Acknowledgement

REACH Community Health Project would like to thank ASH Scotland for the funding to conduct this three months research project with Black and Minority Ethnic (BME) youth living in the Southside of Glasgow.

REACH would also like to thank all participants and the following organisations for their cooperation and the support throughout the project.

- Govan hill Health Centre
- Govan hill Library
- Govan hill Youth Project
- Hindu Temple
- Holly rood Secondary School
- Local Shopkeepers around Cathcart Street
- Pollok shields library
- Shaw lands Academy
- The Meridian Centre
- The Taleem Trust

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Preface

One of the challenges facing health services in Scotland is to recognise the ethnic diversity of people. Health services need to develop an understanding of the cultural beliefs, practices and needs of minority ethnic people. A failure to respond effectively can result in the provision of culturally inappropriate health services.

REACH Community Health Project is an innovative voluntary sector organisation, which aims to provide culturally sensitive and accessible preventative clinical health information to the Black and Minority Ethnic (BME) community living in Scotland. The project is also committed to influencing the process of mainstreaming health services for the BME community, to better address the needs of these communities.

This report presents the results of a research project examining the prevalence and patterns of tobacco use by BME youth, living in the Southside of Glasgow.
The research was carried out by Uzma Aslam, Assistant Manager (Former Youth Health Participation Officer) and Kate Robinson, Sessional Researcher, REACH Community Health Project. This research was made possible through the award of a Tobacco and Inequalities Small Grants Fund to REACH from ASH Scotland in 2005.

This report includes findings from the research and suggestions for actions for health and social care providers and other professionals who have BME youth health on their agenda.

Shehla Ihsan

Chair/Line Manager

Executive Summary

1.1 Introduction

This research project focuses on Black and Ethnic Minority (BME) young people living within the Southside of Glasgow and examines the prevalence and patterns of tobacco use within these 'hard to reach' target groups.

The 2001 Census shows that Pollokshields East, Maxwell Park, Govanhill and Shawlands have a large concentration of the BME population including young people residing in these areas in comparison to the city as a whole. Hence REACH chose these key geographical areas to undertake this project. This three month project was funded through the Phase 1 Tobacco and Inequalities (T&I) Small Grand Fund, managed by ASH Scotland.

1.2 Methodology

The approaches used within this action research project were the following: 1) Questionnaires and 2) Focus Groups and 3) Literature Review. This triangulated approach allowed for both in-depth qualitative and quantitative information to be collated within this research project.

The quantitative questionnaire was piloted with a group of 5 young people from BME backgrounds so as to enable constructive feedback of the questions proposed and enhanced the quality of the questionnaire.

In order to gain a representative view from the target group, the research team recruited from a broad sample of the BME young people living in the Southside of Glasgow (both smokers and non-smokers were included in recruitment). Participants were from 16 to 26 years old.

One Focus Group was undertaken with a group of 8 young males (less than 20 years of age and of Pakistani origin).

The analysis of the data collected within this project was undertaken through the following two themes:

Theme 1: Pattern and Prevalence of Tobacco consumption among BME youth in Southside of Glasgow.

Theme 2: Recommendations for reducing smoking rate among BME youth.

1.3 Results

Around half of the participants said that they used tobacco, with the majority smoking cigarettes. In addition to this many of the participants had started to smoke between the ages of 10 and 12. Most smoked less than 20 cigarettes per day though some did admit to smoking more than this. Stress and peer pressure were the main reasons given for smoking. Current information about the dangers of smoking seemed to have little or no impact on this group of young people. There was a negative perception of BME young women who had taken up smoking.

1.4 Discussion

This three month was carried out in a highly dense BME populated area. Current information about the dangers of smoking seemed to have little or no impact on BME young people. Most participants did not have access to the necessary information relating to the health hazards of smoking. The harmful effects of cigarette smoking were not fully understood by this group though they did feel that more should be done to highlight the negative effects of smoking. There was a resistance among these young males to access smoking cessation services. Some participants stated that they would not go to health professionals to seek advice about smoking due to previous issues concerning patient confidentiality. There were certain other issues related to access of health services by young people as highlighted in the '*Missing Link' Report' (*see Appendix). The participants emphasised self-determination and responsibility as the key factors in any decision to quit smoking. The majority of the male participants expressed negative attitudes towards BME young women who took up smoking.

Prevalence of smoking rates amongst BME youth is on the increase. There is lack of information and concern on the hazards of smoking. BME young people are reluctant in accessing health services in general. Stress and peer pressure were the main reasons identified behind taking up the smoking habit. There is a discrepancy between gender regarding smoke. There is clearly a need of more awareness, anti-smoking campaigns and involvement of BME youth in designing and delivery of smoking cessation services.

1.5 Recommendations

More educational and informational programmes about the dangers of tobacco use should be developed by involving young people in the design and delivery of smoking cessation services

A) Issues regarding gender discrepancy (female smokers) should be explored and policies in place to handle such sensitive issues.

B) Stress and peer pressure were one of the main reasons for smoking – more work should be done to identify the causes and ways to counter them.

Introduction

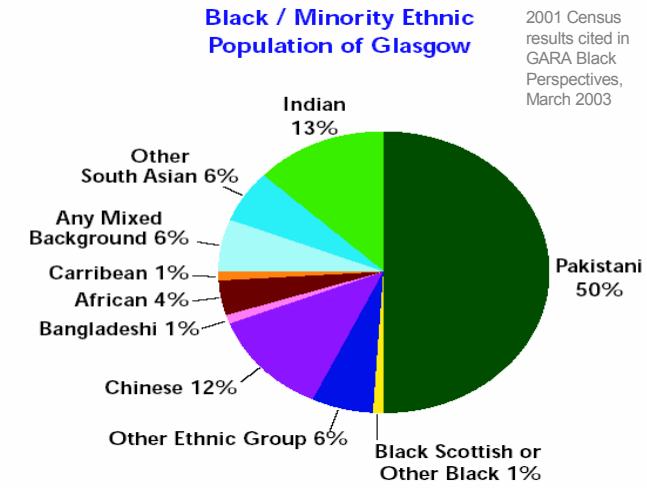
2.1 Background

This research project focuses on Black and Ethnic Minority (BME) young people living within the Southside of Glasgow and examines the prevalence and patterns of tobacco use within these 'hard to reach' target groups. It also examines socio-economic factors and conditions, such as deprivation, family life and peer pressure have effect on smoking rates and to address this issue in a holistic manner. The advantage of focusing on young people is that, by identifying risk early, it optimises the chances of preventing smoke related mortality and morbidity in later life. This three month project was funded through the phase 1 Tobacco and Inequalities (T&I) Small Grand Fund, managed by ASH Scotland.

2.2 Demography

The BME population in the United Kingdom is growing and reached 4.6 million in 2001. The size of the BME population has increased since the 1991 to 2001 by 1.6 million. The total population growth in Scotland increase between 1991 and 2001 was 1.3%. The BME population is also growing and it has increased by 62.3% during the same period (Census, 2001).

- The size of the BME population was just over 100,000 in 2001 or 2% of the total population of Scotland.
- Over 70% of the total BME population were Asian: Pakistanis were the largest minority ethnic group, followed by Chinese, Indians and those of mixed ethnic backgrounds.
- Greater Glasgow Health Board has the highest percentage of the total BME population with 38.7% living within the boundary.



N.B 2001 Census data is likely to be an underestimate of the BME population in Scotland.

It does not include figures for Refugees & Asylum Seekers; recent migrant workers; Gypsy/Travellers.

The 2001 Census shows that Pollokshields East, Maxwell Park, Govanhill and Shawlands have a large concentration of the BME population including young people residing in these areas in comparison to the city as a whole. Hence REACH chose these key geographical areas to undertake this project.

2.3 Smoking Hazards and BME Communities

Smoking is known to have a number of harmful effects on health, e.g. (Asghar et al, 2000).

- Smoking has a major risk factor in Coronary Heart Disease.
- Smokers are twice as likely to have a heart attack as non-smokers
- Smoking 3-6 cigarettes a day doubles the chances of a heart attack
- Smoking can increase the likelihood of many cancers.

People from BME communities are at a higher risk of developing some chronic diseases such as cardiovascular disease (heart disease and stroke) and diabetes. Smoking along with chronic disease increase the complications, like: if an individual has diabetes then smoking increases the chance of having a heart attack, a stroke or damage to feet and legs by 4-9 times.

As shown in REACH's 'Missing Link Report', BME young people are less likely to access services and highlighted below are some of the barriers young people face :

- Lack of Information about Services and Purpose of NHS
- Lack of Respect Shown by the Staff
- Under-Representation of BME Staff
- Waiting time

In lieu of above findings, REACH felt it was important to further investigate and form a template base for why BME young people smoke, their smoking patterns and their views on current information about the hazards of tobacco.

REACH feels that the results from this study could then help to explore the patterns, prevalence and beliefs about smoking among BME youth and to identify, 'what assistance would be required in order to get rid of smoking habit'? Findings can be used to engage BME young people in the design and delivery of services; help to increase their access to appropriate health advice and information.

LITERATURE REVIEW

There is substantial literature on smoking in relation to BME communities in the UK. However, this literature tends to concentrate mainly on the medical and disease prevention aspects of smoking. There are very few studies which provide insight into the prevalence of tobacco usage, and the needs and development of anti-smoking/tobacco policies. The recent studies which have looked at these issues include Health Survey for England (1999); Black and Minority Ethnic Health in Glasgow (February 2006); and an ASH Scotland Report 'Black and Minority Ethnic Views on Smoking: Patterns, Prevalence and Needs in Glasgow' (2004) .

3.1 Smoking in the UK

According to the recent report on smoking statistics in the United Kingdom (August, 2006) found that a large number of adults (12 million) smoke cigarettes, this equates to around 26% of men and 23% of women of the total population. This report is encouraging as it shows that smoking in adults has decreased since 1974 - at that time 51% of men and 41% of women smoked cigarettes. However, the decline in recent years has been heavily concentrated in older age groups. There are also variations between the different groups in the society, for example there has been an increase in tobacco smoking amongst BME youth (BHF, 2004).

3.2 BME Smoking Rates

According to the Health Survey for England in 1999, 44% of the Bangladeshi population smokes as compared to 26% of Pakistanis, 23% of Indians and 27% of the general population (2000). Overall, South Asian men continue to smoke more than the general population. Chinese men and women were less likely to smoke than men and women in the general population. Among Bangladeshi men, aged 50-74 year, 70% of them were smokers and 54% were smokes among 30-49 years (BHF, 2004).

3.3 Scotland

Tobacco use is the single biggest preventable cause of ill health and premature death in Scotland and a major cause of inequalities. Furthermore, Scotland has an estimated 1.4 million smokers, comprising more than one third of the adult population. In Scotland around 13,000 people die every year from diseases related to tobacco smoking, like heart diseases and many cancers. There are also serious health risks associated with passive smoking. Smoking related illnesses cost the NHS an estimated £200 million per

annum in Scotland alone. Smoking rates are generally high among socially excluded groups and may be increasing among certain ethnic minorities (ASH Scotland, 2004).

The current national target is to reduce levels of smoking to 29% by 2010

3.4 BME Smoking Rates in Glasgow

Recent research in Glasgow shows that smoking levels were lower in the majority of minority ethnic communities than in the general population. However, Pakistani men smoked marginally more than the general population.

Percentage of respondents who said they are current smokers

Ethnic group	male	female
Pakistani	36%	5%
General population	35%	32%
Chinese	24%	4%
Indian	16%	4%
African & Caribbean	16%	5%

Source: *Black and Minority Ethnic Health in Glasgow February 2006*

3.5 Smoking and Culture

A qualitative study by Bush et al, (2003) investigating influences of smoking in Bangladeshi and Pakistani communities found that there were similarities with white males regarding cultural context and smoking.

The study found that smoking was seen as an association with male identity, however, in females smoking was associated with stigma and shame. Due to Western influences, smoking is now more prevalent in young Bangladeshi and Pakistani women. Figures from the British Heart Foundation show that women from all BME groups are less likely to stop smoking than women in general (BHF, 2004). It is, therefore, important that certain sub-groups are not overlooked due to popular belief (i.e. it is culturally forbidden for Muslim women to smoke). Any preventive measures should be targeted at both genders regardless of their culture and religion.

3.6 Awareness of Smoking Hazards

A quarter of BME communities from Bangladeshi, Pakistani and Indian origin associate smoking with Coronary Heart Diseases and about half of them were aware of the link

with lung cancer (Health Education Authority, 2000). Despite this, the South Asian community is one of the biggest users of tobacco in the United Kingdom (Bhopal, 2004).

3.7 Chewing Tobacco

It is not only smoking tobacco that is an issue amongst South Asians, but also chewing it. In some BME communities chewing pan (a green leaf which is folded into a small cone like shape, containing beetle nut and ground tobacco) is practised by women and men. There has been recent research conducted in Glasgow within the Dental department in 2004 investigating pan consumption and the incidence of oral cancers in minority ethnic groups (Chauhan, 2004); and Other studies have also shown that there were significantly higher deaths from oral cancer in men originating from the Indian sub-continent which has a long history of beetle nut/pan/tobacco chewing than among the indigenous UK male population (Donaldson and Clayton, 1984). In UK alone quarter of Bangladeshi women chew tobacco (BHF, 2004).

3.8 Services needed for BME Smokers

In an *ASH Scotland report* entitled *'Black and Minority Ethnic Views on Smoking: Patterns, Prevalence and Needs in Glasgow'*, it was found that:

- Smokers were notably unaware of the range of devices and services available to counter smoking habit.
- women who smoke were stigmatised
- the benefits of smoking were seen to largely out-weigh the negatives
- most of the respondents had never heard of ASH Scotland
- Some people had a notion that, anti-tobacco campaign did not visually represent BME communities and new campaign should take into account the cultural factors.

Inclusive strategies and proactive approaches by anti-smoking agencies were seen as the most effective means of tackling smoking within BME communities.

3.9 Attitude towards Smoking

Attitudes towards smoking within groups that may not access traditional health care and who seem to be less targeted by health related advertising, literature and education are often skewed. This lack of information specifically targeted at the BME community can lead to detrimental attitudes by these communities.

RESEARCH METHODOLOGY

4.1 Overview

The main research questions addressed were the following;

1. What is the prevalence of tobacco use by BME young people living in the Southside of Glasgow?
2. What are the patterns of tobacco use by BME young people living in the Southside of Glasgow?
3. What recommendations can be made with regards to information, advice and services motivating to give up smoking by BME youth in Scotland?

The approaches used within this action research project were the following: 1) Questionnaires 2) Focus Groups and 3) Literature Review. This triangulated approach allowed for both in-depth qualitative and quantitative information to be collated within this research project.

4.2 Questionnaires with BME Young People

The quantitative questionnaire was piloted with a group of 5 young people from BME backgrounds so as to enable constructive feedback of the questions proposed and enhanced the quality of the questionnaire.

In order to gain a representative view from the target group, the research team recruited from a broad sample of the BME young people living in the Southside of Glasgow (both smokers and non-smokers were included in recruitment).

An effort was made by the research team to determine patterns of behaviour for the target group of males and females between the ages of 16 and 26. Ideal locations for distribution of BME young people were determined through an informal trial and error process.

Questionnaires were left in a range of public places visited by the target community as shown in the table: It was found that in all of the above locations, the participation rate of the BME young people to questioner was good. However completion of questionnaires were most successful in schools, shops and among youth groups.

Site	Neighbourhoods
Public libraries	Govanhill, Pollokshields, Langside, Cardonald
Doctor's surgeries	Pollokshields, Shawlands
Woman's organisations	Clyde's Place
Secondary Schools	Govanhill, Shawlands
Youth organisations	Govanhill, Pollokshileds
Places of Worship	Southside of Glasgow
Cafes and Shops	Govanhill, Shawlands, Albert Drive

4.3 Focus Groups with Young People

The research team reviewed the questionnaires and then developed the key themes for the focus group. One focus group was held at Youth Counselling Services Agency (YCSA) premises with eight participants – this group was made up of young males between the ages of sixteen and twenty-one. While an attempt was made to recruit female BME members for the group and it was found that they were not willing to share their smoking experiences inspite of the full assurance of the confidentiality.

4.4 Problems Encountered and Overcoming them

It was very hard to get the young people to fill in the questionnaires. So researchers addressed this lack of response by approaching schools where they had a personal contact and working with teachers who distributed the questionnaires in class. Out of two hundred copies of questionnaires distributed only fifty-five were returned.

The questionnaire was not distributed to those agencies dealing with young people from the Refugee and Asylum Seeker community. BME young women were not willing to fully participate in the project due to cultural differences, religious beliefs and the taboo attached to female smokers in these communities.

4.5 Methods of Data Collections

The analysis of the data collected within this project was undertaken through the following two themes:

Theme 1: Pattern and Prevalence of Tobacco consumption among BME youth in Southside of Glasgow.

Theme 2: Recommendations for reducing smoking rate among BME youth.

Results

This section presents the results from the research. The research team's initial plan was to undertake two focus groups with BME young people and to design and distribute a quantitative questionnaire to a selected number of BME young people living in Southside of Glasgow. However the researcher faced difficulties in engaging with BME young people to fill in the questionnaires. Despite a mass distribution of questionnaires at various locations in the Southside of Glasgow, the number of returned forms was low. Out of two-hundred questionnaires distributed only fifty-five were returned. Considering the limited time frame (three months) funds available for the project and constrains cropping up during the course of research, the research team decided to only undertake one focus group.

5.1 Focus Group

One focus group was held – the participants were all male aged from seventeen to twenty-one years old. Females were approached for participation and promised anonymity but they were reluctant to be involved. This raises sensitive and significant issues about BME attitudes towards female smokers.

Theme 1: Pattern and Prevalence of Tobacco consumption among BME youth in Southside of Glasgow.

A) Smoking Prevalence

The Group was comprised of eight participants and all were smokers. Three were covert smokers (smoked one packet or more of cigarettes per day) and five participants smoked less than twenty cigarettes per day.

B) Smoking Patterns

The main form of tobacco consumption within the group was in the form of smoking cigarettes. Some members tried 'hookah' and 'pan' but it was generally felt that these types of tobacco consumption are practiced more by the older generations.

The majority of the participants had first tried smoking between the ages of ten and twelve and said that their entire social circle smokes cigarettes. All of the participants were aware that smoking is harmful to their health because of the danger warnings on cigarette packets.

However, the group felt that the harmful effects of cigarette smoking are not fully explained and

that more should be done to highlight the negative effects of smoking.

Theme 2: Recommendations for reducing smoking rate among BME youth.

C) Reasons for Smoking

The main reason given by the group as to why they smoke was peer pressure, the second most important reason was stress and the third was emotional turmoil. Image, tension and boredom were also given as reasons by the group. Other factors which they felt had an impact on young people smoking was the prevalence of smoking in films and the profusion of tobacco related advertising in the sports, watched by the group.

The group also felt that addiction was the main reason why people continued to smoke despite being aware of the detrimental health effects of doing so. The group also agreed with the notion that smoking leads to the consumption of other stronger drugs such as marijuana.

D) Information and Help to give up Smoking

The participants felt that no matter how many options were presented to them they did not feel motivate to give up smoking. They were aware of Nicotine patches, chewing gums and pills but they had an impression that it would not work.

The group also felt that there were not enough services available to encourage the BME community to give up smoking. It was felt that the support of their GP was not enough to enable them to quit. Some participants also stated that they would not go to a BME health professional to seek advice about smoking due to previous issues concerning patient confidentiality.

When asked about adverts on media specifically targeting BME youth, most of participants said this would not encourage them to quit smoking.

Overall, the group felt that it was entirely up to them, as individuals, to give up smoking and that no health warnings or statistics would encourage them to do so. It was emphasized that it was their own responsibility to quit and only one member stated that he actually wanted to give up.

E) The Smoking Ban

When asked about their opinion on smoking ban, the group voiced that smoking should be

banned in certain places but not everywhere.

Smoking was described as 'disgraceful' but a matter of freedom of choice. It was stated that if people can consume alcohol without area restrictions, then the same should be true of tobacco products.

F) Smoking and Family Members

Some members of the group had grandfathers who had died from smoking related diseases, particularly lung cancer, and elders in the family that suffered recurring chest infections.

They also said that they would not smoke in front of their partner / wife so as not to affect their partner with passive smoking.

G) Smoking and BME Women

The following comments were made on female smokers:

"*BME women who smoke bring more shame to the family than boys who smoke - there is a respect factor attached to the females in the BME community, a greater social responsibility is placed upon them*".

- The group also believed that woman should not smoke due to the harm it may cause the unborn child during pregnancy.
- The group agreed collectively that they did not feel attractive towards female smokers.

In view of participants, females who smoke have a lack of respect for themselves.

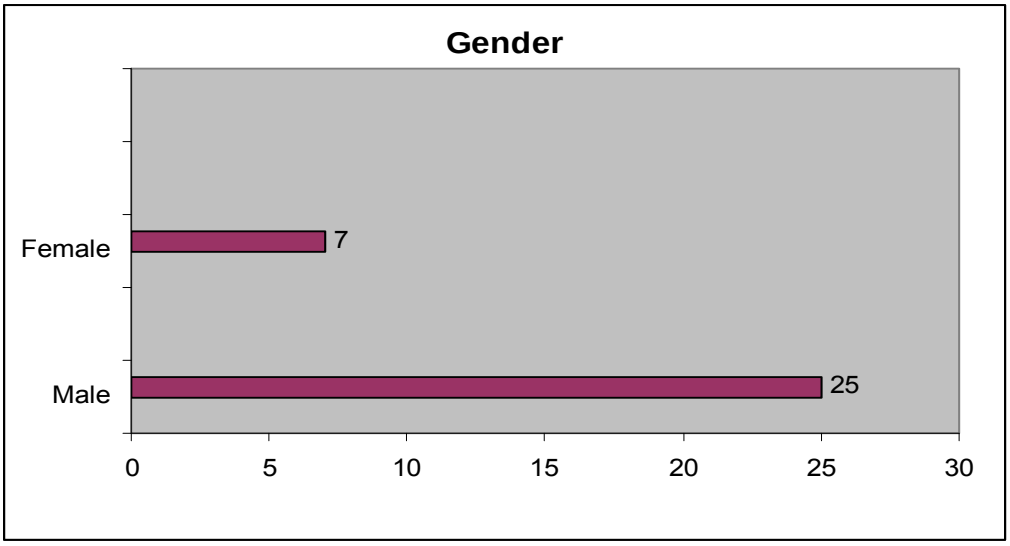
5.3 Questionnaire

Theme 1: Pattern and Prevalence of Tobacco consumption among BME youth in Southside of Glasgow.

Total number of people who responded to the questionnaires was fifty-five. Out of which thirty-two were between the age group of fifteen and twenty-six.

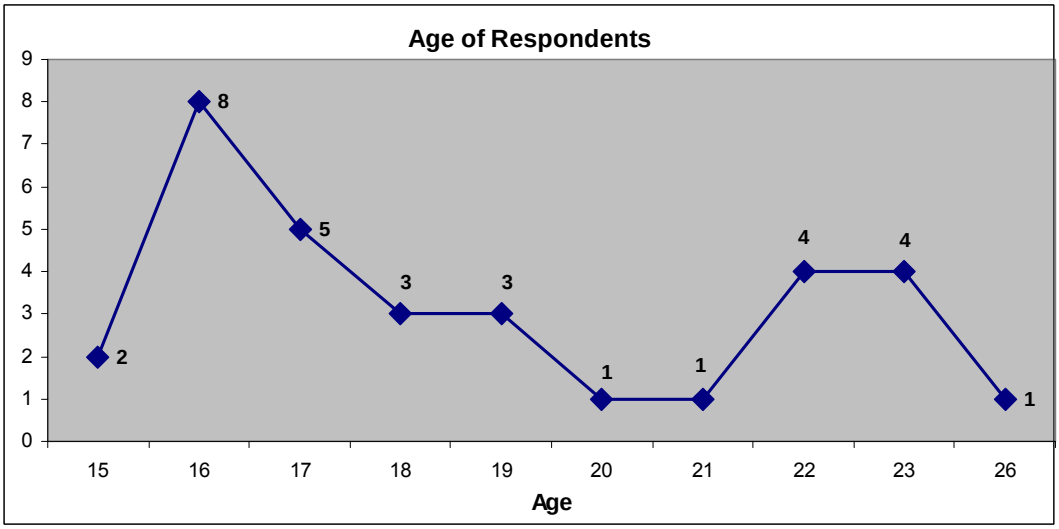
A) Gender

The total respondents from BME young people: Twenty-five respondents were male and seven respondents were female.



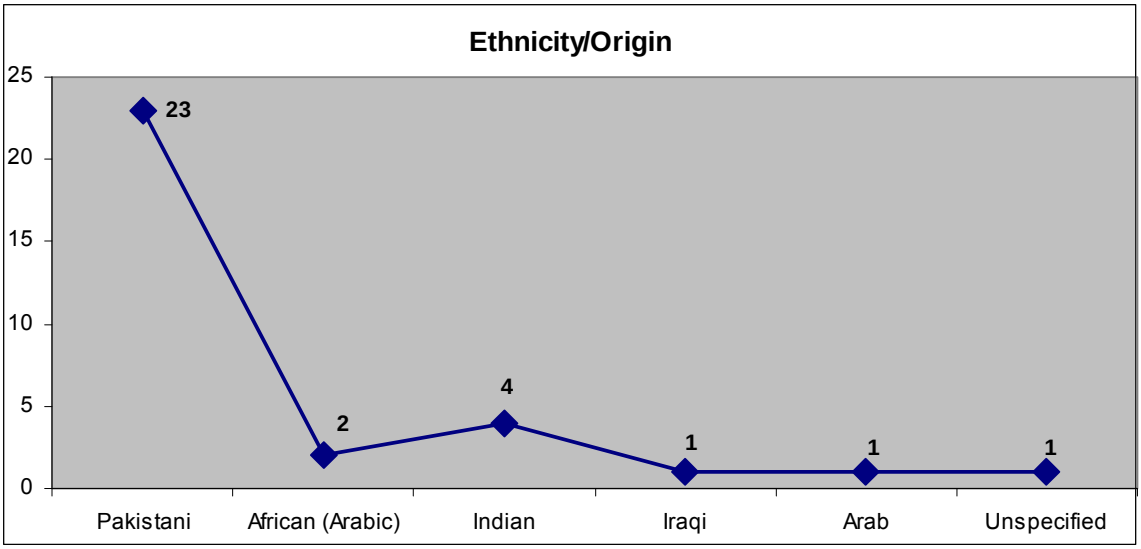
B) Age

Respondents were aged between 15 and 26 years old. The majority were under 20 years old.



C) Ethnicity

The vast majority of participants were from Pakistan / of Pakistani origin. This was a fair representation of the communities living in the Southside of Glasgow.



D) Information about Tobacco/Smoking

Most participants (21 participants) reported they had lack of information available to them on the hazards of smoking.

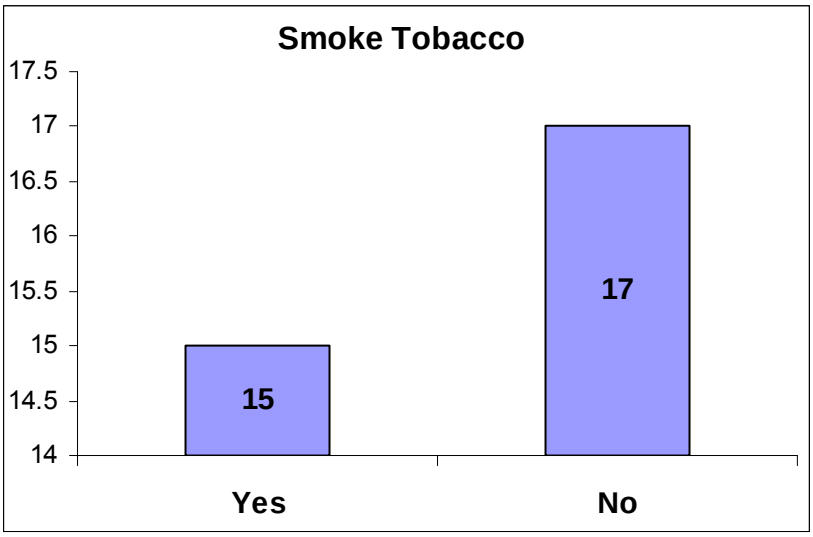
Informational materials that had been noticed included:

- Anti-smoking advertising
- TV Adverts
- Magazine articles/adverts
- Department of Health/Scottish Executive websites
- Cigarette packet warnings

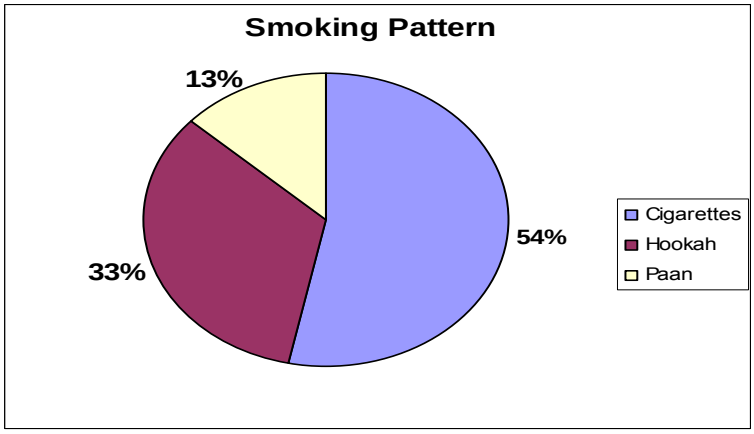
However, respondents generally found this advertising to be unpersuasive.

E) Prevalence of Tobacco Consumption

When asked if they consume tobacco, fifteen respondents said they did and seventeen said they did not.

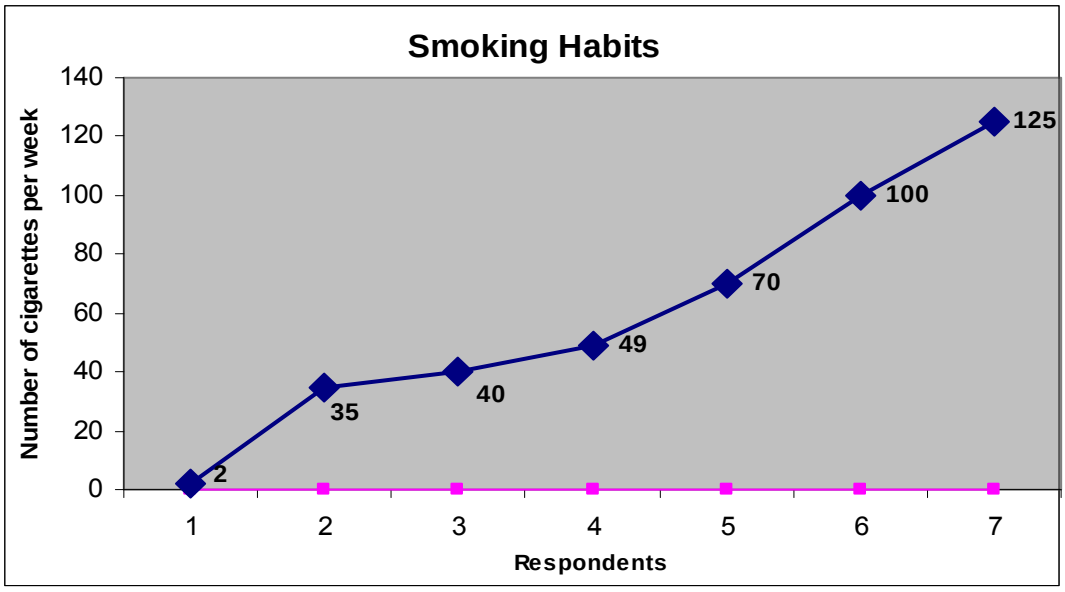


Of those who did use tobacco, eight smoke cigarettes; five smoked 'Hookah' and two consumed 'Paan'.



F) Cigarettes Smoked per week

Those who smoked cigarettes were asked how many cigarettes they smoke during a week – this ranged from two cigarettes to one hundred-twenty five cigarettes – therefore all smoke on average less than twenty per day.

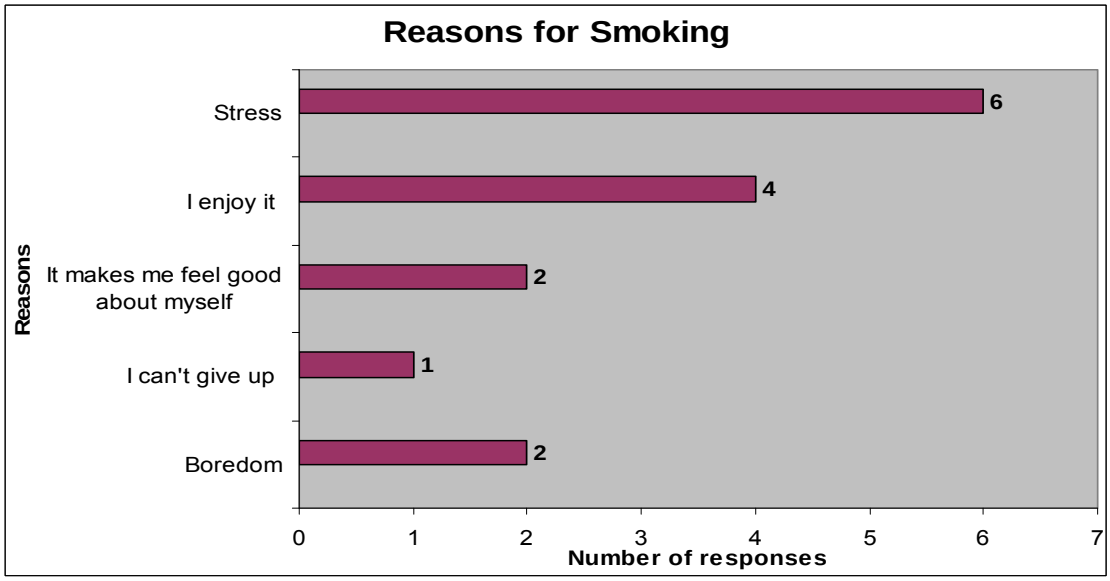


Theme 2: Recommendations for reducing smoking rate among BME youth.

G) Reasons for Smoking

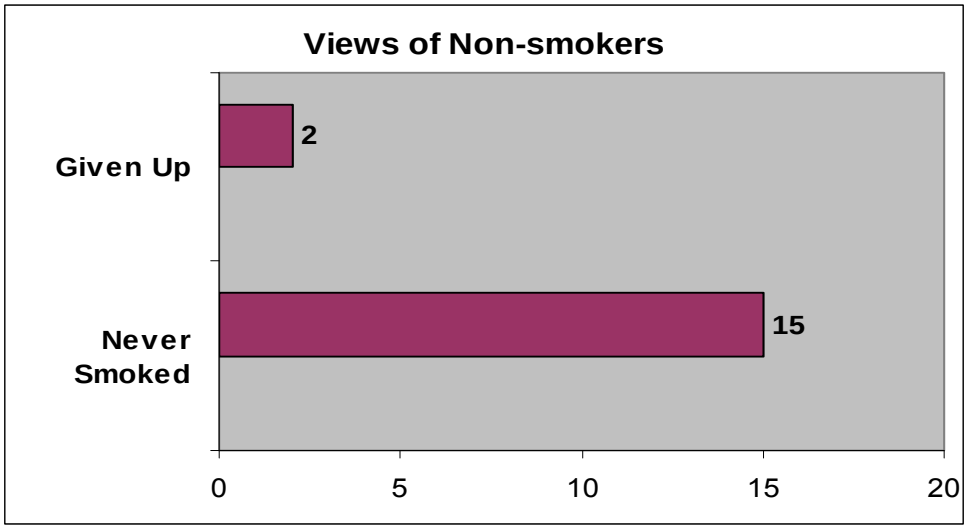
It was important to find out the various reasons given by people for smoking tobacco. The most common reason given was stress (37.5%). Other reasons given were: enjoyment (25%); it makes you feel good about yourself (12.5%); unable to give up (12.5%) and boredom (12.5%).

More attention should be focused on BME youth in provision of information countering stress and professional advice should be readily available abiding by the cultural sensitivities issues and confidentiality; in order to win the trust and have faith in the services provided.



H) Non-Smokers

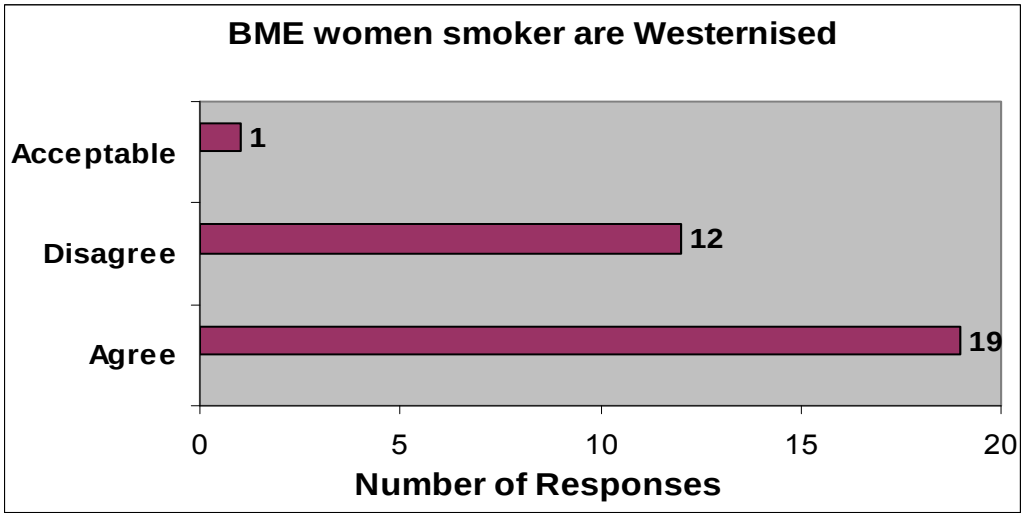
Non-smokers who completed the questionnaire were asked if they had ever smoked - 15 said they had never smoked and 2 said they used to smoke but had given up.



Reasons for giving up: Of those who had given up one said he quit because of coughing episodes, another person said it was a direct result of advertising and he realized that his health was getting worse and he was quite a light social smoker so just decided to quit.

I) BME Women and Smoking

Nineteen people agreed with the statement that BME women smokers were more westernized while twelve disagreed. Only one person agreed with the statement that smoking was acceptable for girls.



Discussion

This three month project was carried out to investigate the prevalence and pattern of tobacco use by BME young people living in Southside of Glasgow. The research was carried out in a highly dense BME populated area, where Pakistanis are the largest minority ethnic group. Findings from previous research on BME communities in Glasgow by Asghar and Hampton, (2000) suggest that smoking prevalence may indeed be higher than previously thought. As Pakistani respondents were identified to be the heaviest smokers in the study and there was also evidence indicating that smoking was on increase amongst BME young girls. Some BME young males expressed a particular disapproval of BME young women smoking which could suggest a certain cultural taboo and negative perception / beliefs that this part of the BME community may have an impact on covert smoking practices.

As indicated in this report, an action research project was undertaken which included one focus group with BME young boys and questionnaires were distributed. Although the target population was BME youth in general, in reality most of the respondents in the focus group were male, under 21 years of age from Pakistani origin. BME young women were approached for participation and promised anonymity but they were reluctant to be involved. This raises sensitive and significant issues about BME attitude towards female smokers.

While distributing questionnaires, attempts to include a response from all minority ethnic communities were made by targeting many multicultural centres. However there was a limited response; which may be partly attributed to the stigma surrounding tobacco use; particularly in the BME community and the subsequent reluctance to publicly admit to the use of tobacco. When visiting schools the researchers involved in this project developed a good rapport with the teachers and managed to distribute many of the questionnaires however BME young people were still reluctant to say that they used or had tried tobacco. Therefore the results obtained could indicate a slightly lower incidence of smoking habits within this particular part of the community.

Around half of those who took part in the study said that they used tobacco, with the majority smoking cigarettes. Most smoked less than 20 cigarettes per day – though some did admit to smoking more than this. The majority of boys in the focus group had started smoking between the age of 10 to 12 and most of them stated that stress due to various reasons and peer pressure were the main factors behind them to start smoking.

The boys who took part in the focus group revealed a lack of information relating to the health hazards of smoking as most participants said they had never seen any information relating to the health hazards of smoking. The harmful effects of cigarette smoking were not fully understood by this group though they did feel that more should be done to highlight the negative effects of smoking. When informed about hazards and consequences, they showed little interest and the consequences of smoking seemed to have little or no impact on this group.

With regards to media anti-smoking campaign, those available on national and international radio / television channels tended to have no effect on the smoking habits of the participants, and BME young males found it neither motivating nor did it encourage them to quit smoking. This group expressed pride in the fact that many of their screen idols smoked in movies. This framed their views towards smoking and indicates to them that there is nothing wrong with smoking.

There was a lack of interest and indeed a resistance among BME young males in accessing smoking cessation services, as the group felt that there were not enough culturally sensitive services available to encourage the BME community to give up smoking. Some participants also stated that they would not go to health professionals to seek advice about smoking due to previous issues concerning patient confidentiality. There were certain other issues related to access of health services by BME young people and they were similar to those highlighted in the '*Missing Link Report' (2004)* (see Appendix).The group also did not understand or have much faith on the reliability of anti-smoking medication available and emphasized self-determination and responsibility as the key factors in any decision to quit smoking.

In this report certain social taboos attached to BME young women smoking were identified: many participants indicated that women are supposed to be the center of household, responsible for imparting moral education to their children. The participants also indicated that there could be medical reasons as to why BME young women should not smoke one such example was when pregnant. The BME community also believes in binary oppositions, for instance, smoking is associated with males instead of females. The participants also showed lack of respect towards the female smokers. It is believed that the women who smoke lack moral values. However, some of the participants were of the view that males and females have equal status and it is acceptable for the females to smoke. This is also backed up by literature indicating that BME women smokers are stigmatized / marginalized in the society (Asghar et al, 2000).

Conclusion

Prevalence of smoking rates among BME youth living in Southside of Glasgow is high in comparison to general population as around half of those who took part in the study were tobacco users, with the majority smoking cigarettes. There is lack of information and concern on the hazards of smoking. BME young people are reluctant in accessing health services in general. Stress and peer pressure are main reasons behind smoking. There is a gender discrepancy regarding smoking habits where cultural barriers exist regarding BME young women smoking. There is clearly a need of more awareness, anti-smoking campaigns and involvement of BME youth in designing and delivery of smoking cessation services.

Recommendations

The overall aims of this research project were to gain an insight into the prevalence and patterns of tobacco use among young BME people living in Glasgow and to find out about their attitudes to current information about the dangers of smoking.

Based on research findings a number of recommendations are given below:

A) More educational and informational programmes about the dangers of tobacco use should be developed for this target group as current literature / campaigns are having no effect. Such programmes should be developed with young people who then can be involved in the design of these initiatives.

B) BME young women who smoke: the special attention should be given to this group considering the negative attitudes expressed within their own community about women who smoke.

C) Stress was one of the main reasons for smoking – more work should be done to identify the causes of stress within this particular subset of the BME community and practical culturally sensitive approaches should be adopted to counteract stressful situations.

D) Peer pressure was another reason given for smoking. Anti-smoking campaigns by young BME icons could one delivery mode to promote the negative message of smoking.

E) It is also recommended that literature should be available in various languages i.e. English, Hindi, Urdu, Punjabi etc. The information should also be provided through various audio visual routes and also include BME radio programs and TV shows.

F) The smoking prevention services for the BME community should be targeted primarily for the youth under the age of 16 years, as this research found that majority of the youngsters started smoking before the age of 16 years.

G) There is a need to develop BME young person's Health Forum in partnership with mainstream agencies, which will offer these individuals a platform to share views and experiences, to help, support and encourage them to avoid and give up smoking.

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Appendices

A) Recommendations of the "Missing Link; BME Community Participation in Health" Report. REACH Community Health Project (2004).

The Missing Link: Black and Minority Ethnic Participation in Health highlights some of the concerns that young people have in accessing health care services. Some of the key barriers in accessing primary care services identified are summarized below:

Lack of respect shown by staff

- Young people feel that staff does not see them as important and that their views and opinions about their health are not respected.
- Both women and men believe that staff do not listen to their needs and are unconcerned about their health

Lack of information about services and purpose of the NHS

- For some recent immigrants, they do not have basic information on the role and remit of the NHS and do not know which services are free and which have a surcharge.
- Lack of information on available services and on health issues that are important to them such as mental health, sexual health, substance misuse and exam stress.

Under-Representation of BME Staff

- Young people want more BME nurses recruited by the NHS
- Women feel more comfortable with female GPs

Waiting Times

- People feel that their health is compromised by the long waiting times
- Perception that waiting times are an active barrier that prevents people from using the health services.

B) Focus Group Questions

1. Smoking Habits

Do you know many people who smoke?

How old when they started to smoke? How many per day?

Are they of the legal age to smoke?

Do their families know they smoke?

Do they smoke openly?

Which form of tobacco/cigarettes/paan etc?

Do they know tobacco is bad for them?

From starting to smoke, have they gone on to try drugs?

2. Why people smoke and what they get out of it?

Why do you think your friends/peers smoke? Pleasure? Boredom? Confidence?

To reject their family or culture influences? To be trendy – impress girls?

3. What measures do people from the BME community take to give up smoking?

Do community influences help? (Support from religious leaders; members of the community?)

Is there sufficient support for BME people in particular from the health services?

Would you go to the doctor for advice on giving up smoking?

Would you be more likely to go to the doctor if he / she was from a BME culture?

Would information on giving up tobacco in BME languages and on BME radio stations, newspapers etc help you to give up?

4. Do you agree with the smoking ban that the Government is going to put into place in the near future?

5. Long term effects of smoking?

6. Do you want to give up?

7. What do you think of BME women who smoke?

C) Questionnaire on tobacco use amongst Black and Minority Ethnic (BME) young people.

Thank you for helping us with this survey. By answering these questions you will help us support people from BME communities who are trying to give up smoking.

Demographics:

1. How old are you? _____

2. Are you male □ female □

3. What is your postcode? _____

4. How would you describe your ethnicity?

African	□	Bangladeshi	□
Caribbean	□	Chinese	□
Indian	□	Pakistani	□
other	□	please state which_____	

Tobacco Use:

5. Have you ever noticed any information available to the public warning about smoking?

Yes □ No □

6. If yes, please tell us anything you can remember about it?
_____
_____

7. Do you consume tobacco, either through cigarettes, the hooka/sheesha, or paan?

Yes □

No □

8. If yes please state which method:

Cigarettes □

Hooka/Sheesha □

Paan □

9. If you smoke a cigarette, which of the following best describes your smoking behavior?

I smoke some day's □

I currently smoke socially □

I currently smoke every day □

How many cigarettes do you smoke per week? _____

10. Why do you smoke?

I enjoy it □ I can't give up □

Boredom □ It makes me feel good about myself □

It's cool □ Stress □

Other (please say below what)

_____
_____

11. How old were you when you first started to smoke regularly? ____ Years

12. Does your family know you smoke? Yes □ No □

Stopping Smoking:

13. Have you ever stopped smoking? Yes □ No □

14. If you did stop, for how long did you stop? _____

15. Would you want to give up smoking in the next few years?

Yes □ No □

16. If yes, would any of the following help you to stop?

Support of friends or family □

Support from own community □

Support of medical services □

Nicotine patches, chewing gum or other method □

Other ways (please mention below)

_____
_____

17. If you would like to give up smoking, would any of the following encourage you to do so? (Please state in order of preference, with 1 being the most influential?)

Advertisements from BME/Asian music channels □

Anti-smoking campaigns specifically targeted for BME people □

Anti-smoking information directed at the broader population □

OR

None of the above □

18. Are you aware of any anti smoking advertisements specifically targeting BME populations?

Yes □ No □

Questions for non-smokers:

19. Which of the following describes you?

I have never smoked □

I used to smoke but gave up □

20. If you have given up smoking, what made you give up?

_____
_____
_____

D) Questions for everyone:

Question	Check appropriate box	Agree	Disagree
21	BME women who smoke are more westernized		
22	Smoking helps to give me confidence		
23	Smoking is very harmful to your health		
24	Smokers are likely to take drugs		
25	Smoking is acceptable amongst males		
26	Smoking can cause lung cancer		
27	Smoking makes me more like my friends		
28	Smoking is acceptable amongst females		
29	My family wouldn't approve of me smoking		
30	Advice on health matters is more acceptable i comes from a BME Organization or leader		
31	BME women who smoke are more independent		

For smokers and non-smokers, any other comments?

_____

_____

_____

Many thanks for your help! If you would like to be informed when the final report from this research is available on the REACH Community Health Project website (www.REACHhealth.org.uk), please provide us with an email address.