This report was prepared for HSCF to support the Public Health Commissioning Strategy for 2014/15, to inform Healthwatch Hackney and to contribute to the knowledge base of the City & Hackney Wellbeing Profile

Community Insight

Into Turkish and Kurdish smoking related behaviour and attitudes in Hackney

October 2013

Prepared by Fred Agbah for the Shoreditch Trust in partnership with Derman

The Fund for Health Community Insight Commissioning Programme

This was a partnership consultation carried out by:

Shoreditch Trust

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Shoreditch Trust is a charity which supports and empowers communities to tackle inequality and exclusion across deprived neighbourhoods in the London Borough of Hackney and beyond, the Trust provides a successful smoking cessation service to the Kurdish, Turkish, and Turkish Cypriot community as part of its wellbeing programme.

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Derman provides a range of health-related services to Kurdish, Turkish, and Turkish Cypriot people, mainly refugees and asylum seekers in Hackney.

Commissioned by:

Hackney CVS, on behalf of the Health & Social Care Forum

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Special thanks go out to all the respondents and focus group participants, particularly the young people who volunteered their time to the consultation.

Introduction

1.1 Background to the Community Insight study

This community consultation with smokers and non-smokers, (that is, both ex-smokers and those who have never smoked) from the Turkish, Kurdish and Turkish Cypriot communities of Hackney builds on other research concerning smoking behaviour within this demographic. The most recent piece of work commissioned by Hackney in this area was in 2009. [1]

The report represents a snapshot of attitudes and concerns around tobacco use, including cigarettes, niche tobacco products such as chewing tobacco, Shisha (also known as water pipes) and smokeless tobacco such as snuff. This new work was commissioned *"To enable different communities to speak directly to policy makers about issues that affect their health and to have discussions within communities about what factors may support community members to make healthier choices."*

Our enquiry focuses on four areas –

1. When people in the Turkish, Kurdish and Turkish Cypriot community start smoking or using tobacco products and why
2. If people feel that the Turkish and Kurdish community has more tobacco users than other communities and if so why
3. How the Turkish and Kurdish community can be supported to quit smoking and stop young people from starting smoking
4. Attitudes to secondhand smoke within the community

The information gathered from a cross section of smokers and non smokers including ex-smokers across age groups, genders and socio economic classifications will be used in the first instance to support the drafting of City and Hackney's Joint Strategic Needs Assessment (JSNA) for 2014/15 which will represent a wealth of 'community intelligence.' This Community Insight response will help to inform a fluid and evolving JSNA for the borough's 238,000 residents. [2]

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[1] *Turkish and Kurdish Smokers in the Borough of Hackney*. Continental Research

[2] City and Hackney Health and Wellbeing profile: Our joint strategic needs assessment 2011/12

1.1.1 Summary and key findings

When and why people begin using tobacco products

Our findings from the Turkish, Kurdish and Turkish Cypriot community in Hackney supports general UK population figures for age of introduction to tobacco products. Most respondents who had smoked began smoking before the age of 18. Those born outside of the UK showed a tendency to start smoking at age 14 or 15. Almost two thirds (65%) of the sample of current and ex-smokers who had smoked regularly at some point in their lives started smoking before they were aged 18.

We found that the main responses to why people started smoking or using tobacco were;

1. Smoking and tobacco use is a cultural norm
2. Stress relief,
3. Rite of passage into adulthood,
4. Peer pressure
5. Modelling adult behaviour

Perceptions of smoking prevalence

People we approached said that they feel that the Turkish and Kurdish speaking community smoke more than other communities they know**.** In the main, stress, cultural differences, social pressure, unemployment and socioeconomic status, as well as the ease of access and affordability of tobacco products are factors. The general perception found was that smoking and tobacco use are acceptable habits. The cultural and social issues of being a migrant population also had a large part to play.

Support to quit and reducing the numbers of new smokers

Although respondents felt that Turkish and Kurdish people in Hackney were more aware of the dangers of tobacco use and its effects on the community than ever before, there is a strong perception that smoking as socially acceptable. We found an overarching belief in the effectiveness of willpower to quit and that using stop smoking services could only be useful if people were ready 'in their heads'.

Our findings showed however that people want support to quit and that stop smoking provision should include:

- Turkish language services
- More promotion of services in local press
- Targeted outreach and awareness raising

In terms of reducing the numbers of people who begin using tobacco products, respondents called for health education for parents in Turkish language, more education in schools and colleges, advertising highlighting the dangers of tobacco, implementation of international strategies such as plain packaging and increased regulation and action on retailers selling illegally to under 18's.

Summary of recommendations

The consultation highlights the need for real involvement from communities in shaping services in order to make them relevant and attractive to potential users. The main recommendations emerging from these discussions are that work needs to be done around cultural perceptions of tobacco in the Turkish and Kurdish community and more significantly, services need to look at ways to address the belief that smoking alleviates stress. Our research shows that a significant number of respondents begin smoking because of the belief that it helps people cope with daily life. In addition, there is a strongly held perception that personal resolve and the will of God is all that is required to break the smoking habit. Willpower and faith could be a useful catalyst for behaviour change and this determination could be harnessed to encourage participation in targeted smoking cessation services.

Offer more targeted mother tongue services

- Increased promotion of mother tongue services and provision of information leaflets and health promotion information in Turkish language.
- Targeted youth work to empower young people to resist and counter peer pressure
- Activities to build physical and emotional confidence

Increase education and awareness around smoking and tobacco related harm

- Convene tobacco specific seminars and conferences
- Smoking cessation teaching and promotion in schools and colleges
- Adult education for parents in Turkish language

Provide bolt on services that help alleviate socio economic stress factors

- Provision within stop smoking services of information and advice on where people can go to access specialist support such as welfare benefits advice, housing advice and wellbeing and lifestyle initiatives.

Denormalise the acceptability of smoking

- Work needs to be done with the older Turkish, Kurdish and Turkish Cypriot population to help shift the belief that tobacco can help users manage stress.
- Initiatives in children's centres, schools and extended services working with children and families could provide learning activities that fully explore the dangers of tobacco use
- There is a requirement for targeted work with young people to counter the perception of tobacco use as benign.

1.1.2 The Turkish, Kurdish and Turkish Cypriot population of Hackney

Turkish immigration to the UK started in the 1930's with Turkish Cypriots coming to the UK as part of their commonwealth rights settling in Hackney and Haringey. The Second World War brought political conflict to Cyprus causing a second migration to the UK. Immigration from the rural areas of mainland Turkey occurred in the 1970's and 1980's with families also fleeing political unrest and seeking a more stable economic future with work available in the rapidly expanding textile industries.

The 1980s and early 1990s saw the UK granting asylum to a large Kurdish community who sought protection from persecution in Iran and Iraq as well as mainland Turkey. Ethnic Alevi Kurds who arrived mostly in the 1990's fleeing conflict and discord with territories adjoining Turkey make up a unique group, many of whom hold Turkish passports.

Much has been recorded about the 'invisible' nature of Hackney's Turkish, Kurdish and Turkish Cypriot community with concerns predating both the 2001 and also the 2011 census for England and Wales, both of which failed to adequately capture the ethnic make up of the British Isles. Community and administrative data utilising locally captured and verifiable figures has proven to be more accurate in mapping the borough. [3]

"*Turks, Alevi Kurds and Turkish Cypriots living in the UK are sometimes termed 'invisible minorities', since social markers are not always present and complex interrelationships are in place between the three groups*." [4]

A 2011 estimate by Mayhew Harper Associates puts the figure for the Turkish community in Hackney as 11,400 however this does not incorporate the significant Kurdish population.

"Estimating the size of the Kurdish population is particularly problematical as Kurdish people mainly originate from Turkey, Iran, Iraq and Syria, but country of birth figures for these states also include other ethnic groups." [5]

The 2011 census for England and Wales reports that 15,000 Londoners cite Kurdish as their first language with 71,000 people in the capital using Turkish as their mother tongue, Turkish being the seventh significant minority language spoken in the UK.

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[3] Counting Hackney's population using administrative data; An analysis of change between 2007 and 2011. Mayhew Harper Associates, 2011

[4] Assumed and invisible roles of families and kinship in long term care provision among Turkish migrants in the UK. Dr Shereen Hussein Kings College London, Dr Sema Oglak, Dokuz Eylul University, Turkey.

[5] Turkish, Kurdish and Turkish Cypriot Communities in London. Greater London Authority April 2009

2001 Census figures for London show a high proportion of unpaid home carers, not in employment within the Turkish, Kurdish and Turkish Cypriot population with the Kurdish population having the highest rates of unemployment within the wider group.

Women are more likely to be not in employment and caring for children or older relatives, however gender classification for home carers in this category is unavailable. Students account for a high proportion of those not in work, according to Census figures, and those working in family businesses were not necessarily counted. Turkish Cypriots had the highest incidence of self employment within the Turkish and Kurdish ethnic group.

In recent years there has been a migration away from traditional Turkish and Kurdish settlement in the inner London boroughs of Hackney and Haringey to outer London Boroughs, particularly Enfield. This could partly be attributable to the introduction of Local Housing Allowance in April 2008 which saw a decline in affordability of private rented accommodation for those claiming welfare benefits in the inner London boroughs including Hackney.

Because of the significant numbers of Turkish and Kurdish people migrating out of the Hackney borough, we felt it was important to include in this report, those who study or work in Hackney, retain family links or access services in the borough.

1.2 Research Methodology

Shoreditch Trust and Derman worked in partnership to reach a cross section of the community. Both organisations have a long track record in providing better health outcomes for individuals and communities within City and Hackney including reaching those who are seldom seen or heard.

The Shoreditch Trust led on research design, implementation and analysis. We designed a survey and evaluation plan to include some statistical analysis in a research context that would correlate to qualitative responses.

Questionnaires were developed and translated for the Turkish speaking public with a specific questionnaire for service providers and Turkish/Kurdish stop smoking advisors, with the aim of reaching a minimum of 100 individuals by using trained community researchers to complete the fieldwork. This included a specific young peoples' questionnaire with a link posted on Twitter and Facebook social media platforms. We planned three focus groups.

All respondents were fully briefed of their rights in terms of information collection, storage and use. Written consent was gained before participation and respondents were aware that comments and quotes could potentially be used in the public domain but would be indistinguishable.

A broadly qualitative approach was taken to match the requirements of the study and statistical analysis was used to examine the breakdown of the pertinent themes. Qualitative fieldwork data was further explored with focus groups discussing the main findings that came of the questionnaires. More time would have allowed us to recruit a broader spectrum for the focus groups and to match the age range and socioeconomic demographic of the questionnaire respondents.

Existing quantitative data from Turkish and Kurdish stop smoking clients was included from Shoreditch Trust's Community and Bilingual Stop Smoking Service and used to enhance the scope of the research and enable a wider framework of socio economic and empirical findings to be examined.

By linking into our constituent groups we were able to dovetail existing work with clients and their families in order to engage smokers, ex smokers and non smokers. In doing this we anticipated that we could survey a cross section of age groups.

The review utilised the strategic links within the Shoreditch Trust's Community and Bilingual Stop Smoking Service, which works closely with the Turkish, Kurdish and Turkish Cypriot community offering culturally specific interventions, including a weekly Turkish breakfast clinic, Sunday school clinics and mother tongue stop smoking interventions in secondary care. To date the service has taken nearly 200 local people from the Turkish community through 12 week smoking cessation programmes. We also capitalised on Derman's work within GP surgeries and their outreach service which supports the Turkish and Kurdish community, including HIAC advice and information sessions run in GP surgeries. Existing Derman groups include specific projects for men and for those who have experienced domestic violence.

Shoreditch Trust's stop smoking clinics, community outreach events and Community Champion volunteer programme has access to harder to reach members of the Turkish and Kurdish community, and both organisations engage with those less likely to access services.

Two of our researchers were already known in the community as workers within the Health Trainer service. We also utilised existing partnerships with relevant community leaders and service providers.

A variety of methods were used in gathering feedback and responses. The approach we proposed made the best use of existing activities and collaborations. The investigation was also an opportunity for further development of community research skills for local outreach workers, volunteers and facilitators, some of whom were service users who had come through Shoreditch Trust programmes.

1.2.1 Data Collection

We identified appropriate analytical tools and techniques that would draw insight to the research. The study used several data collection methods:

1. Face to face interaction with all ages of the respondent group with information collected by community research workers incorporating a short qualitative attitude survey. Information was collected in people's homes, at GP surgeries, at the Hackney One Carnival, the London Alevi Centre and Cemevi, the Azizye Mosque. Opportunistic sampling was used in shops and cafes as well as local Turkish Cypriot football clubs and supermarkets.

2. Social media interaction with young adults - we planned outreach to existing networks, contacting organisations such as Young Hackney, youth hubs, and the Youth Parliament, using Facebook and Twitter interfaces to encourage users to complete a survey via a link posted on the wall of our Smokefree Hackney page and Tweeted via the Shoreditch Trust Twitter accounts.

3. Three focus groups were convened to explore the main themes to come out of the fieldwork.

4. We conducted telephone interviews and sought responses to a questionnaire for Turkish and Kurdish organisations and service providers, gathering their perceptions of attitudes within the community.

5. In depth qualitative and quantitative semi - structured telephone interviews were planned with four Turkish/Kurdish smoking cessation advisors.

We chose a variety of methods that we hoped would be engaging and appeal to different age groups and audiences within the community, delivered in a range of settings to maximise reach.

1.2.2 Background to the Community Insight survey primary data respondents

Of the 80 respondents to the main Community Insight survey, 43 gave their ethnicity as 'Turkish', 17 as 'Kurdish', 6 as 'Turkish Cypriot' and 13 as 'Turkish and Kurdish'. One respondent did not state their ethnicity.

31 respondents were male, 44 were female, and 5 did not state their gender. Figure 2 shows the age distribution of respondents, with the most frequently stated age category being '45-59' (45%). Nine were aged 24 or under.

As shown by Figure 7, 46% of respondents are smokers, 18 (23%) are ex-smokers, 23, (29%) are non-smokers and two did not state whether or not they currently or had previously smoked.
60% of respondents to the written questionnaire said that they or someone else in their household smoked or used tobacco.

1.2.3 Data analysis

Quantitative and qualitative data were collated, transcribed, inputted and compiled for submission to an external data analyst.

We used a combination of statistical and thematic analysis, pulling quantitative data from the questionnaires for SPSS analysis before drawing themes from the qualitative enquiries posed within the paper questionnaires and focus groups. An external evaluation team carried out quantitative analysis on raw data supplied by our research team in SPSS and Excel datasets.

Primary data responses:

- Brief Interaction survey – 80
- Social media survey – 20 responses, two filtered out
- Focus groups – 13 responses
- Community stop smoking advisors – 5 responses
- Organisations – 4 responses and 4 late submissions (filtered out)

Primary data questionnaires

1. Community Insight Research Study Survey of Turkish and Kurdish community members
2. Community Insight Research Study- Feedback from organisations' survey of local organisations
3. Survey Monkey online questionnaire for young people (via facebook and Twitter link)

Secondary data responses:

- Existing data from the Turkish, Kurdish and Turkish Cypriot users of the Community and Bilingual Stop Smoking Service from 2011 to 2013 - 182 responses

Secondary data questionnaire

1. NHS Community and Bilingual Stop Smoking Service Baseline Health Questionnaire

The project lead compared and correlated findings with national and local research. Analytical data was assessed and examined and used to illustrate our findings and show any correlations or associations. The final evaluation report was written up by the project lead for submission to the research commissioners.

1.3 Limitations of the study

Although this consultation was able to reach a wide demographic and mostly achieved its aims in terms of information gathering, it is important to note some significant limitations that affected the execution of the consultation and also access to the target groups.

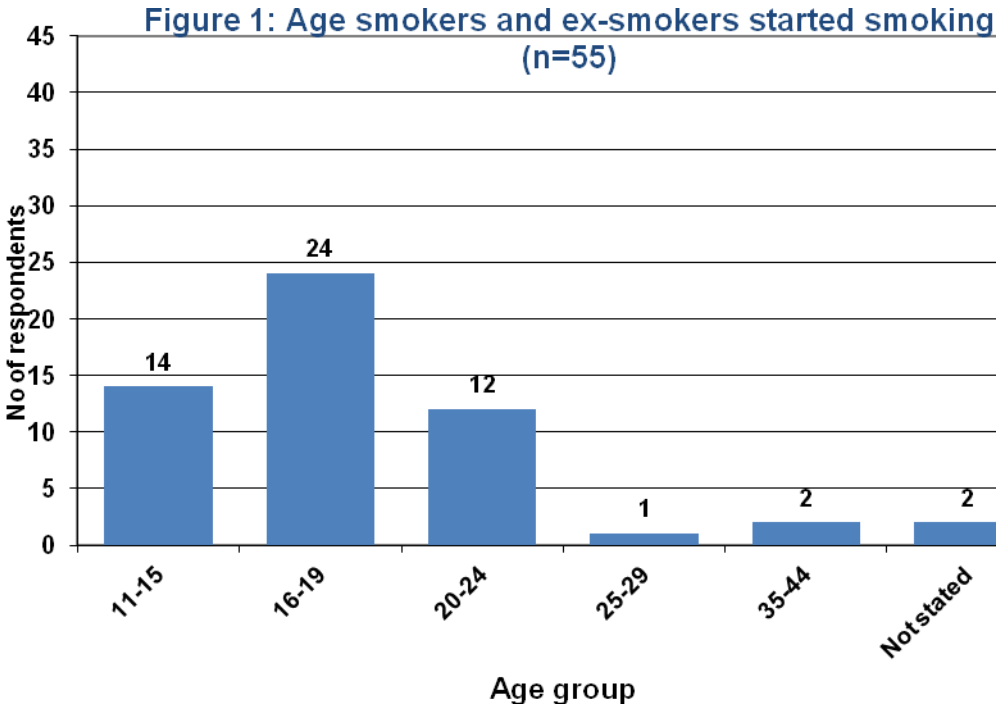
- The timing of the commission was not culturally sensitive to the diaspora. Many people return to Turkey for several months during the summer to visit relatives and rekindle close family ties, particularly with older rurally based relatives that they may be supporting from the UK.
- There were no opportunities to collect data at the three main Turkish and Anatolian festivals that take place in the borough each year as they had already taken place when the commission was assigned.
- The relatively low budget for the consultation was unrealistic in terms of the information and analysis required to gain the best scope from the investigation.
- The timeframe for information collection, analysis and report writing was short and therefore extremely challenging. This meant that some important data were not able to be used, for example, in-house data on white British smokers that could have been compared with available information on equivalent Turkish and Kurdish smokers. In addition four late submissions from organisations were discounted in analysis.
- Accurate population figures on the local Turkish and Kurdish community were difficult to source with ONS and census data proving to be unreliable. According to a recent population count undertaken for the borough by Mayhew Harper Associates "*ONS population counts do not use all available evidence especially administrative data which is more up to date and verifiable and so official figures are out of date before they are published*".
- The sample although broad was not large enough to draw unequivocal conclusions. However, we were able to extrapolate and evaluate the main themes, and the numbers and diversity of participants helped to underpin common narratives.

2.0 Main findings

Background to respondents' smoking and tobacco use

Figure 1 shows the data for the age at which respondents to the Community Insight Research Study community survey started smoking. For the 55 smokers and ex-smokers in the survey sample, the most commonly chosen age group for starting smoking was '16-19' (44% - 24 participants).

Findings from the NHS Community and Bilingual Stop Smoking Service Baseline Health Questionnaire analysis showed an age for starting smoking that concurred with this finding. For the 172 respondents who stated that they were smokers and responded to this question, the mean age given for starting smoking was 18.03 years. The ages given by respondents for starting smoking ranged from 6 to 51 years of age.



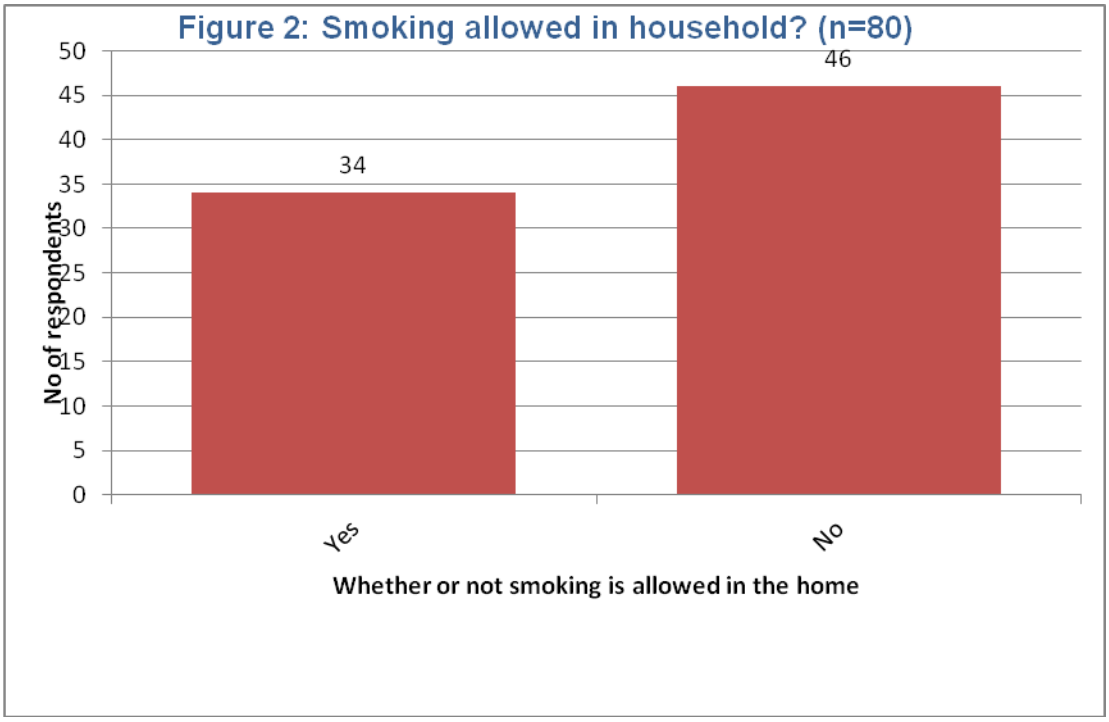


Figure 2: Smoking allowed in household? (n=80)
50
45
40
35
30
25
20
15
10
5
0
No of respondents
34
46
Yes
No
Whether or not smoking is allowed in the home

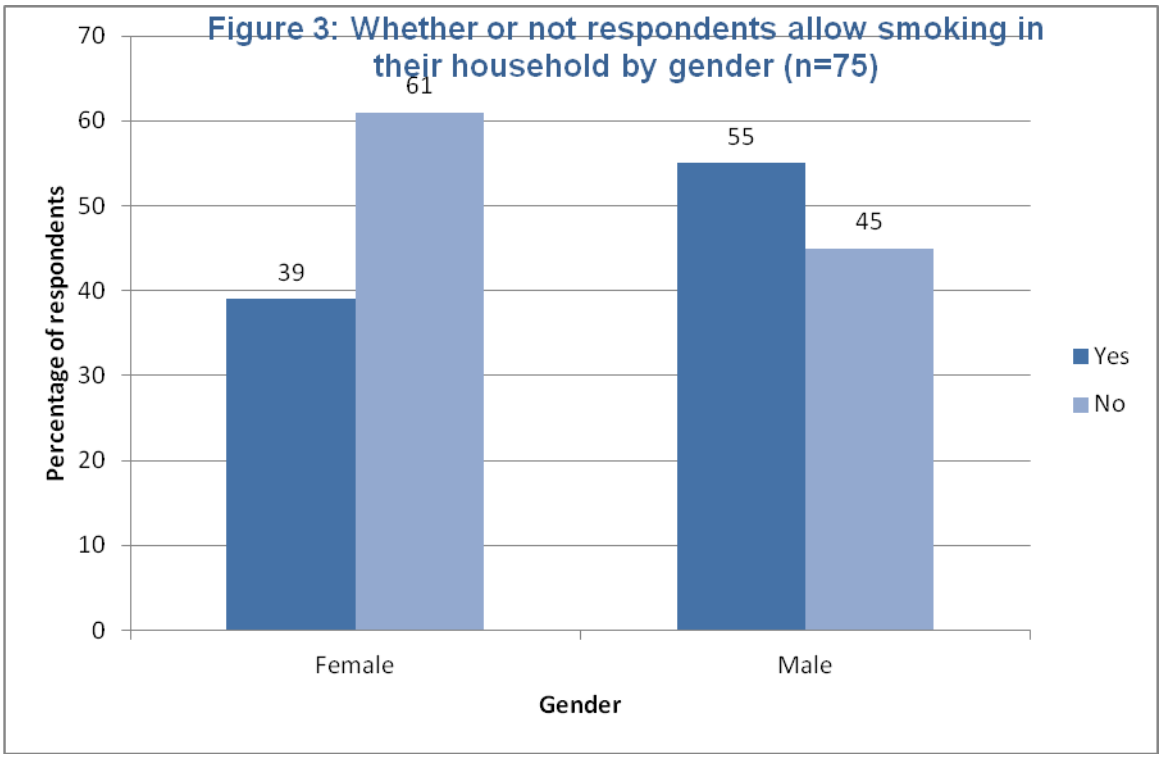
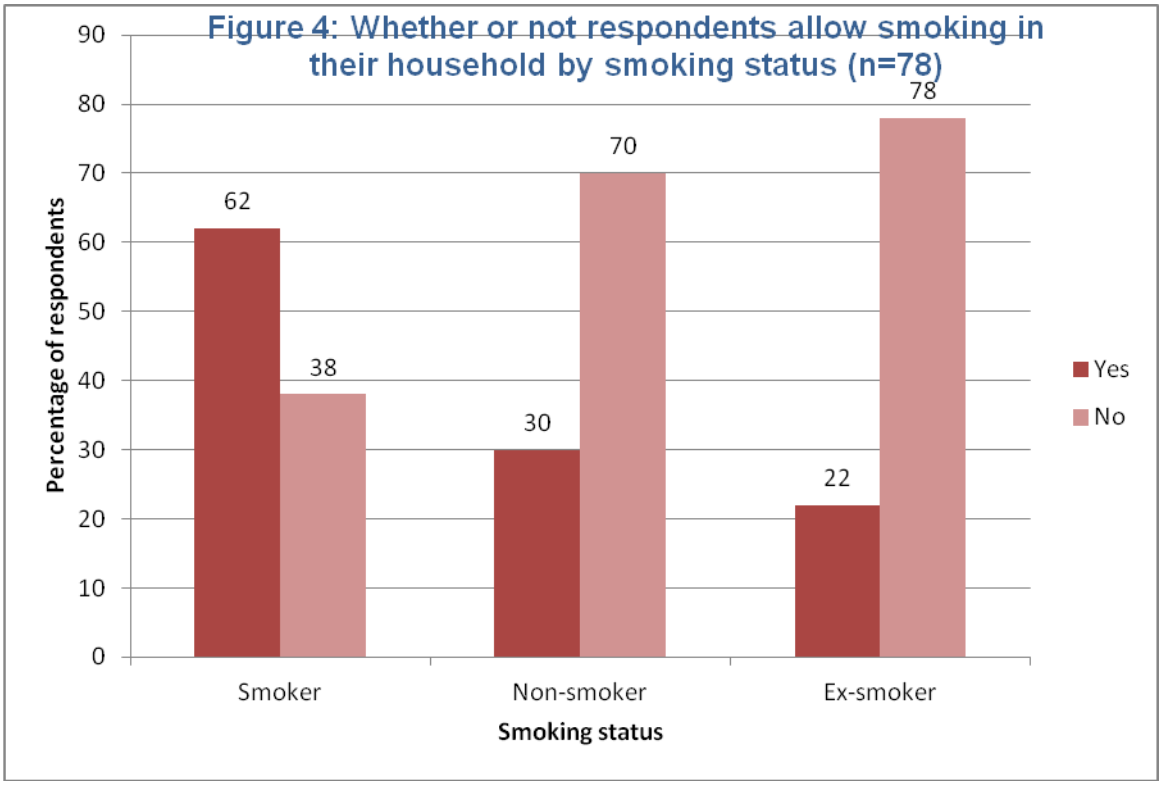
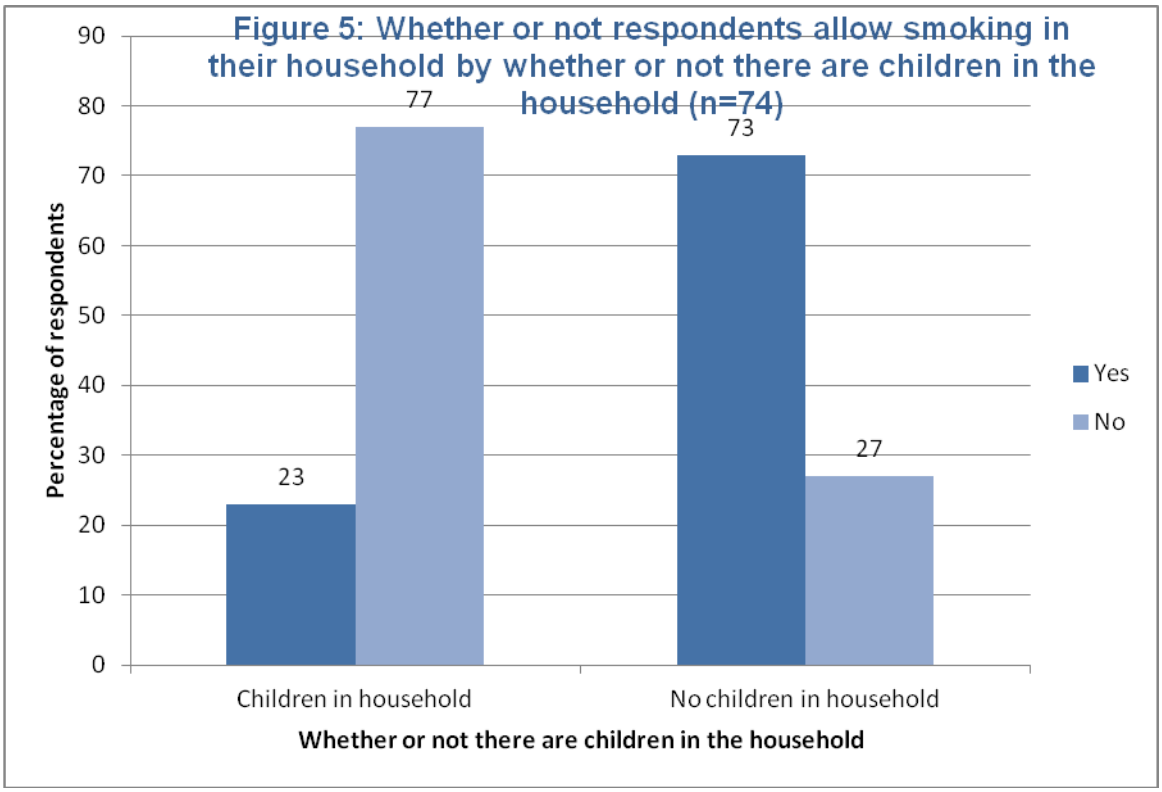


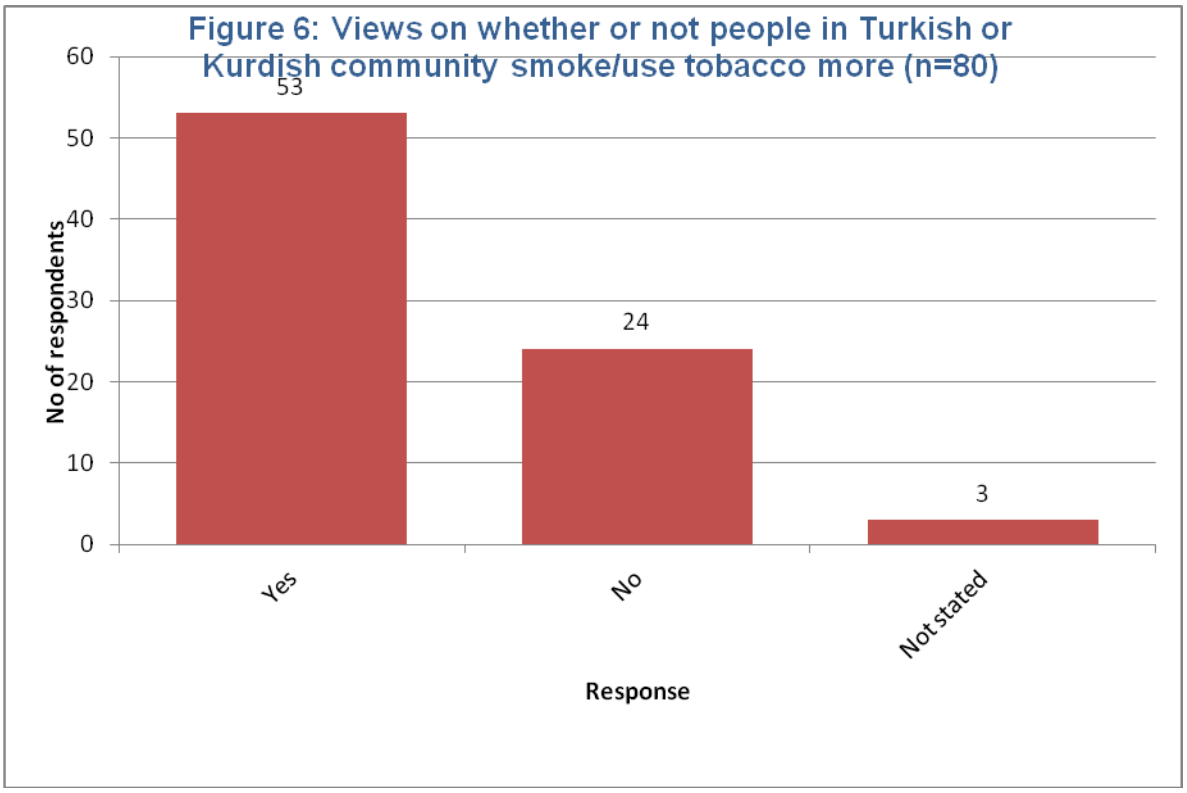
Figure 3: Whether or not respondents allow smoking in their household by gender (n=75)
70
60
50
40
30
20
10
0
Percentage of respondents
39
61
55
45
Female
Male
Gender
Yes
No



73% of respondents (22 out of 30) who did not have children living in their household stated that they allowed smoking in their home, whereas 23% of respondents (10 out of 44) who had children living in their household stated that they allowed smoking in their home.



Community members who completed the Community Insight Research Study survey questionnaire were also asked whether or not they felt that 'people in the Turkish or Kurdish communities smoked or use tobacco products more than in other communities'. Figure 6 presents the analysis of data for this question, and shows that the majority (53 - 66%) of the 80 respondents answered 'Yes' to this question.



The most commonly cited reasons given by respondents to the Community Insight Research Study, for why they feel that people in the Turkish or Kurdish community smoke or use tobacco products more than in other communities, related to stress and the pressures of day-to-day life.

Figure 7 below, presents findings for the 4 organisations who provided responses to the 'Community Insight Research Study- Feedback from organisations', on whether or not their organisation felt that 'people in the Turkish or Kurdish community smoke or use tobacco products more than in other communities'. Figure 7 presents the analysis of data for this question, and shows that 2 organisations answered 'Yes' to this question and 2 answered 'Don't know'.

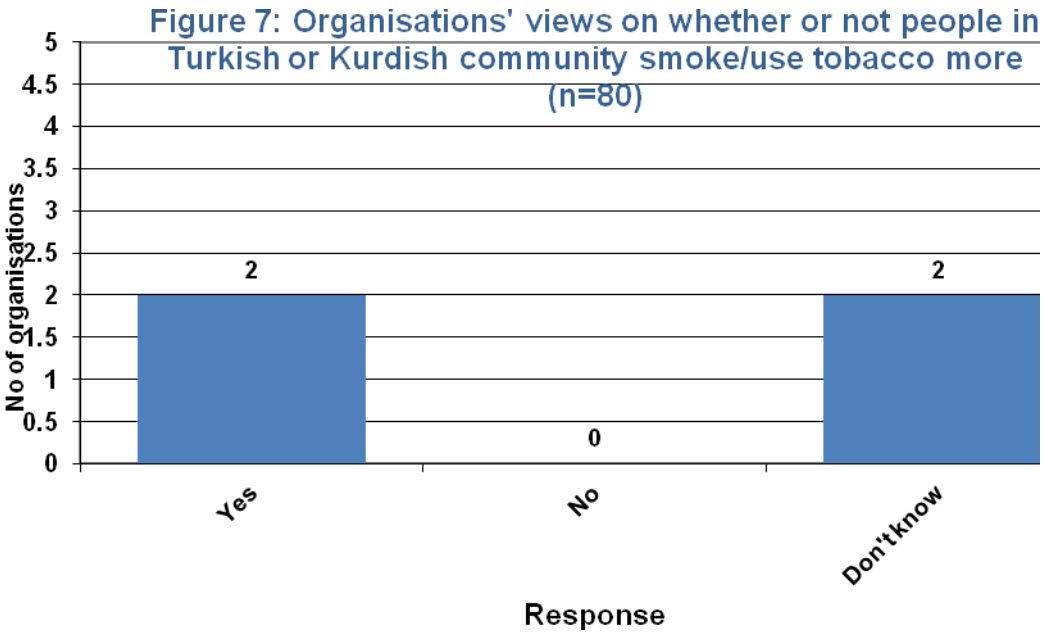


Figure 7: Organisations' views on whether or not people in Turkish or Kurdish community smoke/use tobacco more (n=80)
No of organisations
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
2
0
2
Yes
No
Don't know
Response

3.0 Discussion

3.1 Age at which people begin using tobacco products

In 2013 Cancer Research UK estimated that around 205,000 children in the UK start smoking every year, with two thirds of adult smokers in the reporting that they began smoking before the age of 18.

Our results showed that similar to mainstream UK figures respondents who smoked or had previously smoked began smoking before or around the age of 18. Figure 15 shows the data for the age at which respondents to the *community insight survey* started smoking. For the 55 smokers and ex-smokers in the insight survey sample, the most commonly chosen age group for starting smoking was '16-19' accounting for 44% of participants.

Information from the larger secondary data source, NHS Community and Bilingual Stop Smoking Service Baseline Health Questionnaire showed an age for starting smoking that concurred with national figures. For the 172 respondents who stated that they were smokers and responded to this question, the mean age given for starting smoking was 18.03 years. The ages given by respondents for starting smoking ranged from 6 to 51 years of age.

3.2 Reasons for starting smoking

The reasons people gave for starting to smoke varied;

- ***"It is from a young age my cousins and people around me smoked"***
- ***"It was about me actually wanting to start ... because I thought it looked interesting."***
- ***" If you don't smoke you can't join certain groups"***
- ***Some cigarette companies give free cigarettes to young people to experiment it in social places."*** (Clubs in Turkey and Spain)
- ***"Bullying, don't want to be different, so people smoke to be like others, to be normal"***
- ***" Modelling adult behaviour [demonstrates with a pen held like a cigarette]"***
- ***" The way older people held cigarettes is appealing"***
- ***"In my country at university, you are missing your family and have to fit into your friends groups, so that's the reason you start smoking, to join them isn't it?"***

People reported that in their youth, smoking was a rite of passage and a normal part of growing up;

"Back then it was a cool thing to smoke amongst our age group. We actually did not know it was a bad thing until I grew older. It was harder to quit here due to stress until I became ill."

- Kurdish male respondent

"Almost expected to try in when young. Also wanted to be equal to boys."

- Turkish Cypriot female respondent

" It started off at a young age, where we offered to each other, I had problems while I was smoking, I could only go up three stairs at a time, now I can manage 20 stairs at a time"

- Focus group participant, male

" I started smoking age 14 to 15 with friends, when I came to the UK I started smoking a pack a day, I missed family abroad and also had problems with my family"

- Focus group participant, female

"I've seen a couple of people since they were 10 years old they were smoking and even the Dr says stop, they didn't stop it."

A quarter, (25%) of respondents stated that they thought peer pressure was key to people starting to smoke or use tobacco, particularly for young people.

- ***"Peer pressure as I think a lot of people start from a young age."***
- ***"Peer pressure as it feels good in a group of friends."***
- ***"Because of friends – encouragement. When all friends smoking want to be part of that."***

Another key reason given for people starting smoking, particularly young people was that smoking makes people feel grown up. Approximately 10% of respondents to the paper questionnaire gave this as a reason for people in the Turkish and Kurdish community starting to smoke or use tobacco. Comments included:

- ***"Want to prove that they are grown up."***
- ***"To feel grown up."***

Not all of the smokers who responded to the enquiry started as young people, similar to UK trends, a small number reported taking up the habit after the age of 18.

"When I come to this country I started smoking and I think it was related to stress as I did not know English, left my kids behind and also had money problems." -Turkish female respondent

"It started off with friends then became a habit, I thought, 'let me sort this problem before I quit' then other problems came" -Turkish female respondent

"I started off with my friends saying have a cigarette with coffee, one with coffee, two with coffee, then I started having packs, I was 42 at that time. Once, I felt my kids at home to go to the pub to buy cigarettes. Once at the supermarket, I only had money to buy cigarettes and chose not to spend it on sweets for the kids like they wanted. I came home and cried"

"I used to be a secretary in an office, because I had a lot of communication with people who came in the office, they would offer me one, I would smoke a little to be polite." - Turkish female respondent

3.3 The main reasons people in the Turkish and Kurdish community start smoking or using tobacco

Stress and social acceptability are the main reasons for tobacco use in the community. The perception is that tobacco relieves stress and this perception is difficult to dispel. However reasons for starting to use tobacco in the first instance are more deeply entwined with attitudinal and social factors. There is an overriding feeling that smoking and tobacco use is normal within the Turkish and Kurdish community in Hackney.

Although most respondents started using tobacco regularly before migration to the UK and before they began to manage societal and domestic responsibilities, they told us that day to day stress is a key reason for starting to use tobacco. Of those who did not pinpoint stress, reasons for started smoking included the rite of passage into adulthood, peer pressure, and the desire to copy or model adult behaviour.

The most commonly cited reasons given by respondents for why they felt that people in the Turkish or Kurdish community start smoking or using tobacco products, related to managing stress and the pressures of day-to-day life. Approximately 40% of the 80 respondents to the Community Insight questionnaire felt this. For some respondents, 'general' day-to-day stress is a key factor, whilst for others, pressures such as being away from a home country, being unemployed, or coping with intergenerational relationships, are specific factors.

> ***"The most common stress is language barriers, some people have their children still in Turkey, others are still classed as asylum seekers or refugees, so cannot visit home again until their case is resolved"***

In terms of relapse for quitters, an overarching belief is that stress is the reason those who have previously quit return to tobacco use. Respondents to the Community Insight questionnaire were asked why they thought people who quit go back to smoking or using tobacco, and were given seven options and asked to choose as many as applied. Figure 43 presents the findings for this question, and shows that the most commonly chosen response was 'Got too stressed' (50 respondents), followed by 'Craved too much' (35 respondents), 'Put on too much weight' (15 respondents), 'Thought they could smoke a few and stop easily' (11 respondents), 'Socialising' (9 respondents), 'Something else' (5 respondents), and 'Shisha smoking' (2 respondents).

Of the 182 smokers who completed the Stop Smoking Service Baseline Health Questionnaire, around a quarter of men and women stated their main reasons for going back to smoking were 'Craved too much' (28% of male respondents) and 'Got too stressed' (25% of male respondents). There were similar findings for females, with women's most commonly stated reasons for going back to smoking being 'Got too stressed' (27%) and 'Craved too much' (26%). These results highlight the continued perception of 'stress' as a driver for smoking and tobacco use.

"It's mostly to do with stress, my son's worries are due to finding work and unemployment, one day he is working and the next day, there is no work, so that it's a big problems, when he does work, he spends most of his money on cigarettes"

Our discussions with organisations also pinpointed stress, worsening living conditions, homesickness and depression, but also lack of support and encouragement to quit.

Although acute craving for tobacco is cited as an equal driver to relapse, the feedback from focus groups and from other qualitative responses in the two main questionnaires did not place any significant emphasis on cravings. Craving and withdrawal did not come up at all when people elaborated on the nature of stressors on the questionnaires or in the discussion groups. Weight gain after quitting did not come up in the focus groups when talking to those who had quit, although the belief that one could smoke a few and stop easily was raised twice in group discussions.

When smokers and ex-smokers in one of the focus groups were asked, *'is there anything other than using tobacco that relieves this stress?*' responses included;

1. "Walking and exercise, getting fresh air "
2. "Sewing"
3. "Art"

4. “Gardening and looking after flowers”
5. ““Theatre & cinema”
6. “It’s a bad thing, so there should be nothing else that could replace it”

In the focus groups and within the paper questionnaires, low socio-economic status was noted as a stressor and driver to smoke. Of the 182 secondary data respondents, (those smokers who used the Community and Bilingual Stop Smoking Service), half of all clients, (50%) stated that they had not obtained any qualifications and only 13% were in employment. Almost two-thirds (62%) of the sample was made up of unpaid home-carers, those who have been unemployed for a year or more, and included respondents who stated that they were sick or disabled or unable to return to work. Also indicative of the number of lower income households was that 89% of respondents (162 out of 182) stated that they were ‘entitled to free prescriptions’.

Financial hardship and culture clashes correlated to stress between spouses and family members, with employment and maintaining family businesses a key stressor within marital and also family interrelationships.

“Financial problems, business are hard. Self employment and financial stress, not earning enough. When he smokes he can think and it is His time” -Turkish female respondent

“If business is going well he[husband] can relax but he regularly needs cash, so that causes stress” -Turkish female respondent

“It’s a different culture you have to fit in, you can have problems if your husband’s business goes wrong and when your kids are brought up English” -Turkish female respondent

“Adults have work stress and stress of family responsibilities, you think in the end I am gonna die ....so you just smoke it” - Turkish male respondent

“It’s a different culture you have to fit in, you can have problems if your husband’s business goes wrong and when your kids are brought up English” - Turkish female respondent

The pressures of bringing up children and younger family members are also a contributory factor. The differing cultural expectations of children came up frequently.

"The kids are stuck in between. At home there is a different culture, at school a different culture that does sometimes have an effect on the parent's relationships with the child. They want to raise their children according to their culture, but....." -Turkish female respondent

"Pocket money [is an issue]. I have a young child and I don't want to teach him to have a lot of money.....but when my child goes to school, other children will say 'I get this pocket money, I get this and I get that', my child comes home saying 'How can they have money and I don't'. So we want to bring up children on our own but the outside factors stop that." - Turkish female respondent

"Kids have a different culture to you, kids are stuck between two culture" - Turkish female respondent

"I try to make rules for my kid, but when he goes outside he can do anything he likes. What your friends do, the other kids are going to do the same, like smoking." - Turkish female respondent

Several parents said they felt that they no longer had authority over their children due to external influences such as school, the media and advertising. Parents in the focus groups expressed the feeling that their own childhoods and the value systems they were raised with differed from those of their offspring.

"It's about respect. The way we want to raise them, they need to respect our elderly people, help them... but nowadays with children it's more 'I want this, I need to have this, whether they've got money or not. They've lost their respect towards older people. In the past they would look after older people, think about their family situation, but now it's not like that, it's totally changed." - Turkish female respondent

A number of focus group participants expressed the opinion that smokers find it easier to blame stress and external factors rather than taking accountability for their habit.

- ***"I hear a lot of people that say stress affects businesses going wrong, but I don't understand that, it is an excuse, why not smoke less when happy?"***
- ***"I went through a lot of stuff and the government did not help within these issues, I never considered smoking"***
- ***"Cigarettes are unhealthy and un-economic, you are smoking your money"***
- ***"I don't believe stress makes you smoke more, it is just a habit over the years and has nothing to do with stress it's about willing to quit"***

When asked if stress was a factor when they first began illicit smoking as children, focus group respondents had mixed views. As in the general UK population, people in the Turkish and Kurdish community begin smoking out of curiosity, peer pressure, a desire to fit in and as a form of modelling adult behaviour, however once stress factors come into play, perceptions change to fit the belief that tobacco use alleviates stress.

"People see a way of feeling better about a problem a cure for problems"- *Male respondent*

"When you grow up you've got work stress, you've got more responsibilities. You have to pay your way? You have to look after your family, you don't get much help from outside.....you don't think 'I'm going to get damaged from these cigarettes', just smoke it because of stress. You can't handle responsibility so you are going to smoke more. "

"People don't knows the consequences of smoking. You start off by thinking it's cool but now I want to quit"

"It differs, I have seen people whose habits changed, but for some, it didn't" - Turkish female respondent

A relatively large number of focus group respondents highlighted what they felt was a level of cultural acceptability of smoking within the Turkish and Kurdish communities, stating that this helped to encourage the take-up and continuation of smoking. Some people in the groups also mentioned the role that children's upbringing and socialisation play, in whether or not they become a smoker, suggesting that children may be more likely to smoke if they are surrounded by cigarette smoking and smokers on a day-to-day basis and come to view smoking as 'normal'.

Some respondents noted that adults may also feel pressure to smoke due to the widespread nature of smoking within the community.

- ***"People start smoking because they see it from each other, taking example of each other."***
- ***"Surrounded by smokers, too tempting not to try it."***
- ***"I started because all my male relations in Turkey smoked."***

The organisations consulted discussed the importance of cultural factors in smoking behaviour, with three drawing particular attention to the acceptability of smoking within Turkish and Kurdish communities as a key reason. In a similar vein to individual respondents, organisations also highlighted the role of stress factors in encouraging members of the community to smoke; for example, organisations mentioned loneliness and isolation feeling homesick and environmental pressures. One organisation cited multiple potential reasons, which included; ignorance of the dangers of tobacco, peer pressure, lack of general education, parental smoking leading to smoking by young people, ease of access and affordability of tobacco products, proliferation of advertising and promotion and a lack of effective strategies to discourage smoking.

A second organisation told us;

"They think that it is habit or cultural thing. Sometimes they smoke for entertainment, sometimes feel lonely...they feel homesick. Internal and external problems, environmental pressures. All of those factors cause them to smoke."

Although living in the UK was perceived as stressful, being an asylum seeker was cited by only a few respondents as a stressor, perhaps reflecting the fact that the number of people in the UK from the Turkish and Kurdish diaspora claiming asylum continues to decline, with only 189 asylum applications from Turkish citizens of Kurdish ethnicity and 268 applications from Iraqi citizens of Kurdish background submitted in 2012. [6]

[6] Welfare needs of Turkish and Kurdish communities in London; A community based research project. Middlesex University. July 2013

3.3.1 Gender and smoking behaviour

Gender issues came up from both men and women, one male spokesperson from a well known organisation noted;

- ***"Women's treatment by men and these people turn to their "little friend" - cigarettes."***

- ***"When Turkish or Kurdish women come to Britain, and they mostly come to cities here, there is much less pressure, if any, for them not to go to cafes (when in Rome) especially younger Turkish and Kurdish women. Women are becoming more independent, especially when they get to the UK."***

In the focus groups we were able to look more closely at initial drivers for women and girls to smoke. Women in the focus groups expressed the view that traditional male expectations of females are in conflict with the independence women feel living in the capital.

- ***"Girls are scared and feel they should hide [their smoking]"***

- ***"Girls try it as a form of rebellion"***

- ***"Everyone is working, earning their own money, so they can do whatever they want to do"***

- ***In Turkey, it's against the culture for a lady to go out with a cigarette but here it's a bit more free so they smoke even more"***

Women accessing welfare benefits also said they experienced more freedom and autonomy in the UK;

"In my country, there is less freedom and people need to get money from their husbands, my friend had to save money to get cigarettes, now the government gives you money, so women can smoke."

Some women reported feeling conflicted between the dangers of cigarette use and their relatively new found economic freedom, the growing acceptability of women smoking in public, the ability to claim the same status as men and to fulfil their desires to emulate role models and peers. However, peer pressure to take up the habit and the perception that smoking relieves stress, remain key factors in why females begin smoking. Women who had come to the UK from the Turkish mainland particularly felt that arriving here was a driver in taking up tobacco use.

- ***"I believe many women started smoking when they came here because they missed family back home. I went through a lot myself when I came here, I can't really talk about it, it's too painful"***

- ***" UK is a country with a lot of stress, my English is not enough, letters come and I need to find translators which causes stress"***

- ***"I didn't initially feel it helped with stress, I was really forced into smoking by my friend"***

- ***"When I came to this country from Cyprus, I was very stressed because I was separated from my mother and my family but I never smoked. Back home, no women smoked, it was not the culture, a friend who I met here influenced me to start smoking"***

A number of male respondents reported the need to prove themselves when growing up and that they also felt under pressure to conform to gender stereotypes;

"I started because all my male relations in Turkey smoked. I thought it was 'manly' to smoke and when I did it felt good." -Turkish male respondent

"I think it starts off with thinking it's a good thing to smoke and also show off to people." -Turkish male respondent

"It is "manly" to smoke. All friends smoke and [you] want to fit in." -Turkish male respondent

"***Someone offers you a cig, and if drinking… especially a Turkish coffee"*** -Turkish male respondent

"Males are free, if a male smokes cigarettes, it says 'this is a man"- Female respondent

"It's like a proof of being grown up for boys." -Kurdish male respondent

3.4 Perceptions of smoking prevalence

The 80 respondents who completed the Community Insight questionnaire were asked whether or not they felt that 'people in the Turkish or Kurdish communities smoked or used tobacco products more than other communities they know'. Figure 22 shows that two thirds, 66% of respondents answered 'Yes' to this question. There was a broadly similar pattern of findings, with the majority stating that they felt that 'people in the Turkish or Kurdish community smoke or use tobacco products more than in other communities', regardless of gender or age of respondent.

There were a number of reasons why people felt that the Turkish and Kurdish community have a higher smoking prevalence than other communities. These reasons mirrored the responses people gave for why smokers in the community first begin using tobacco products.

The most commonly held opinions on why people feel that the Turkish and Kurdish community smoke or use tobacco products more than in other communities relate to stress and the pressures of daily life, stated by a quarter of respondents, as well as the social acceptability of the habit, pinpointed by one fifth of respondents, (n=80).

- ***"When first arrived in this country there was a lot of problems that Turkish and Kurdish community was feeling as we did not know nothing. This caused stress and pressure. It was also very hard as we left our family behind."***

- ***"Cigarettes do not help depression, I thought cigarettes would help but they didn't"***

"Depression is the first reason, then young people start very early as they see from their parents and relatives and want to act like them, bad role models, not enough warning from parents, schools and other sources stopping for the young peoples' curiosity, invitation and teasing by smoker friends and social isolation if they don't smoke. Lack of organised approach or campaign to tell about dangers of smoking in Turkish as Turkish speaking people especially over 35s live in as an isolated society, for example they do shopping at certain places, visiting only their friends, relatives and community centres, men spend time at typical Turkish cafes at Kingsland Road, Kingsland High Street, Stoke Newington Road and Newington Green surrounding areas" -Turkish Kurdish organisation

Comments also related to the commonplace nature of smoking and again, the early socialisation of children to view smoking as normal;

- ***"They learn it from adults in family and from people around them and they envy, it's a custom in villages."***
- ***"In our village adults smoke so kids learn from them."***
- ***"Because they are encouraged when young."***
- ***There are too many commercials all around. It's an addiction, once they try they can't give up easily so it becomes a long time bad habit.***

Similarly, a number of participants stated that cultural expectations and a perceived acceptance of smoking as normal within Turkish and Kurdish communities was a key reason for smoking, and that this helped to encourage the take-up and continuation of smoking.

- ***"It is an acceptable habit."***
- ***"You go to parties, weddings, etc. and everyone smokes."***

Other reasons given by a number of participants for why people in the Turkish or Kurdish communities smoke or use tobacco products more than in other communities, included peer pressure to smoke.

- ***"Bullying, don't want to be different, so people smoke to be like others, to be normal"***
- ***"Yes, family tradition, friends' influence, social strata, anti-social behaviour, gang culture, bad influence and stress."***

The relative affordability of cigarettes is also a factor. Hand rolled cigarettes are popular within the community, possibly because of the cheaper cost of loose tobacco compared to manufactured cigarettes. 60% of the 179 respondents who used the Community and Bilingual stop smoking service, stated that they smoked hand-rolled cigarettes, although not exclusively.

- ***"In Turkey, it's more expensive, here it's cheap [affordable] because you work. In Turkey, they use rolling tobacco in the villages more than cigarettes, religious people make and sell it"***

- ***"Cigarettes are cheaper in Turkey and people bring them back, Turkish makes use cheap, tobacco it's sold by the Kilo in villages £22 per kilo. It is sold as pure tobacco"***

When probed on whether cigarettes were cheaper from Turkish outlets in Hackney respondents commented;

- ***"I have heard they do it illegally, those cigarettes are smuggled, meant to be sold under the counter. They can be cheap. I heard that they are really bad."***
- ***"Cigarettes are cheaply sold under the counter in Turkish shops, imported from a different country the main brands"***

3.4.1 Prevalence of niche tobacco products and Shisha use

The community intelligence that we collected brought out pertinent comments on the use of Shisha and other niche tobacco and nicotine products that we were able to explore further in our focus groups.

Visual images on show cards were used at the start of the focus group sessions before discussion began. In order to gain unbiased and immediate feedback on the images selected, each image was given separately and respondents were asked not to confer with each other, language and literacy support was given but no prompts were offered. We asked respondents to note the first thing that came to mind when presented with the images, which were:

A packet of cigarettes in plain packaging

A Shisha pipe

An electronic cigarette

Quit Here logo

“Unhealthy, death”

“Being trapped with smoking” “I feel like I’m going to get unhealthier and I really hate it but I cannot quit”

“I hate it. Illness, bad smell comes to my mind”

“HATE”

“Makes her feel sick”

“Modern poison”

“Smelly”

“”I quit a week ago, and I’m still fighting to start. I feel disgusted when I look at it” “Hate”

“Bad smell”

“Disgusting”

“Bad habit”

“It’s attractive at first sight, but it’s as harmful as cigarette”

I don’t like it at all. It looks nice, but I don’t like it and I hate its smell”

“Hate, bad”

“New luxury habit”

“Reminds me of smoking”

“Hate because it’s a tobacco product”

“Stinking”

“Something interesting”

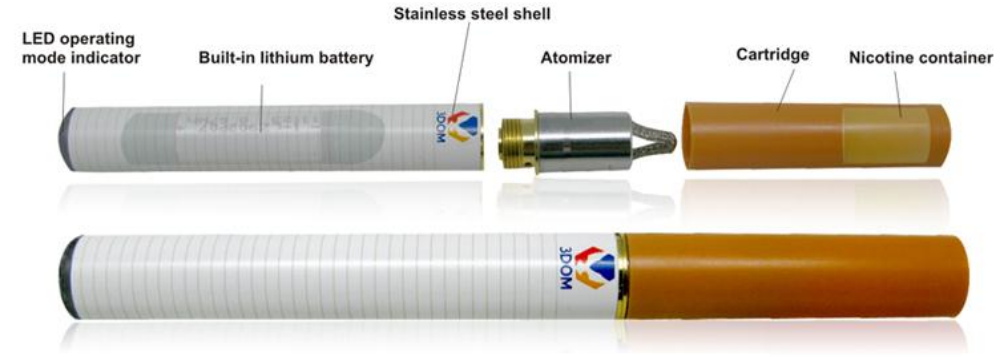
“Never thought of it but it will be a bad habit”

“Smoking”

“I don’t use it, it’s bad but people use it for pleasure”

“Pleasure”

“Poison”



"Unhealthy"

"I don't know much"

"Reminds her of smoking cigarette"

"It's not different from the normal cigarette. They are just deceiving themselves"

"I don't believe that it stops smoking. Everyone who tried it started smoking again. The most important thing is your willpower"

"Better than cigarette"

"Good technology, like smoking"

"Does not work. Pointless"

"Unbelievable, interesting, stinking, disgusting"

"Looks like a modern gun"

"I do not think it's useful"

"Technology"

“Very good idea”

“It’s a good thing to help people. I would be pleased”

“Doesn’t mean anything”

“Help people to quit. Free from the poison”

“”Must quit”

“Help, Safe, Life”

“We need Oxygen”

“Stop Smoking “

“Clean, fresh weather”

“Logo – Advertising”

“Sounds good”

“Lifesaver”

“Cigarette end”

When people in the focus groups were asked about Shisha prevalence and in what situations Turkish, Kurdish and Turkish Cypriot people use Shisha, the responses were mixed. Some reported growing use amongst young people as an opportunity to socialise around a shared experience, others didn't think there was any remarkable prevalence whilst a few saw it as a growing problem. Respondents described their experiences of usage;

- ***" Special occasions or cafes"***
- ***"Talking, having a nice time"***
- ***"Mostly it's just enjoyable, something different than cigarettes."***
- ***"I never saw it at home [in Turkey]"***
- ***"Yes, they smoke cigarettes more than other communities or as much as they do, but Shisha and chewing is very rare."***

> ***"Shisha and cigarettes is different, the smoking process is different. You can put your different fruit flavours, its fun because it doesn't finish easily. You can breathe smoke more get more nicotine, mostly they use for fun in a group with coffee, tea or sweets, it takes more time than cigarettes, half an hour to 45 minutes. When you smoke [Shisha] first time you get dizzy but you get used to it."***

In the focus groups, the question as to whether Shisha was harmful elicited a range of opinions.

- ***"I have heard that filter system makes you take less smoke, there is a different filter system so its less harmful"***
- ***"I believe it's as harmful as cigarettes"***

- ***"I find both cigarettes and Shisha harmful, it smells, Shisha and cigarettes are the same, my son was using it on the balcony with friends, I broke it and threw it out"***

There was no clear evidence from the questionnaires or discussion groups that Shisha use is a traditional cultural pastime, many people in the focus groups regarded Shisha as a modern introduction to youth culture.

"I don't believe it's cultural"

"You don't see your parents doing it"

"Shisha was not popular in Cyprus but it's a recent thing just in the last ten years, it was more popular in Turkey, not Cyprus"

"People use Shisha more in Turkey, older people do it more there than here. In Turkey, it's not forbidden, so the older people's social clubs use it more openly, here it's in modern cafes, where old people don't go"

Niche tobacco products are not considered widely used within the community and emerging technologies such as electronic cigarettes have even lower prevalence at present.

Comments on Electronic cigarettes;

- ***"It's a new technology, isn't it?"***
- ***"My husband used electronic cigarettes but neither of us liked it, my husband tried them to stop smoking"***
- ***"I have not tries them"***
- ***Same as cigarettes. You can use more than cigarettes but it doesn't affect other people so you can smoke all day. I would say worse because you can smoke all the time- 24 hours. You can use more.***

There was broad agreement amongst focus group participants that the use of oral tobacco products is rare these days.

- ***"Chewing tobacco is an Asian thing."***
- ***"I once met a pregnant woman who quit smoking, but she took tobacco out of the cigarette and used to chew that"***

3.4.2 Cigarette display in the home

No one in the focus groups said they keep cigarettes, Shisha or tobacco products at home to offer to visitors. A few people were aware of older relatives who kept cigarettes on display for visitors but none of the focus group participants did this themselves.

- ***"Before it was so popular, it was just out on the tables, out of the packet in a nice bowl or in a special case, it shows that you are rich"***
- ***"It is a long time since, I saw cigarettes in a bowl, everyone carries it in their pocket".***
- ***"They put it on the table in posh cigarette holders on the tables at weddings, they had big plates of cigarettes on the table. The last time I saw that was three or four years ago, but last year in Turkey at a wedding, there were no cigarettes on tables"***
- ***"Usually on top of the fridge or somewhere high or in my bag, I don't allow people to smoke inside, so don't have them out"***

3.5 Support to quit and reducing the numbers of new smokers

Respondents to the Community Insight paper questionnaire (n=80) were asked to state one main reason why they felt people in their community wanted to stop smoking or using tobacco, and were offered one of six options to choose from. Although people were asked to choose one option, some chose more than one.
Almost everyone, males (87%) and females (93%), indicated that the most commonly stated reason for wanting to stop was, 'To protect my health' (respondents to the secondary data within the Stop Smoking Service Baseline Health Questionnaire). This suggested that people were well informed of the dangers of tobacco use.

These findings are strongly backed up by the analysis of the data from the Stop Smoking Service Baseline Health Questionnaire. On this questionnaire, respondents were presented with 5 reasons from which to choose their one main reason for wanting to give up smoking. We found that for all age categories the most commonly cited reason for wanting to give up smoking was *'To protect my health'.* This response was given by a very high percentage of respondents in each age category, with 100% of respondents aged '29 and under' providing this as their reason for wanting to stop smoking. For 30 to 44 year olds, 83% cited 'To protect my health' as their main reason for wanting to quit smoking, and 92% of those who were 45 and over gave this as their main reason for wanting to stop smoking.

> ***"Everyone has the right to try things, but they should understand the affects on their health, a neighbour has a hole in her throat now"***

When asked to choose one reason why they felt people in their community wanted to stop smoking or using tobacco, all four of the organisations who completed the 'Community Insight questionnaire also chose *'To protect their health'.*

- ***"My daughter smokes and that's really bad and unhealthy, as a woman, if you smoke, your health gets worse and women's skin is more sensitive, it also affects your organs and lungs"***
- ***"My husband's doctor said, If he doesn't stop, he will die because he has liver disease"***

A common feeling in the Turkish and Kurdish community is that people should be able to command the strength of their own resolve to quit and that using services could be effective only if people were ready to quit *'in their heads'.*

Figure 44 presents the findings for the options presented to Community Insight respondents, and shows that the most popular option chosen was *'Doing it myself'* half of all respondents followed by 'GP surgery' (33 respondents – 41%). A relatively small number of respondents chose 'Stop smoking clinics' (11 respondents – 14%) and 'Pharmacy service' (10 respondents – 13%).

- ***"I tried to quit before with [stop smoking] services, but it didn't work, I didn't finish it [cigarettes] in my head a lot of people around me just quit themselves"***

- ***"Everyone is different; I can't give you the answer to that. It's all about your control! It's up to the person to control it, stay away from smokers or areas where people are smoking"***

Focus group commentators who were unable to quit on their own reported frustration and powerlessness, whilst those who had quit without support were generally unable to understand the difficulties felt by those without sufficient 'willpower'. There was also feedback that related to the power of external forces including Allah, and a reliance on the Will of God in accomplishing a quit.

"I go to meetings and I quit because I prayed to God"

"It's up to you. I stopped, controlled myself and said 'I'm not going to buy cigarettes'. I did want to smoke, I had money, I was going to the shop, but I know if I buy it I'm not going to quit. I did something else, used my brain. I will talk to my friends, but I give myself pressure to stop."

- ***"There's a lot of people around me who just quit smoking without help, just finished it off in their brain and also I have a friend who wants to quit but it's not absolutely finished because in their mind it isn't finished."***
- ***"You have to finish IN YOUR HEAD, then take action"***
- ***"You have to wipe it out from your head, you should be able to help yourself to quit"***
- ***"Your will can overcome the addiction"***
- ***"I've quit by myself. I believe you can do it in your head"***

Participants were also asked: *'Are there any other ways that help with stopping smoking?'*

"Clinics could be held near my home, better if there was a building that does just does this, just does stop smoking" – Female respondent

"I believe that the clinic here is quite good. More advertisement could work. More in more places- on the street, in different areas, in other boroughs, very close to home."

"Community clinics are good and I need one that's run well, those need to be more in other boroughs, maybe a voucher could be given to encourage people, a conference could be convened with a voucher, to encourage people to attend" – Female respondent

"I don't really know how to encourage people to use Stop Smoking Services, I told friends to come today to learn more, joining things like this is important" – Female respondent

One woman said that peer pressure can also be positively harnessed as a catalyst to quit;

"My husband stopped because others did not like habit… stayed in bed for three days and used yoghurt to stop. Yoghurt was cutting his nicotine needs [Turkish yoghurt]. He found it [yoghurt] helped him personally – it is not something everyone believes"

Some people did appear to be aware of the range of services available;

- ***"A friend went to the pharmacist"***
- ***" A man from Derman came to our nursery to run a programme"***
- ***"Also someone visited the community clinic at Homerton Hospital"***

However these respondents were likely to be regular users of community venues and therefore were more likely to see leaflets and posters advertising services

Organisations who completed the 'Community Insight survey were also asked to choose which option they thought was the 'MOST EFFECTIVE to use when people are trying to quit', from the following list: 'Local venues such as community centres, libraries and community halls', 'GP surgery', 'Pharmacy service', 'Doing it myself'. Two organisations chose 'Local venues such as community centres, libraries and community halls', one chose 'GP surgery', and one gave no response.

In terms of suggestions for 'other ways to help', educational initiatives were the most commonly cited ways of helping people to cease their tobacco use. The following were the most common suggestion, with people offering multiple answers.

- 39 respondents (49%) suggested ‘Cessation promotion in schools and colleges’.
- 37 respondents (46%) suggested ‘Seminars and conferences’.
- 32 respondents (40%) suggested ‘Adult education in Turkish’.
- 31 respondents (39%) suggested ‘Information and leaflets in Turkish’.
- 26 respondents (33%) suggested ‘Outreach and awareness-raising’.
- 25 respondents (31%) suggested ‘Adverts explaining the dangers of tobacco’.
- 17 respondents (21%) suggested ‘More Turkish language services’.
- 17 respondents (21%) suggested ‘More generic services and information’’

“My experience running a stop smoking project for four years and being Level II advisor I can say that [with] no support after stop smoking and no social changes they go back easily. This kind of health project should continue, otherwise one off project is waste of money and energy in the communities where smoking has very deep roots and cultural connections.”

3.6 Attitudes towards secondhand smoke

Within the focus groups secondhand smoke was unequivocally perceived as a danger to others. The majority of the people we spoke to did not allow smoking anywhere in their homes, those that did had a designated area for members of the family who were smokers or for guests. This was usually the kitchen or outside the property. This was supported by results from the fieldwork. A common theme from the focus group discussions was that people did not feel always feel comfortable asking guests not to smoke but that this feeling was changing with increased awareness of the dangers of secondhand and sidestream smoke.

Seventy five respondents answered the question on whether or not smoking was allowed in the home, (44 females and 31 males), with the majority of females (61%) stating that they did not allow smoking in their home, and the majority of males (55%) stating that they did allow smoking in their home.

For the 34 respondents who did allow smoking in their home, the most common rooms where smoking was allowed were the ‘Kitchen’ cited by 62% of respondents who allowed smoking in their home ‘Living Room’ cited by around half of the respondents and ‘Balcony’ cited by just over a third of respondents who allowed smoking in their properties.

"Secondhand smoke is harmful to children"

"I feel scared because I don't want my kids to feel it's a good thing"

"I don't do it because I don't want my kids to become passive smokers"

"He smokes less now he goes out, when he thinks about our daughter he goes outside"

"My husband has cut down from I packet to 1 or 2 a day, he smokes nowhere at home, if he wants to smoke he just smokes outside or on the balcony"

Non smokers and ex-smokers generally felt negatively about people smoking around them;

- ***"I feel like I'm drowning in smoke, I tell them about the dangers of smoking"*** – Ex-smoker
- ***"I feel upset that people smoke around children, I tell their parents that it's really bad, they have pure clean lungs and they are damaging them"*** – Ex-smoker
- ***"I warn parents that it is bad and there is also a fire risk, I know many people who have had fire incidents due to smoking, you are harming people next to you, the atmosphere and yourself"***

In terms of occupational status, one finding was that the vast majority who stated that they worked in a 'Routine or Manual' occupation (10 of the 12 Routine and Manual respondents in the Community Insight survey), said that they allowed smoking in their home, which was in contrast to the general pattern where the majority of respondents stated that they did not allow smoking in their household.

A small gender difference was found for whether or not respondents allowed smoking in their homes with men being more permissive.

A difference was also found in terms of smoking status. The majority of smokers (62% - 23 out of 37) allowed smoking in their homes, whilst a minority of ex-smokers (22%- 4 out of 18) and non-smokers (30% - 7 out of 23) allowed smoking in their homes.

We found a strong correlation between having children in the household and allowing smoking in the home. Respondents who have children living at home are less likely to allow smoking in their home. 73% of respondents (22 out of 30) who did not have children living in their household stated that they allowed smoking in their home, whereas only around a quarter of respondents (10 out of 44) who do have children living in their households stated that they allowed smoking in their home.

3.7 How young people in the community can be prevented from starting smoking or using tobacco products

The most commonly stated suggestion for preventing people in the Turkish or Kurdish community starting smoking or using tobacco was education, with approximately 35% of participants giving this response. The main view is that schools and colleges have a duty to educate on the dangers of smoking and tobacco use, as early as possible.

"Educating them, working with schools, more communication, working with young people and with parents."

"Educate young Turkish people – go to youth centres, clubs etc. Maybe go into schools."

"They should learn at school like sex education, my daughter is disgusted by picture of smoking"

Linked to this feedback is the view that education in UK schools currently lacks consistency as Personal, Social and Health Education (PSHE) programmes are non-statutory and maintained schools in England and Wales are not required to follow them. Under section 3d of KS2, Developing a healthy, safer lifestyle; the national curriculum suggests that "*pupils should be taught which commonly available substances and drugs are legal and illegal, their effects and risks*." Key stage 2 also suggests a curriculum cross reference is made to health, "*the effects on the human body of tobacco, alcohol and other drugs, and how these relate to their personal health*." [7]

Maintained schools in Hackney are not required to report on PSHE provision and there is currently no available data on which schools provide health education on tobacco use.

[7] Department for Education. Personal, Social and Health Education (PSHE): Key stage 2

A related suggestion was cited by a number of respondents, with approximately a third stating that publicity and awareness-raising about the dangers of smoking and tobacco, for example through advertisements or leaflets, would help to prevent young people starting to smoke.

Some respondents also highlighted the importance of educating parents about the dangers of smoking. Comments related to education included:

- ***"More information given out as I believe that people can be lazy and need things to their feet such as leaflet."*** **[Need things to hand]**
- ***"Information on the harms of smoking."***
- ***"Warning about causes of smoking should be advertised."***

Participants stated that families also had a responsibility to raise awareness about the risks of smoking with their children and with young people, and that this was key in prevention. The role of parents in preventing their children from starting to smoke was highlighted by a number of people, who felt that parents played an important role in educating their children about the harms from tobacco, and should if they could, be positive role models by being non-smokers or not smoking around their children.

Reducing the incidence of adults smoking around young people was a popular suggestion to counter modelling and the perception of tobacco use as normal.

"Young people are imitating their parents…my daughter was telling her father to stop smoking or he will die because of smoking. But he didn't quit and now my daughter has started smoking."

"Parents shouldn't smoke when their kids are around, tell your kids that smoking is very bad habit and smoking is not solution if they are having difficulty in their life."

"When I smoked, my children were small. When I was asleep, my child took my cigarettes, smoked in the toilet, it was not my children's fault, it was my fault"

"My daughter has spots and marks on her skin because of cigarettes, she had clear, shiny skin, now I tell her 'your beauty has gone!' – you are still pretty, but stopping smoking will help her"

Many respondents, said there should be a greater range of stop-smoking services, information and resources provided in the Turkish language, and promoted more in the press and that this would help to prevent people starting to use tobacco.

- ***"More information in Turkish, such as leaflets and education."***
- ***"Have more services with Turkish translator."***

A small number of people stated that positive activities for young people, such as sport and other types of physical activity, would help to prevent young people starting to smoke.

- ***"Sports and social activities could be good options for young people."***
- ***"Organising positive activities, raising awareness, role models."***
- ***"For example give a project to the youth section of an organisation to manage it themselves with offering training to some of the leading members." [Edited to protect the anonymity of the organisation].***

In relation to reducing the numbers of young people who begin using tobacco products, respondents called for a ban on cigarette manufacturing and sales, education in schools, adult education programmes, tobacco regulation such as plain packaging, and increased vigilance and action on retailers selling illegally to under 18's.

3.7.1 Young peoples' beliefs and attitudes to smoking

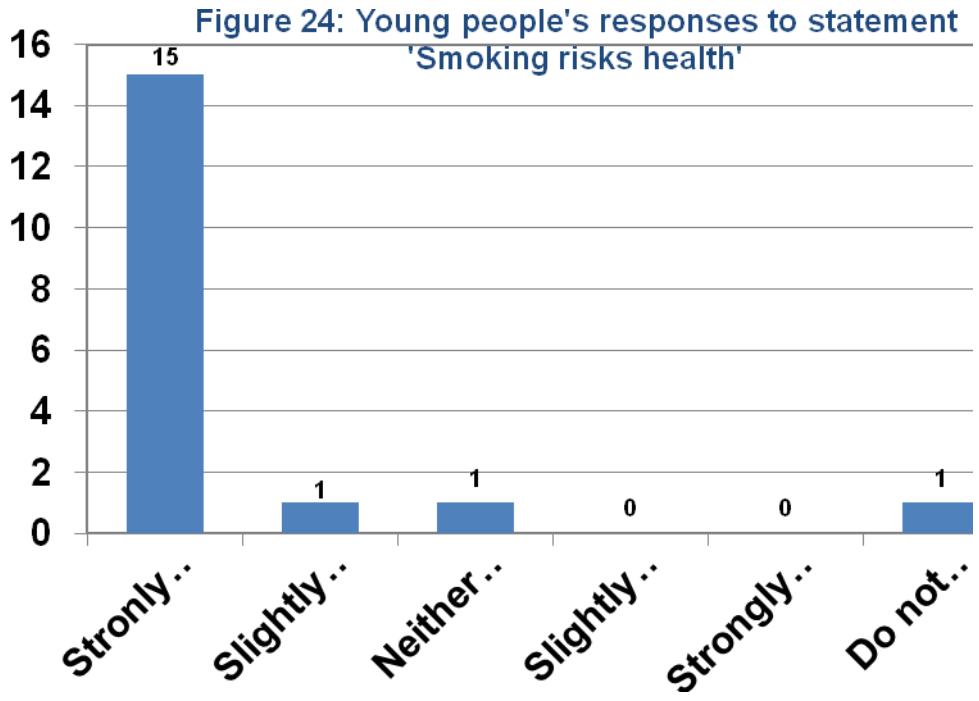
Although many of the adults we spoke to expressed concerns about the threat of tobacco to the health of younger members of the community, young Turkish and Kurdish people themselves indicated strongly in our online survey that traditional attitudes to tobacco use are changing and that there is a much greater awareness amongst young people of the dangers to health. Nevertheless, the numbers of young people that go on to use tobacco continues to cause concern indicating a disconnection between awareness and behaviour.

Young people were asked to click a link via Facebook to an online survey where they were given a selection of seven statements, on a summative scale of:

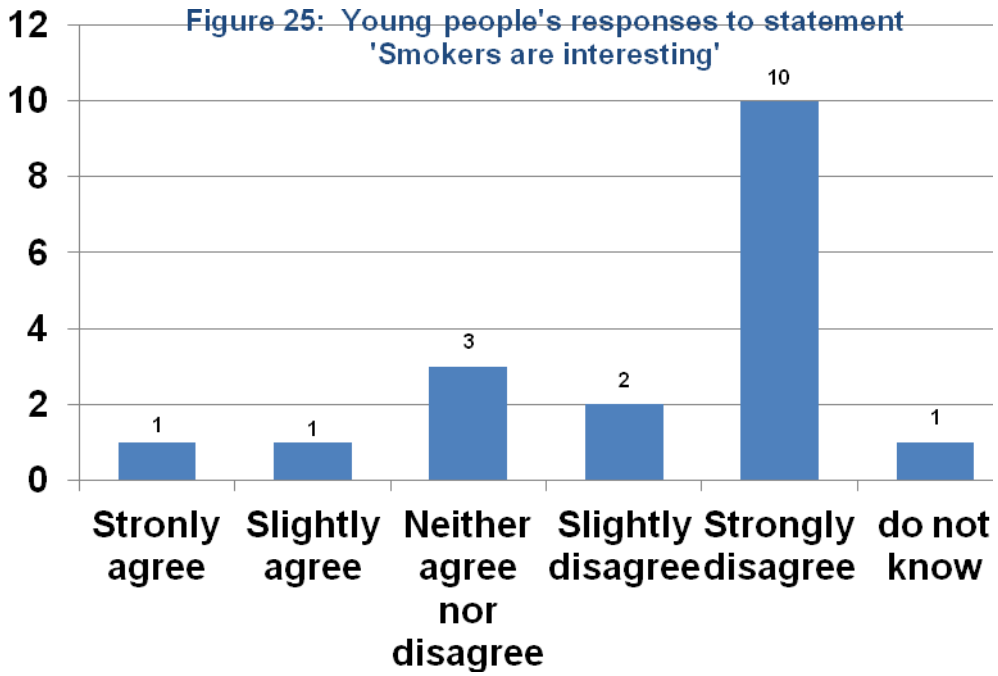
- ‘Strongly agree’
- ‘Slightly agree’
- ‘Neither agree nor disagree’
- ‘Slightly disagree’
- ‘Strongly disagree’
- ‘Do not know’

Nine out of 18 (50%) of respondents, stated that they were ‘female’, and 9 out of 18 (50%) stated that they were ‘male’.

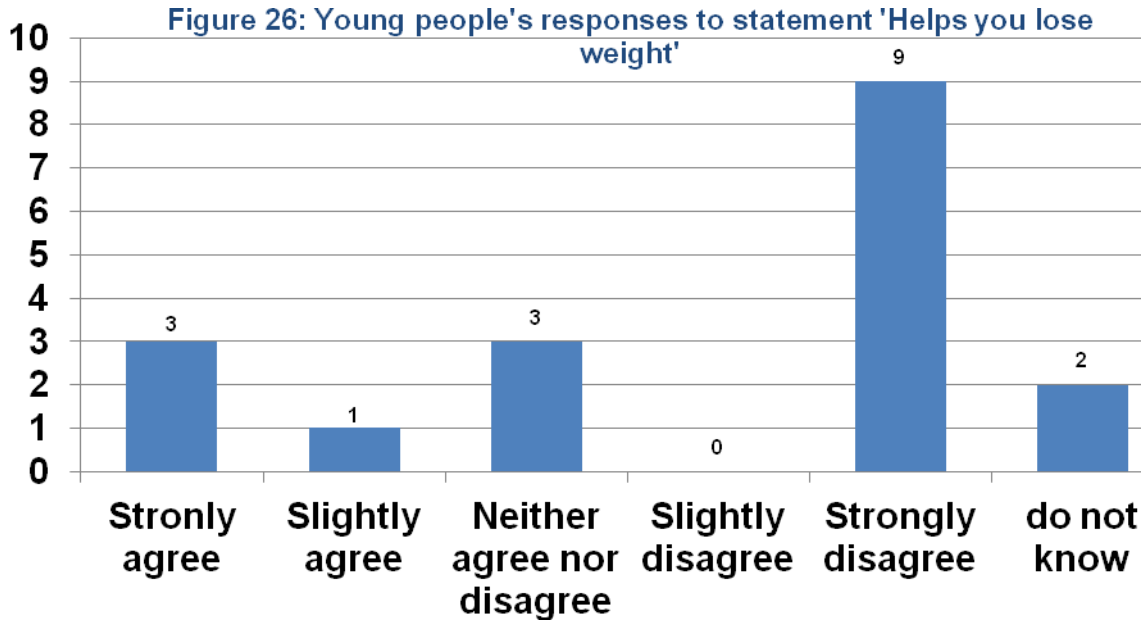
Of the 18 respondents who completed the questionnaire, four respondents (22%) stated that they were 16 years old (the most commonly cited age group for respondents), three (17%) were aged 18, and two respondents (11%) were aged 20 years and 25 years respectively. There was one respondent in each of the following age categories - 12 years, 17 years, 19 years, 21 years, 27 years, 28 years, and 30 years. The mean age of respondents was 20.1 years.



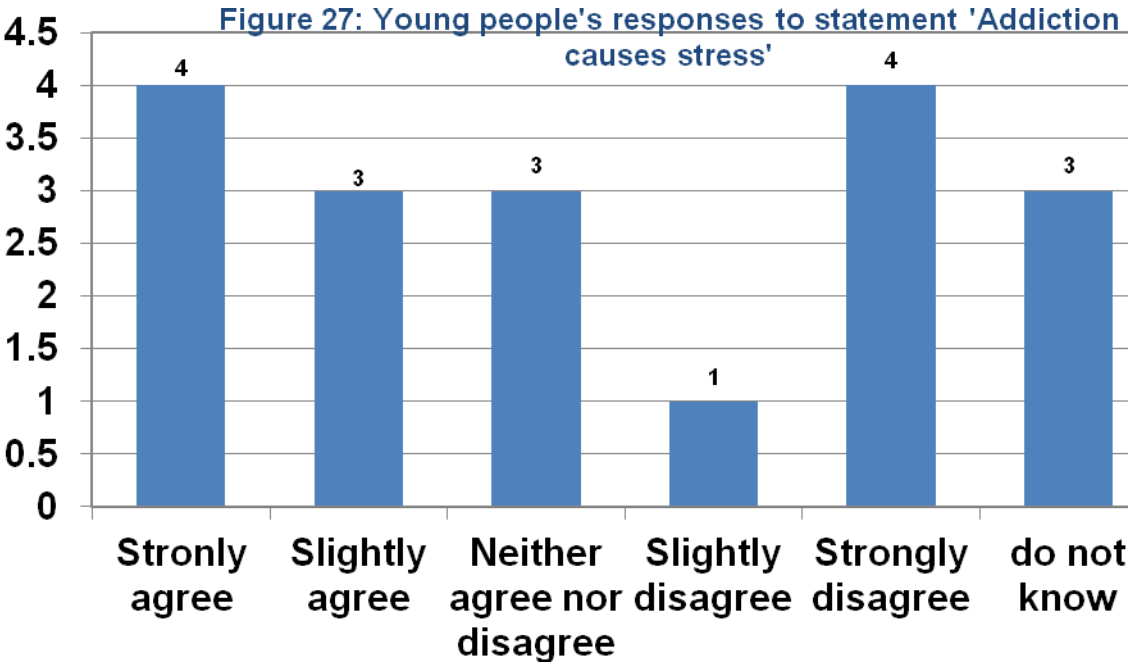
As Figure 24 shows, 89**%** of respondents (16 out of 18) agreed with the statement ‘**Smoking risks health’** (15 ‘Strongly Agree’ and 1 ‘ Slightly Agree’), with 1 respondent answering ‘Neither agree nor Disagree’ to this statement, no respondents disagreeing with the statement, and 1 respondent answering ‘Do not know’.



As Figure 25 shows, two respondents agreed with the statement **'smokers are interesting'** (one 'Strongly Agree' and one 'Slightly Agree'), with 3 respondents (17%) answering 'Neither agree nor Disagree' to this statement. Overall, 67% of respondents (12 out of 18) disagreed with the statement (two slightly disagreed' and 10 strongly disagreed), and one respondent answered 'Do not know'.

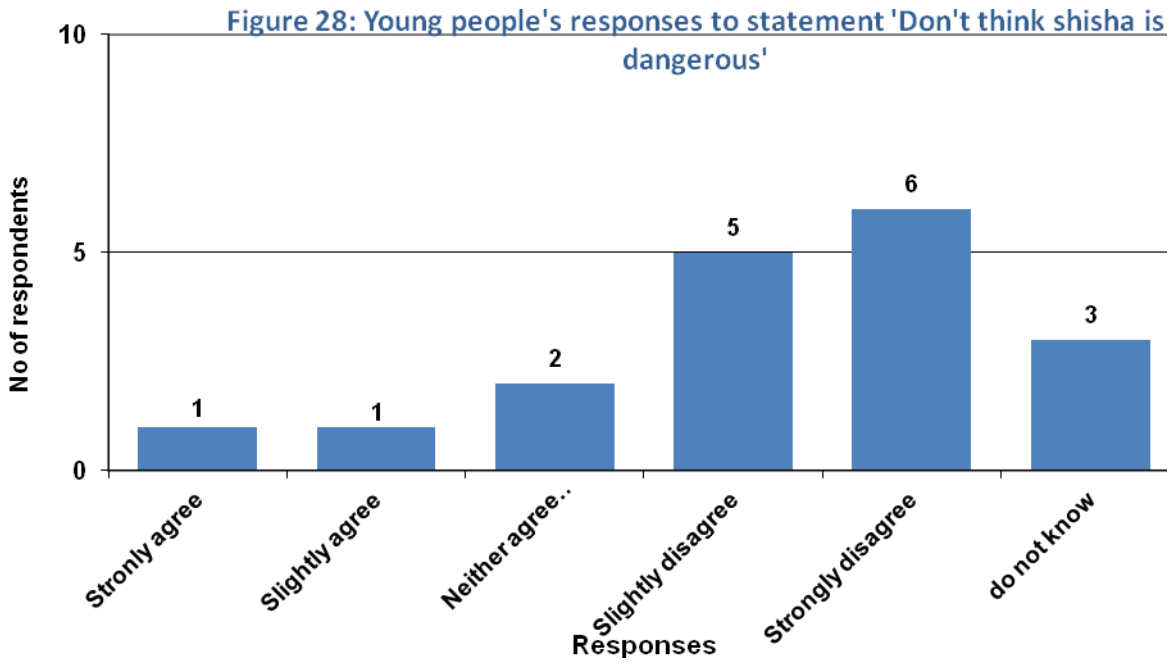


As Figure 26 shows, 4 out of 18 respondents (23**%**) agreed with the statement **'Smoking helps you lose weight'** (3 'Strongly Agree' and 1 ' Slightly Agree'), with 3 respondents answering 'Neither agree nor Disagree' to this statement. Half of respondents (9 out of 18 – 50%) stated 'strongly disagree' to this statement, and 2 respondents answered 'Do not know'.

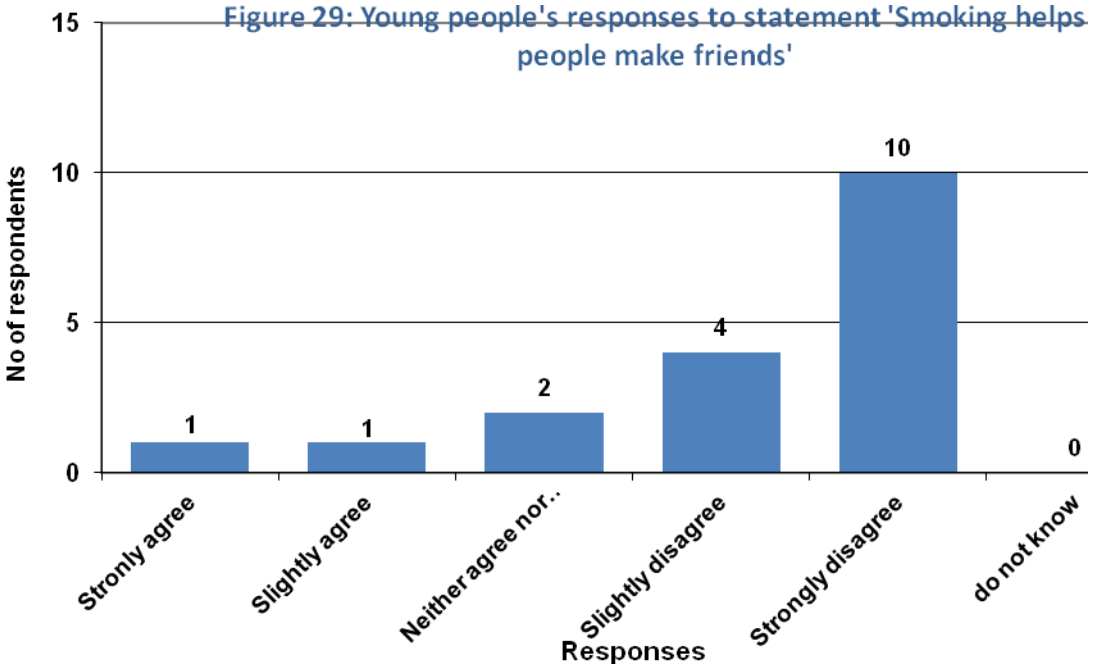


As Figure 27 shows, 7 out of 18 (39**%)** of respondents agreed with the statement **'Addiction causes stress'** (4 'Strongly Agree' and 3 'Slightly Agree'), with 3 respondents answering 'Neither agree nor Disagree'. Five out of the 18 respondents (28%) disagreed with this statement (1 'Slightly disagree', 4 'Strongly disagree'), and 3 respondents answered 'Do not know'.

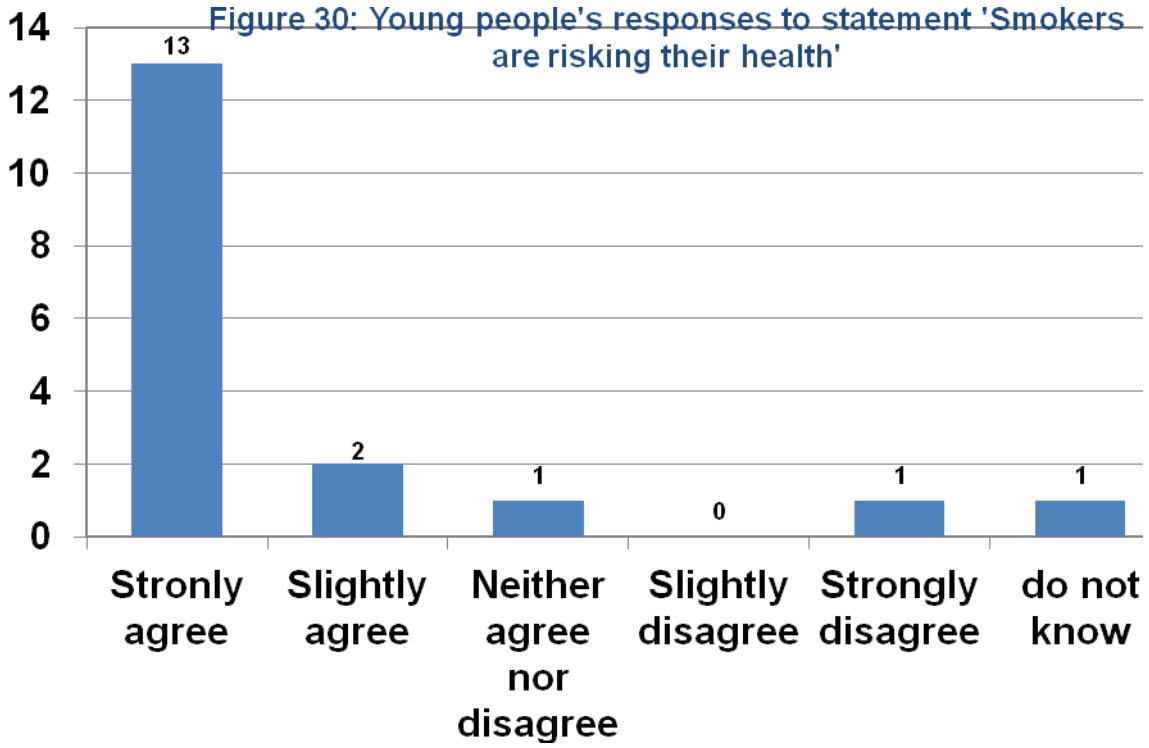
Figure 28 shows, 2 out of 18 respondents (11%) agreed with the statement **'I don't think Shisha is dangerous'** (1 'Strongly Agree' and 1 'Slightly Agree'), with 2 respondents answering 'Neither agree nor Disagree' to this statement. Overall, 11 out of 18 respondents (61%) disagreed with this statement (5 'slightly disagree' and 6 'strongly disagree'), and 3 respondents answered 'Do not know'.



As Figure 29 indicates, 2 out of the 18 respondents (11%) agreed with the statement **'Smoking helps people make friends'** (1 'Strongly Agree' and 1 'Slightly Agree'), with 2 respondents answering 'Neither agree nor Disagree' to this statement, and 14 out of 18 disagreeing with this statement (78% - 4 'slightly disagree' and 10 'strongly disagree').



As Figure 30 below shows, 15 out of 18 respondents (83%) agreed with the statement '**Smokers are risking their health'** (13 'Strongly Agree' and 2 'Slightly Agree'), with 1 respondents answering 'Neither agree nor Disagree' to this statement, 1 respondent disagreeing with this statement, and 1 respondent answering 'Do not know'.



4.0 Conclusions and recommendations

a. Listening to the Community

The main recommendations emerging from these discussions are for more direct consultation with communities in shaping services in order to make them relevant and attractive to potential users. Further work needs to be done around denormalising tobacco use in the Turkish and Kurdish community and more significantly looking at ways to address the belief that smoking alleviates stress.

b. Offering more targeted services

Respondents pointed to the need for more promotion of mother tongue services and provision of more detailed leaflets and health promotion information in Turkish language. The QUIT HERE logo in both English and Turkish language which featured in the focus group consultations was viewed positively. Targeted young peoples services were called for, particularly youth work to empower young people to resist and counter peer pressure to build confidence that would enable self motivation not to start smoking.

c. Increasing education and awareness around smoking and tobacco related harm

A recurring perception is that little is being done in schools and parents feel dislocated from the education system. Provision of health education around the dangers of tobacco in schools and colleges was a frequent request from those who had children (the majority within the focus groups). The general feeling was that statutory services have a role in ensuring that the right messages are getting through to young people.

There was a call for more mother tongue adult education around smoking related harm. The validity of these appeals is backed up by recent recommendations from NICE, the National Institute for Health and Clinical Excellence;

"Integrate information about the health effects of tobacco use, as well as the legal, economic and social aspects of smoking, into the curriculum. For example, classroom discussions about tobacco could be relevant when teaching a range of subjects including biology, chemistry, citizenship, geography, mathematics and media studies." [8]

There is certainly scope for investigation into whether initiatives that offer a whole family approach to health education around tobacco could increase awareness of the key issues and facilitate discussion between children and parents.

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[8] School-based interventions to prevent the uptake of smoking among children and young people - National Institute for Health and Clinical Excellence, 2010.

d. Providing bolt on services that help people manage and alleviate socio economic stress factors

By far the most widely reported reason respondents gave for starting smoking was that they felt stressed by daily life issues. It was significantly reported that people in the Turkish, Kurdish and Turkish Cypriot community feel that life in the UK is difficult and that cultural differences exacerbate the general stresses of living in a big city. Examples included language barriers, having refugee or migrant status as well as housing and social welfare concerns. Respondents reported feeling highly stressed at the general level of postal correspondence, paperwork and household administration they deal with which they are not always able to read or understand.

Respondents felt that there is undue pressure placed upon younger family members to help deal with these tasks and that there is also a reliance on costly solicitors for issues that may not warrant the level of expertise legal organisations typically provide.

One recommendation would be to expand the current evidence base to include data on the socioeconomic challenges that smokers face. This would enable treatment services to react in a way that supports a whole person approach to wellbeing. Expanding the remit of specialist stop smoking services who work with communities with higher smoking prevalence could include signposting to welfare benefit support or offering information and advice on where people can go to access other health services.

e. Denormalising the acceptability of smoking and reducing smoking prevalence

The investigation revealed that despite the positive advantages of fairly robust tobacco controls in the UK and the existence of health education initiatives, respondents felt under social pressure to smoke as the behaviour is so common within the wider Turkish and Kurdish community. Our findings strongly concurred with the 2009 study conducted by Ethnic Dimension that concluded, "*Turkish participants suggested that smoking was considered a normal part of life in Turkey and almost a cultural norm*" [9]

Our research shows that a significant number of respondents begin smoking because of the belief that it helps people cope with daily life. In addition, there is a strongly held perception that personal resolve and the will of God is all that is required to break the smoking habit. Willpower and faith could be a useful catalyst for behaviour change and this determination could be harnessed to encourage participation in targeted smoking cessation services.

Our findings indicate that by working alongside the Turkish, Kurdish and Turkish Cypriot community in Hackney, significant work could be done to shift the belief that tobacco can help users manage stress and to increase awareness of the clinical evidence base for quitting with medication and support .

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[9] *Smoking cessation & ethnic minority communities*; Findings of qualitative research project with Somali, Polish and Turkish communities in London. The London Social Marketing Unit and NHS Commissioning Support for London. July 2009

5.0 Bibliography and further reading

City and Hackney Health and Wellbeing Profile: JSNA data update, September 2012

Smoking cessation & ethnic minority communities; Findings of a qualitative research project with Somali, Polish and Turkish communities in London. The London Social Marketing Unit and NHS Commissioning Support for London. July 2009.

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7.0 Appendices

Appendix A Graphic representation of data findings

Appendix B Research questionnaires

This section presents findings for:

- Primary data from the Community Insight Research Study survey of Turkish and Kurdish community members
- Primary data from the 'Community Insight Research Study- Feedback from organisations' survey of local organisations
- Primary data from the Facebook survey of young people
- Secondary data from Turkish and Kurdish respondents to the NHS Community and Bilingual Stop Smoking Service Baseline Health Questionnaire

Response rates

In total, 80 community members completed the Community Insight Research Study questionnaire. Data from all 80 respondents were included in the analysis of survey data.

Four organisations completed the 'Community Insight Study – Feedback from organisations' questionnaire. The small sample size meant that the analysis that could be carried out of organisations' responses was limited.

In total, 18 young people completed a short Facebook Survey questionnaire related to their smoking behaviours and attitudes to smoking.

In total, 182 completed responses to the 'NHS Community and Bilingual Stop Smoking Service Baseline Health Questionnaire' were analysed in order to provide background to, and support the findings of, the 'Community Insight Research Study'. Completed questionnaires were analysed for all those respondents who identified their ethnic origin as 'Turkish or Kurdish' – 182 in total.

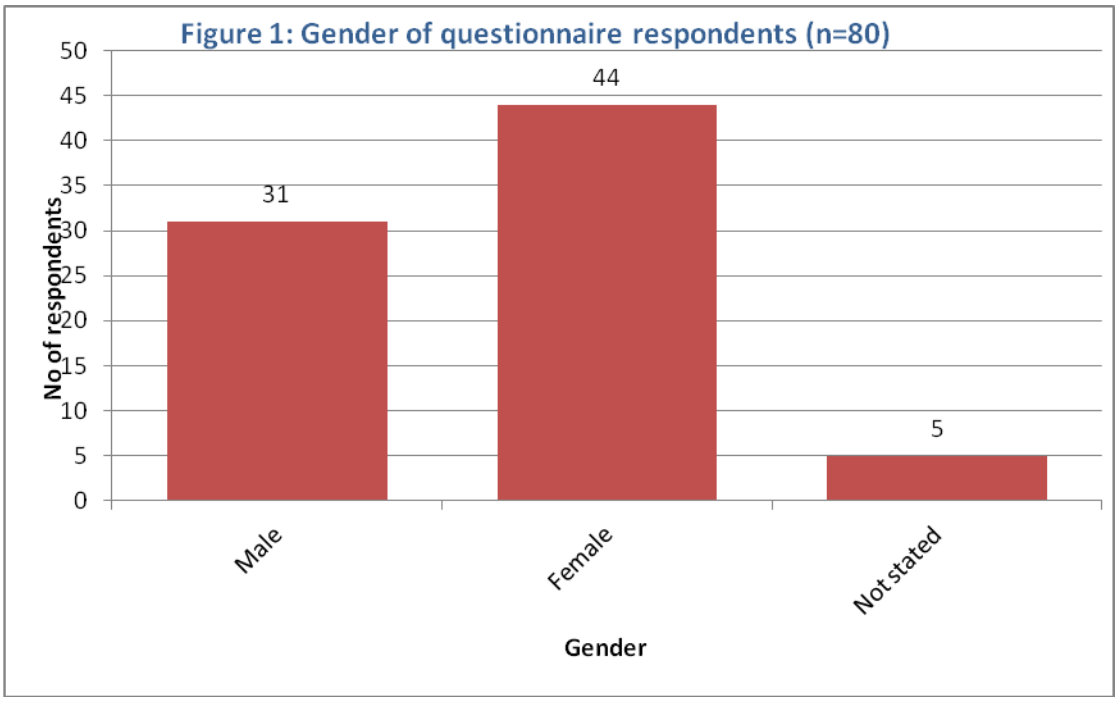


Figure 1: Gender of questionnaire respondents (n=80)
No of respondents
50
45
40
35
30
25
20
15
10
5
0
31
44
5
Male
Female
Not stated
Gender

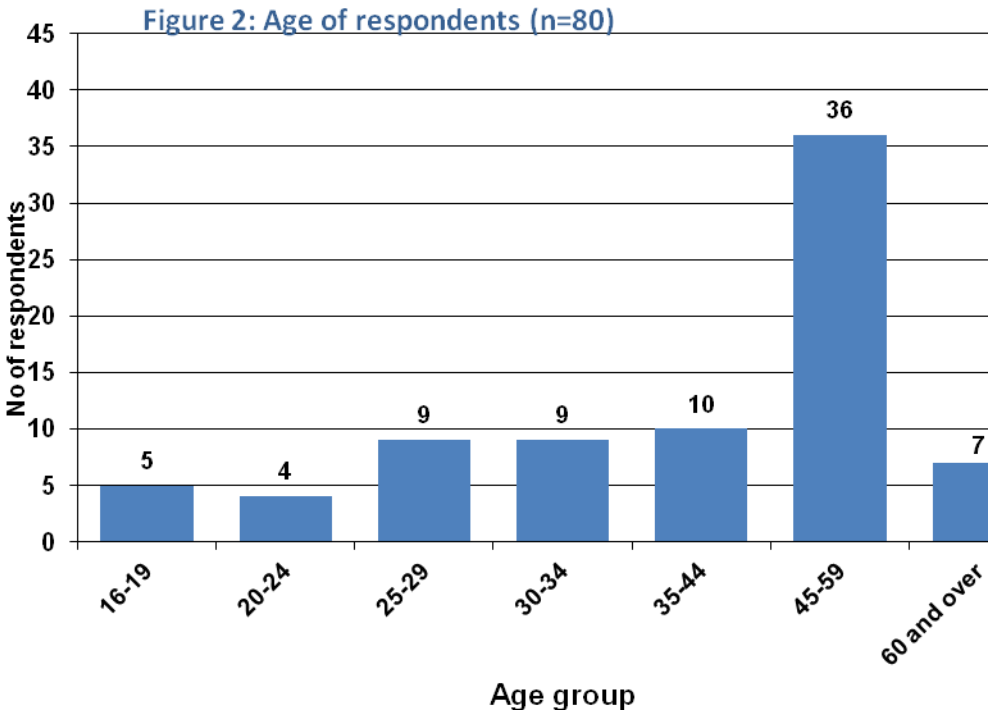


Figure 2: Age of respondents (n=80)
No of respondents
45
40
35
30
25
20
15
10
5
0
5
4
9
9
10
36
7
16-19
20-24
25-29
30-34
35-44
45-59
60 and over
Age group

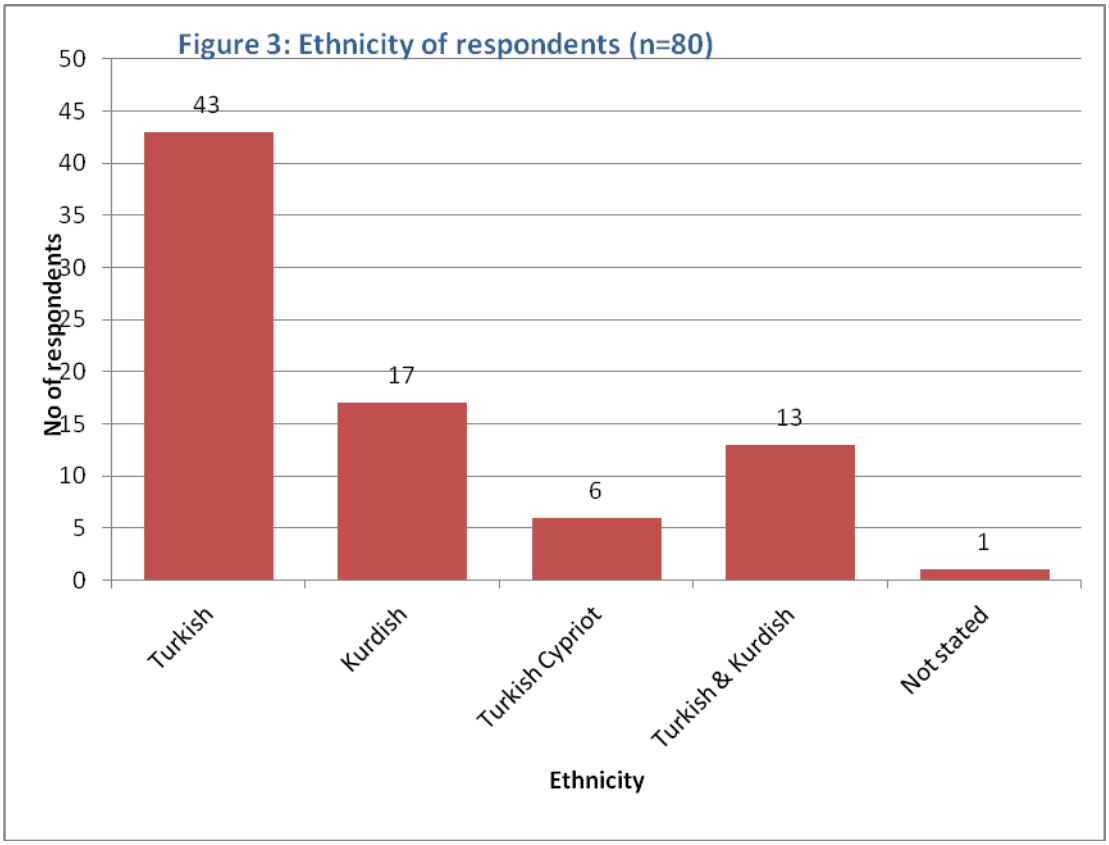


Figure 3: Ethnicity of respondents (n=80)
No of respondents
50
45
40
35
30
25
20
15
10
5
0
43
17
6
13
1
Turkish
Kurdish
Turkish Cypriot
Turkish & Kurdish
Not stated
Ethnicity

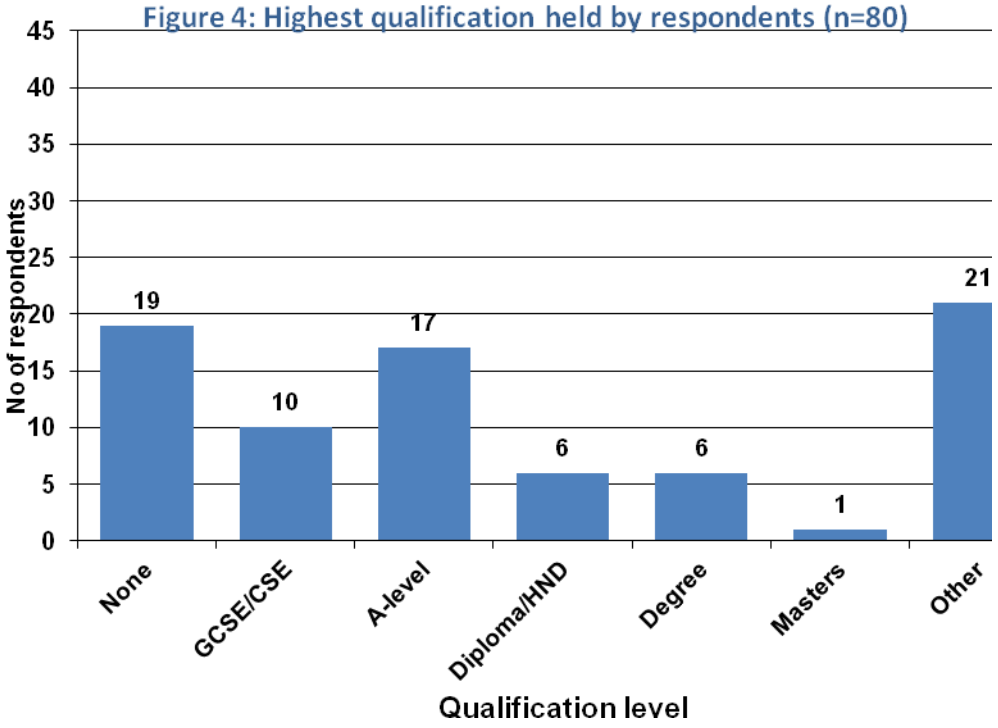


Figure 4: Highest qualification held by respondents (n=80)
No of respondents
45
40
35
30
25
20
15
10
5
0
19
10
17
6
6
1
21
None
GCSE/CSE
A-level
Diploma/HND
Degree
Masters
Other
Qualification level

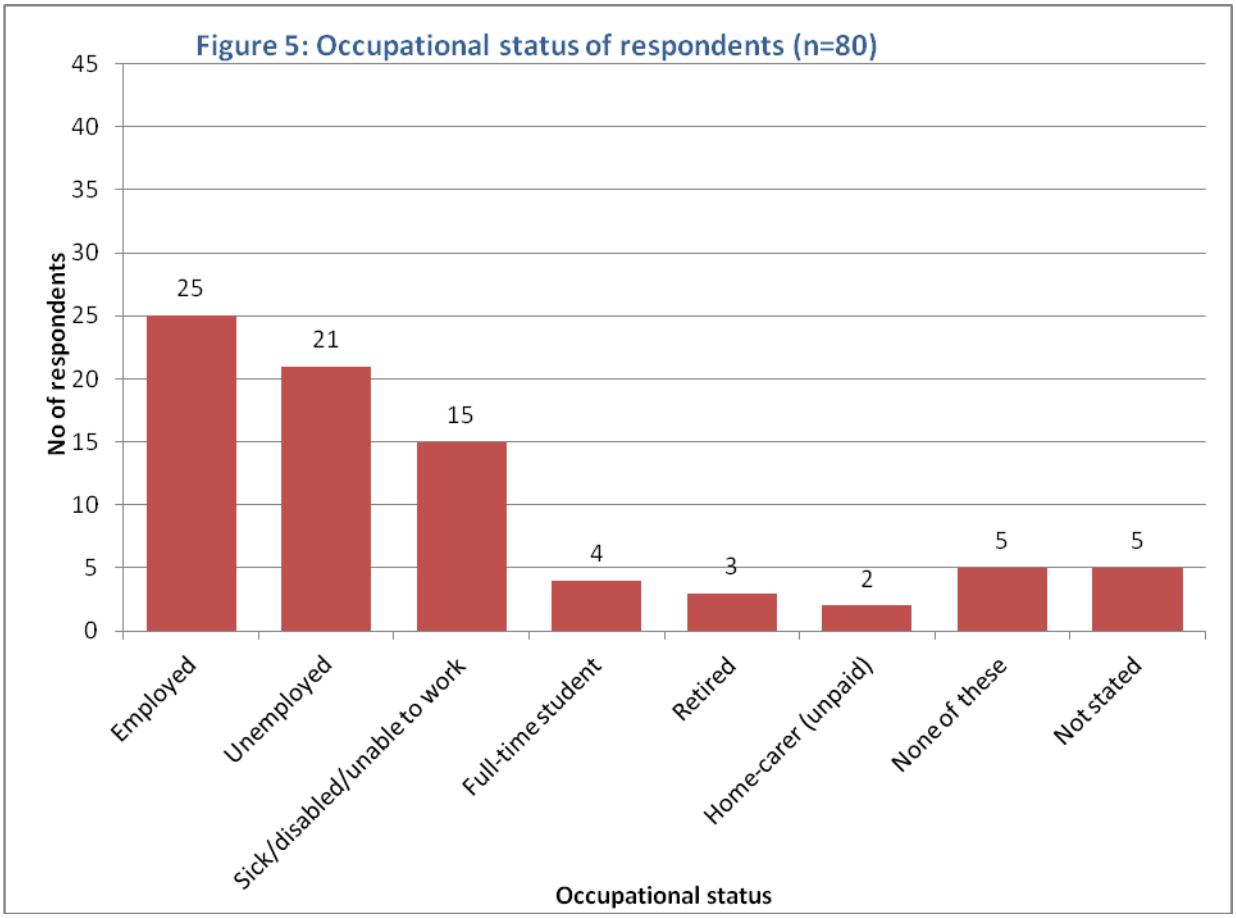


Figure 5: Occupational status of respondents (n=80)
No of respondents
45
40
35
30
25
20
15
10
5
0
25
21
15
4
3
2
5
5
Employed
Unemployed
Sick/disabled/unable to work
Full-time student
Retired
Home-carer (unpaid)
None of these
Not stated
Occupational status

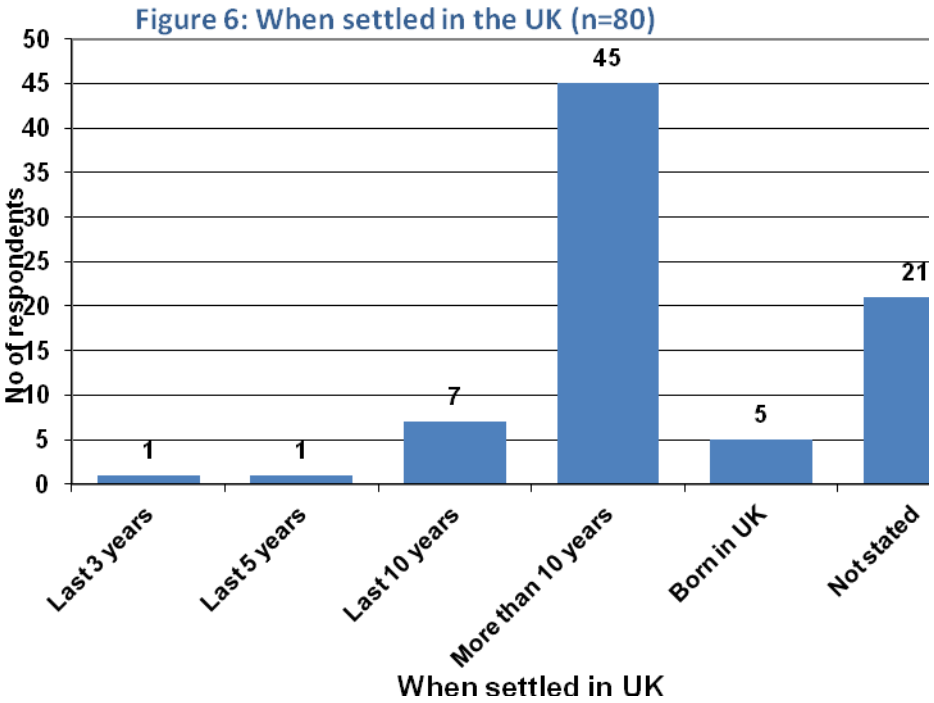


Figure 6: When settled in the UK (n=80)
No of respondents
50
45
40
35
30
25
20
15
10
5
0
1
1
7
45
5
21
Last 3 years
Last 5 years
Last 10 years
More than 10 years
Born in UK
Not stated
When settled in UK

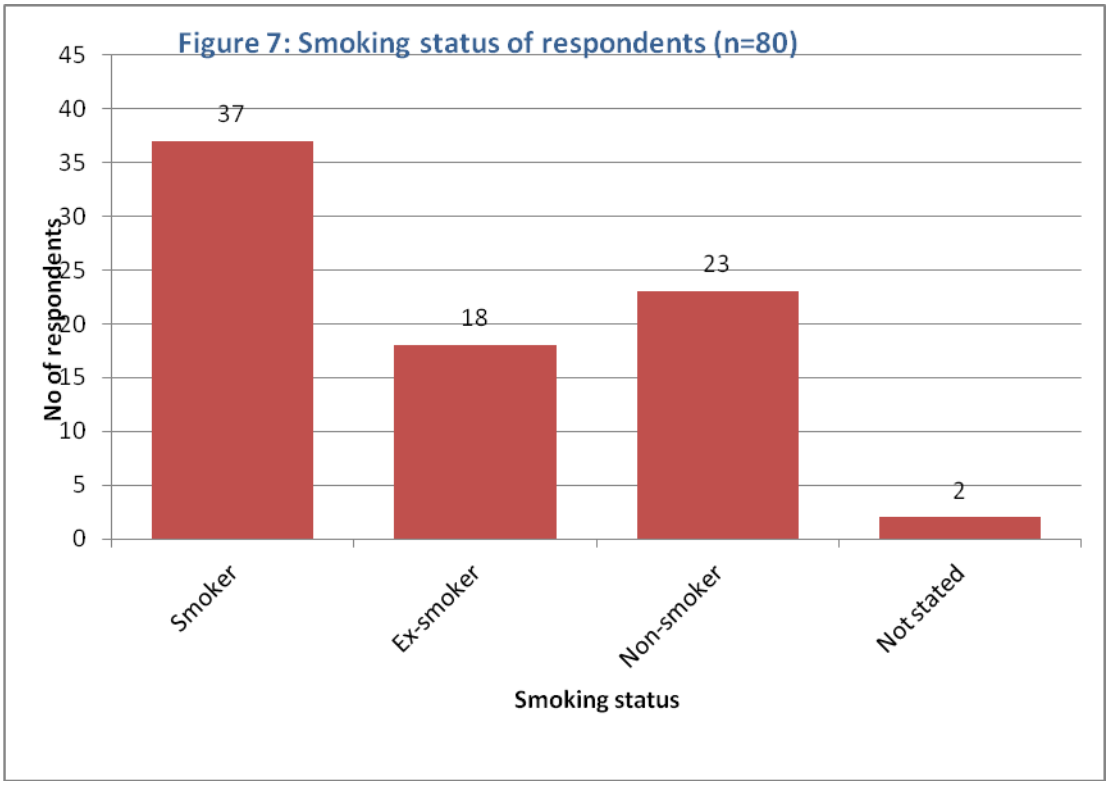


Figure 7: Smoking status of respondents (n=80)
No of respondents
45
40
35
30
25
20
15
10
5
0
37
18
23
2
Smoker
Ex-smoker
Non-smoker
Not stated
Smoking status

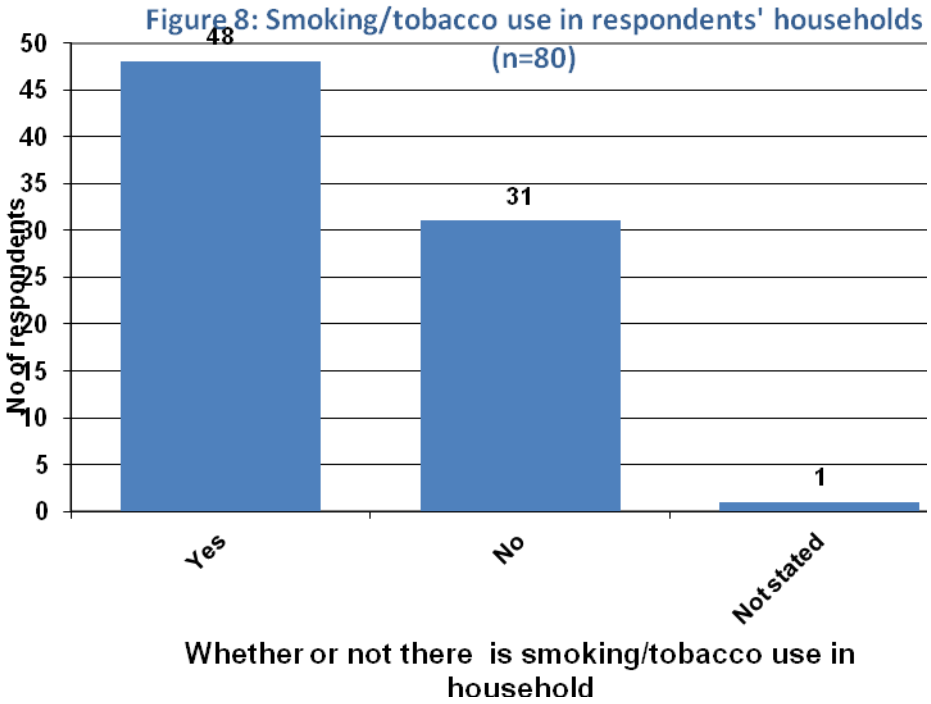


Figure 8: Smoking/tobacco use in respondents' households (n=80)
No of respondents
50
45
40
35
30
25
20
15
10
5
0
48
31
1
Yes
No
Not stated
Whether or not there is smoking/tobacco use in household

Figure 9: Age distribution of respondents

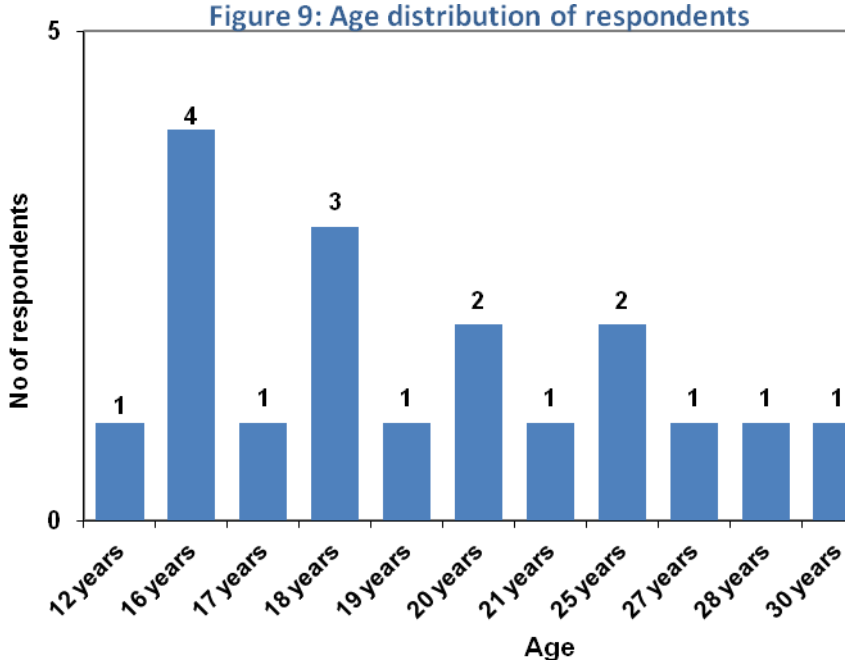


Figure 10: Smoking status

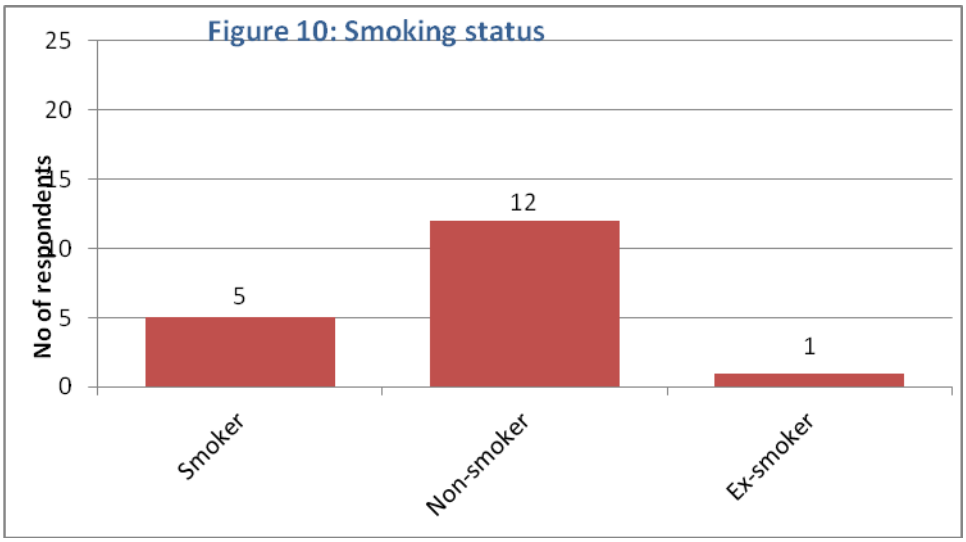


Figure 11: Respondents' marital status

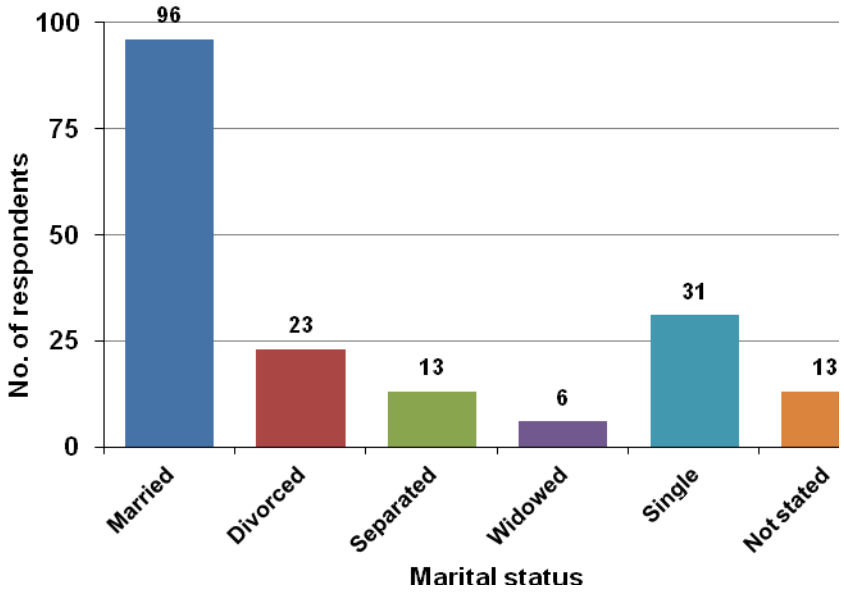
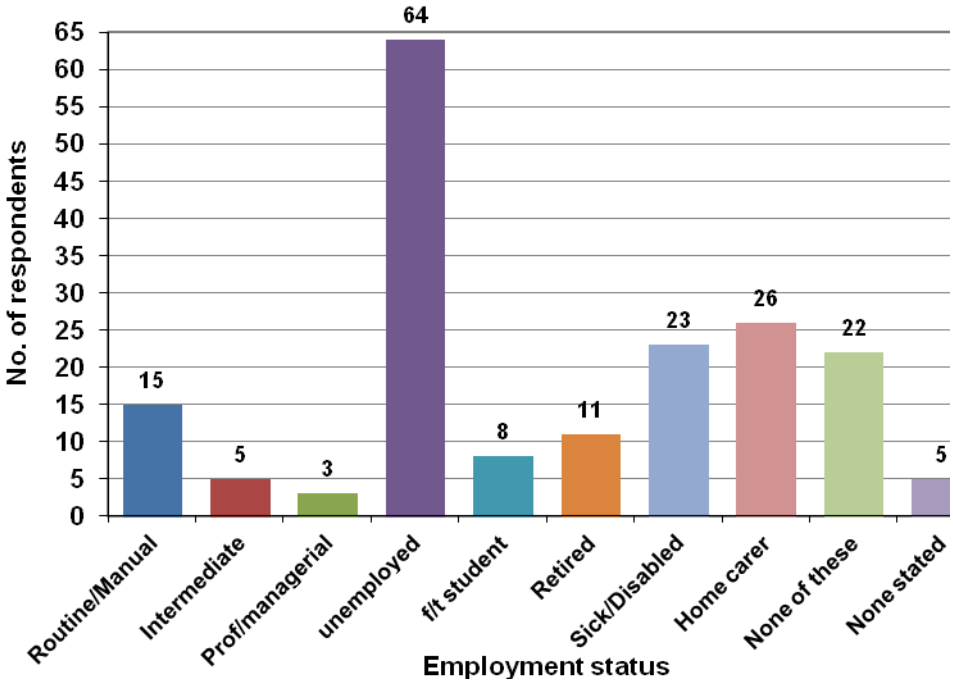


Figure 12: Respondents' employment status



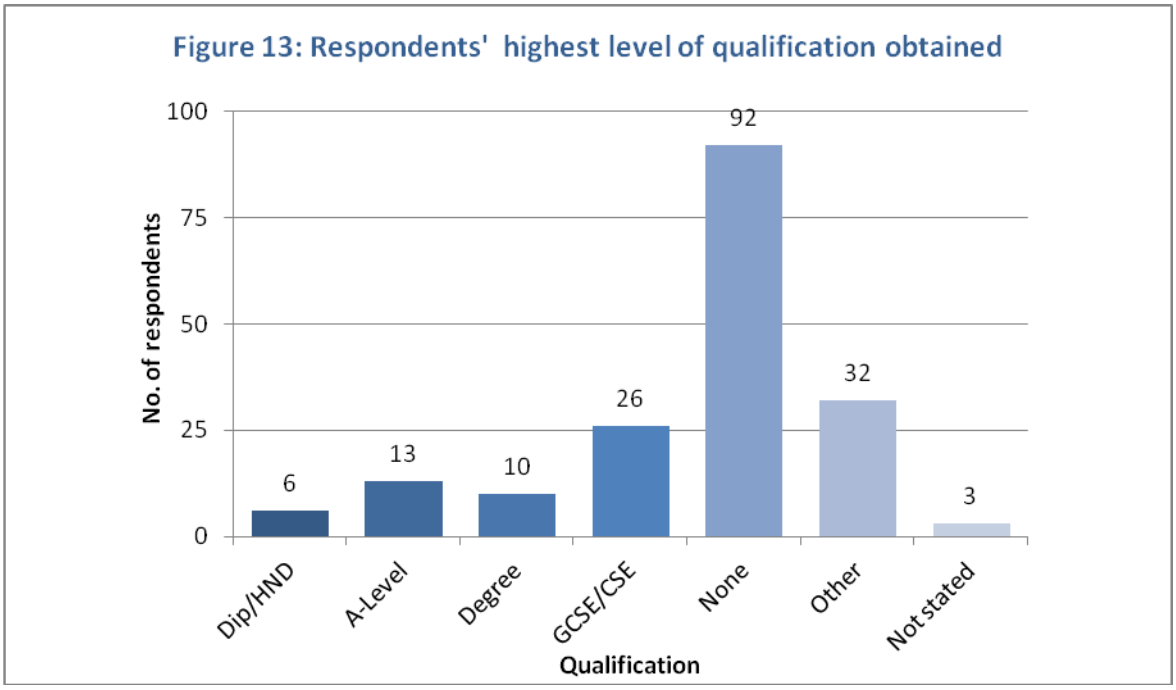


Figure 13: Respondents' highest level of qualification obtained
100
75
50
25
0
No. of respondents
92
32
26
13
10
6
3
Dip/HND
A-Level
Degree
GCSE/CSE
None
Other
Not stated
Qualification

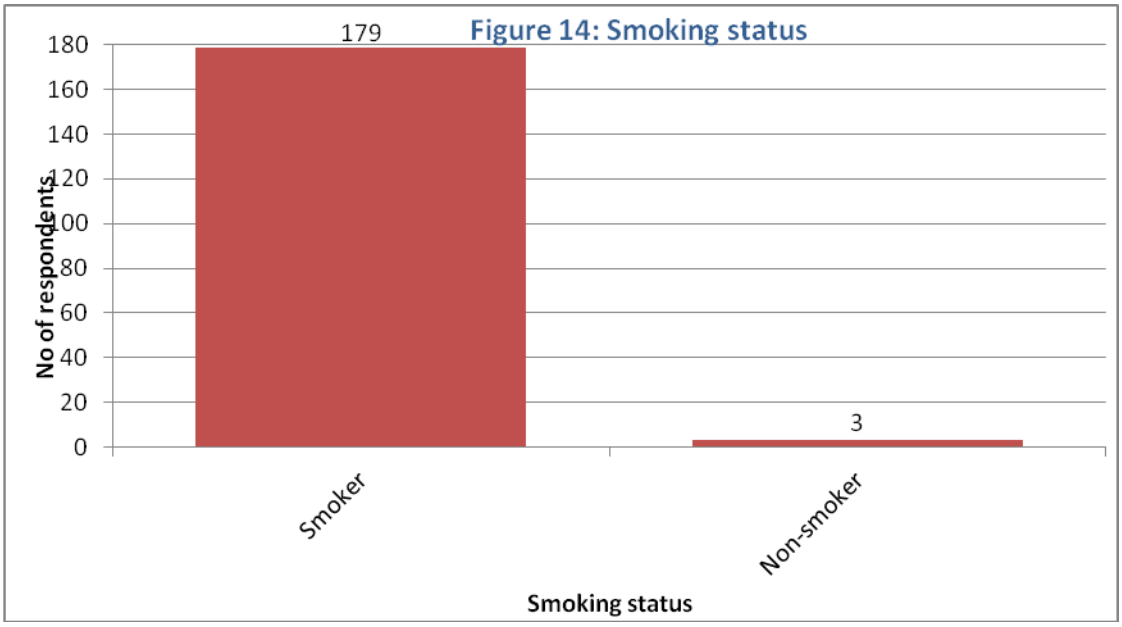


Figure 14: Smoking status
180
160
140
120
100
80
60
40
20
0
No of respondents
179
3
Smoker
Non-smoker
Smoking status

Figure 15: Age smokers and ex-smokers started smoking (n=55)

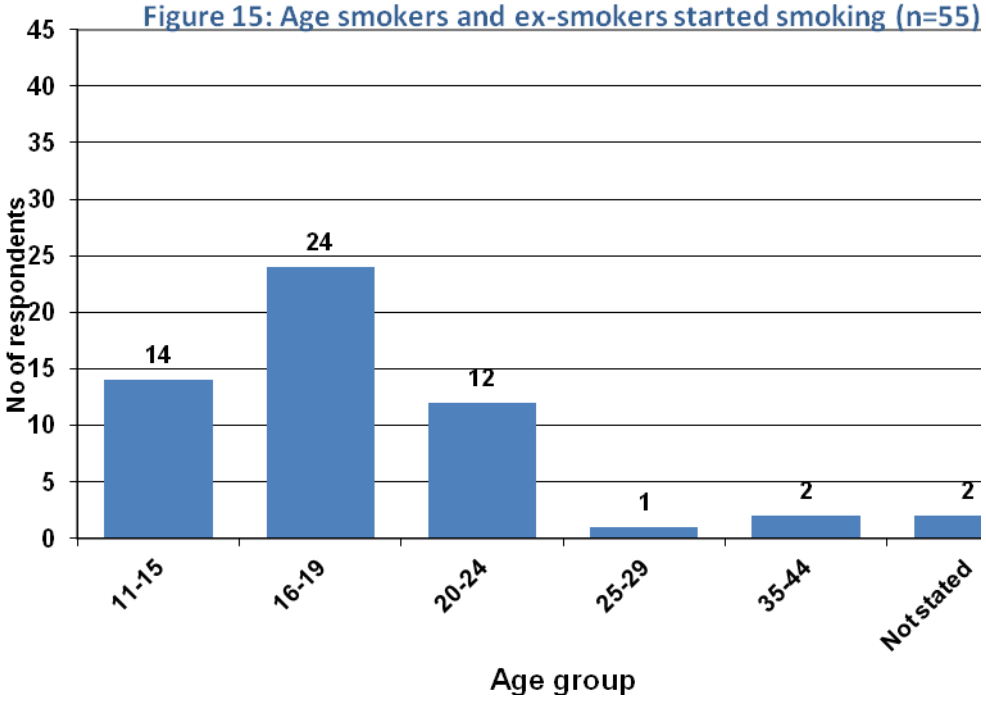
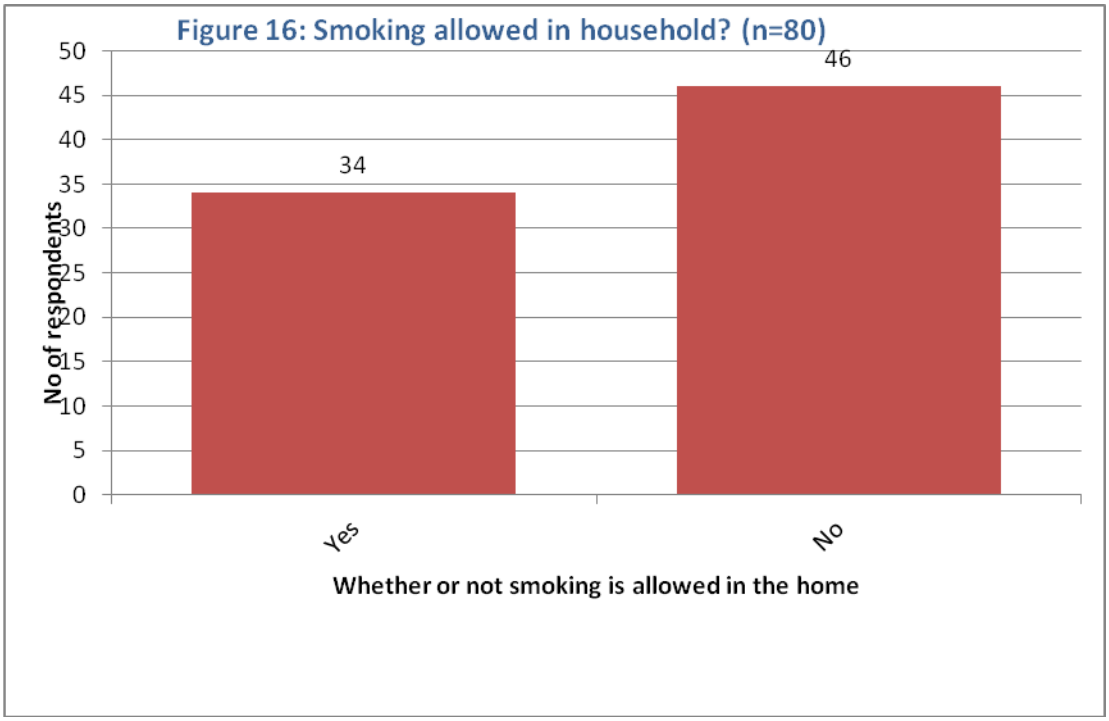


Figure 16: Smoking allowed in household? (n=80)



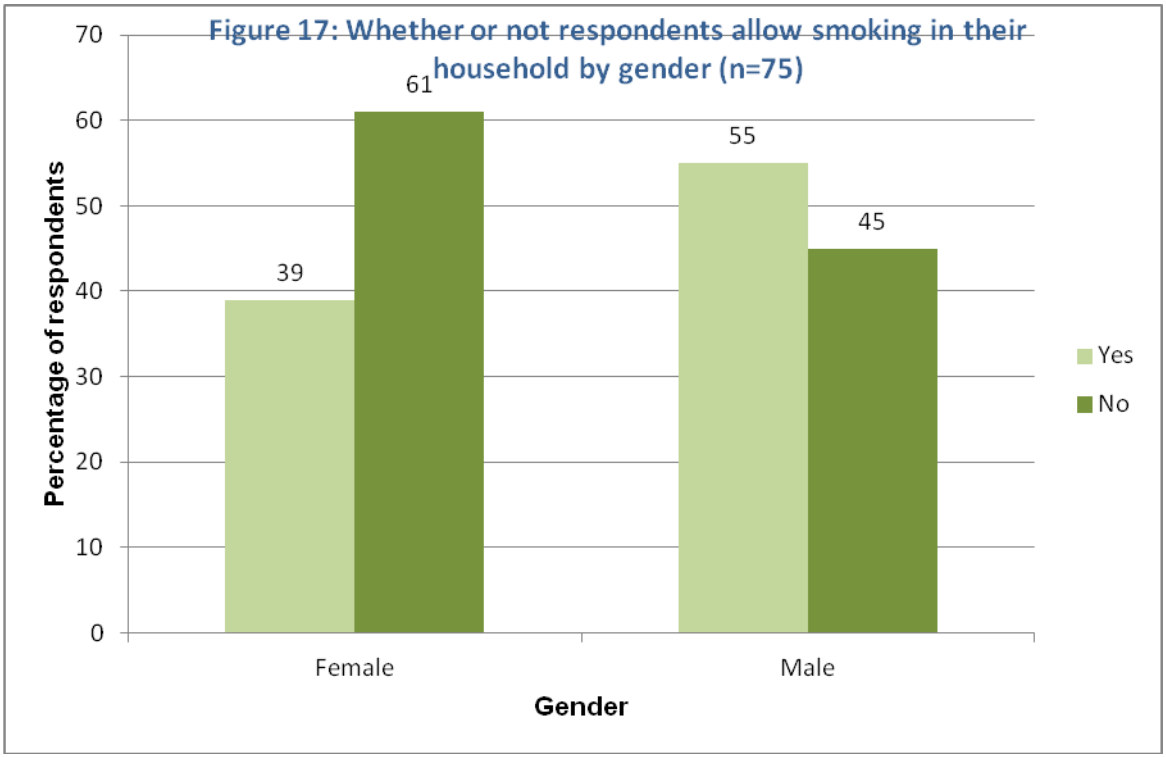


Figure 17: Whether or not respondents allow smoking in their household by gender (n=75)
Percentage of respondents
70
60
50
40
30
20
10
0
61
39
55
45
Female
Male
Gender
Yes
No

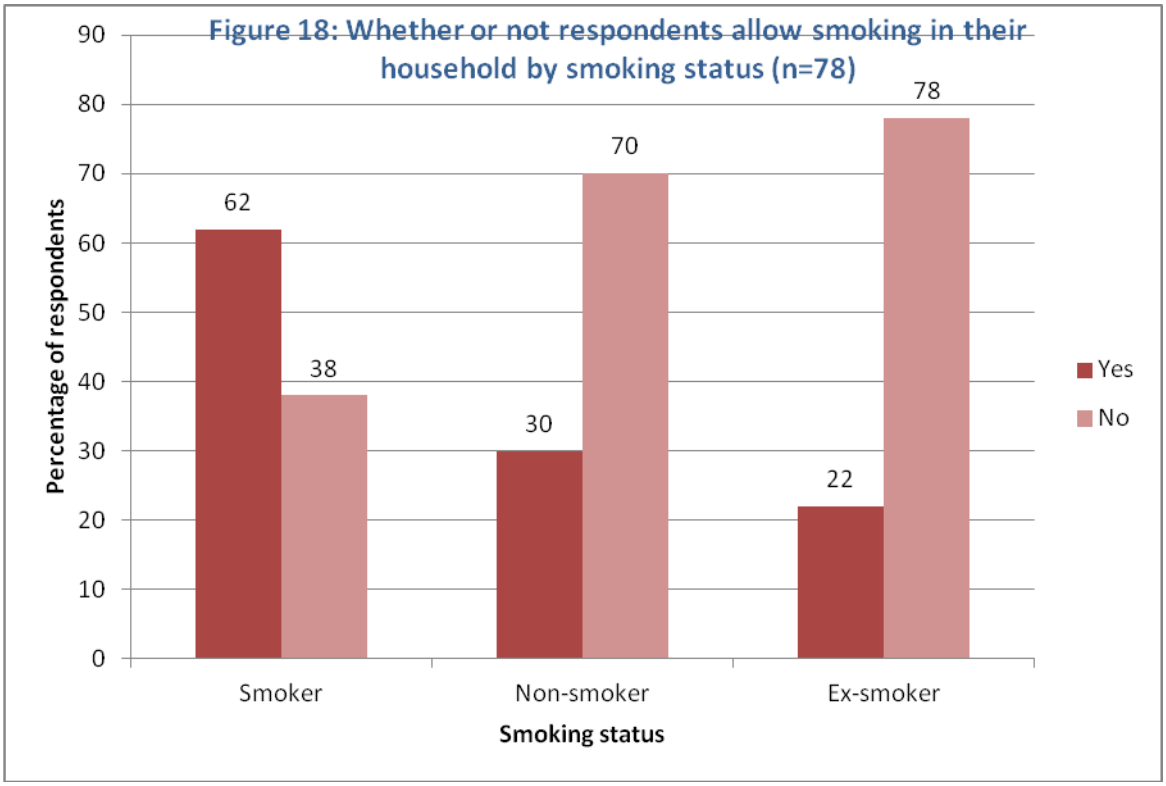


Figure 18: Whether or not respondents allow smoking in their household by smoking status (n=78)
Percentage of respondents
90
80
70
60
50
40
30
20
10
0
62
38
30
70
22
78
Smoker
Non-smoker
Ex-smoker
Smoking status
Yes
No

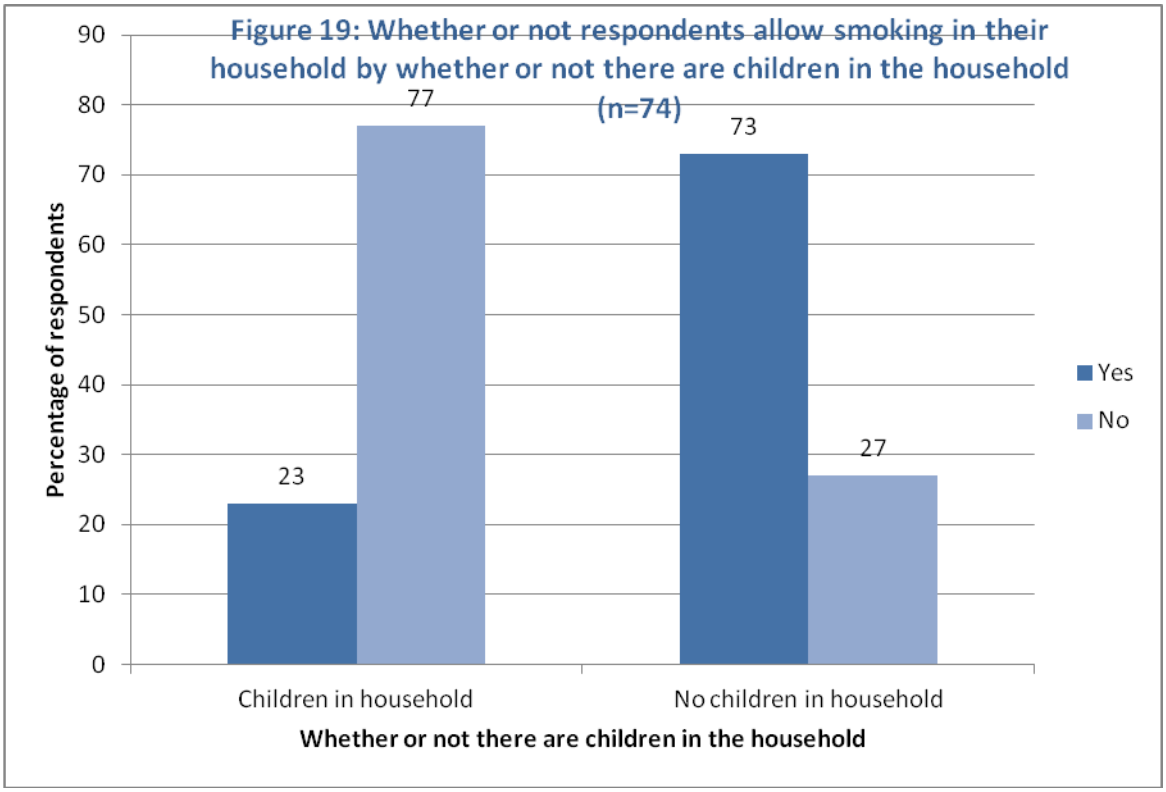


Figure 19: Whether or not respondents allow smoking in their household by whether or not there are children in the household (n=74)
Percentage of respondents
90
80
70
60
50
40
30
20
10
0
77
73
23
27
Yes
No
Children in household
No children in household
Whether or not there are children in the household

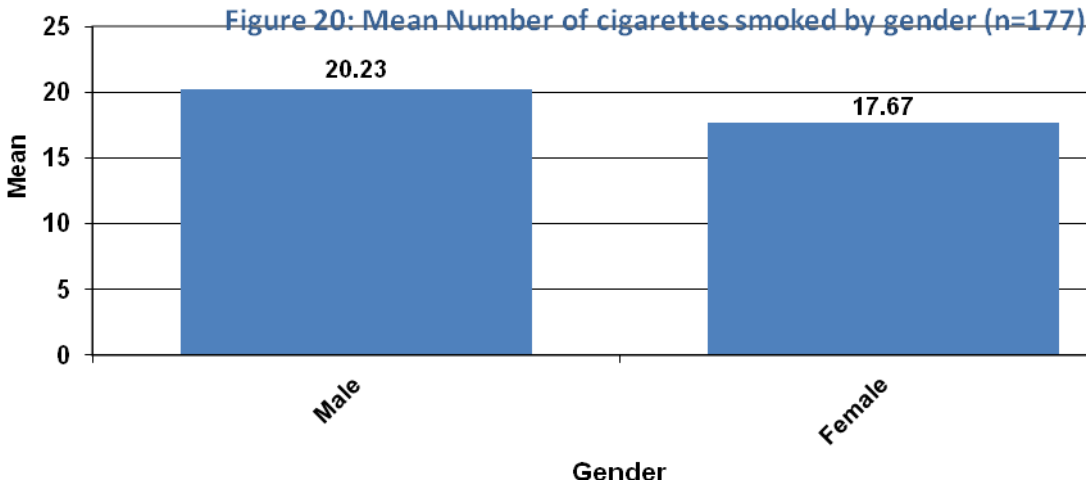


Figure 20: Mean Number of cigarettes smoked by gender (n=177)
Mean
25
20
15
10
5
0
20.23
17.67
Male
Female
Gender

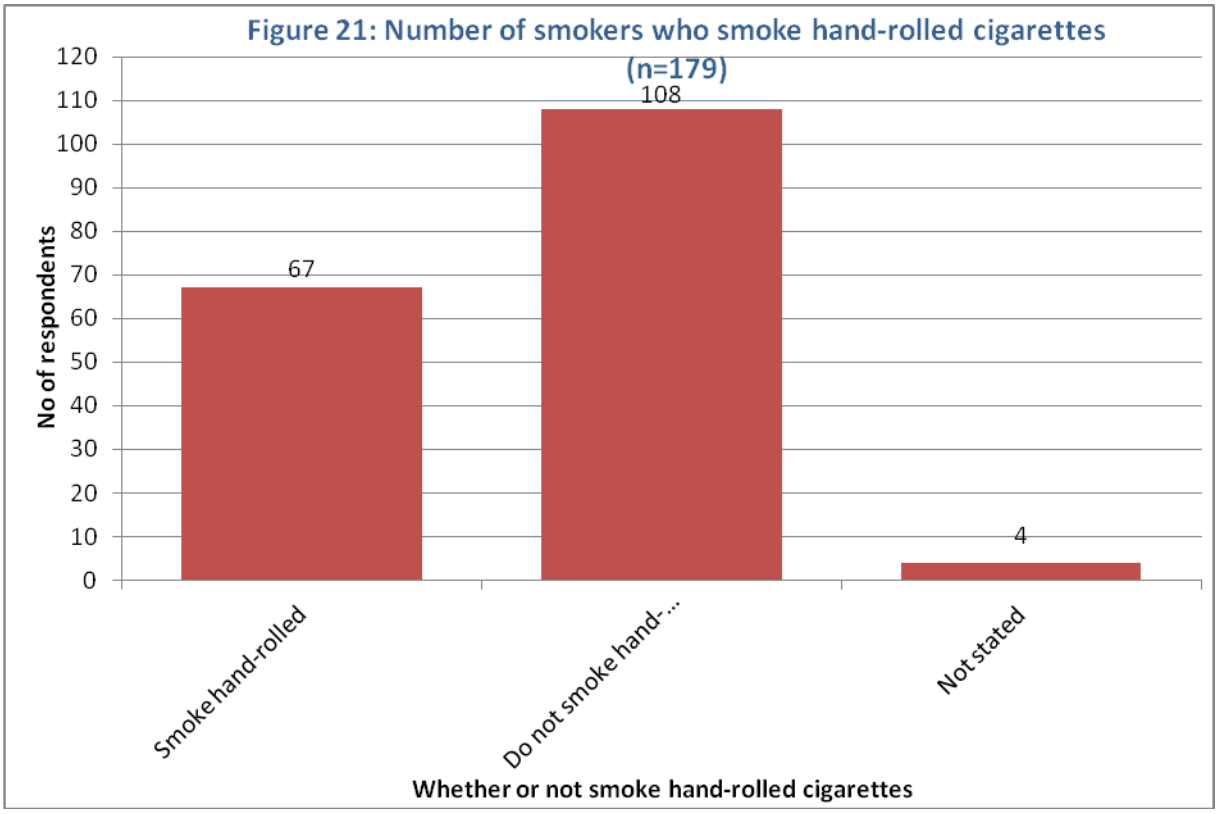


Figure 21: Number of smokers who smoke hand-rolled cigarettes (n=179)
120
110
100
90
80
70
60
50
40
30
20
10
0
No of respondents
67
108
4
Smoke hand-rolled
Do not smoke hand-...
Not stated
Whether or not smoke hand-rolled cigarettes

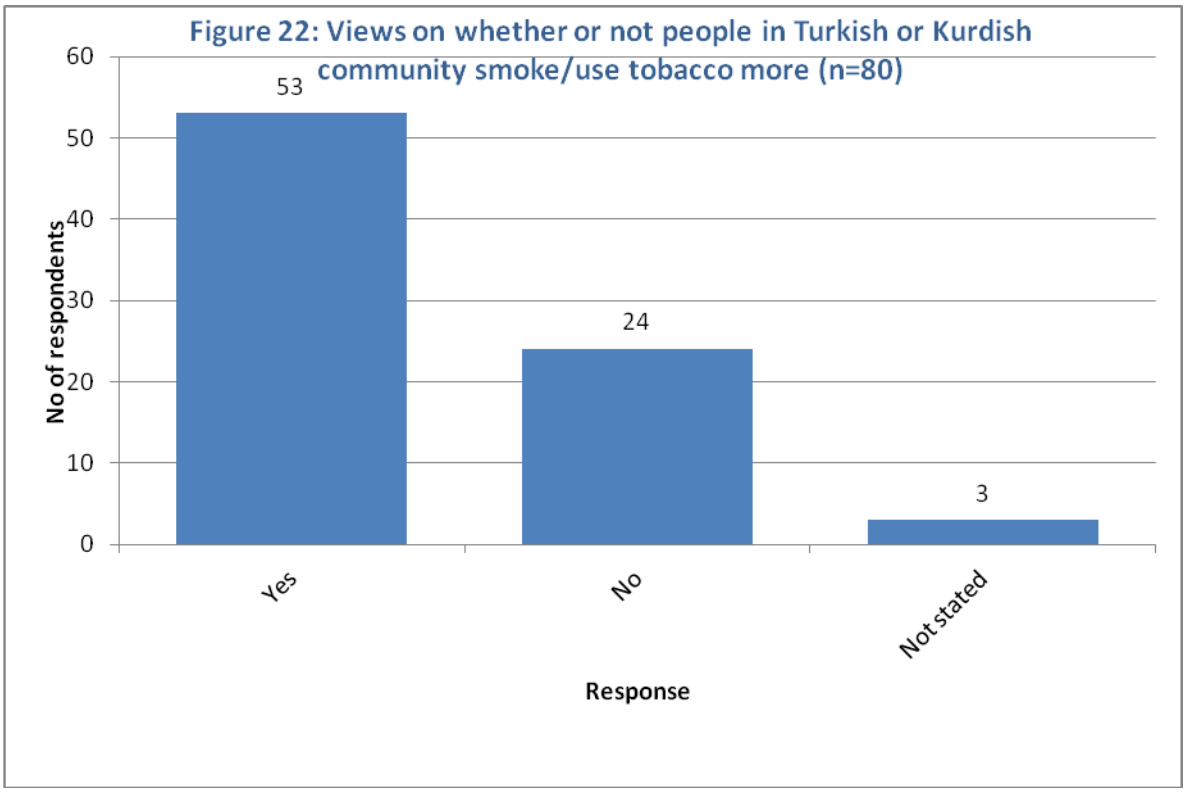


Figure 22: Views on whether or not people in Turkish or Kurdish community smoke/use tobacco more (n=80)
60
50
40
30
20
10
0
No of respondents
53
24
3
Yes
No
Not stated
Response

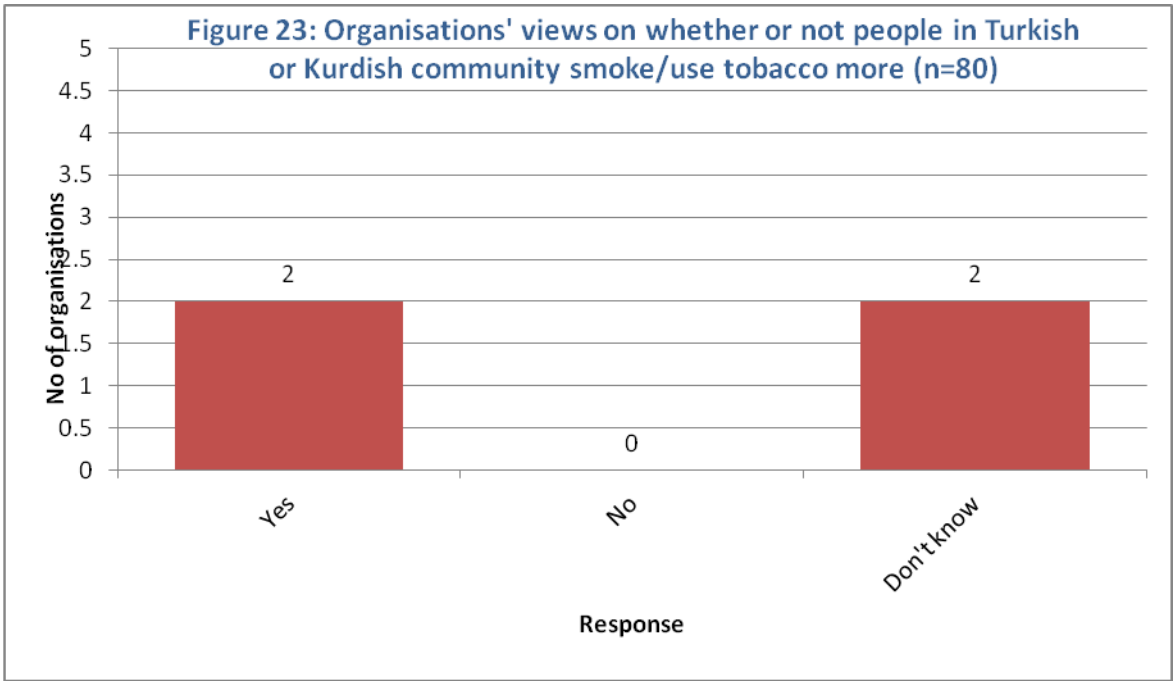


Figure 23: Organisations' views on whether or not people in Turkish or Kurdish community smoke/use tobacco more (n=80)
No of organisations
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
2
0
2
Yes
No
Don't know
Response

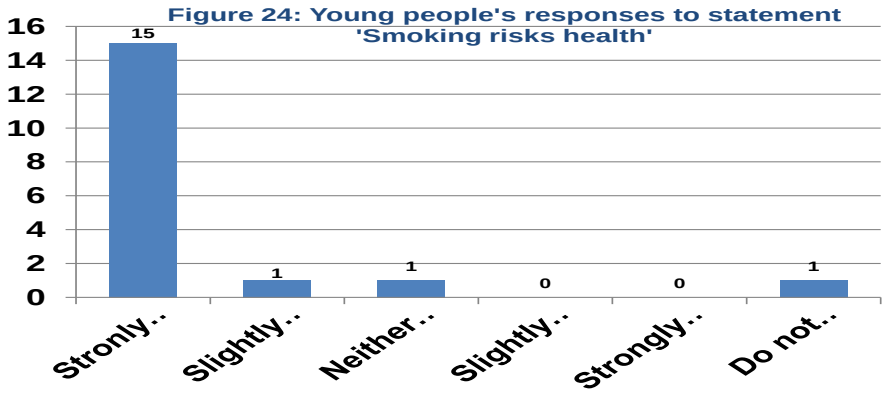


Figure 24: Young people's responses to statement 'Smoking risks health'
16
14
12
10
8
6
4
2
0
15
1
1
0
0
1
Stronly..
Slightly..
Neither..
Slightly..
Strongly..
Do not..

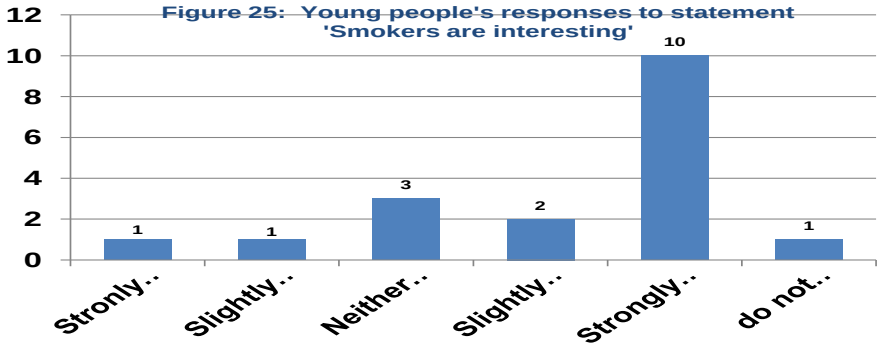


Figure 25: Young people's responses to statement 'Smokers are interesting'
12
10
8
6
4
2
0
1
1
3
2
10
1
Stronly..
Slightly..
Neither..
Slightly..
Strongly..
do not..

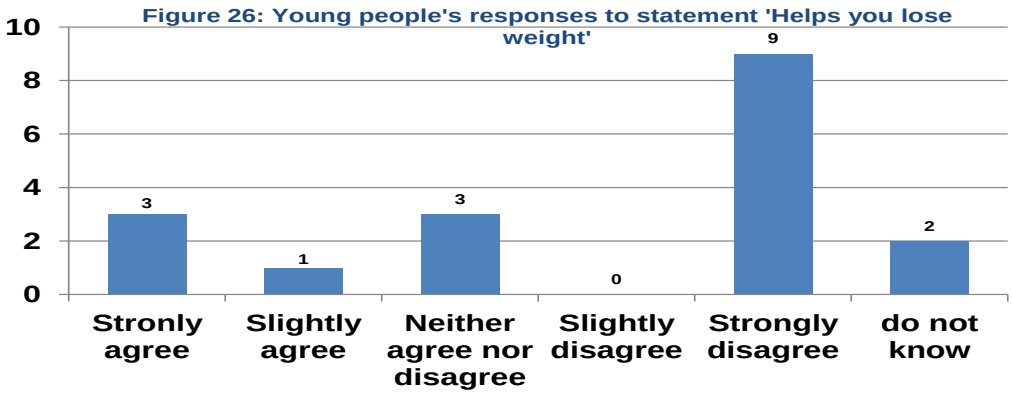


Figure 26: Young people's responses to statement 'Helps you lose weight'
10
8
6
4
2
0
3
1
3
0
9
2
Stronly agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Strongly disagree
do not know

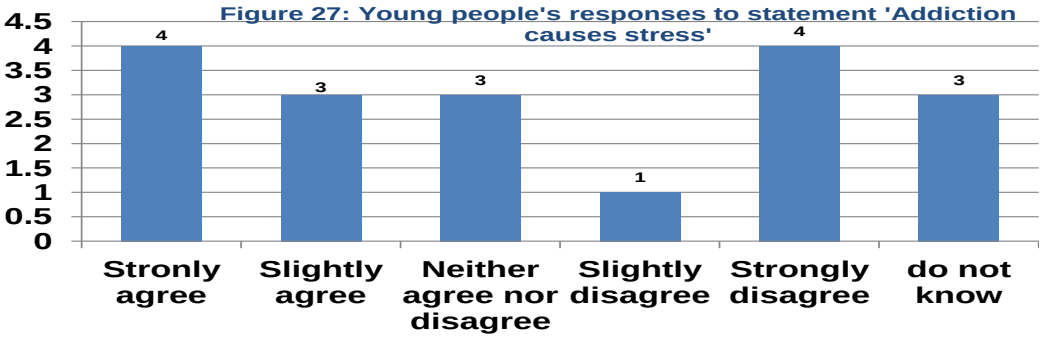


Figure 27: Young people's responses to statement 'Addiction causes stress'
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
4
3
3
1
4
3
Stronly agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Strongly disagree
do not know

Figure 28: Young people's responses to statement 'Don't think shisha is dangerous'

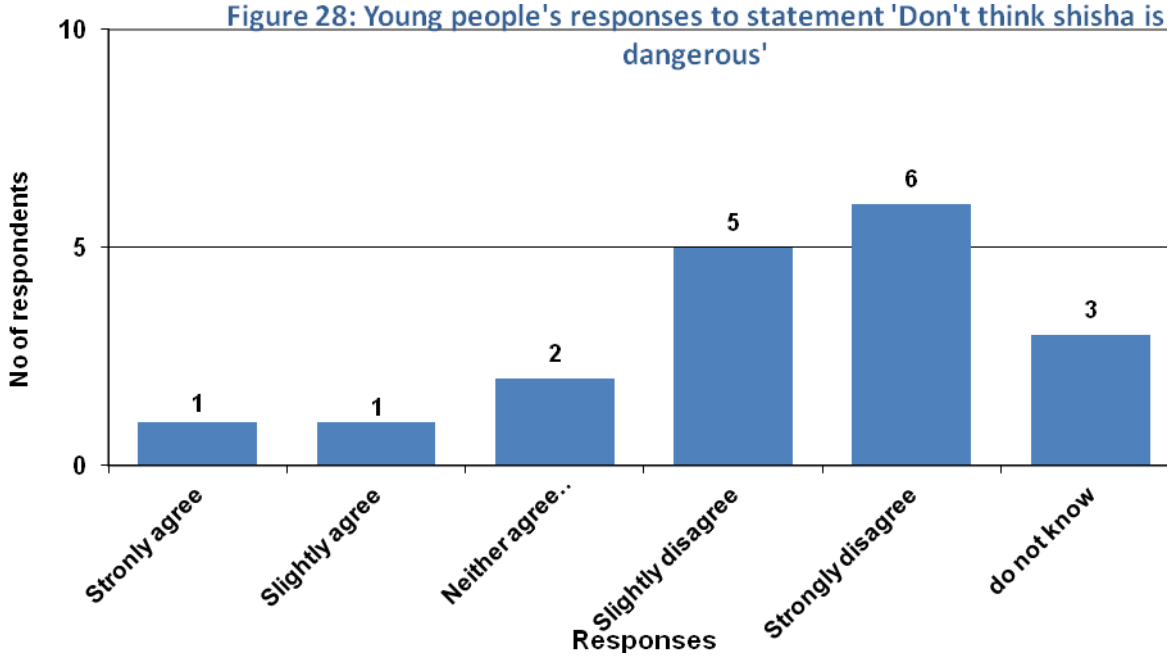
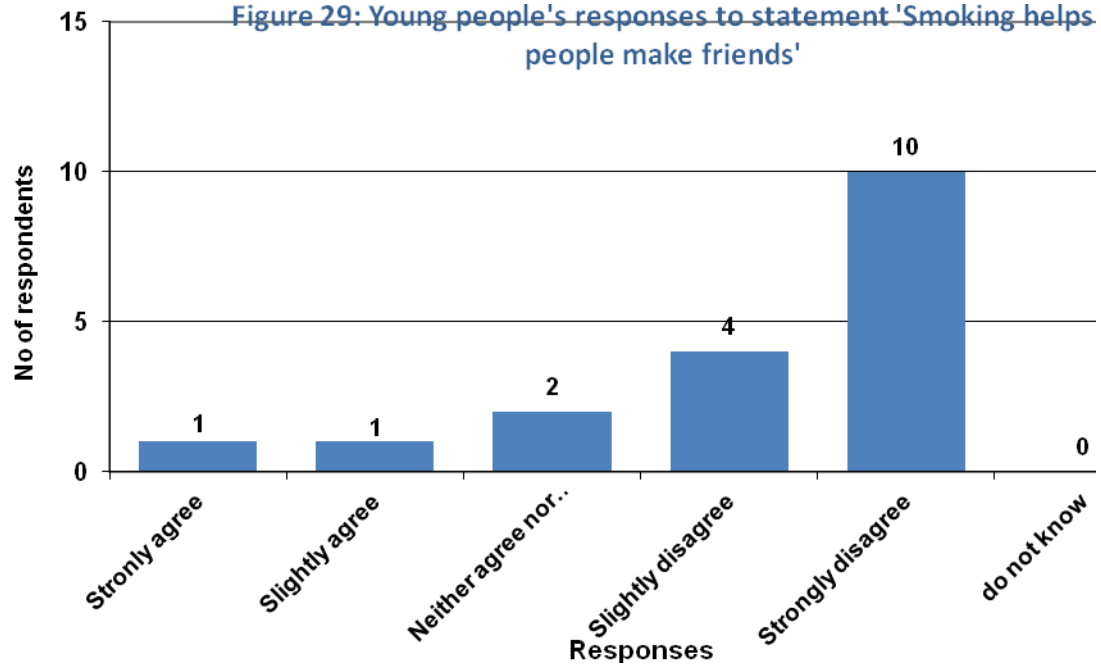


Figure 29: Young people's responses to statement 'Smoking helps people make friends'



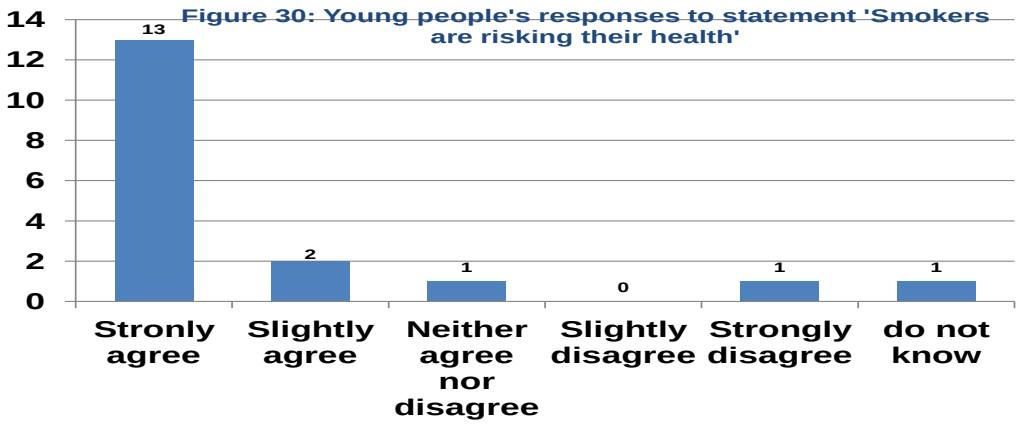


Figure 30: Young people's responses to statement 'Smokers are risking their health'
14
12
10
8
6
4
2
0
13
2
1
0
1
1
Stronly agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Strongly disagree
do not know

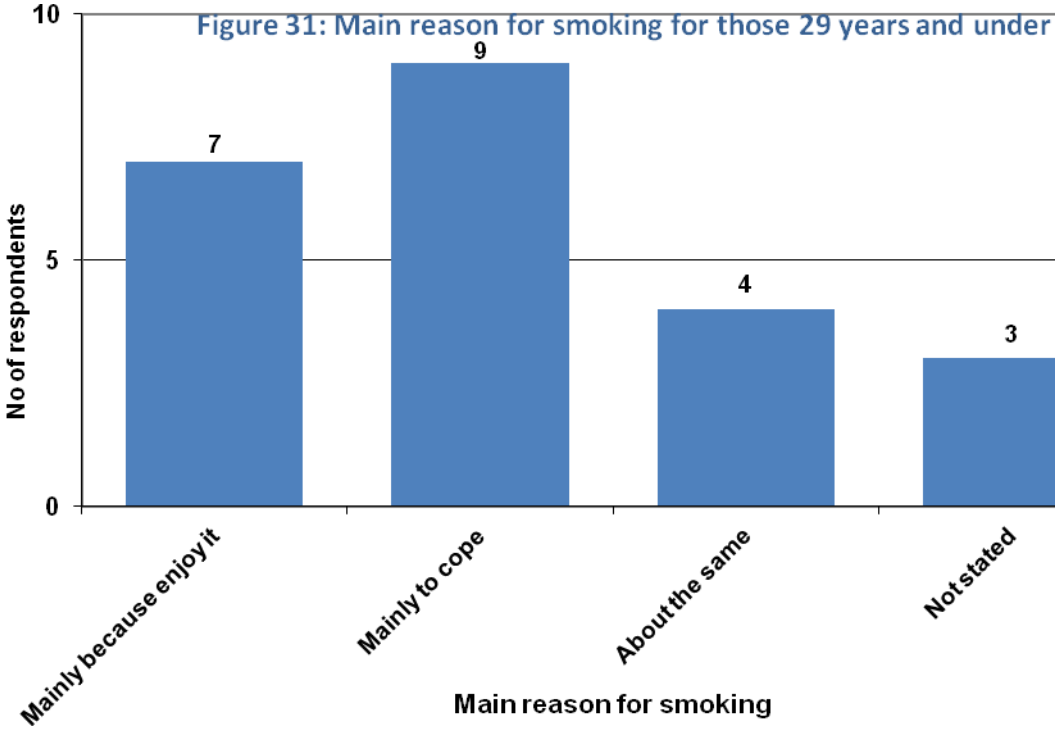


Figure 31: Main reason for smoking for those 29 years and under

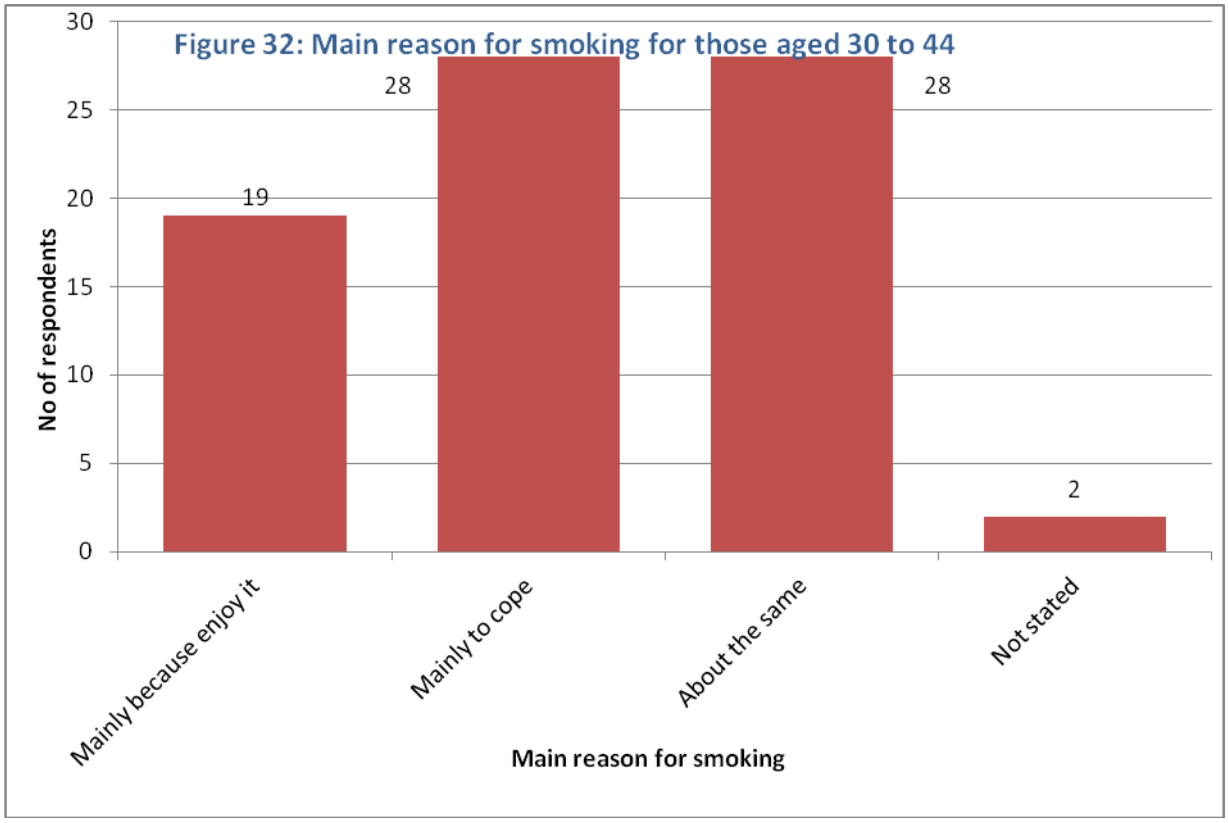


Figure 32: Main reason for smoking for those aged 30 to 44
30
25
20
15
10
5
0
No of respondents
19
28
28
2
Mainly because enjoy it
Mainly to cope
About the same
Not stated
Main reason for smoking

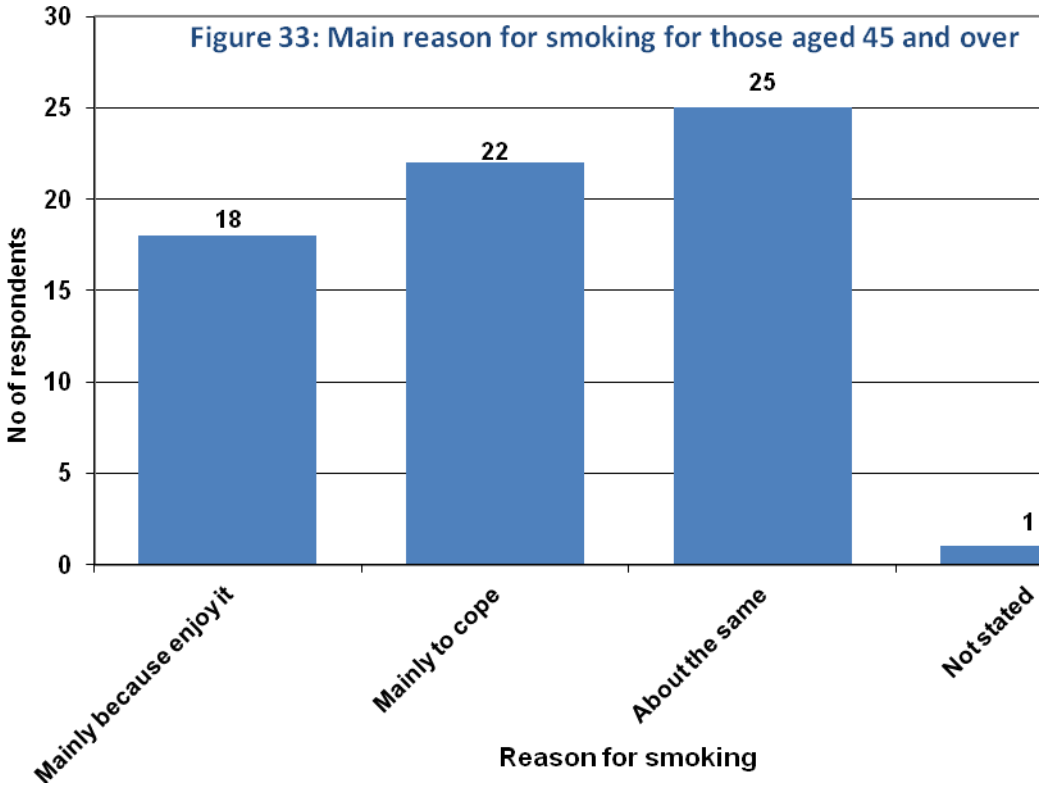


Figure 33: Main reason for smoking for those aged 45 and over
30
25
20
15
10
5
0
No of respondents
18
22
25
1
Mainly because enjoy it
Mainly to cope
About the same
Not stated
Reason for smoking

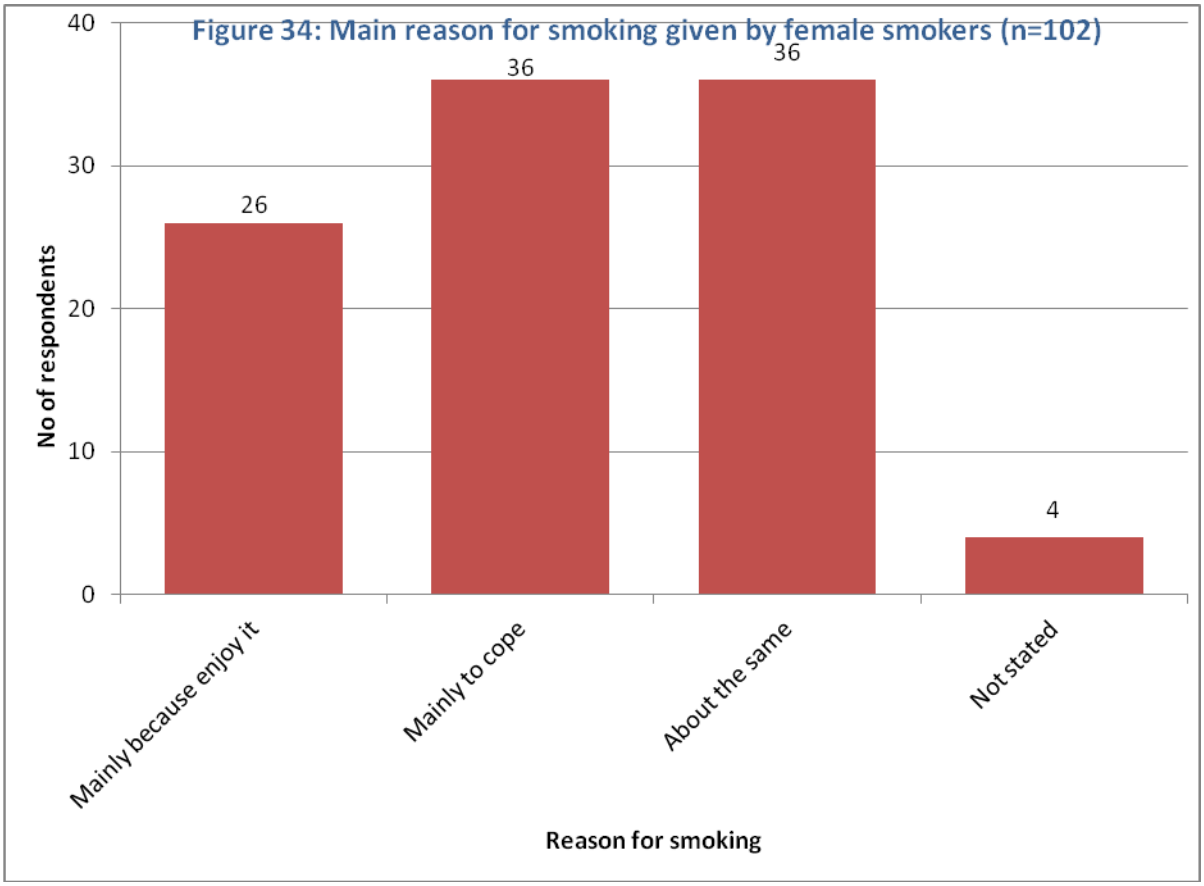


Figure 34: Main reason for smoking given by female smokers (n=102)
40
30
20
10
0
No of respondents
26
36
36
4
Mainly because enjoy it
Mainly to cope
About the same
Not stated
Reason for smoking

Figure 35: Main reason for smoking given by male smokers (n=75)

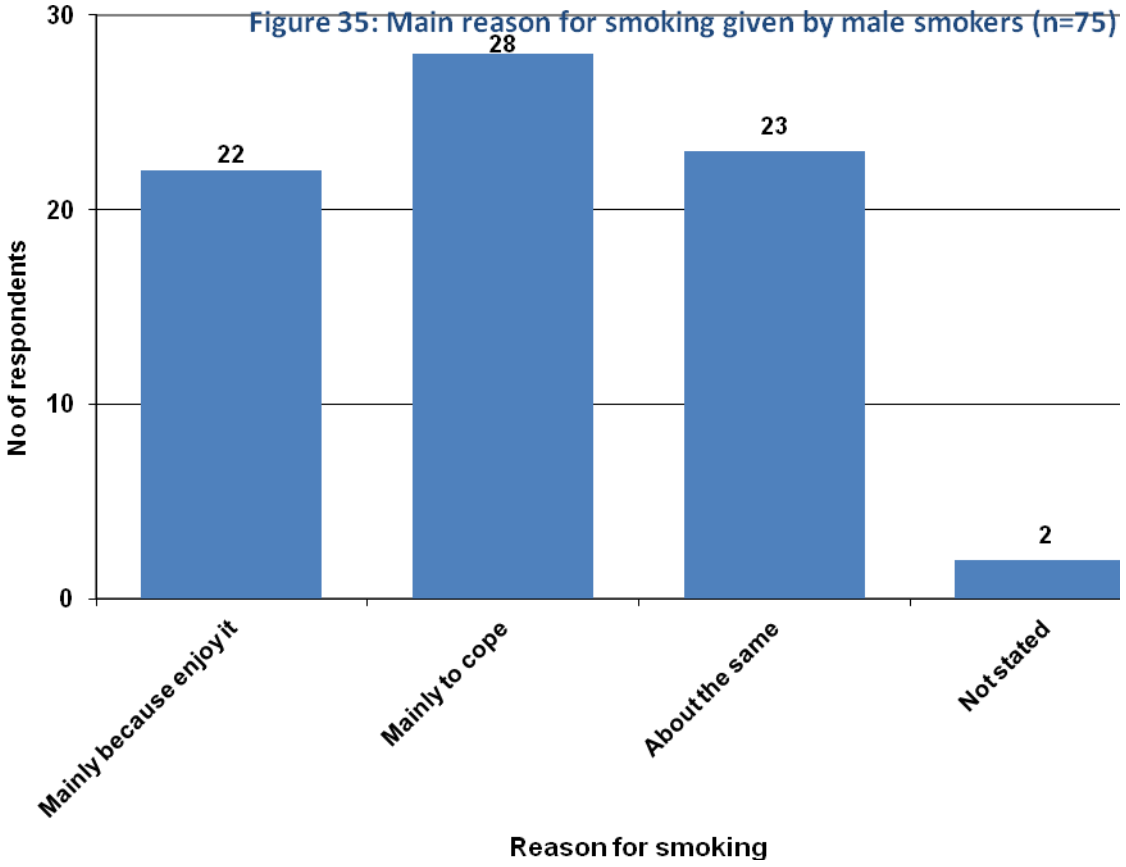


Figure 36: Number of times female respondents have tried to give up smoking

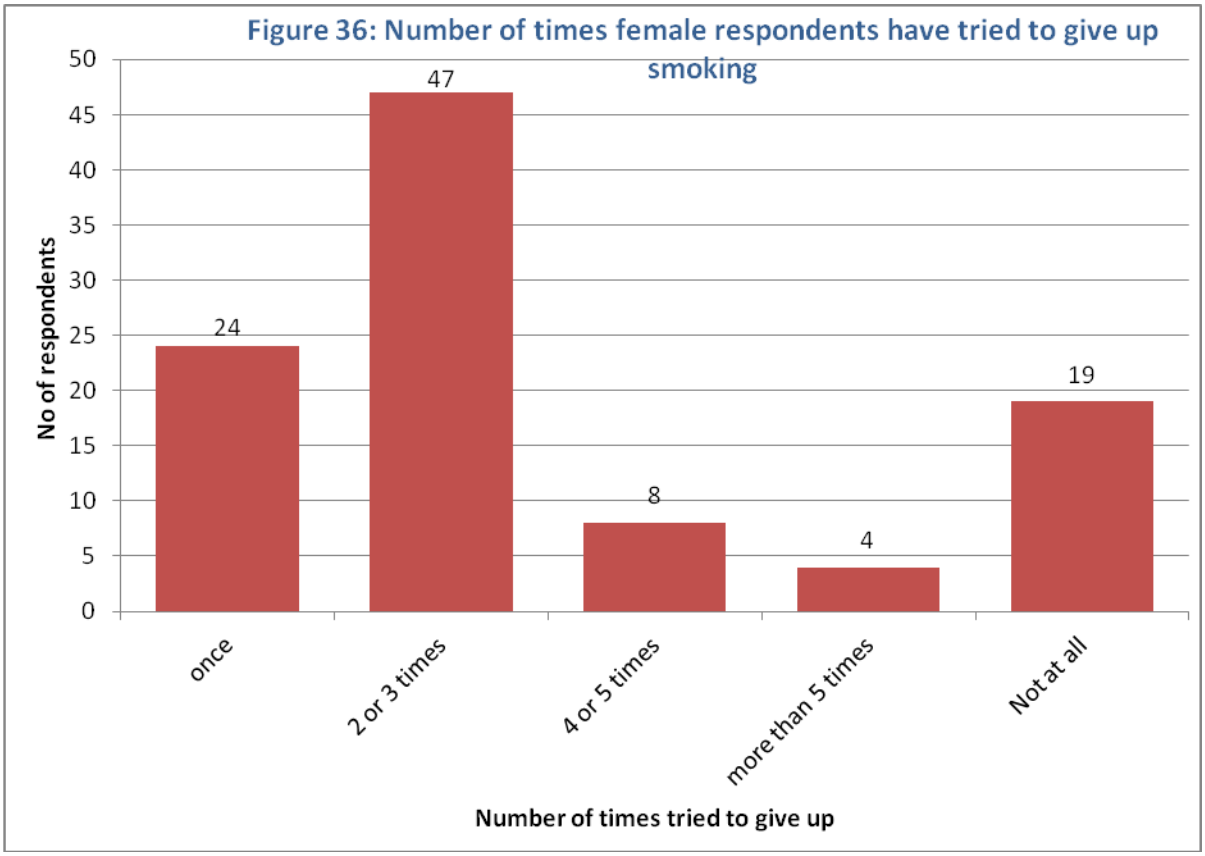


Figure 37: Number of times male respondents have tried to give up smoking

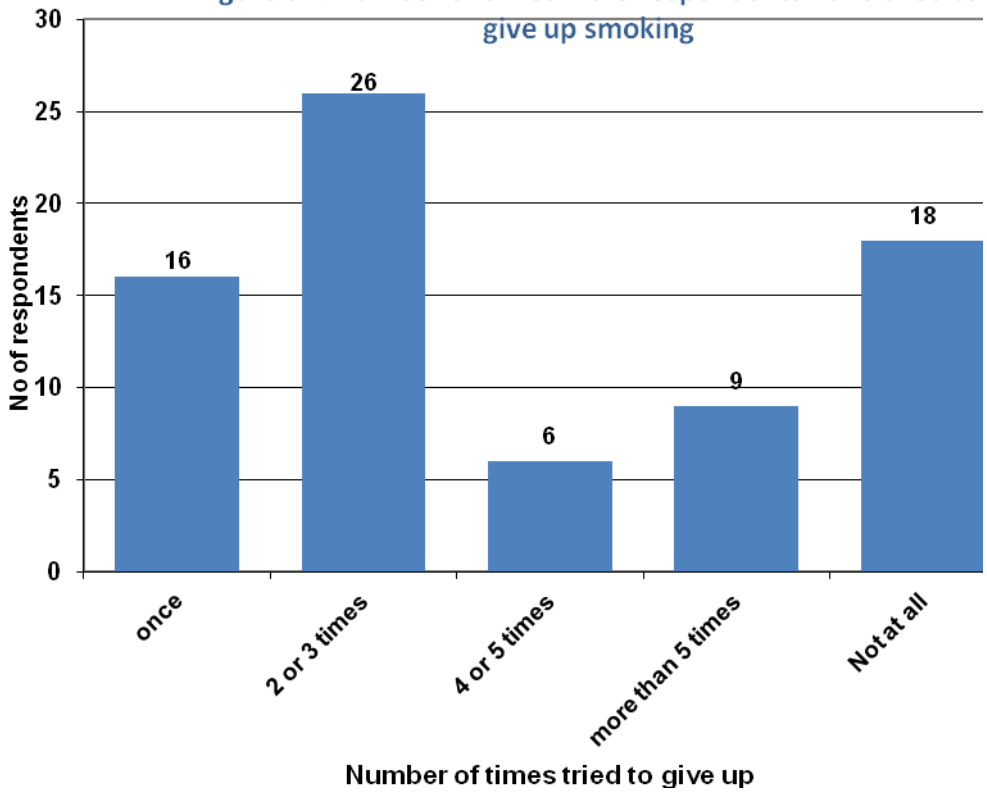


Figure 38: Number of times 29 year olds and under have tried to give up smoking

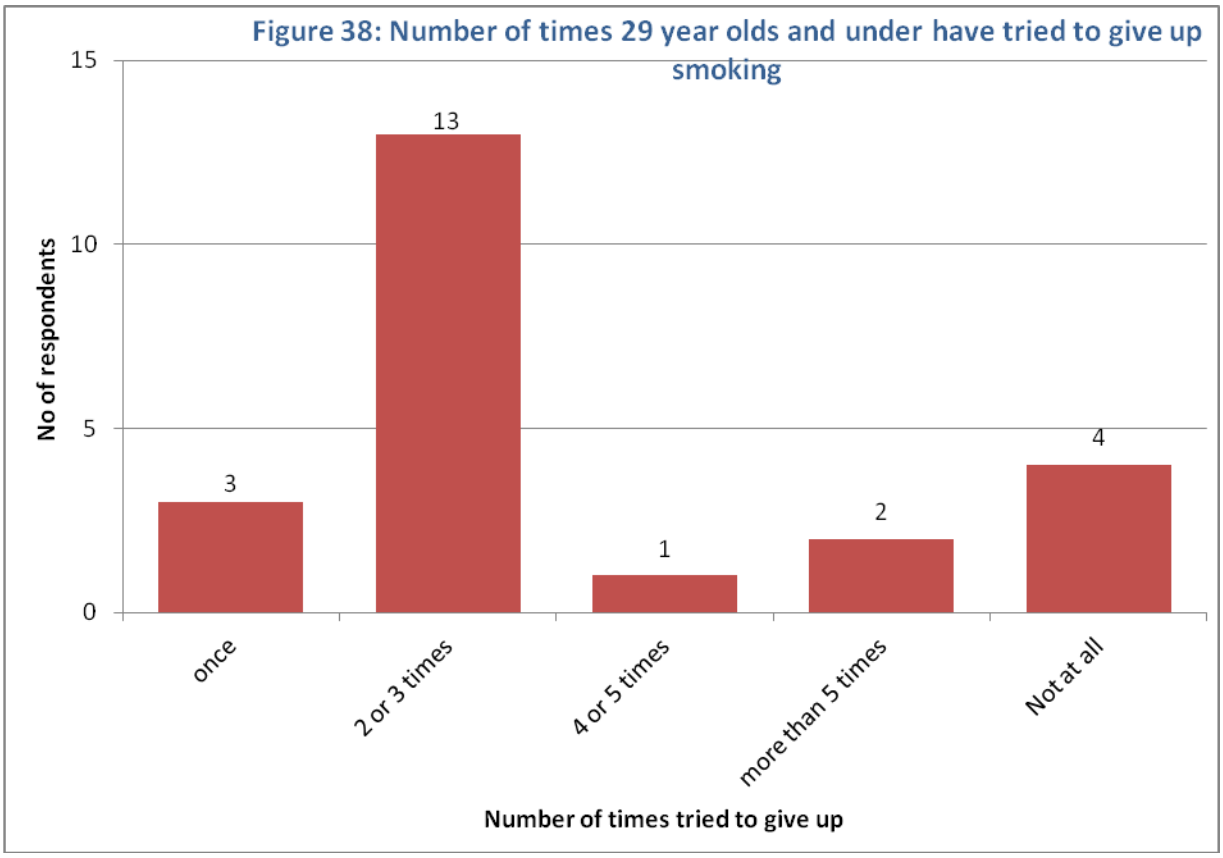


Figure 39: Number of times 30 to 44 year olds have tried to give up smoking

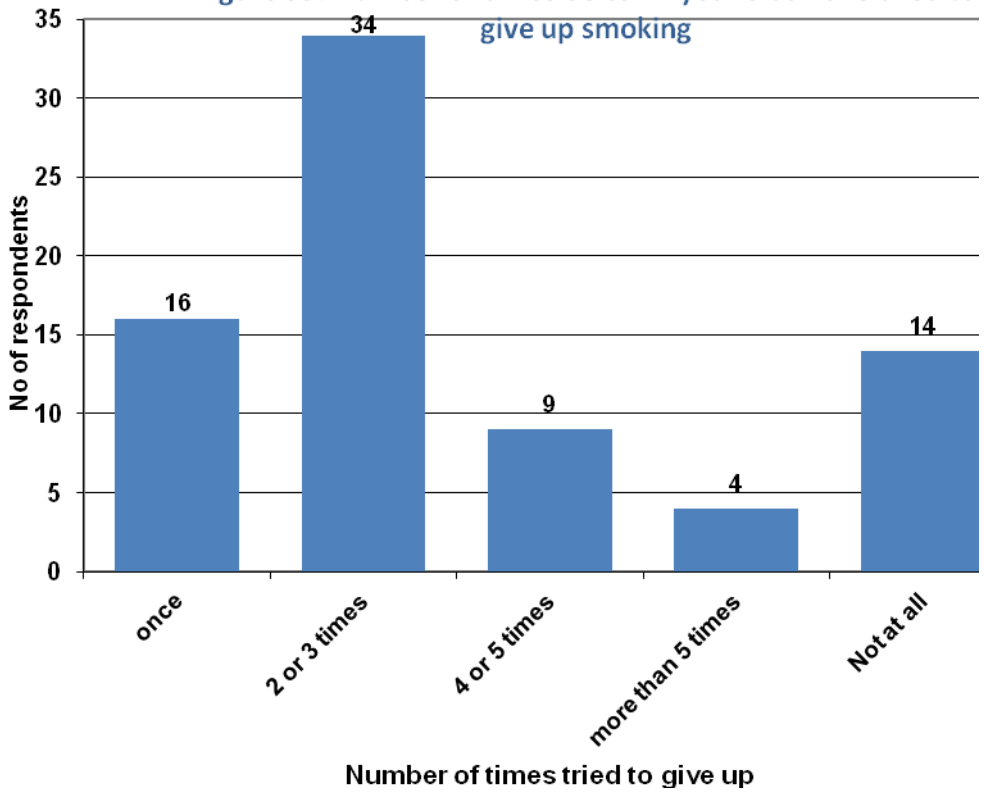


Figure 40: Number of times those who are 45 and over have tried to give up smoking

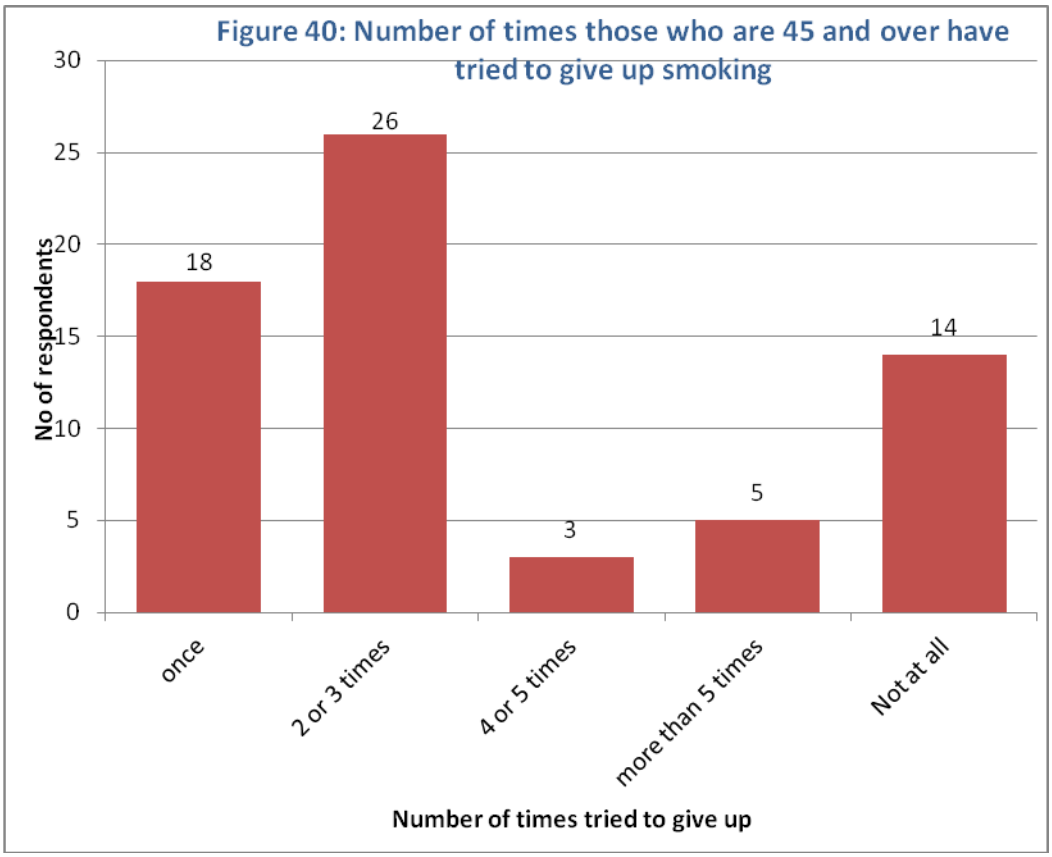
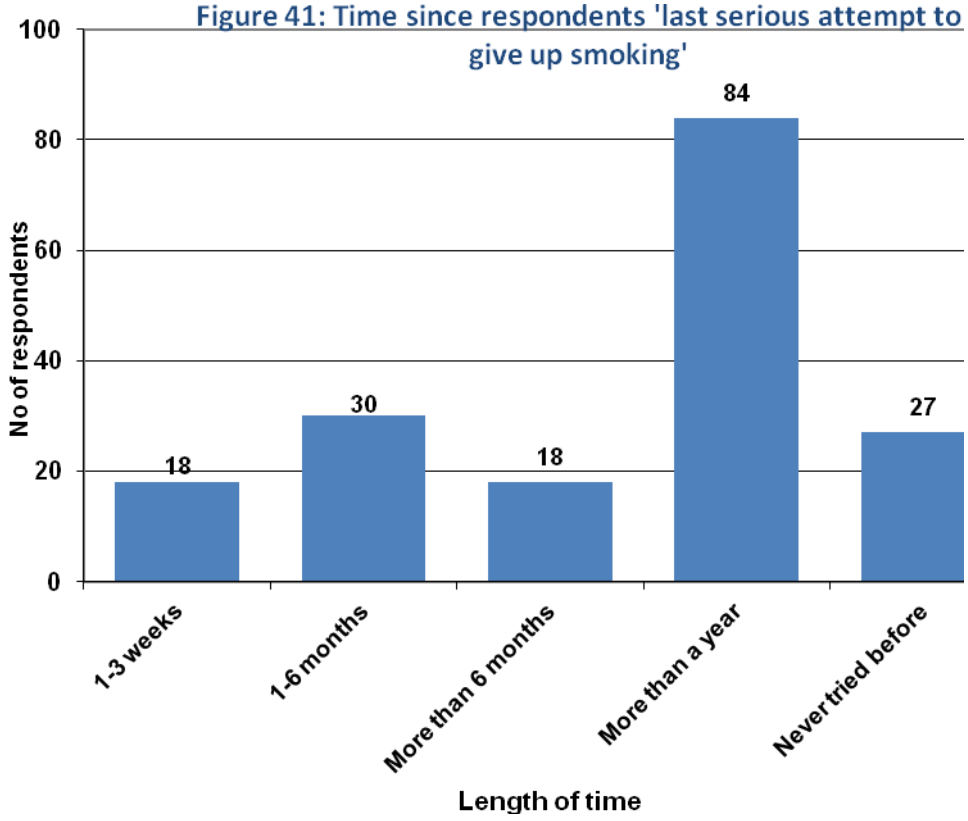


Figure 41: Time since respondents 'last serious attempt to give up smoking'



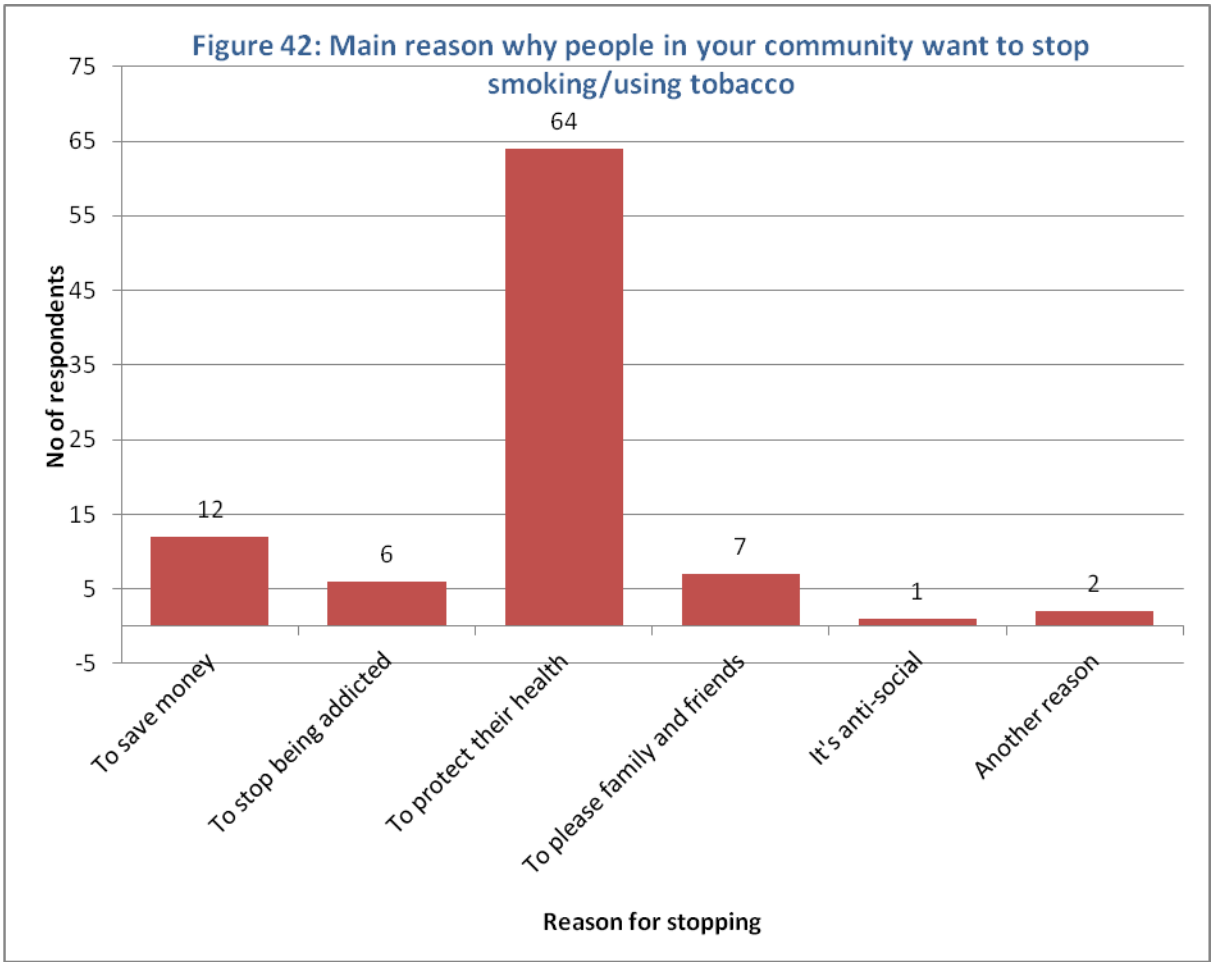


Figure 42: Main reason why people in your community want to stop smoking/using tobacco
75
65
55
45
35
25
15
5
-5
No of respondents
64
12
6
7
1
2
To save money
To stop being addicted
To protect their health
To please family and friends
It's anti-social
Another reason
Reason for stopping

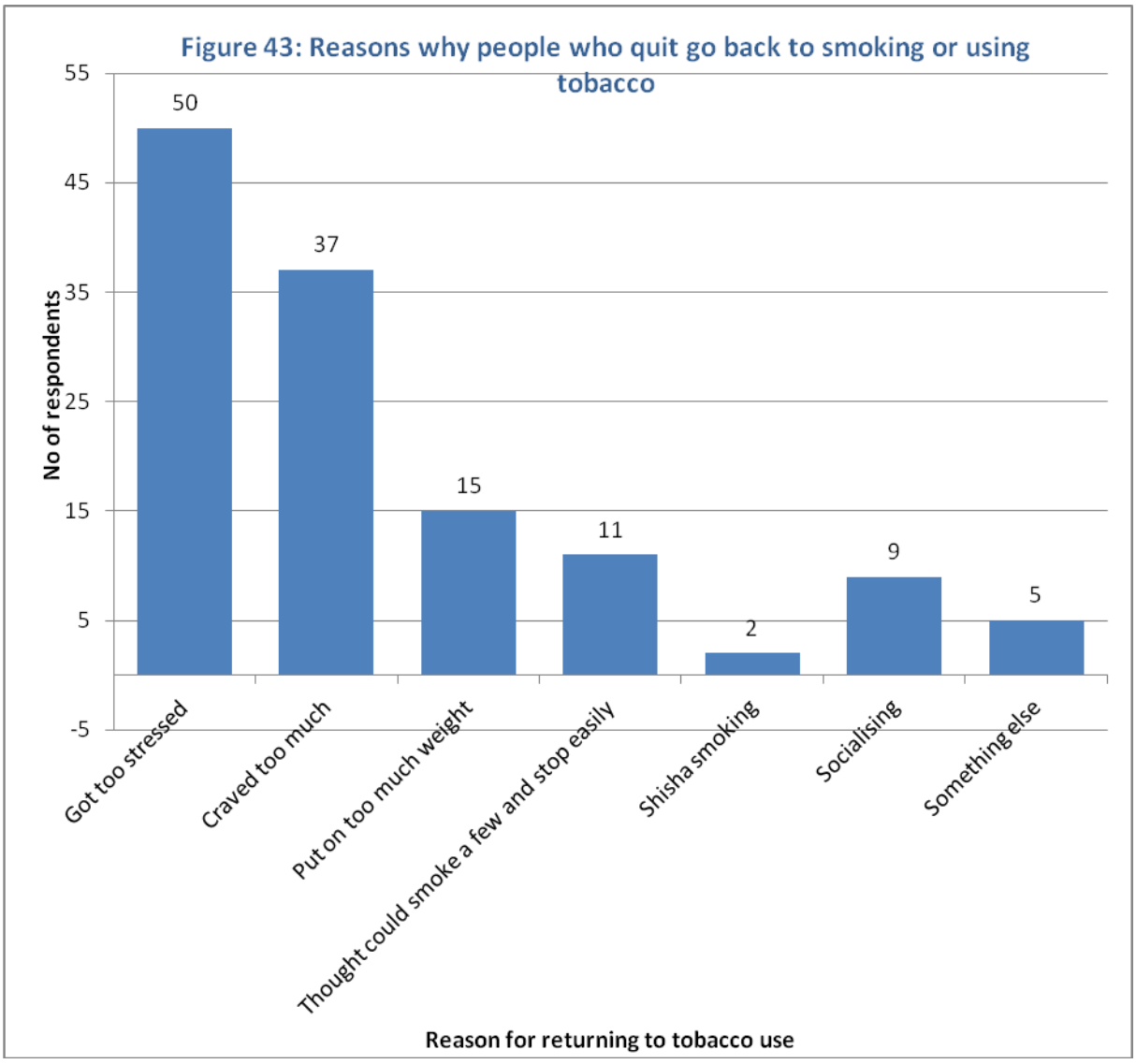


Figure 43: Reasons why people who quit go back to smoking or using tobacco
No of respondents
55
45
35
25
15
5
-5
50
37
15
11
2
9
5
Got too stressed
Craved too much
Put on too much weight
Thought could smoke a few and stop easily
Shisha smoking
Socialising
Something else
Reason for returning to tobacco use

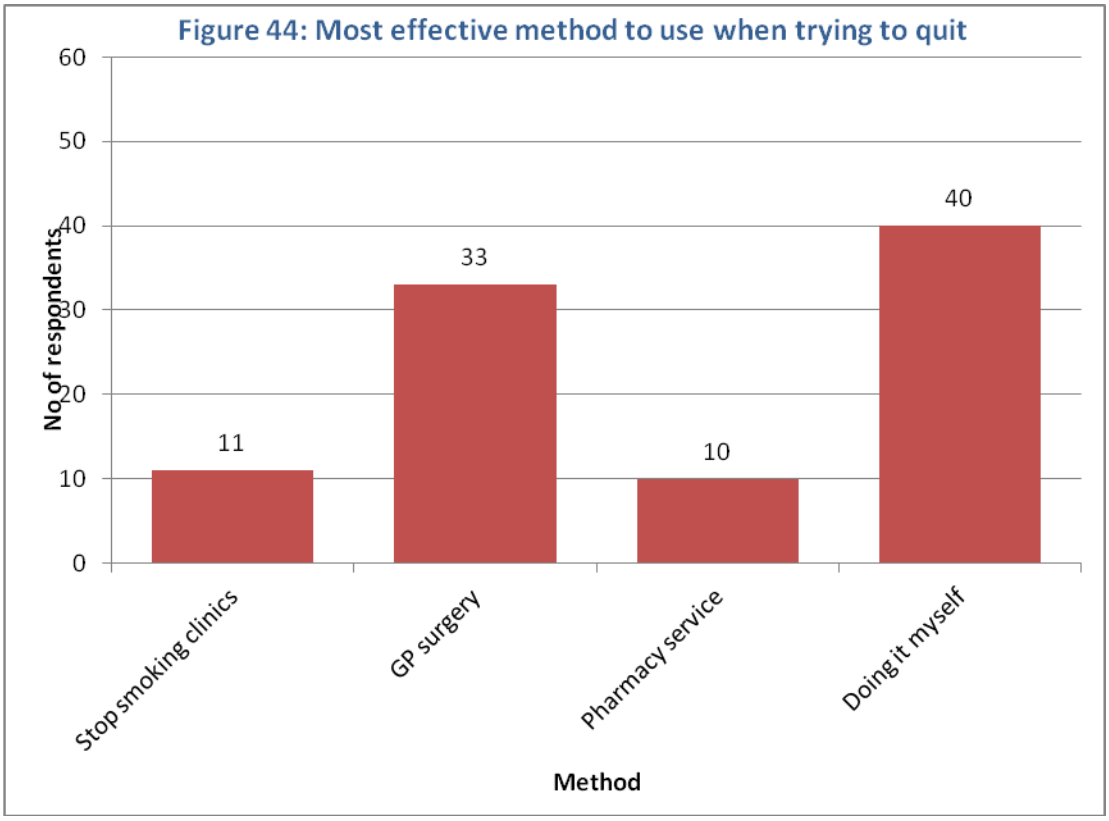


Figure 44: Most effective method to use when trying to quit
60
50
40
30
20
10
0
No.of respondents
11
33
10
40
Stop smoking clinics
GP surgery
Pharmacy service
Doing it myself
Method