewed to obtain background information regarding community anti-smoking initiatives. The majority of these were recruited through contacts established while recruiting for the focus groups. As such, it was envisaged that the information obtained from the interviews would bear some relevance to the data collected in the focus groups.

The key learning points from these interviews were as follows:

- There is currently little service provision for smokers within these communities.
- There is need for more up-to-date information regarding smoking at a local community level as national guidelines tend to be limiting.
- There are no specific services for African-Caribbean smokers other than those provided for all smokers.
- Consequently, smoking cessation health promotion for African-Caribbeans is subsumed in the initiatives and work carried out among the general population.
- General service provision for South Asian communities, however, is far greater although few initiatives specifically address health risks associated with smoking and tobacco chewing.
- Smoking among South Asian communities is becoming more common and consequently there is an increasing need for health promotion to address the health risks of smoking.
- However, education surrounding smoking and chewing tobacco needs to be undertaken in a culturally sensitive way to ensure effective health promotion.
- One means of achieving this is to engage with the community at a grassroots level, for example, initiatives must also overcome the difficulties with female smokers who are reluctant to admit to their smoking.
- This is a particularly important issue given that there is a prevalence of smoking among younger girls who tend to dismiss health advice.

Definitions

There are a number of basic ingredients that go into making paan whether it is a sweet paan or one that is lined with tobacco. The first is chuna, which is a white chalky substance mixed with water to make paste and applied on the inside of the betel leaf. The second is katha, which is a mix of different herbs in the form of powder. If a purchaser asks for a sweet paan then the betel leaf has added to it sweet shredded coconut, and if a purchaser asks for a tobacco paan then the betel leaf is lined with tobacco. There were also other ingredients that were not clearly described. Often, there are no labels indicating the ingredients of paan.
Overview of existing research

As recently as 1994 the Health Education Authority (HEA) acknowledged a comparative dearth in research regarding tobacco use among ethnic groups (HEA, 1994). Indeed, it was highlighted that despite the *First National Survey of Ethnic Minorities* (HEA, 1992) ‘most research on black and minority ethnic groups has tended to be disease-led’ (HEA, 1994: 2). In an effort to address this, in 1994 the HEA started to investigate lifestyle factors associated with certain medical conditions among ethnic groups including smoking and tobacco use.

Topics covered included levels of smoking, passive smoking and reasons for giving up smoking. The sample was intended to be statistically representative of the UK population, so that the results were comparable to UK-wide health and lifestyle surveys. Findings in this review are predominantly taken from the HEA’s *Second Health and Lifestyles Survey* (2000), which examines smoking and chewing tobacco patterns among ethnic minorities, focusing specifically on cigarette smoking prevalence, cigarette consumption, smoking cessation and knowledge levels of health effects associated with smoking among African-Caribbean, Indian, Pakistani and Bangladeshi communities.

In addition, the 1997 study by the HEA of coronary heart disease among South Asians provides a useful background to health beliefs and behaviours in relation to smoking and chewing tobacco. It is acknowledged that these findings are not necessarily representative of the general UK population, however, the employed methodology sought to represent all viewpoints in contrast Modood et al’s (1997) findings in *Ethnic Minorities in Britain: Diversity and Disadvantage* are considered to be nationally representative, and Rudat’s (1994) study provides detailed information on tobacco use among ethnic minorities.

The HEA also produced a briefing paper, *Tobacco and Ethnic Minorities* (1997), which details some of the possible cultural and religious factors used to explain smoking patterns, for example, religion, church affiliation and traditional customs.

**Levels of smoking**

Available evidence suggests that while smoking levels among ethnic groups are very different from each other, they are generally lower, or about the same, as in the general UK population (Rudat, 1994; HEA, 2000). The HEA (2000) report found high smoking prevalences among Bangladesh and African-Caribbean people (28% and 27% respectively) with lower rates among Pakistani (15%) and Indian people (10%). See Figure 1.

Explanations for the differences in smoking rates among ethnic groups are mainly cultural and religion based (Modood et al, 1997) particularly for Hindus and Sikhs, and to a lesser extent, Muslims. Indeed, significant differences in smoking levels among different religions (as opposed to ethnic) groups have been identified (HEA, 1997).

**Figure 1: Percentage of current regular smokers by ethnic group (source: HEA, 2000)**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
<td>15%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>10%</td>
</tr>
<tr>
<td>African-Caribbean</td>
<td>8%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>6%</td>
</tr>
<tr>
<td>England*</td>
<td>7%</td>
</tr>
</tbody>
</table>

*Source: Health Survey for England, 1994*
For example, smoking rates among the Sikh community are significantly lower than among other Asian communities in the UK (4% of Sikhs report that they currently smoke), which may be explained by the strict code of conduct prohibiting smoking for observant Sikhs (HEA, 1997). In contrast, the higher level of smoking among Muslim men (approximately one third are current smokers) may be explained by there being no formal ruling on the issue of tobacco use (HEA Briefing Paper 1997). Smoking rates have also been found to vary among South Asians and African-Caribbean Christians. The 1997 HEA Health and Lifestyles Survey found that among South Asian and African-Caribbean Christians in the UK 33% of Methodists, 25% of Anglicans, 22% of Roman Catholics and 20% of Baptists were current smokers (HEA, 1997).

It has also been suggested that high smoking rates among Bangladeshi males may be related to deprivation and socio-economic marginalisation (HEA Briefing Paper 1997) and that varying levels of smoking among South Asians is related to whether they were born in the UK or not (Modood et al, 1997). For those born outside the UK, religious and cultural factors were significant in explaining differences in smoking rates. For those born in the UK explanatory factors were more culturally based, such as parental disapproval.

Despite such suggestions, however, it is important to note that it may not necessarily be possible to explain smoking prevalence only in terms of cultural and religious factors, as to do so may be misleading (HEA, 1997).

Levels of regular smoking by gender and age
It is important to note that the ‘headline’ figures discussed above actually disguise significant variation by gender and age within each ethnic group and that these variations are far greater than those found within the general UK population. Unlike the general population, where gender differences in smoking rates have almost disappeared, smoking rates have remained significantly higher among men than women in all ethnic groups (HEA, 2000).

As illustrated by Figure 2, the HEA (2000) report found very high rates of current regular smoking among Bangladeshis (49%) and African-Caribbean (34%) men, and very low rates for Indian men (18%). (The rate for Pakistani men was 28%.) These figures contrast with those for the general male population, which was found to be 30% by the Health Survey for England, 1994. As such it is important to note here that there is significant variation in overall smoking rates among ethnic groups and that the smoking rates for Bangladeshi and Indian men vary significantly from those found in the general male population.

In contrast, smoking levels among women in all ethnic groups are relatively low in comparison to the general female population (recorded as 27% by the Health Survey for England, 1994), and extremely low for South Asian women (see Figure 2). The 2000 HEA report found the highest smoking rates for female ethnic groups among African-Caribbean women (21%), whereas very low rates were recorded for Bangladeshi women (6%), Indian women (3%) and Pakistani women (2%).

Rates of smoking also vary considerably according to age within each ethnic group for both men and women (see Figure 3). Particularly high rates of smoking have been
found among Bangladeshi men aged 50-74 years (70%) and 30-49 years (54%), and for African-Caribbean men aged 50-74 (64%) (HEA, 2000). Rates of smoking for female ethnic groups also vary according to age. Whereas younger African-Caribbean women show rates similar to the general female population (29% among 16-29 year olds and 23% for 30-49 year olds compared to 27% for the general female population), rates for older African-Caribbean women are very low (4%).

Among South Asian women, the only significant rates of smoking occur among older Bangladeshi women (50-74 years: 14%) (HEA, 2000). It is worth noting here that it has been suggested that the low rates of smoking recorded among women of Asian origin may be attributed to social pressures relating to their position in Asian communities and their acceptable public behaviour (HEA, 1997).

**Giving up smoking**

Around two-thirds of smokers, irrespective of ethnic background, want to give up smoking (Rudat, 1994). Among ethnic groups, factors such as social support, particularly among Indians, and medical advice, particularly among South Asians, have been cited as important in the process of attempting to give up smoking.

Reasons cited for failing to give up among ethnic groups are similar to the UK population generally, namely stress and lack of willpower — although among a sample of younger Bangladeshi restaurant workers, the influence of peer-pressure and need for a fashionable self-image were also mentioned (CIO, 1998).

African-Caribbeans and South Asians were less likely to have given up smoking than those in the wider population of England. A third of Indian people (35%), a quarter of African-Caribbean people (28%) and Pakistani people (26%), and less than a quarter of Bangladeshi people (17%) who had ever smoked were now ex-regular smokers. This compares to just under half (46%) of the whole population of England.

Reasons cited for cessation have been found to be health related. South Asians, particularly, highlighted that diagnosis of particular health problems, or advice from their GP was an important contributory factor. Modood et al (1997), however, found that cultural and religious reasons were cited as more significant than health reasons for non-UK born South Asians.

While financial reasons have been shown to contribute to cessation for the UK population as a whole, Rudat (1994) notes that finance does not appear to be as relevant among ethnic groups. This finding is supported by Modood et al (1997) whose interviewees suggested that sharing cigarettes is common practice in Bangladeshi and Indian groups.

**Constituents of chewing mixture**

When comparing different studies of tobacco chewing, there appears to be little consensus over the definition of substances chewed. Pearson et al (1999) describes ‘paan’ as a mixture of betel vine leaves, arecanut and lime, and notes that tobacco is sometimes added to this mixture. In contrast, Rudat (1994) describes paan as a green leaf chewed with limestone and betel nuts.

In addition, while the HEA (1997) and Pearson et al (1999) noted that a large proportion of people add tobacco to the chewing mixture (for example 28% of Bangladeshis), Modood et al (1997) states that tobacco might already be added at the point of sale without the respondents’ knowledge.

In fact, Modood’s findings highlight that purchasers of ‘ready-made’ chewing substances are often unaware of, or do not fully understand, the ingredients of the substance they are buying. As such, knowledge of its tobacco content is minimal and purchasers may be buying ‘ready-made’ chewing mixtures containing tobacco without their knowledge.

Results from self-report studies into levels of tobacco chewing must therefore be treated with caution when they do not distinguish between respondents who purchase ‘ready-made’ and those who do not.

---

**Figure 4: Percentage of ex-regular smokers who have given up smoking by ethnic group**

*Source: HEA, 2000*
Levels of chewing tobacco

Preliminary research (Summers et al, 1994; Bedi and Gilthorpe, 1995) into tobacco chewing has shown that it is most commonly found among Bangladeshis (66%), that a higher proportion of women chew than men, and that this increases with age (96% of 50-74 year olds). Similarly, the 2000 HEA survey found that tobacco chewing (on its own or with other products) seems to be widespread among Bangladeshi people, but very limited among Indian and Pakistani people.

Thirty-two per cent of Bangladeshis reported recent tobacco chewing, with particularly high rates for women aged over 30 (78% of Bangladeshis aged 30-49 and 92% of Bangladeshis aged 50-74 reporting recent tobacco chewing). Fewer Bangladeshi men reported chewing tobacco recently, although over a third aged over 30 reported doing so (HEA, 2000).

In addition, Pearson et al’s study of oral cancer (1999) found that more women were heavier chewers than men, and, conversely, that more men were light chewers than women. Pearson et al (1999) also found that while the average age at which chewing began was 21 years old, some began chewing as young as six years old.

In contrast, very few Indians and Pakistanis reported tobacco chewing, with or without other substances (2% and 1% respectively) (HEA, 2000).

As can be seen from Figure 5, Bangladeshis rarely chew tobacco on its own. However 29% reported having recently chewed tobacco with betel nut/sopari and 23% reported chewing tobacco with paan (HEA, 2000). Chewing betel nut/sopari or paan without tobacco has also been found to be much more prevalent among Bangladeshi people (39% and 29% respectively) than Indian or Pakistani people (HEA, 2000). Despite these findings there has been an identified need to further investigate this area of tobacco use to gain improved understanding of both its prevalence and the constituents of substances chewed.

Chewing and health

Studies that have examined the perceived relationship between tobacco chewing and health tend to vary in their conclusions. While, on the one hand, Modood et al’s study (1997) found that invariably Bangladeshis, Indians and African-Asians tended to link the chewing of substances – that include tobacco – to ill health and disease.

In contrast, Pearson et al (1999) found that 43% of respondents were unaware that paan chewing could be bad for health. For those who were aware of adverse health effects, most cited them as relating to the mouth and stomach. However, according to Modood’s et al’s study (1997) chewing tobacco was considered by some to be more harmful than smoking because cigarettes were believed to remove harmful pathogens through their filters.

In Pearson et al’s study (1999), 14% of respondents admitted being addicted to chewing (a finding supported by Modood et al, 1997). Despite this, a quarter of males and 5% of the females had actually given up. None of those who had given up chewing reported having any difficulties.

At the same time, those who were currently chewing expressed no desire to give up. These findings draw attention to the complexities of giving up tobacco chewing. Indeed, Pearson et al (1999) identifies the need for further research into the reasons why people give up chewing paan, which require greater understanding.

Health beliefs, attitudes and behaviour

Health beliefs, attitudes and behaviour among ethnic groups have been shown to vary according to ethnic group, and degree of acculturation (Beishon and Nazroo, 1997; McAllister and Farquhar, 1992; Rudat, 1994). Other important factors include religious and regional diversity. For example, while Pakistanis and Bangladeshis are predominantly Muslim, Indians and Africans include

---

1 This is particularly the case with the Bangladeshi community, 50% of whom have settled in the UK since the 1980s. As such they have distinct social features from both the UK population as whole and other ethnic groups (Jones, T., 1996).
Muslims, Hindus, Sikhs and Christians (Beishon and Nazroo, 1997). Beishon and Nazroo (1997) also note the influence of lay health beliefs on the way in which health education messages are assimilated and acted upon, and on the way in which people interact with health services. Lastly, they also note the importance of factors, which are beyond the individual's direct control, such as racism and poverty, which Beishon and Nazroo term 'the interface between culture and socio-economic position' (1997: 6).

Beliefs related to health and smoking
Ethnic minorities have been shown to possess relatively poor knowledge concerning the link between cigarette smoking and disease (HEA, 2000) and to be less likely to cite smoking as a health risk than the UK population as a whole. While 18% of the UK population mention smoking as a factor they consider to adversely affect their health, the percentage of ethnic group members was lower. Even when accounting for the lower levels of smoking among ethnic groups, those who relate smoking to ill health is still proportionately lower than the UK average (Rudat, 1994).

The Second Health and Lifestyles Survey (HEA, 2000) provides data concerning knowledge about the links between smoking and heart disease, lung cancer, throat and mouth cancer and other respiratory diseases among ethnic groups, illustrating that levels of knowledge vary between and among ethnic groups.

Lung cancer was found to be the disease most likely to be linked with cigarette smoking by each ethnic group - 52% of African-Caribbean and Indian, 47% of Pakistani and 41% of Bangladesh people identifying a link. African-Caribbean people differed from the other groups in that a larger proportion of women than men identified a link between smoking and lung cancer, however, in each ethnic group knowledge of a link between lung cancer and smoking decreased with age (HEA, 2000). See Figure 6.

Heart disease was found to be the second most likely disease to be linked with smoking, with approximately a quarter of African-Caribbeans and South Asians acknowledging it (African-Caribbeans 27%, Indians 23%, Pakistanis 27% and Bangladeshis 27%). Women were found to have more awareness of this link in each ethnic group than men. The knowledge that smoking can cause heart disease decreased with increasing age among South Asian women, was more prevalent among Indian and African-Caribbean men aged between 30-49 than any other age group, and there was less knowledge of the link among Bangladeshi men aged 50-74 than any other age group (HEA, 2000). See Figure 7.

Knowledge of a link between smoking and other respiratory diseases was poor in all ethnic groups, with 16% of African-Caribbeans, 15% of Pakistanis, 12% of Bangladeshis and 11% of Indians identifying a link. Indian, Pakistani and Bangladeshi men and African-Caribbean women were more likely to identify a link between smoking and other respiratory diseases than their counterparts (like they were for lung cancer). No clear pattern was found by age (HEA, 2000). Less than 1% of people from each ethnic group identified throat and mouth cancer as a serious illness death linked to smoking.

In terms of stress levels and smoking, Jones (1996) found that Bangladeshi men attribute smoking to high levels of stress. It has been suggested that this is due to the lack of support networks available to Bangladeshi men (CIO, 1993). While these support networks are traditionally provided within the family structure, wider community support was not deemed a sufficient

\* For example, the majority of Bangladesh people live in the inner cities where housing quality is low, children's education is poor and 'insecurity and racism are everyday problems' (Jones, T., 1996)
substitute for family/personal matters such as finance, matrimony or illness. Conversely, however, while Pakistanis and Bangladeshis cite stress at home as having adverse health effects, this does not correspond to a higher level of smoking.

**Health promotion**

The 1997 study of coronary heart disease (Beishon and Nazroo, 1997) states that the primary source of health advice and information for both whites and ethnic groups is the GP. Topics discussed by African-Caribbeans are similar to the UK generally. However, evidence from the UK Health and Lifestyles surveys and the HEA (1994) highlights that men from both white and ethnic groups are less likely to discuss health education issues at a doctor's surgery. All ethnic groups show relatively high proportions of people who require advice about coping with stress.

Bangladeshi men, more than any other member of white or ethnic groups, are more likely to consult a member of primary health care staff about smoking (HEA, 1994). Yet Rudat (1994) found that among all ethnic groups, smoking was more likely to be discussed with a GP rather than other primary health care workers. Indians were shown to be least likely to discuss smoking than people from other ethnic groups or the UK population as a whole (1% of Indians, 6% of UK population).

A small proportion of women, and even smaller proportion of men, from each ethnic group thought that smoking was a ‘difficult’ topic to discuss. Similarly, a relatively high proportion of Bangladeshi and Pakistani men wanted advice about giving up smoking and heart disease.

Beishon and Nazroo (1997) note that school education in the country of birth is one of the few places that people receive information about the pros and cons of chewing products. The other source of information was community elders.

Bangladeshis are the most linguistically disadvantaged of all ethnic groups (MORI, 1993 cited in Pearson et al, 1999: 520). It seems unsurprising therefore that Pearson et al (1999) found that approximately three-quarters of the respondents in their study incurred language difficulties when using health services. This finding was more common for females than for males. Consequently they note that language difficulty was the primary reason for Bangladeshis not visiting the dentist.

In a similar vein, Beishon & Nazroo, (1997) found that a small minority of English speakers preferred to see a GP of a similar ethnic background while non-English speaking South Asians preferred to see a GP who spoke their language. Yet, few people of South Asian origin make use of alternative practitioners.

Unfortunately, follow-up data from health promotion discussions is not a sufficiently adequate base from which to draw conclusions about how people access health information. However, Rudat (1994) found that there is a general reliance on printed materials. At the same time, the HEA’s (1994) findings indicate that Indians, Pakistanis and Bangladeshis are less likely to encounter promotion leaflets and magazines that other ethnic groups. In particular, Rudat (1994) notes that printed material is limiting for the Bangladeshi community because of both illiteracy problems and the unavailability of material in the native language. Beishon and Nazroo (1997) highlight the possibility of non-English speakers acquiring health information (often inadvertently) through their child’s education.

Mass media was the primary source of health information. Television was the most common source, followed by magazines and radio (HEA, 1994), although a proportion of some ethnic groups has not encountered health information from mass media sources, in particular 25% of Indians, 30% of Pakistanis and 40% of Bangladeshis. Indeed, Bangladeshis are the least likely to have received information from the television (30%) compared with African-Caribbeans (69%).

Radio is a relatively uncommon source of information among ethnic groups other than South Asians who have been found to often listen to local Asian language radio stations for health information (Beishon and Nazroo, 1997). Bedi and Gilthorpe, 1995 (cited in Pearson et al, 1999) recognise the potential for using the radio medium as a means with which to promote better health.

*T This is because the number of follow up options is varied, and there are insufficient numbers in each sub-group*
Tobacco related behaviour

Research findings

This section explores the smoking and tobacco using practices and behaviour of all the focus group participants. Included in this section are participants’ responses to questions regarding why, how, and when, they started to use tobacco and the habits and practices associated with its current use.

Initial experiences with tobacco

Smoking

The majority of participants had started smoking at a very young age and there were no apparent gender differences although the age at which participants started to smoke did vary according to ethnic groups. While the African-Caribbean participants stated they had started smoking as young teenagers, Pakistani, Indian and Bangladeshi participants said they had started as early as ten years old.

There appeared to be a number of reasons why participants had initially started to smoke at a young age. Firstly, the image of smoking was important. Smoking was associated with looking and feeling ‘cool’ and the ability to ‘belong’ to particular peer groups, particularly among African-Caribbeans.

‘... the first time I actually took the smoke down I threw up and I still carried on. I was really stupid and followed fashion ... Just to be in with the good crowd at work because they were all older than me ...’

African-Caribbean female: 18-29

‘I was probably in my second year at secondary school and wanted to be accepted among all those boys that always seemed to get all the attention. I started to do everything that they did which, among other things, included smoking.'

Pakistani male: 28

Although coercion was rare, the existence of social pressure among peers was apparent (see also CIO, 1998).

Smoking was perceived as a mechanism by which many could increase their self-confidence, join a particular peer group or gain acceptance and kudos among friends.

‘It’s like “follow your leader” more or less sort of thing, where perhaps we’d get a group smoking and then they’ll pass it round, you know, try it.’

African-Caribbean male: 30-49

‘I had my first cigarette at a friend’s bash, I must have been 10 or so, when everybody else does something you want to feel part of it otherwise you’re not really accepted.’

Bangladeshi male: 21

‘... when you’re a teenager you’re conscious of yourself anyway ... a cigarette helped to give you the courage to walk through a crowd of people. I didn’t enjoy it, but just to have it in my hand and puff away ... I could feel (good).’

Older African-Caribbean female

One of the most important reasons for smoking at a young age among the Pakistani, Indian and Bangladeshi participants was the influence of seeing older role models smoking (both tobacco and hooka), particularly members of the family.

‘For me the fact that my grandfather and father used to sit and smoke, was one of my earliest memories. So as soon as I had the chance I sneaked into a corner and had a smoke – I was probably no more than 10 at the time.’

Indian Sikh male: 45
'I must say that I first had a puff of the hooka when I was very young. It was the noise that fascinated me. I remember everyone laughing at my attempts to copy the elders.'

Pakistani female, 36

'I started to smoke at a very young age because my father smoked hooka at that time and would always let me have a go on his hooka. As soon as I started going to school I started to buy the cigarettes....'

Bangladeshi male: 67

Third, stress was a primary reason for those who had started to smoke later in life. In particular, Pakistani, Indian and Bangladesh participants related their starting to smoke with stress at work or stress in relationships.

'I came to it when I hit rock bottom, things in my life weren't going as I had wanted them to and the most natural comforter seemed to be drinking and smoking.'

Indian Sikh male, 29

Some African-Caribbean participants stated they had started smoking as a deliberate act of rebellion against either their parents or a partner.

'I kind of smoked out of defiance really. No, it was great and I can remember the first time when I came home with one.'

African-Caribbean female: 30-49

Some Bangladeshi participants claimed that they had never considered the reasons why they had started to smoke because it was such an integral part of their lives. There was consensus in this group that smoking was almost an automatic reaction.

'I smoke without even knowing that I am smoking that's how much a part of my life it is.'

Bangladeshi male: 29

The availability of differing forms of tobacco in South Asia was also an important factor affecting the age at which the Pakistani, Indian and Bangladeshi participants started to smoke.

'Back home it was, and still is, so easy to begin and continue smoking. I must have had my first biri at the age of five... there is no regulation which says that tobacco cannot be given to a child or someone under a particular age. We use to go to school and with one or two rupees buy a single cigarette from the stalls that are set up outside the schools.'

Pakistani male: 45

'smoking in Bangladesh was different. It was often in the form of a rolled up cigarette that was brought from a street vendor. The whole experience was completely different.'

Bangladeshi male: 52

Many African-Caribbean participants, particularly in the younger groups, said explicit health education emphasising the health risks associated with smoking was insufficient to deter them from starting to smoke.

Similarly, while several of the younger participants recalled their dislike at seeing their parents' or other adults smoking, it had ceased when they, themselves, had started to smoke.

'I remember I hated smoking because I used to see my father and my cousin and they smoke a lot in the house and I hated it, but somewhere along the line I had a cigarette and I started smoking'

African-Caribbean male. 30-49

Chewing

Pana was used among most Indian, Pakistani and Bangladeshi participants (use among Bangladeshis is particularly high*). The age at which participants started to chew tobacco varied. Older participants, all of whom had migrated from Bangladesh, had started to chew in their pre-teens. This was much earlier than the current young Bangladesh community and was argued to be due to the lack of age restrictions on chewing in Bangladesh.

Among Bangladeshis it appeared that the older participants had started to chew tobacco first and then had started to smoke, while the younger participants who had been born in the UK had started smoking first and then taken up chewing tobacco.

*This finding corresponds with that of Rudat (1994) and Jones (1996) who have noted that stress is one of the primary factors that leads people (both ethnic groups and the UK population as a whole) to smoke.

**The majority of respondents came from homes where one or both parents, and/or other close relatives, had smoked.

This confirms research regarding pana's high use in the Bangladesh community (see HEA, 1997, Summers et al., 1994, Bedi and Gilthorpe, 1995.
The majority of participants' first experiences of chewing were as children in the family setting.

'Back home all people use paan. The young children will often have sweet paan, but will also use tobacco in this. For the children in Bangladesh paan is like the chewing gum that children use in this country.'
Bangladeshi male: 47

'I started using paan when I was a young girl in my mum's house.'
Bangladeshi female: 36

'Paan is offered like sweets to all. The very young children are not given it, but I have seen a five year old chewing some of granddad's tobacco paan.'
Bangladeshi male: 49

While chewing tobacco chewing was prevalent among the older participants, it was growing in popularity among the younger participants who were born in the UK.

However, some of the younger participants expressed reservations about chewing tobacco. In particular, they were conscious that excessive use of paan left orange coloured stains on the teeth and lips. As a result, some individuals avoided using paan, and tried to discourage their parents from using it, offering cigarettes as an alternative.

Current reasons for smoking

Smoking as a social activity
Most participants, particularly the younger ones, viewed smoking as a recreational and social activity. As a result, it often accompanied a social drink and was, in part, perceived to heighten the socialising experience.

'I think smoking – like drinking – is a great form of socialisation. We live in a world where getting to know people is important, or certainly making friends. The easiest way around this is to offer someone a cigarette or buy them a drink.'
Indian Hindu male: 27

'I'm just a social smoker. I can go like the whole week without cigarettes, but as soon as I'm drinking though that's when I need a cigarette.'
African-Caribbean female: 18-29

Invariably, social evenings were the time when most smoking took place, partly because of the influence of others smoking.

'I normally buy a pack of ten and if I'm going out I will buy 20.'
African-Caribbean female: 30-49

'I think the only way to really socialise and get to know people ... is to go to the pub, eat smoke and drink ... I do smoke socially, not otherwise.'
Pakistani male: 35

Social pressure
For some participants, mainly from the Pakistani, Indian and Bangladeshi groups, the social aspect of smoking involved a degree of social pressure in order to 'keep in with the crowd' (see also CIO, 1998).

'When everyone you mix with, namely your friends, family and other associates all smoke it is a bit difficult not to. You have to like the same sort of things and also do the same sort of things to be able to keep in with the crowd.'
Pakistani male: 31

'I would say that it is because of the role that my friends had in my life that I still smoke today, it is peer pressure really.'
Indian Hindu male: 52

Stress: smoking as a coping mechanism
A number of participants, particularly Bangladesh men, saw smoking as a stress reliever. A large number of the Bangladesh men worked in manual jobs and saw smoking as a distraction from the boredom and stress of their work.

For many participants, smoking was a coping mechanism with which to deal with stress at both work and in relationships, particularly the family setting (see also Beishon and Nazroo, 1997).

'My smoking habit came from my stress ....'
Bangladeshi male: 37

'... you're in a stressful situation and it's kind of a less stressful situation when you take a cigarette and depending how many cigarettes you smoke, depends how you handle stress isn't it?'
African-Caribbean male: 18-29
‘When I’ve had a really long hard day in the shop, and everything has gone wrong that could possibly go wrong, I look forward to... having a real good smoke. There is nothing better to relieve stress.’

Pakistani male: 41

Similarly, some Bangladeshi participants thought the pace of life in Britain was stressful and they were more inclined to smoke to relieve stress.

Stress: smoking as a calming mechanism
Some participants said smoking enables them to remain calm in stressful situations as it created feelings of well-being and contentment. As such, smoking is a comfort.

‘The reason I smoke is because I feel it comforts me, it is difficult to explain, but this feeling that you get that everything will be all right... For me I suppose cigarettes are a comforter...’

Pakistani female: 19

‘The only time that I smoke is when I am nervous; I must say I don’t enjoy it, but it helps me become calm... there is also something within me, which tells me have a cigarette and you will be okay...’

Indian Hindu male: 43

‘When things get tough at home I resort to smoking. Life has its ups and downs and whenever the wife is giving grief or just generally it all seems difficult, the cigarettes are the only comforter really...’

Bangladeshi male: 32

While some participants said stress was the reason they started smoking, others said it was the primary reason why they had started again after a period of cessation.

‘I’m back on it again because of stress, stress from girls and family...’

African-Caribbean male: 18-29

Boredom and inactivity
There was a perceived correlation between smoking, boredom and inactivity. Indeed some highlighted that smoking itself was an ‘activity’ that gave them something with which to occupy themselves.

‘I only smoke when I’m bored. So I guess I smoke for something to do...’

Indian Sikh male: 29

‘If I’m busy, I may even go the whole day without a cigarette... but if I don’t have anything to do I can go through a packet a day. So I guess it’s for something to do...’

Indian Hindu male: 39

‘When my hands are empty and I have nothing to do, I find that I start smoking. I think it is a habit more than anything else and it gives you something to do...’

Bangladeshi male: 41

For African-Caribbean participants, unemployment was seen as contributory factor to smoking.

‘I smoke... about 40 a week if I’m not working [but] if I’m working it can be as low as 10.’

Older African-Caribbean male

‘With unemployment it’s just queues of people crashing out with cigarettes.’

African-Caribbean male: 18-29

Similarly, while employed African-Caribbeans smoked much less during work hours (some of which may be due to being located in no-smoking offices), their smoking levels outside work hours dramatically increased.

‘Where I used to work you couldn’t smoke, so I’d actually go through the whole day without a cigarette... but then as soon as I’d come out of work I’d probably smoke three in a row.’

African-Caribbean female: 30-45

Some African-Caribbean men found that smoking aided concentration and helped them think more clearly.

‘I can’t answer that question straight off without thinking, so what I do is I start the answer and then I go through the motions of bringing out my cigarette... and it will take longer, bring out the first stick and go through the rigmarole, but while I’m doing that... I’m thinking.’

African-Caribbean male: 30-49

Among some of the African-Caribbean and Bangladeshi participants smoking created an opportunity to take a break from what they were doing, both work-related and non work-related. As such, smoking itself provided a form of entertainment.
'I work for the police and the phone is always ringing . . when the phone stops ringing you have to go out and smoke because there's no TV, no radio . . we don't even have like a canteen or anything like that.'
African-Caribbean female: 18-29

'Sitting and talking and drinking tea and smoking, what else is there to do. We have to fill our time with something . . .' 
Bangladeshi male: 47

Addiction
Indian, Pakistani and Bangladeshi participants did not readily acknowledge the addictive nature of nicotine. They preferred to see themselves as light smokers who could give up if they really wanted to.

'I wouldn't say that it is an addiction because if it was, if I didn't have it I would crave for it wouldn't I?' 
Indian Hindu male: 39

'I wouldn't say that it is an addiction, I know the risks to my health from smoking, but it is something that I enjoy doing . . .' 
Bangladeshi male: 18

Conversely, African-Caribbean participants cited addiction to nicotine as a major reason for smoking

'I just can't stop . . I think I'm addicted to the nicotine . . I don't know if I enjoy (smoking) but I recognise that I'm addicted to nicotine.' 
Older African-Caribbean female

'Nicotine is definitely a drug . . . You can't become addicted to anything except a drug and you have to feed that.' 
African-Caribbean male: 30-49

Habit
The habitual aspects of smoking such as, lighting a cigarette, smoking first thing in the morning, during a tea break and following a meal was integral to some participants' lives

'... when I've had a good meal I have to have a cigarette ' 
African-Caribbean female: 18-29

'It's like drinking tea, or doing something else that you do out of habit. You never really think why you are doing it, it becomes a part of you really doesn't it?' 
Pakistani male: 36

'My missus is a nurse and they get tea break but they never say "a tea break", they say "a fag break" . . .' 
Older African-Caribbean male

'Something is missing if you don't have a cigarette.' 
African-Caribbean male: 30-45

Digestion aids
Among the Pakistani, Indian and Bangladeshi participants, smoking after a meal was particularly important because it was believed to aid digestion, or relieve indigestion. Despite this belief, some of the Bangladeshi participants acknowledged that their smoking would cause other health problems. However, because smoking was perceived to be better, instantaneous and more 'natural' than medication it was therefore believed to be less harmful.

'For indigestion the best thing is cigarettes – It has to do with the fact that smoking cigarettes is by far more natural than taking all those medicines in which you don't know what they have put. With cigarettes relief is also instant whereas with medicines this is not so . . .' 
Bangladeshi male: 46

'I use the hooka or cigarettes for my indigestion. I have been advised by the doctor to use them because it relieves my indigestion ....' 
Pakistani female: 49

'I suffer from terrible wind problems in my stomach the only relief I get is by having a cigarette, but how do you tell people . . .' 
Indian Hindu male: 52

Weight control
Some of the female African-Caribbean participants believed that smoking contributed to keeping weight under control due to tobacco acting as an appetite suppressant, but also because smoking gave the smoker something to do other than eat.

'If I don't smoke . . well, you need something to keep you busy, so I'm eating.' 
Older African female
‘One of the reasons I’m reluctant to give up (is) ‘cos I don’t want to replace smoking by stuffing my face.’

Caribbean female: 25-39

Reasons for chewing

Culture and tradition

Reasons for chewing paan and using the hooka were strongly related to desires to continue traditional practices among the Indian, Pakistani and Bangladeshi older participants. The term ‘ritual’ was widely referenced to describe the sharing involved in the social activity of chewing paan and smoking a hooka.

‘Traditionally much time was taken to prepare and line the paan with many different things before the tobacco was placed inside. Today those people who use paan as a social activity still prepare it in this way and you will find that family and friends encourage all those sitting around the room to take part . . .’

Bangladeshi female: 43

‘It is difficult to explain, but tradition and culture are something that do not die . . . It was the same thing with chewing tobacco paan, after every meal it was done as an almost ritualistic gesture . . . Tradition plays a very strong role in the lives of people who perhaps have migrated. The reason being that they may want to hold onto the past and are afraid to let go – it serves as an important measure for identity. I would say that chewing tobacco for me is a tradition more than a habit . . .’

Pakistani female: 62

Female participants particularly highlighted a sense of responsibility in keeping alive the ritual of smoking and chewing because it had been passed down from past generations.

‘I know in our families, the hooka was something that always had great traditional value . . . Today we only use the hooka when it is a special occasion, but still do so to keep those very old memories and traditions alive.’

Pakistani female: 34

‘When there is something that has been started in your family from generations, you feel responsible in some way, for continuing it . . . When my husband and I came to this country we felt it important to continue this tradition and had the same set up with friends and family who would come to visit . . .’

Pakistani female: 62

Social activity

Most participants saw the ritual of chewing as a traditional social activity and therefore something that took place in the company of friends and family. Indeed, there was much emphasis on family, the community and sharing. The chewing of tobacco appeared central to the sharing experience.

‘Every community has their own ways of hospitality. Within our community when you go round to someone’s house the first thing that they will do is to offer you paan, and then ask if you would like tea. This has to do with the customs from Bangladesh and the importance that communities living outside of Bangladesh give to their ancestral practices. It is a way of keeping in touch with your own culture in the best possible way.’

Bangladeshi female: 51

‘Chewing tobacco in paan is seen as a social activity that helps people to have the time and sit and talk to each other at the same time as enjoy the flavour and the experience of the paan . . .’

Bangladeshi female: 43

Stress and boredom

Some participants, particularly Bangladeshis, highlighted that they took comfort in chewing paan because it enabled them to relax in times of stress. This was often related to having ‘something to do’ or relieving tension in unfamiliar or difficult situations. This was particularly the case among those who had migrated because when they had first moved to Britain paan chewing was a familiar ritual associated with their own traditions.

‘I started to eat paan more when I came to this country because I think it was a way of dealing with the big change . . . It gives you something to do, but also gives you comfort, so you don’t feel afraid or tense when you are outside among many different people who don’t understand your language . . .’

Bangladeshi female: 36

‘It gives us something to do, and look forward to. . . I only use tobacco in my paan when I feel tired or need to be relaxed . . .’

Bangladeshi female: 36
Social and cultural attitudes to smoking

General attitudes towards smoking
Younger African-Caribbean participants were particularly considerate smokers and were cautious not to offend non-smokers with their smoking behaviour. There was also a general consensus that smoking may be unacceptable if people are eating nearby.

‘If I’m in a group of people I say do you mind if I smoke and if they say they do, then I won’t do it.’
African-Caribbean female: 18-29

In some instances, however, smoking was an act of defiance in a relationship, particularly among women with non-smoking partners.

‘.. especially with boyfriends. Oh God, you’re smoking enough tonight, I’m not going to kiss you .. Well don’t then, get out of my house!’
African-Caribbean female: 18-29

‘I don’t like sneaking and – you know? – I’m almost 40 and why should I be sneaking away from people all because I want to smoke, so I just said well ..’
African-Caribbean female: 30-49

Among the Bangladeshi participants – as with other South Asian communities – smoking was generally seen to be a ‘bad’ thing and was associated with ‘gangsters’ and ‘loose people’. The majority of Bangladeshis who smoked therefore did so discreetly out of respect for other members of the community.

‘I don’t think that the community will ever recognise smoking as a “good” thing because it is ingrained as being something that only bad people do ..’
Bangladeshi male: 25

There was a difference in responses between older and younger Bangladeshi participants. Many of the younger participants were more likely to smoke in public although they refrained from smoking in front of older members of the family (discussed in more detail below).

The extent to which many of these individuals were prepared to go to hide their smoking habit was a clear indication of their smoking not being sociably acceptable among the Bangladeshi community.

‘It is crazy but I think where parents think that smoking is wrong you need to be able to respect their feelings about it ..’
Bangladeshi male: 32

A significant number of participants from all ethnic groups saw smoking as an undesirable social activity. Indeed, they felt that although smoking had given them status while they were teenagers, it was now detrimental to their status. Several participants suggested that smokers are increasingly ostracised, highlighting examples of workplaces banning smoking and no-smoking pubs.

Women smoking
Many of the female participants, particularly the Pakistanis, Bangladeshis and Indians, highlighted that smoking among women was not an acceptable activity. A number of them acknowledged that they, or other female friends and relatives did not like seeing other women smoke.

One woman said it was ‘unladylike’ (African-Caribbean female: 18-29), while others felt that smoking bore some association with prostitution. These attitudes tended to stem from religious beliefs, cultural tradition, and the expectations of women within each cultural group.

‘If you’re in Barbados smoking a cigarette you will get .. I mean not even just a look, they will say to you, you are disgusting .. in Barbados .. that means she’s smoking drugs or she’s a prostitute.’
African-Caribbean female: 30-49

‘If a woman is seen smoking, within her own community, you can guarantee that before the end of the day her father will find out and that’s it she’s had it .. Smoking women or girls are seen as disgraceful and that they have destroyed the honour of the family.’
Bangladeshi female: 21

‘.. with the general image of a woman smoking being one of a loose woman, it was always a case of hiding my habit .. I know that this is a cultural thing more than a religious one because Muslim men can smoke and no-one will take a second look, but it’s different with women .. My older sister says that no-one will marry me, if they find out that I smoke.’
Pakistani female: 29

This may shed light on why rates of smoking among women from ethnic groups are lower than the UK average (HEA, 1999).
The women in our religion are not suppose to smoke, nor the men, I think, but the men do smoke and do so publicly ....'  
Indian Sikh female: 17

While smoking was culturally unacceptable for women, in contrast, the chewing of tobacco among women was an activity that most Bangladeshi participants were proud of, particularly within the family. As a result, one female stated that chewing paan was a 'safer alternative' to smoking because it was acceptable.

'We know – that is you are caught smoking – the price you pay will be heavy, then why not chew paan instead, which is a safe alternative. It's strange but when you chew paan I have seen my mum almost with pride tell her friends that I chew paan and yet if someone was to tell her that they had seen me smoking, she would not be able to show her face with the embarrassment ....'  
Bangladeshi female: 21

Smoking with the family  
Perhaps because smoking was seen as culturally unacceptable for women, many of the female participants also stated that it was unacceptable within their family setting too. Because of this, some did not smoke in the company of their parents who, consequently, were unaware their daughters smoked.

'. . I'm 31, and I was still hiding that I smoked from her [mother] and then I thought, well what are you doing, you're living in your own house . . . but then I said I know she'll kill me.'  
African-Caribbean female: 30-49

'. . I know that if my mum was to ever find out that I smoked I would be dead.'  
Indian Sikh female: 17

Smoking within the family setting was also avoided among male and female Bangladeshi participants. Similarly, African-Caribbean men (typically aged between 30-49) whose parents were still living in their native country, particularly in Nigeria, did not smoke when they went 'home' on holiday for the same reasons.

Nor indeed did some Indian and Pakistani men smoke in the company of their parents. Parental disapproval of smoking was seen as a cultural issue. Overall, however, cultural influences only seemed to dictate where and when people smoked rather than influencing whether people gave up smoking.

'Let me explain the reason I sit in the back garden is because I am not allowed to smoke inside the house. My wife doesn't mind too much but my parents live with us and my mum and dad would rather die than see their son smoking a cigarette . . up to today it has never been something that has been discussed openly.'  
Pakistani male: 41

For African-Caribbeans, smoking was particularly frowned on by parents where the participant had been born outside the UK and therefore had first-hand experience of the cultural values.

Most African-Caribbean participants mentioned they did not smoke in the company of non-smoking families, girlfriends/boyfriends and, particularly, children. In these circumstances they were quite happy to go outside to smoke

'. . me and other smokers we've got up and gone outside and they say, oh, why are you getting up? It doesn't matter, we'll get up and go and have a cigarette and come back and I don't mind doing that.'  
African-Caribbean female: 18-29

'My partner's nearly 45 and his mother has never seen him smoke. He doesn't smoke in front of my father. It's not the done thing to sit in front of your parents and smoke.'  
African-Caribbean female: 30-45

Relationships between smoking, chewing and other drugs  
The combined use of marijuana and tobacco appeared to be common, though not universal, among African-Caribbean participants, particularly the men. Among older Caribbean participants, many of whom had grown up in the West Indies, the use of marijuana was an integral part of their culture and lives. Much of this was due to its perceived medicinal properties and use as a relaxant. In a number of groups it was suggested that the effects of marijuana were preferable to the effects of alcohol.

'I think alcohol causes more trouble than dope, and dope relaxes you more.'  
Older African-Caribbean male
'My mum will say that when she was in Jamaica she used it ... (when the children were) teething ... she'd boil the flowers.'
African-Caribbean female, 30-45

Some of the younger males said that ‘in general’ they smoked dope as often as, or more often than, they smoked cigarettes. They cited how they break cigarettes in half and only smoked part of them as a means of getting the right amount of tobacco for subsequent use with marijuana in a ‘joint’. One young male suggested that some of his friends only smoke cigarettes when they cannot get marijuana.

‘In this country it’s very expensive so they use cigarettes but ... most of the people who smoke (marijuana) don’t smoke cigarettes generally’
African-Caribbean male: 30-45

These sentiments were echoed in other focus groups. As such, it seems possible that some young people who claimed to be ‘non-smokers’ were non-smokers of cigarettes but in fact smoked marijuana. Indeed, some of the African-Caribbean women suggested that marijuana is ‘more available’ locally than it used to be and that ‘it’s like picking up a cigarette’.

The precise relationship between cigarettes and marijuana smoking appeared complex and deserves further, more detailed investigation. In particular, language use associated with marijuana and smoking needs clarification as the term ‘smoking’ is capable of different meanings depending on context.

On a different note, for some participants, particularly those from the Bangladeshi groups, smoking cigarettes was an alternative to chewing paan as paan was often difficult to find or difficult to use in public. For example, one participant stated that carrying paan around in plastic bags or small containers made life difficult.

‘When it comes to chewing paan in this country I think it is just not possible the environment is different. How can you carry it around with you, this is why it is easier to smoke cigarettes ...’
Bangladeshi male: 35

‘I only smoke cigarettes when I have run out of paan, but the reason for using it is habit I think.’
Bangladeshi male: 62
Health knowledge

Research findings

This section explores participants’ health perceptions in relation to their general health and their health in association with tobacco use. Included are responses to questions about the impact of smoking on current and future health, and pregnancy.

General health knowledge and practice

Many of the younger participants expressed the view that exercise was an important aspect of positive health promotion. A number attended a gym, while others undertook as much exercise as possible within their everyday lives, especially walking.

'I go to the gym and I work out before my day and sort of, you know, you're still rushing throughout the day and at the end of the day then you sort of crash out, but I try to keep to it. I try to go at least twice a week .....
African-Caribbean female. 18-29

Among the Bangladeshi participants, diet and exercise were not activities that could be easily assimilated into Bangladeshi culture because they were such unfamiliar concepts. Indeed, one participant stated: ‘Things like exercise, eating healthy and other such health promotion things I think are not properly understood.’ (Bangladeshi female. 32). Because of this, health advice was not always acknowledged

‘... you're not going to change those practices overnight because someone tells you to .....
Bangladeshi male: 35

It was commonly agreed that there had been a lack of education regarding diet and exercise among those older participants who had lived in Bangladesh during their formative years. Most admitted that their children were better informed and educated, although one participant stated:

‘Ignorance is sometimes a good thing; people who know too much I feel do nothing but cause problems for themselves ....’
Bangladeshi male: 52

Among the younger Bangladeshi participants, particularly those who had grown up in Britain, attitudes to diet and exercise were more positive, particularly among the younger males who were quite conscious of their health and weight. Indeed, many participated in football and were members of the local gym. Some, but not all, were also careful about their diet.

‘Yes, I go the gym, I try not to eat fatty foods, and am aware of what a healthy diet and lifestyle consists of.’
Bangladeshi male: 21

Some of the Pakistani and Indian participants also stated that exercise was not something that was compatible with their cultural lifestyle.

‘I would love to be able to swim, and jog, but I think the kind of community that we live in makes all of that really difficult So the only way out for me is to close the door in my bedroom and do some exercises to the tape. This is a luxury, because some girls my age don’t even have that.’
Pakistani female 16

‘Our life styles don’t include exercise, we work hard, come home eat and go to sleep ... Our people have a lot more responsibilities than the English community, each month I earn and send money back home because I have family back there that I support. If I
don't work hard they don't eat, so tell me how can I have the time to exercise . . .'
Pakistani male: 34

Others considered their daily routines to consist of enough regular exercise that additional physical activity was not needed.

'I would say that I have plenty of exercise all day. I am on my feet, I get up early in the morning and look after my family and do the housework, all day. If this isn't exercise then what is?'
Pakistani female: 34

Most African-Caribbean participants spoke of the importance of diet. Some claimed to minimise their consumption of 'sweets and chocolates and sugary stuffs'. The older African-Caribbean men noted the importance of vegetables, fruit and good cooking

Diet was most important among female African-Caribbean participants who, while acknowledging the importance of fruit and vegetables, felt that a small amount of 'junk food' was not a problem. Most expected diet and weight to become a greater concern as they grew older and given that they saw smoking as an appetite suppressant there was little motivation to give it up.

'Once I've given up I've put on a lot of weight - most people do. When I've gone on diets I had to smoke more because it fills me up (and) I don't eat as much.'
Older African female

Health perceptions in relation to tobacco use

Maintenance of good health was believed to derive from 'moderation in everything', and this included smoking. As such, a number of participants, particularly African-Caribbean women, described themselves as 'social smokers', feeling that smoking in a social setting was important in helping them to relax. Overall, participants highlighted many other health hazards that were believed to have a greater effect on health than smoking. These included drinking alcohol and using illegal drugs.

'I think that drink more than smoking affects you mentally as well, whereas I don't think smoking does because it doesn't colour your judgement, whereas drinking does.'
African-Caribbean female: 30-49

Some participants, particularly Pakistani and Indian participants, saw smoking as integral to an enjoyable lifestyle. Some of them believed that they were offsetting the risks of smoking by engaging in other behaviours considered healthy

'I am careful what I eat – no red meat – or maybe only once every other week I eat lots of salads, and drink lots of water. I go to a gym twice a week, and enjoy being healthy. I don't consider my smoking to make me unhealthy, but that is my view ...'
Indian Sikh female: 28

Others considered leading a healthy lifestyle to be boring and unachievable.

'I find that after work, friends meet up and I can comfortably have five or six pints. Yes, my stomach is sticking out, but that is middle-age fat. I don't have time to exercise ... and I smoke to relieve the stress of work ... Maybe one day I'll have a heart attack, but at least I can say that I enjoyed my life and health when I had it '
Indian Hindu male: 48

'It is impossible to be a health freak and find people to mix with. The club scene is really the only place that you can get to meet interesting people and if you don't go there and do all those things that are normal to that crowd of people, then there is no way that you are going to be able to enjoy life ... I mean – might as well enjoy life while you can, what's the point otherwise ...'
Indian Sikh male: 19

Lastly, some of the older Bangladesh participants made little reference to the association between ill health and smoking. Instead, ill health was believed to derive from the differences in living conditions in Britain compared to Bangladesh.

'Half of the illnesses that we old people have here were unheard of in Bangladesh, but it can be expected. The air is different here ... Also the type of life that we live here is very different from back home. Here you eat all sorts of things, because there is more variety but there is little exercise ...'
Bangladeshi male: 67
Perceived state of health in relation to smoking

Because the majority of participants felt they were reasonably good health it was difficult for them to recognise, and accept, the detrimental effects that smoking was having on their current health (see also Rudat, 1994).

In the absence of 'here and now' health problems resulting from smoking, they tended to believe that health problems caused by smoking would occur in the future.

Even then, for some participants, health problems that occur as a direct result of smoking were considered unpredictable. Because of this unpredictability many participants appeared to dismiss the health risks of smoking.

'Although I have been smoking since I was a teenage, I have not had any health problems as such. But I think that I have been very lucky ....' Indian Hindu male: 49

'People nowadays they'll smoke. They might think of what's going to happen maybe next few days but not (further ahead) ....' African-Caribbean male: 18-29

Despite this, some participants stated they had experienced breathlessness, coughing and wheezing as a direct result of smoking. However, these symptoms were considered a predictable, and acceptable, result of a smoking habit. As a result, participants were prepared to 'put up with it'.

'The occasional cough, that appears during the winter, and wheeziness, apart from that I have no problems with my smoking. I suppose at the end of the day that is expected.' Indian Sikh male: 32

Indeed, one participant stated that despite his smoking aggravating his problematic asthma he did not want to give up smoking.

'My only problem is my asthma, which really causes problems. I have been told that it would be better for me to give up smoking, but really I don't think I could do that. So I put up with the asthma -- I use the inhalers and all the other medication and I cope ...' Indian Hindu male: 58

Those who participated in sports also noted a degree of breathlessness, although this tended to be attributed more to age and level of fitness than to smoking. Some expressed a belief that exercise and a healthy diet could help ameliorate the effects of smoking.

'I used to play netball and that was the first thing as you finish a match, who's got a cigarette and everyone would be smoking, but yet they're fit and they have stamina and everything and it didn't, you know, impinge them.' African-Caribbean female: 30-49

'I am very health conscious and take care of what I eat and what I do. I exercise regularly and try not to eat fatty foods. But at the end of the day I think if I am so careful I need to reward myself and I do so by smoking a cigarette.' Pakistani female: 20

Perceived state of health in relation to chewing

Most Indian, Pakistani and Bangladeshi participants saw little correlation between health risks and tobacco or the chewing of paan (see also Pearson et al, 1999). Instead, concern tended to be focused around three specific health problems: mouth ulcers (see also Modood, 1997), cancer of the pallet and dental problems. Even then, one participant appeared to hold the dentist responsible for her cancer of the throat and mouth rather than her paan chewing habits:

'My mouth problems began when I went to the dentist. I was told by my friend not to go to the dentist, and that they would just mess my mouth up and they did. I went in because I had a pain in my tooth and before I knew it they had told me that I had dangerous ulcers in my mouth and that I needed to be referred to the London Hospital ... So when my urgent appointment came I went and I was told by the doctors there that I had cancer in the throat and mouth ... I would say to anyone never go to the dentist and I pray that God does not even put my worse enemy through what I have seen in these last two years of my life ...' Bangladeshi female: 52
**Perceived future health in relation to smoking**

While the perceived risks of smoking on current health were seen as minimal, most participants, particularly the younger ones, highlighted their concerns regarding the effects of smoking on their future health. These concerns centred on the development of coughs, chest problems, the risk of heart disease, and lung cancer.

In contrast, the older participants appeared to be more fatalistic about their future health, particularly older South Asians who tended to have less knowledge of the health risks of smoking.

'When you're my age you don’t think to the future, you just wait for death. I mean look at me, what chance have I got of seeing this year out, very little I would say with all the illnesses I have ...'

Bangladeshi male. 67

However, while younger participants acknowledged the serious health risks associated with smoking, they counteracted their concerns with the belief that either it would never happen to them, or, that death – whether from health problems or not – was inevitable.

'Well you hear things on radio and on TV and you see it happen to people but you just go “oh that won’t happen to me” You just believe it won’t happen to you.’

African-Caribbean female. 18-29

'I personally think even if it does enhance cancer, breathing problems, tuberculosis, whatever, the fact is people are going to die anyway.’

African-Caribbean male. 30-49

'Everyone comes with a set time to life and a prescribed time to die. It is nature’s population control and everyone has to have a reason to die. So someone dies because they ate too much and became ill and others die because they smoked too much ...'

Pakistani female. 29

Many participants referred to incidences where someone they had known who had smoked all their life had lived into their eighties or nineties. Similarly, others stated they knew people who had never smoked but had died prematurely. In the absence of a predictable and direct link between smoking and death (or ill health), people assumed that they would escape illness. While, therefore, they accepted smoking was not good for health (except perhaps as a short-term stress reliever), they were unwilling to accept the likelihood of serious poor health in the long term. It is notable that the majority of participants who expressed these views were younger

'... It's not just cigarettes that will kill you I mean the air outside, you know, the air outside is bad for you; the food is bad for you; everything.'

African-Caribbean female. 18-29

Many participants saw smoking as one of a number of factors which adversely affected their health and would lead to possible death. Indeed, many factors in life were seen as presenting a health risk to the point where life itself was seen as a health risk. This was particularly true of the younger Indian and Pakistani participants who cited both social and environmental factors, as well as food and stress, as greater risks to health than smoking.

'I think everyone who smokes knows the health risk that it carries but everything in life has a health risk, you drive a car, you could have an accident and become crippled for life. You drink too much alcohol, your liver will give up working, you eat too much and weigh more than you should, you run the risk of high blood pressure, heart attack etc Life is a health risk I’d say and I believe that you should live life to the full and if it means that you enjoy smoking two packets of cigarettes a day then so be it.’

Indian Sikh female. 22

I don’t think it has anything to do with just smoking. Yes, smoking is not good for you, but nor is anything else, if it is not taken in the right combination I mean if I eat too much red meat, or I eat too many fried things, this will all affect my health. People tend not to understand this; instead they will just say that if you smoke you are more likely to suffer from a serious illness’

Pakistani male. 27

Some participants referred to health scares associated with smoking, but stated that they simply reinforced what they already knew and had chosen to ignore.

'My Mum lost her left lung ... [and] gave up smoking just like that .. Then six months later she was there puffing away on a milder brand and we went

---

13 These relate to similar findings from Rudat’s (1994) study
We always say that if she continues she's going to die and she doesn't like that.  
African-Caribbean female: 30-45

then I was diagnosed with having angina. The first thing I was told that I needed to give up smoking. But I carried on. I recovered well from the balloon treatment that I had and felt fine in myself. Seven years later I had a heart attack and I had to have heart bypass surgery—this really took a lot out of me. At one point I was so weak that I thought I would die. When I recovered I was told that I either give up smoking or risk another heart attack which would end me. I gave up smoking not because I wanted to live longer but because I couldn't go through everything I had experienced during the heart operation.  
Pakistani female: 51

Distinctions were made between the effects of smoking on health, and the effects of heavy smoking. A number of participants believed that moderate smoking would have minimal adverse effects on their future health. Indeed the participant above who was diagnosed with angina stated:

... I think to myself some people smoke so much and nothing happens to them, and there was me wasn't a heavy smoker and neither a regular one, so why me?  
Pakistani female: 51

Smoking and pregnancy

Most male and female participants agreed that it is essential for pregnant women to give up smoking in order to protect the health of the baby. Some African-Caribbean participants acknowledged the need for both parents to give up smoking before conception to maximise the chances of having a healthy baby.

'It's got to stop before you even think of getting pregnant, you've got to stop before then before there's any chance of you being pregnant because the damage is done, you know, in the first three months. That's when the damage is done.'  
African-Caribbean female: 18-29

The younger African-Caribbean female participants felt that their smoking behaviour was very much related to the life stage they were in. As such, all anticipated that they would give up smoking prior to having children. The majority also felt that they would not take up smoking again after the birth of the child.

.. when I start having children that is when I will stop and I will stop and hope not to carry on.  
African-Caribbean female: 18-29

Similarly, Pakistani women acknowledged the need to give up smoking for the benefit of their child but they also saw it as a 'price to pay' for being a woman

'I was told by everybody who knew I smoked, especially my in-laws and my own family that I was being selfish and that my days of being a happy-go-lucky young married woman were over. The health visitors, the GP all gave the advice that if I wanted to give my child a good start in life I needed to stop smoking. It almost seemed as if the price to pay for being pregnant and then a mother was having to give up my cigarettes...'  
Pakistani female: 37

Perceived future health in relation to chewing

Because the relationship between chewing paan and health risks was rarely raised in the focus groups, it would appear that participants had very little understanding of the effects of paan chewing on their health. Instead the importance of chewing as a cultural tradition appeared to overshadow any potential concerns of the health risks. Overall, participants, particularly the older Bangladeshis, were convinced that chewing paan was an ancient tradition that had little effect on health

'I don't think there is anything wrong in chewing tobacco, it has been done for centuries by our ancestors. Nothing has happened to anyone, people in this country just want to make something out of it for no reason. I will never give up my paan....'  
Bangladeshi male: 47

'I think the things that we have been doing all these years can't be changed, so what is the point in listening to these people that say you do this wrong, and that you shouldn't do this, what is right and wrong as far as health behaviour is concerned is dependant on different communities.'  
Bangladeshi male: 64

'When it is something that you can't do, why should you force it on yourself because the doctor thinks that something will happen to you? I have chewed paan since I was a young girl and I would be lost without it....'  
Bangladeshi female: 37
Giving up smoking

Research findings

None of the Bangladeshi participants had ceased chewing paan or tobacco use. Consequently there was no discussion in the focus groups of the difficulties and motivating influences in giving up paan. As such, the following section explores the participants' responses to questions regarding their deterrents and influencing factors in giving up smoking and, for those who had done so, the experience of giving up smoking.

The experience of giving up smoking

Only a minority of participants had attempted to give up smoking. Of these, a number had subsequently started to smoke again. The addictive qualities of smoking were noted by many of the African-Caribbean participants:

'The actual wanting to stop, and actually stopping, is two different things, because your body is actually dependent on something.'
African-Caribbean male: 18-29

Those participants who had started smoking again after giving up viewed their ability to give up, even for a short time, as an achievement.

There was a general consensus, particularly among African-Caribbean participants, that when giving up smoking, cigarettes would normally have to be substituted, even temporarily, with something else:

'(You) need a surrogate, a substitute, so you don’t smoke I tried jogging and I stopped smoking for three months .. then I just stopped and starting smoking again.'
African male: 40-50

Although patches had been used as a substitute they were felt to be expensive and of limited use.

'When you get the craving you remember the patch because you’re not supposed to smoke when you’re wearing one ... [for me] it couldn’t fill the craving so I stopped [using them].'
African-Caribbean male: 40-50

One Pakistani participant stated that her friends had purchased a plastic cigarette to help her give up smoking. Her ability to give up, however, seemed to be due more to the social support from her friends than the plastic cigarette itself.

'... every time I said that I felt like a cigarette they would give me that plastic one. It became a real joke after a while, that I think although I was really craving sometimes for a cigarette, the amusement used to make me forget ...'
Pakistani female: 24

In addition to the more practical smoking aids, some of the Indian and Pakistani participants said using tobacco with paan eased the difficulty of giving up smoking. Others stated that smoking aids were futile and that willpower was the main determinant in successfully giving up.

'If you don’t have the willpower to stop, no patch, no medicine, no injections are going to make you stop.'
African-Caribbean male. 30-49

'I think it’s something that you will do when you choose to do it.'
African-Caribbean male: 30-49

'I just got up one day and thought that’s it, I’m not going to smoke anymore and I didn’t. Everyone I knew couldn’t believe what had happened ... it seemed as if everyone wanted some sort of an elaborate answer ...'
Bangladeshi male: 32

Tobacco and England’s Ethnic Minorities
Some participants were resigned to the notion that once you had smoked there would always be a tendency to return to it.

‘I think it’s a habit that no-one can get out of their system. Once you’ve smoked you’re likely to go back to it at some time in your life …’
Indian Hindu male: 23

Influencing factors in giving up

The threat of health problems
Some participants felt that if they were diagnosed with serious health problems, or terminal illness, they would give up smoking.

‘If people tell me I will die tomorrow if I don’t give up smoking, I think I will give it up. I will give it up.’
African-Caribbean male: 30-49

Indeed some participants had experienced the threat of terminal illness and had successfully given up smoking as a result (see also HEA, 2000)

‘When I was told that if I didn’t give up smoking, I only had a limited time to live I realised that I had to give up. So I did. I said to myself right that’s it. It’s either the cigarettes or your life and I chose my life. I was determined I suppose which is why I had no problem or maybe it is because I am a strong person by nature.’
Indian Hindu male: 51

Some Bangladeshi participants, although they had not actually experienced it themselves, knew of people who had given up smoking as a result of a serious health risk. However, the majority stated that even though they are aware that cigarettes were harmful they would continue to smoke in the belief that nothing would happen to them.

‘I think when you know that you have become ill because of your smoking, then you have no choice but to give up smoking. I have a very good friend who has been diagnosed with some form of growth in his throat and the doctors put it down to the fact that he smoked almost 35 cigarettes a day. He has now been forced to give up, so personal situations are a reason for people giving up smoking …’
Bangladeshi male: 31

Though there was again an overall acceptance that smoking should stop during pregnancy, and in some cases the nature and effects of pregnancy had encouraged people to give up (‘… it made me sick …’). One participant stated he had given up to protect the health of his child during his wife’s pregnancy:

‘… when my wife became pregnant I was told by the midwife that I should give up smoking because it could affect the health of my child. So I gave up smoking …’
Bangladeshi male: 33

It was pointed out by one of the younger male Caribbean informants that the message that pregnant women smoking is bad for unborn children is not obviously persuasive:

‘The majority of mothers who give birth to kids don’t have a problem … if [there was] a higher percentage of children affected by smoking that would encourage people to cut down when pregnant or give up totally. But they make these claims but when the kids are born they’re healthy, so [people think] why should I stop smoking?’
Caribbean male

Religious and cultural factors
A minority of the African-Caribbean participants had succeeded in giving up because they felt smoking was incompatible with Christianity in Caribbean culture. Indeed, one participant viewed the offer of a cigarette as a ‘temptation’.

‘… there’s a temptation like religiously and you can look at it that way. You take it in a different context.’
African-Caribbean female: 30-49

‘Christians are not supposed to smoke.’
African-Caribbean male 30-49

‘I gave up because I wanted to be a Christian. It ain’t right [to smoke]. I crave for it, but I overcome that and once [I] became a Christian and going to church, I shouldn’t be doing it.’
African-Caribbean female: 18-29

In particular, the West Midlands Christian churches appeared to actively discourage smoking among the congregation, particularly the female members. Similar sentiments were echoed among the Indian and Pakistani
participants (see also Modood, 1997), particularly among women who stated that smoking was either forbidden or disapproved of in their religion and culture. Given that these women had already stated that the cultural expectation of them as women was one in which smoking was frowned upon, it would appear that their religious motivation to give up smoking may also be intertwined with their image as women.

‘I think that every one time I have thought to give up it has been because of religious and cultural reasons.’
Indian Sikh female 24

‘I was always told, since I was a child, that smoking was “haram” [prohibited] within our religion, so when I started smoking I tried to justify my actions to myself all the time, but nevertheless always felt guilty for smoking. Every time I tried to give up smoking it was because the guilt got too much ...’
Pakistani female 29

Some of the Muslim participants highlighted that Ramadan was an ideal opportunity to give up smoking. Although the younger participants stated they did not practise their religion as strictly as the elders, all participants held Ramadan sacred.

‘There are so many people that I know that have tried to give up smoking during the month of Ramadan.’
Bangladeshi male 20

Therefore, both younger and older participants viewed Ramadan as a ‘good’ time to give up smoking. Both Muslims and Sikhs said that the religious community had the greatest impact on their smoking behaviour.

‘Our imam at the mosque speaks on different topics from the Quran, and I remember he did one on smoking and the illness that smoking can give you. When you hear information like that from someone who you respect and look up to, I think it has more of an effect. I used to smoke, not too much, but sometimes, and ever since I heard him talk I have almost given up.’
Pakistani male 23

‘When I became involved with the Gurdwara, and started helping out I realised I had to give it up because it was something that was not appreciated. So I did ...’
Indian Sikh male 49

For those who had not yet considered giving up, some stated that religious or cultural reasons would be their main motivation.

‘... if I were to give up smoking it would be for religious or cultural reasons more than anything else. I suppose it has to do with what you believe ...’
Indian Sikh female 24

However, most participants appeared to hold contradictory views on the relationship between smoking and religion. While many of the older participants stated that religion was a major influence in giving up smoking, few had actually successfully given up. In addition, the influence of religion in attempts to give up smoking appeared to be lessening among younger generations, with the exception of Ramadan among Muslims.

Influence of friends, family and partners

Disapproval from friends, relatives and partners was widely acknowledged to influence whether or not participants had, or indeed would, give up smoking.

‘I gave up because he didn’t like it,’ said one African woman (who was no longer with the same partner and was now smoking again).

‘Well, when I have a girlfriend that doesn’t smoke, I don’t smoke.’
African-Caribbean male 18-29

‘Well after college, when I went to university and the friends that I made and the place that I lived in were also all non-smokers. I used to feel horrible when lighting a cigarette. You know you feel that odd one out. So I decided to give up.’
Pakistani female 24

This was particularly important with regard to the effect of participant’s smoking on the health of family members, especially children.

‘I gave up smoking when our daughter started to suffer with breathing problems. My smoking meant that the life of our only child was being affected, so I decided to give it up and I did. I am pleased to say that I never went back to it.’
Indian Hindu male 34

Among the Bangladeshi, Indian and Pakistani participants, a reluctance to smoke in front of children...
was more prevalent among the younger generations. This was due to an awareness of the effects of passive smoking on the child’s health, and because parents did not want to set a 'bad example’ for their children, thereby encouraging their child to smoke. In contrast, older participants did not consider smoking in front of children to be wrong.

Lastly, confirming Rudat’s (1994) findings that social support is an important factor in the process of giving up smoking, particularly among Indians, this study also found that social support was important among Pakistani and Indian participants. They noted that without help from friends and relatives they would not have been able to give up smoking.

'I think I’ve been lucky to be able to have good people around me, that helped me. I think without them I would not have been able to do it.’
Pakistani female: 24

Giving up during pregnancy
For those who had been pregnant, it was clear that they had found it difficult to give up smoking during their pregnancy. Indeed, one woman stated that to combat the difficulties of giving up smoking she had used tobacco lined in paan because she found it helped.

'I remember when I found out that I was pregnant with my first child, by that time I had been smoking for about five to six years, the first thing that I was told by the doctor was that I needed to give up smoking. It was a time of great difficulty, I was being sick at the same time as craving for a cigarette. It was then that I started to use tobacco lined in paan. Not too much just a little bit, but I found it helped. I don’t know if it was because mentally, I knew that I was still getting something that was similar to cigarettes.’
Pakistani female: 37

For those female participants who had given up smoking when pregnant, some had done so for the sake of the wellbeing of their child in mind. Subsequently, however, all had resumed smoking after the birth of their child.

'Once I had had the baby and because it was the first and you don’t know what do, the stress of everything made me pick up a cigarette and start smoking again.’
Pakistani female: 37

Cost
The cost incurred by smoking was voiced as a concern among some African-Caribbean and Bangladeshi participants. It is important to note, however, that only a few participants smoked large quantities while the majority said their smoking was confined to particular situations. Because smoking was viewed as a recreational activity, cigarettes were seen as relatively inexpensive in comparison to other activities among the African-Caribbean participants.

'I remember saying if it gets to £2 I’ll give it up and I remember saying when cigarettes get to £4 I’m going to give up and now I’m saying if cigarettes get to £5 I’ll give up.’
African-Caribbean female: 18-29

'It’s cheaper to buy cigarettes than to buy a McDonald’s or a hamburger.’
African-Caribbean male: 18-29

'However little money I have at the start of the week I always find money for cigarettes ... even though I moan and complain and say I don’t have any money and I’m broke, I always find it.’
African-Caribbean female: 40-50

Among the Bangladeshi participants, the cost of cigarettes could be overcome with planning. As such, they spoke of 'weekly or monthly budgets' for cigarette consumption and smoking 'sensibly'

'If I’m not careful I end up spending all that I earn, or certainly a large part of it, on my cigarettes. So what I have started to do is set down a maximum limit for myself. I try very hard not to spend over that amount on cigarettes …’
Bangladeshi male: 32

'What I do is light a cigarette take a few puffs and then put it out. I then put that cigarette back into the packet and reuse it later on in the day. It actually feels as if you have had two cigarettes, when really it’s the same one …’
Bangladeshi male: 27

In contrast, the African-Caribbean participants stated that they would continue to buy cigarettes despite price rises. As such, tax and other price increases were not seen as sufficiently large to be a significant disincentive.
‘I mean they put the money up because they know there’s a nation of addicts out there ... Put it up a little you know, 20 pence. You don’t even think about it, you just go and you will buy it, you know?’
African-Caribbean female, 18-29

Overall therefore, while cost was a consideration in theory, in practice it did not lead to any of the participants giving up smoking. Some of the Nigerian participants noted that cost may have been a barrier to taking up smoking when they were young but because cigarettes could be bought individually in Nigeria they had never had to pay for a full packet.

‘In Nigeria they sell you one and that one is smoked halfway and you keep it while you finish eating.’
African-Caribbean male, 18-29

Deterrents to giving up
Many participants had no wish to give up smoking because their immediate concern was with their enjoyment of life. Even when imagining a situation where they were faced with diagnosis of terminal illness, many imagined that they would continue to smoke because it improved the quality of their life.

‘Somebody else might sit down and say okay, listen, the doctor said if I smoke I’m going to die. Okay. Now if I don’t smoke, what kind of quality of life would I have?’
African-Caribbean male, 30-49

‘I suffer from diabetes, but I am in control of my health, because I am careful about what I eat and how much I eat and when. My smoking is not good for me, but I cannot help it and at the end of the day it is a source of great enjoyment.’
Indian Sikh male: 49

Some of these comments derived from the unpredictability of the link between smoking and ill health (see part two for further details). One participant in particular felt that although he had led a healthy life he had still become ill. As a result he now smoked, despite illness, because of the enjoyment he gained from it.

‘I think I spent all my life being careful about what I ate and did with myself and then at the age of 32 I became quite ill. I was diagnosed as having angina, since then I haven’t really recovered. I now don’t really care about what I eat and think to myself that I need to enjoy my life. Yes, I smoke and will continue to do so, being extra health conscious has got me nowhere.’
Pakistani male: 41

Others felt that although they smoked they showed no signs of illness and therefore there was nothing to worry about in the immediate future.

‘I think to myself, if there is harm to be done, which there is, then that has already happened. What’s the point in giving up now ....’
Bangladeshi male: 62

‘Different people’s bodies react in different ways to things that they eat and use, like smoking. I’ve been smoking for a number of years now and I feel fine so for me to continue to smoking I think isn’t a problem.’
Bangladeshi male: 46

Most felt that only the most extreme health messages would have any influence on their giving up but only if it was personal to their own health.
This section explores participants' knowledge of health risks associated with smoking and chewing. Included are participants' responses to questions relating to their sources of knowledge and their reactions to information about smoking and its health risks.

Sources of information

Broadcast media: television and radio
Television was widely referenced as the primary source of information for most participants from all ethnic groups (see also HEA, 1994). High-profile cases such as the death of Roy Castle and publicity surrounding the illness of Hurricane Higgins had made a considerable impact on some of the African-Caribbean participants, causing them worry and anxiety. Despite this, none of them had given up smoking.

'They had a programme on the television and it's one of my most favourite snooker players and I watched him and thought oh my god... he's now suffering with lung cancer and I should really give up but it's so hard... It's depressing me, so I smoke more....'  
African-Caribbean female: 30-49

'Sometimes when I go and switch on the TV and I listen to the news and they're talking about cancer... smoking... lung cancer... and I know it's not health... just something that is no good but you can't stop.'  
African-Caribbean male: 18-29

Within the Pakistani, Indian and Bangladeshi groups, television and radio were particularly important sources of information. Indeed, radio has been cited as one of the most useful media with which to promote health information (Bedi and Gilthorpe, 1995). However, South Asians have previously been found to listen exclusively to local Asian radio for health information. Our study found that accessing television and radio was, in part, due to participants' inability to read English that, thereby, prevented them from using newspapers, magazines and leaflets as an information resource. This was particularly the case with older participants.

'What is someone like me going to understand from an English newspaper, they probably have a lot of useful information in there, but if you can't read it what's the point? I can barely read Urdu. So I get most of the information that I have from the television as well as the radio.'  
Pakistani female: 62

'The radio station also does a health programme in Bengali once a week. The English channels are difficult for me to understand... everyone needs entertainment and information in their own language.'  
Bangladesh male 48

Across the Pakistani and Indian groups it was apparent that the younger participants accessed both mainstream British television and Asian television. The older participants, however, tended to exclusively watch Asian channels.

Zee TV and Asianet were the most frequently mentioned channels. Access to Asian specific television was clearly important to participants because it was culturally familiar.

'I watch Zee TV and Asianet. They have shows on that talk about different health topics; it wasn't long ago that they did one on smoking and the harms of it... I think this makes more sense to me, because you have people from the same background and culture talking to you in a language that you understand.'  
Indian Sikh male: 48
Despite the following participant highlighting that Zee TV had broadcast information regarding the use and effects of paan it was apparent that information about paan was difficult to access.

'Although I have seen and heard a lot about cigarette smoking there is never anything on paan. Someone was saying that Zee TV did something a while ago, but I think I missed it. There should be more education around this.'

Pakistani female: 62

Printed media: magazines and books

The Pakistani, Indian and Bangladeshi groups cited printed media as a good resource for information regarding smoking. Once again, younger participants tended to read both national papers and magazines (such as Cosmopolitan) as well as Asian magazines such as Blitz. In contrast, those older participants who could read usually accessed Asian specific daily newspapers such as the Jang and the Punjab Times. Overall, reading was a far more commonplace activity among younger participants, as some older participants were unable to read. Indeed, it appeared that reading was very much an enjoyable activity for these younger participants.

'I'm afraid I'm the kind of person that reads everything I see, so you know sometimes you notice the ad on the billboard or an ad in the magazine.'

Pakistani female: 23

'It's interesting to be able to read about other people's experiences with smoking. The magazines on health and beauty often have different cases... I find them interesting as well as a source of information....'

Indian Sikh female: 24

'I tend to read quite specific stuff. If I need information on something I will go and find it, whether it be in the library or a bookshop.'

Indian Hindu male: 24

GPs and health information leaflets

Few participants claimed that they had received information from the health sources that were useful or accessible*. Although a few African-Caribbean participants felt that information gained from their GP was important, the remainder ignored it. In particular, they highlighted that a GP's credibility as an advisor regarding smoking and health was often undermined when he or she was known to be a smoker. Overall, it appeared that participants felt GPs were quite dismissive of their needs.

'He'll say "Do you smoke?" and if you say yes, he'll write you off. You smoke, you've brought it on yourself...'

African-Caribbean female: 30-49

'Doctors and nurses should really be the people that are giving this information, but it seems that they never have time for anybody. So naturally people are forced to go elsewhere to find out the information. The easiest way is the television and radio, and that is what I do.'

Indian Sikh male: 46

'... many GPs would not give time just to have a chat unless there is something really wrong with you...'

Bangladeshi male: 61

Information leaflets provided by health services were also given little credence. In particular, participants in the Pakistani, Indian and Bangladeshi groups stated that leaflets were inaccessible at both a language and information level. One participant highlighted that health leaflets could not be assimilated because the information was not culturally familiar to the Bangladeshi community.

'I personally don't think that they are written bearing in mind the ordinary person on the street and then you have the added thing about people from different communities who can't read English as well as those who can't read at all. If you think about it, this kind of material is of no use to them.'

Indian Hindu male: 38
'I know I see many leaflets and things but I think the Bangladeshi community is not ready for this yet; they are a new community, more recent than the Pakistanis and Indians to settle into Britain, I think it will take time Their traditions are important to them and chewing tobacco is one of them ...'
Bangladeshi female: 32

Some older Pakistani and Indian participants stated that because their GPs did not speak their language they had to rely on friends and relatives to provide them with information

'I can't read and write and my eyesight isn't really as it should be. The doctor, even though he is one of our own, he sometimes speaks in a language that I don't understand. So I always have one of my grandchildren with me. They will explain things to me, as well as telling me what they think about certain things.'

Pakistani male: 63

Overall, language difficulties appear to present distinct barriers for members of the South Asian communities accessing health information.

Advertising campaigns
The majority of African-Caribbean participants referenced health promotion campaigns and advertising when discussing information about tobacco use and health risks. In particular, they noted exposure to health warnings on cigarette packets, billboards and they were all aware of No Smoking Day. However, there were contradictory views about the impact of anti-smoking publicity. The warning messages on cigarette packets were considered to be so 'everyday' and obvious that their impact was minimal. In contrast, with constant exposure the millennium-linked poster campaign was argued by some to be effective because you couldn't forget its message: 'Should (be) there all the time. it would keep it in your head.'

All participants agreed about the importance of anti-smoking publicity. However, many felt that in a broader context, publicity about health tended to be overwhelming and inconsistent.

Information sharing in the community

Although none of the African-Caribbean participants highlighted a sharing of information in their community, many of the Bangladeshi participants stated that their main source of information came from their fellow community members. This was primarily due to their frequent contact with friends and relatives in familiar religious and cultural settings.

'If you want to know something I think the best thing to do is to talk to people within the community. Much information is passed around like this anyway. Of course our young children watch television and read newspapers but our older members of the community will listen instead to the imam or other people of their own age. '

Bangladeshi male: 26

'I think you learn more from friends and people around you from their experiences than you do from reading a magazine.'

Bangladeshi female 27

In particular, the imams were cited as a rich source of information for many of the Bangladeshi participants. The Friday sermons were argued to be a powerful means by which to convey information, particularly as both older and younger participants were likely to be present.

'There is a real need to start to utilise the local communities - I feel the mosques and the imams are the best people to spread the message as far as anti-smoking is concerned this is a source that hasn't been tapped into. The imams can speak to the people in their language and quote them from the Quran - this is far more effective as far as our people are concerned.'

Bangladeshi male: 38

In addition to the imam, other community workers were highlighted by Bangladeshi participants as being an effective means to spread information because they were respected in the community.

'I think if the message is to be put across to the people then it has to be people from within the respective communities that are respected - who are used to spread the word ...'

Bangladeshi male. 35
The same sentiments were similarly expressed among the Pakistani and Indian participants:

'It is also important to have experienced people from the Asian communities talking to their own people because they understand the culture and traditions of the people that they are talking to.'

Indian Hindu male, 48

These findings appear to confirm Belshon and Nazroo's (1997) findings that community elders are a good source of information regarding health among some ethnic groups. In addition, this study found information to flow also from younger members of the community who have access to health education at school and who have the ability to translate English information. This suggests that information is shared within the community and the family as well.

Reactions to sharing information

There was considerable variation in the amount of participants' information about the effects of smoking and chewing on their health (indeed, a few learnt new facts during the focus group discussions). Despite this, the proliferation of information in the current 'information age' was widely referenced, particularly among young Pakistani and Indian participants. Accessibility of a diverse range of information regarding smoking was therefore considered relatively easy by some:

'We live in the information age don't we, and there is so much out there, it depends what you read and take on board and what you read and leave behind.'

Pakistani female, 23

'It is important to be able to take information from different sources, like we have the Internet and all the other forms of media and technology. Information on smoking and health information generally is available everywhere and yes, different people will look in different places for the information that they need.'

Indian Hindu male, 24

In particular, a number of older Bangladeshi participants highlighted an increase in the amount of information in Bengali stating that this reduced their feelings of isolation because it felt like a 'home from home'.

Those with the most knowledge were among the heaviest smokers although this appeared to have little deterrent effect on their smoking. Only a very small minority felt that access to detailed information about risks of smoking would have an effect on their smoking behaviour. In fact, some of the African-Caribbean participants actively avoided finding information in order to continue smoking:

'I think if I knew too much about cigarettes I probably wouldn't smoke.'

African-Caribbean female, 18-29

Conversely, a few African-Caribbean participants stated that although they would continue smoking they preferred to be well informed:

'I know it's wrong and I know it's stupid but I'm still doing it, I'm going to carry on smoking and I know I'm going to carry on smoking but it sounds good if I know all the information I need and I know you can get bronchitis and emphysema.'

African-Caribbean female, 18-29

Most participants felt that they dismissed health information either because there was simply too much of it, or because information could be conflicting, and thereby confusing.

'You read different things and see stuff around you all the time, but I don't think people really take much notice of everything. In this day and age we are bombarded with too much information.'

Indian Sikh female, 23

'What I would like to see more of is specialist individuals giving correct information on health issues. You get told different things all the time .. I mean who do you believe?'

Pakistani female, 47

'Every day something new [in] research ... if you watch the BBC and research did that and it will give you this, so you don't even know what they're telling you is true. Do you see what I'm saying, so it doesn't scare you.'

African-Caribbean male, 18-29

Bangladeshi participants highlighted that the bombardment of information was futile because decisions and discussion about the harm of tobacco were primarily community based.
'At the end of the day it is up to the people in the communities themselves to start to talk about the benefits and harms of such things. You can't impose something from outside which is alien to the way of life of these people and expect them to take it on.'
Bangladeshi male, 28

'With many of our people the understanding isn't there, they pick something up and then take it completely out of context.'
Bangladeshi male, 22

African-Caribbean participants also cited their rejection of information or messages that explicitly stated not to smoke.

'You're not going to read an article really on stopping smoking... you're going to flick through to the TV pages.'
Older African-Caribbean male

In particular, No Smoking Day attracted universal disapproval among African-Caribbeans. Indeed it was suggested that No Smoking Day might actually be counterproductive because it was so forceful.

'Oh, I'll definitely light up because I'm not being told how to live my life.'
African-Caribbean female, 30-45

'All of us tend to smoke more on that day... I always tend to smoke more because I know somebody is going to say to me “Aren’t you giving up, you shouldn’t be smoking, it’s national No Smoking Day.”'
African-Caribbean female, 30-49

Some of the Pakistani and Indian participants highlighted that information should be specifically targeted at Asian communities for it to be effective.

'If you ask me what is needed I think it is important to have a lot more of the material in the media aimed at our communities... The policies that the government makes, need to start taking into account the minority communities.'
Pakistani male, 36

Finally, participants across all ethnic groups noted that despite a recent decrease in cigarette advertising there was no corresponding decrease in smoking among the young. African-Caribbean participants stated that they thought children were now smoking at a younger age (this was noted by the under-30s as well as the older informants) and were 'more blatant' about it than children had been in the past.

The African-Caribbean men stated that they felt the government gives out contradictory messages about smoking. On the one hand, extensive publicity is given to the health risks associated with smoking and people are encouraged to give up the habit.

However, it is well known that the government derives substantial income from tobacco taxes and its efforts were considered insincere. Indeed there was a widespread feeling that there was a great deal of hypocrisy in the government's approach.

'There's a hidden agenda for the government when it comes to smoking. I really do think they want people to continue smoking, then eventually get private medical insurance so that then you have to fund the [impact on your health].' African-Caribbean female, 30-45

'I don't think they put up the price of fags to make you stop smoking. It's just to get more money out of our pockets.'
African-Caribbean male, 18-29

'... the government raises the price but just enough so that you'll still be able to afford to go out and buy a packet and it's still making a lot of money of it because it raises a lot of revenue for them.' African-Caribbean female, 30-49

One informant who worked for government noted the hypocrisy of her employer banning smoking in the building while needing the income that smoking generates. There was not only perceived tension between anti-smoking publicity and the government need for the income derived from smoking but also, more radically, about smoking being allowed at all, given its known effects.

'... you have these labels on the box, Smoking can kill you... but it's so readily available. It's paradoxical. Why does the government allow them on the shelves in the first place?'
African-Caribbean female, 18-30
'The strange thing about the government . . is the way they've licensed tobacco companies. It's unbelievable that they license people to kill like that. It's unbelievable.'
Older African-Caribbean male

Furthermore, some African-Caribbean participants felt that some of the general 'health' promotion messages were not objective because they were being produced by commercial organisations to sell particular commercial products such as foodstuffs.

Lastly, the majority of participants from the African-Caribbean, Pakistani and Indian groups felt that anti-smoking information should be targeted more at the young because they are in a better position to change their habits.

I think they should try doing this [Quitline presentation] with the younger ones – after all I think we are all too old to change our ways. Most of us are on our last legs anyway.'
Indian Hindu male: 58

Several noted that it was most important to try to stop the young from taking up smoking, as they would not miss what they had never had. To achieve this it was most important not to make smoking appear attractive through advertising and the television.
Summary of findings

This section provides a summary of the main research findings. More specifically, tobacco related behaviour and attitudes towards tobacco use are summarised in relation to key differences between ethnic groups.

Tobacco related behaviour

- Reasons for starting to smoke and the age at which smoking commenced varied according to ethnic origin. Most notably, the South Asian participants had started smoking at a much younger age than African-Caribbeans, usually in their pre-teens and primarily due to the influence of seeing elders smoke.
- Current reasons for smoking were similar across all ethnic groups although South Asians placed greater emphasis on smoking to relieve stress and indigestion and were less likely to acknowledge the habitual and addictive nature of smoking.
- Smoking appeared to be a more unacceptable activity, especially for women, among South Asians. In contrast, the chewing of tobacco among South Asian women was admired, particularly within the family.
- Smoking within a family setting was disapproved of in all ethnic groups.
- The chewing of paan was apparent among the majority of South Asians, particularly among the older generation and among Bangladeshis, and was strongly related to desires to continue traditional practices and its sociability in the family and community.

Health knowledge

- Clear differences existed in health knowledge and behaviour according to age and ethnic group. Most notable, younger participants from all ethnic groups saw exercise and diet as important aspects of positive health promotion while older South Asians saw the unfamiliarity of health promoting behaviours as incompatible with their cultural lifestyles.
- There was a dearth of knowledge and understanding regarding health promotion among the older Bangladeshis while, in contrast, older African-Caribbean participants acknowledged the importance of diet.
- In the absence of current health problems and the lack of a predictable link between smoking and ill health in the future, the majority of participants from all African-Caribbean, Indian and Pakistani groups appeared to dismiss the associated health risks.
- Few of the older Bangladeshis participated made reference to the association between smoking and ill health. Instead, ill health was believed to derive from the differences in living conditions in Britain compared to Bangladesh.
- Current experience of coughing, wheezing and breathlessness was considered an acceptable part of having a smoking habit across all groups.
- Concerns were expressed among younger participants of the effects of smoking on future health while, in contrast, the older participants were more fatalistic and, particularly older South Asians, had less knowledge of the health risks of smoking.
- Despite voicing concerns, it is notable that many of the younger participants thought the link between ill health and smoking to be unpredictable and believed they would escape health problems. South Asians in particular highlighted that other social and environmental factors posed a greater risk to their health than smoking.
- Distinctions were made between the health effects of heavy smoking and moderate smoking across all ethnic groups. Moderate smoking was believed to have minimal adverse effects on future health.
The majority of participants, both male and female from all ethnic groups, stated that it was essential for women to give up smoking during pregnancy.

There was a distinct lack of knowledge and understanding regarding the correlation between health risks and chewing among South Asians, particularly Bangladeshis.

Giving up smoking

None of the participants had given up chewing

A small minority of participants had attempted to give up smoking and of these, a number had subsequently resumed smoking. While African-Caribbean participants highlighted a need for cigarette substitutes, South Asian participants highlighted their use of paan as a substitute for cigarettes

A number of factors were cited as influencing the desire to give up smoking. However, it is notable that most of these appeared to be hypothetical and related to giving up in the future. Indeed, the majority of participants expressed little desire to give up smoking because it contributed too much to their enjoyment and quality of life

The primary factor influencing the desire to give up smoking across all ethnic groups was diagnosis of serious health problems or terminal illness

Furthermore, religious and cultural factors were cited across all ethnic groups. Some African-Caribbean participants had given up smoking because it was incompatible with Christianity. While Indian and Pakistani participants, particularly women, stated that smoking was either forbidden or disapproved of in their religion and culture. Ramadan was cited as an opportunity to give up by some of the Muslim participants, even those that were not practising. Both Muslims and Sikhs highlighted that their religious community had the greatest impact on their smoking behaviour although few had actually given up.

Disapproval from friends, family and partners was widely acknowledged to influence smoking behaviour

Lastly, Pakistanis and Indian participants highlighted the importance of encouraging social support while giving up smoking.

Information about the health risks of tobacco use

Information about the health risks of tobacco was obtained from a number of sources. The most widely referenced sources, across all ethnic groups, were broadcast and printed media.

Asian specific broadcast information (such as Zee TV and Asianet) was particularly important among South Asian participants, especially older participants, as it avoided language difficulties. While younger South Asian participants accessed printed media written in both Asian and English, the older participants tended to read Asian material only.

The majority from all ethnic groups said the information from health services was useless or inaccessible. South Asians cited language difficulties and cultural unfamiliarity with the health information.

Participants from all ethnic groups felt that healthcare staff were often dismissive of their needs.

African-Caribbeans made reference to health promotion and advertising campaigns, some of which were deemed successful while others were highly criticised. Overall, participants from all ethnic groups thought that anti-smoking publicity was important but perceived some messages as being hypocritical.

South Asian participants highlighted the importance of information sharing in the community and stated that their main source of information came from fellow community members, including family members and children who had access to school education and the ability to translate English.

Reactions to smoking information

The majority from all groups were dismissive of health information about smoking as it was overwhelming, inconsistent, confusing and often conflicting.

African-Caribbeans particularly rejected health messages that stated explicitly not to smoke. Consequently, No Smoking Day attracted universal disapproval and was argued to be counterproductive.

Bangladeshi participants were also dismissive of information as they felt decisions and discussion about the harmful effects of tobacco were primarily community based.

The majority of participants from African-Caribbean, Indian and Pakistani groups felt that anti-smoking information should be targeted more at the young.
Appendix A

Details of focus groups

<table>
<thead>
<tr>
<th>Location</th>
<th>Ethnic group</th>
<th>Religion</th>
<th>Gender</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford</td>
<td>Pakistani</td>
<td>Muslim</td>
<td>Male</td>
<td>16-29</td>
</tr>
<tr>
<td>Bradford</td>
<td>Pakistani</td>
<td>Muslim</td>
<td>Male</td>
<td>30-49</td>
</tr>
<tr>
<td>Bradford</td>
<td>Pakistani</td>
<td>Muslim</td>
<td>Female</td>
<td>30-49</td>
</tr>
<tr>
<td>Bradford</td>
<td>Pakistani</td>
<td>Muslim</td>
<td>Female</td>
<td>50-64</td>
</tr>
<tr>
<td>Leeds</td>
<td>Pakistani</td>
<td>Muslim</td>
<td>Male</td>
<td>50-64</td>
</tr>
<tr>
<td>Leeds</td>
<td>Pakistani</td>
<td>Muslim</td>
<td>Female</td>
<td>50-64</td>
</tr>
<tr>
<td>Leicester</td>
<td>Indian</td>
<td>Hindu</td>
<td>Male</td>
<td>16-29</td>
</tr>
<tr>
<td>Leicester</td>
<td>Indian</td>
<td>Hindu</td>
<td>Male</td>
<td>50-64</td>
</tr>
<tr>
<td>Leicester</td>
<td>Indian</td>
<td>Hindu</td>
<td>Male</td>
<td>30-49</td>
</tr>
<tr>
<td>Southall</td>
<td>Indian</td>
<td>Sikh</td>
<td>Male</td>
<td>16-19</td>
</tr>
<tr>
<td>Southall</td>
<td>Indian</td>
<td>Sikh</td>
<td>Male</td>
<td>30-49</td>
</tr>
<tr>
<td>Southall</td>
<td>Indian</td>
<td>Sikh</td>
<td>Female</td>
<td>16-29</td>
</tr>
<tr>
<td>Whitechapel</td>
<td>Bangladeshi</td>
<td></td>
<td>Male</td>
<td>16-29</td>
</tr>
<tr>
<td>Whitechapel</td>
<td>Bangladeshi</td>
<td></td>
<td>Female</td>
<td>16-29</td>
</tr>
<tr>
<td>Whitechapel</td>
<td>Bangladeshi</td>
<td></td>
<td>Male</td>
<td>30-49</td>
</tr>
<tr>
<td>Whitechapel</td>
<td>Bangladeshi</td>
<td></td>
<td>Male</td>
<td>50-64</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>Bangladeshi</td>
<td></td>
<td>Female</td>
<td>30-49</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>Bangladeshi</td>
<td></td>
<td>Female</td>
<td>50-64</td>
</tr>
<tr>
<td>Birmingham</td>
<td>African-Caribbean</td>
<td></td>
<td>Male</td>
<td>16-29</td>
</tr>
<tr>
<td>Birmingham</td>
<td>African-Caribbean</td>
<td></td>
<td>Male</td>
<td>30-49</td>
</tr>
<tr>
<td>Birmingham</td>
<td>African-Caribbean</td>
<td></td>
<td>Female</td>
<td>16-29</td>
</tr>
<tr>
<td>Birmingham</td>
<td>African-Caribbean</td>
<td></td>
<td>Female</td>
<td>30-49</td>
</tr>
<tr>
<td>South London</td>
<td>African-Caribbean</td>
<td></td>
<td>Male</td>
<td>16-29</td>
</tr>
<tr>
<td>South London</td>
<td>African-Caribbean</td>
<td></td>
<td>Male</td>
<td>30-49</td>
</tr>
<tr>
<td>South London</td>
<td>African-Caribbean</td>
<td></td>
<td>Female</td>
<td>16-29</td>
</tr>
<tr>
<td>South London</td>
<td>African-Caribbean</td>
<td></td>
<td>Male</td>
<td>30-49</td>
</tr>
<tr>
<td>North London</td>
<td>African-Caribbean</td>
<td></td>
<td>Male and female mixed</td>
<td>*</td>
</tr>
<tr>
<td>Newham</td>
<td>Bangladeshi</td>
<td>Muslim</td>
<td>Male</td>
<td>16-29</td>
</tr>
<tr>
<td>Newham</td>
<td>Bangladeshi</td>
<td>Muslim</td>
<td>Male</td>
<td>45+</td>
</tr>
<tr>
<td>Surrey</td>
<td>Bangladeshi</td>
<td>Muslim</td>
<td>Male</td>
<td>23-33</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>Bangladeshi</td>
<td></td>
<td>Muslim</td>
<td>34-44</td>
</tr>
<tr>
<td>Lewisham</td>
<td>Caribbean**</td>
<td></td>
<td>Male and female mixed</td>
<td>25-39</td>
</tr>
<tr>
<td>Lewisham</td>
<td>Caribbean***</td>
<td></td>
<td>Male and female mixed</td>
<td>40+</td>
</tr>
<tr>
<td>Lewisham</td>
<td>Caribbean****</td>
<td></td>
<td>Male and female mixed</td>
<td>16-29</td>
</tr>
<tr>
<td>Lewisham</td>
<td>African*****</td>
<td></td>
<td>Male and female mixed</td>
<td>18-24</td>
</tr>
</tbody>
</table>

* The majority were older participants. The aim was to recruit 50-64 year olds, but this proved very difficult, so slightly younger participants were included where necessary

** Comprised individuals from St Lucia, Barbados, Grenada, Antigua and Jamaica

*** Comprised individuals from Trinidad, St Kitts, Antigua, Barbados, Jamaica and Grenada

**** Comprised individuals from Barbados, Jamaica, St Lucia, Grenada, Trinidad and Tobago, St Vincent

***** Comprised individuals from Nigena, Uganda and Ghana
Appendix B

Recruitment questionnaire

This form is the property of Quality Fieldwork, 86 Aldridge Rd, Perry Barr, Birmingham B42 2TP [tel: (0121) 344 4848] and is CONFIDENTIAL.

<table>
<thead>
<tr>
<th>JOB: SSMR/582</th>
<th>HEALTH AND ENVIRONMENT RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RECRUIT 10 for 8 attending</td>
</tr>
</tbody>
</table>

SHOW ID
Introduce yourself as an interviewer from Quality Fieldwork, which is helping the Health Education Authority find out people's knowledge, beliefs and attitudes towards smoking.

Assure of confidentiality.

RESPONDENT'S NAME: ...
ADDRESS: ...
POST CODE: ...
PHONE NUMBER: ...
INTERVIEWER: ...
TAXI REQUIREMENTS: ...

PLEASE ALSO RECRUIT FROM A RANGE OF AREAS OF DIFFERING LEVELS OF DEPRIVATION (ie different kinds of housing areas)

RECRUITMENT CRITERIA

Q1 Have you ever smoked tobacco regularly?
   Yes 1 Q2
   No 2 Thank and close

Q2 Do you smoke tobacco nowadays?
   Yes 1 Q3
   No 2 Recruit 3/4 Go to Q4
RECRUITMENT QUESTIONNAIRE (Cont.)

Q3: Have you ever seriously tried to give up smoking tobacco?

Yes 1 Continue. Recruit 3/4
No 2 Continue: Recruit 3/4

Q4: In which country were you born?

Inside the United Kingdom 1 A mix of
Outside the United Kingdom 2 both in all groups

CLASSIFICATION

Gender

MALE 1 Groups 2 and 4
FEMALE 2 Groups 1 and 3

Age

Write in ______

19-29 1 Groups 1 and 2
30-49 2 Groups 3 and 4

Employment Status

Full time employed 1
Part time employed 2
Self employed 3
Full time student 4
Retired 5
Other 6

SEG (household):

Occupation (or former occupation) of CWE

(If retired) Work related or private pension received?

Qualifications

Staff resp for A8

AB 1 Minimum 2
C1 2 Minimum 2
C2 3 Minimum 2
DE 4 Minimum 2
RECRUITMENT QUESTIONNAIRE (Cont.)

Status

Which of these best describes your situation?

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married/living with partner, no children in household</td>
<td>1</td>
</tr>
<tr>
<td>Married/living with partner, children in household</td>
<td>2</td>
</tr>
<tr>
<td>Living alone with no children</td>
<td>3</td>
</tr>
<tr>
<td>No partner and with children in household</td>
<td>4</td>
</tr>
<tr>
<td>Sharing with others (no children)</td>
<td>6</td>
</tr>
<tr>
<td>Living with parents and no children under 16 in household</td>
<td>7</td>
</tr>
<tr>
<td>Living with parents with children under 16 in household</td>
<td>8</td>
</tr>
</tbody>
</table>

Tenure

<table>
<thead>
<tr>
<th>Tenure Type</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner occupier</td>
<td>1</td>
</tr>
<tr>
<td>Council rented</td>
<td>2</td>
</tr>
<tr>
<td>Private rented</td>
<td>3</td>
</tr>
<tr>
<td>Housing association</td>
<td>4</td>
</tr>
<tr>
<td>With parents</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Health

In general, how would you describe your overall health, leaving aside any short term illnesses you may be suffering from at the moment?

<table>
<thead>
<tr>
<th>Health Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>In very good health</td>
<td>1</td>
</tr>
<tr>
<td>In quite good health</td>
<td>2</td>
</tr>
<tr>
<td>In rather poor health</td>
<td>3</td>
</tr>
<tr>
<td>In very poor health</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix C

Focus group topic guide

Introduction

Smoking behaviour
When did you start smoking/chewing?
What age?
Why did you start?
What or who influenced you?
Do the people around you smoke/chew – ie in your household, wider family, friends?
Why do you smoke/chew?
What do you like about smoking/chewing?
Do other people smoke/chew where you work and is smoking acceptable?
Do many other people in your community smoke/chew?
How acceptable is smoking/chewing within your community?
Do you and those around you have any particular smoking/chewing habits, practices, rituals that may be different from other groups of people?

Health
What do you feel about your present state of health?
Do you have any particular concerns about your present state of health?
What health concerns do you have for the future?
Which of these is most important to you?
What effect do you feel smoking/chewing has on your health?
How important is this to you?
What other factors do you feel influence your health (eg exercise, diet, alcohol)?
Are these factors more or less important than smoking/chewing?
Do you expect this relative importance to change with age?

Health promotion
Have you ever tried to give up smoking/chewing?
If so, why?
What, if anything, would encourage you to give up smoking/chewing?
Do you do anything to help maintain and/or improve your state of health?
What do you do and why?
What encourages you to do something to promote your health?
What puts you off doing this?

Sources of information about tobacco and health
Where do you obtain information about health?
Which of these sources is most important and why (eg press, specific booklets, doctors, pharmacy, friends, family)?
What do you know about tobacco/smoking and health?
Where did you obtain information about this?

Life stages
Do you feel that smoking/chewing is influenced by the stage of life you are in?
Does having children affect (or would it affect) smoking/chewing behaviour?
What about pregnancy?
What effect does smoking have on your quality of life?
How important an influence is it?

Relative importance of other factors
How important is each of the following factors to you in relation to smoking/chewing?
To what extent would any of these factors make you want to give up smoking/chewing, existing health problems, longer term health worries, general social acceptability, views of friends and family, cost?
Are there any other factors that would influence your giving up smoking/chewing?

Giving up smoking
Those who have given up smoking:
What led you to give up smoking?
How did you go about giving up?
How do you feel now about other people smoking?
Bibliography


CIO (1993). *Building on Strengths, Enquiry into Health Activity in the Asian Voluntary Sector.*


HEA (1997). *Tobacco and Ethnic Minorities,* prepared for the HEA by the Centre for Research in Ethnic Relations, University of Warwick, published on behalf of World No Tobacco Day.


Tobacco and England’s Ethnic Minorities

The research described in this report was originally commissioned by the Health Education Authority (HEA) as part of its smoking research programme. In keeping with its remit, the Health Development Agency (HDA) aims to publish the outstanding reports from the HEA’s smoking research programme and to continue to disseminate the findings from these and other studies as widely as possible.

The primary objective of this qualitative research was to ascertain appropriate methods of intervention for reduction of tobacco use among black and other minority ethnic groups. The research was intended to inform the development of national and local interventions around tobacco use for black and minority ethnic groups.

Additionally, the research sought to examine the levels of knowledge regarding tobacco use among minority ethnic groups and to assess responses to health promotion initiatives.

The data collected in this study provides valuable information with which to recommend appropriate methods of intervention for the reduction of tobacco use among black and minority ethnic groups.

The results clearly have value to the public health field and will help inform the work of all those working in this priority area.