

Understanding influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study

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Abstract

Objective To gain detailed understanding of influences on smoking behaviour in Bangladeshi and Pakistani communities in the United Kingdom to inform the development of effective and culturally acceptable smoking cessation interventions.

Design Qualitative study using community participatory methods, purposeful sampling, one to one interviews, focus groups, and a grounded approach to data generation and analysis.

Setting Newcastle upon Tyne, during 2000-2.

Participants 87 men and 54 women aged 18-80 years, smokers and non-smokers, from the Bangladeshi and Pakistani communities.

Results Four dominant, highly inter-related themes had an important influence on smoking attitudes and behaviour: gender, age, religion, and tradition. Smoking was a widely accepted practice in Pakistani, and particularly Bangladeshi, men and was associated with socialising, sharing, and male identity. Among women, smoking was associated with stigma and shame. Smoking in women is often hidden from family members. Peer pressure was an important influence on smoking behaviour in younger people, who tended to hide their smoking from elders. There were varied and conflicting interpretations of how acceptable smoking is within the Muslim religion. Tradition, culture, and the family played an important role in nurturing and cultivating norms and values around smoking.

Conclusion Although there are some culturally specific contexts for smoking behaviour in Bangladeshi and Pakistani adults—notably the influence of gender and religion—there are also strong similarities with white people, particularly among younger adults. Themes identified should help to inform the development and appropriate targeting of smoking cessation interventions.

Introduction

Studies in the 1980s of combined heterogeneous South Asian populations in Britain suggested that smoking rates were similar to or lower than rates in the white population,^{1,2} but recent surveys in the United Kingdom have shown that smoking is much more common among Bangladeshi men (49%) than among white (29%), Pakistani (28%) or Indian men (19%).³⁻⁵

The rate is particularly high (56%) in Bangladeshi men aged 50-74.⁴ Cancer of the trachea, lung, and bronchus is the commonest cause of death from cancer in South Asian men, and the second commonest in South Asian women.⁶ Smoking is the principal risk factor for these cancers.

Sex and age differences in smoking rates in South Asian populations are marked. In South Asian women, smoking rates are reportedly low (Bangladeshi women 4%, Indian women 1%, Pakistani women 2%)⁴ though possibly underestimated.⁷ National smoking prevalence is strongly associated with socioeconomic status in Bangladeshi people living in the United Kingdom, although the association is less clear in the Pakistani population.⁵

Detailed understanding of attitudes, beliefs, values, and behaviours in relation to smoking in minority ethnic groups is lacking. Such understanding is necessary to inform development of smoking cessation strategies that are culturally appropriate for these communities.⁸⁻¹⁰ We report community based, qualitative research (March 2000 to March 2002) that aimed to gain such insights in Bangladeshi and Pakistani communities.

Methods

Participatory approach

We used a community participatory approach previously developed successfully in these communities,¹¹ in which members of the Bangladeshi and Pakistani communities in Newcastle (box 1) participated in study development, implementation, and analysis. After community publicity, application, and interview, 13 bilingual “community researchers” (six men and seven women) were recruited from the local South Asian population and attended a 14 week, accredited training programme in qualitative research.

These researchers were responsible for organising, recruiting, undertaking, and translating in-depth interviews and focus groups, facilitated by JB. In discussion with the research team, the community researchers also developed interview topic guides, publicity for the study, and strategies for recruiting participants and contributed to data analysis.

Research methods

The community researchers held semistructured, in-depth interviews with 37 participants and 24 focus

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Box 1: Bangladeshi and Pakistani communities in Newcastle upon Tyne

Bangladeshis are the most recent immigrant group among South Asians in the United Kingdom. In the 1991 census, 1292 residents in Newcastle upon Tyne identified themselves or their family members as Bangladeshi (0.5% of total population of the city), and 2913 (1.2%) identified themselves as Pakistani. Both communities are mainly concentrated in five of 26 wards in the city

In these five wards Pakistanis and Bangladeshis typically have higher levels of socioeconomic deprivation than white residents.¹² Recent national surveys have also shown Bangladeshis to be the poorest and least well educated, and further disadvantaged with respect to their health³

The dominant religion is Islam among both Bangladeshis and Pakistanis

Smoking rates among the Bangladeshi and Pakistani communities in Newcastle are broadly similar to the rates for those populations nationally¹³

groups (with 104 participants). Interviews and focus groups were based on topic guides, translated into relevant South Asian languages by the community researchers. Twenty pilot interviews and focus groups took place to give the community researchers confidence, test the feasibility of recruitment techniques, and refine the topic guides. Topics discussed included smoking behaviour, views on what influences smoking, and understanding of how smoking affects health.

Research participants were sampled purposively from the local Bangladeshi and Pakistani communities on the basis of ethnic group (that is, Bangladeshi or Pakistani), sex, age, smoking status, and occupation.

Both male and female smokers were recruited. Participants were recruited informally through existing community based religious and non-religious organisations, groups, and social networks by using a “snowballing” technique—whereby a small number of informants put the researcher in touch with others, who then nominate friends, colleagues, and other contacts, and so on.¹⁴

The community researchers were “matched” as closely as possible to the participants in terms of language spoken, sex, and age.¹⁵ Single sex and ethnic focus groups were held to respect and increase cultural acceptability, and, as far as possible, focus groups contained participants of similar ages.

A total of 141 people (87 Bangladeshi and 54 Pakistani) aged 18-80 years participated. The table shows characteristics of the participants. Participants were broadly typical of the Bangladeshi and Pakistani populations of Newcastle, with slight under-representation of people aged over 50 and slight over-representation of people aged 18-29.

Translation

Sixty per cent of focus groups and interviews were conducted in English, the rest in Punjabi or Urdu (for Pakistanis) or Bengali or Sylheti (for Bangladeshis). All interviews and focus groups were audiotaped and transcribed verbatim with participants’ permission. The community researchers translated the tapes in Punjabi, Urdu, Bengali, and Sylheti into English. About a fifth of these translations were also sent to an independent translation agency. The two sets of translations were compared for consistency; no substantial differences in meaning were identified.

Analysis

We analysed the transcripts by identifying recurring, emergent themes using constant comparison of the interview transcripts.^{16 17} Data generation and analysis continued until no new themes or ideas were emerging. JB led the analysis, with the community researchers and members of the research team reading a proportion of transcripts to agree a thematic framework to be used for coding, thus improving the reliability of the analysis. We used the NUD*IST 4 textual analysis software to help us to do this. To refine our interpretations, we discussed the analysis at a meeting with local community workers and organisations.

Results

Four highly inter-related themes were found to influence views on smoking: gender, age, religion, and tradition.

Gender

Smoking in men was viewed with a strong sense of social acceptance, social bonding, and tradition and was seen as a “normal” part of “being a man.” This view was particularly strong among Bangladeshi participants. It was intimately bound up with notions of male identity. Macho and fashionable images were associated with smoking and reinforced by Indian films and popular media (box 2).

Many of the men described how they were more likely to smoke, and to smoke more cigarettes, when they were in the company of other smokers (box 2). A

Characteristics of 87 Bangladeshi and 54 Pakistani participants. Values are numbers (percentages) of participants

	Bangladeshi	Pakistani
Age (years):		
18-29	36 (41)	22 (41)
30-49	32 (37)	22 (41)
≥50	19 (22)	10 (19)
Men	50 (58)	37 (69)
Age left full time education (years):		
Did not attend school	5 (6)	5 (9)
<16	15 (17)	3 (6)
16	22 (25)	12 (22)
17-18	20 (23)	13 (24)
>18	10 (11)	8 (15)
Not known	15 (17)	13 (24)
Languages spoken:		
South Asian language only	17 (20)	3 (6)
South Asian language and English	56 (64)	40 (74)
English only	1 (1)	1 (2)
Not known	13 (15)	10 (19)
Smoking status:		
Current smoker, men	30 (60)	19 (51)
Current smoker, women	7 (19)	3 (18)
Former smoker, men	8 (16)	5 (14)
Former smoker, women	2 (5)	0
Never smoked, men*	12 (24)	13 (35)
Never smoked, women*	28 (76)	14 (82)

*Or tried only once or twice.

Box 2: Being a man and smoking

"Boys see their fathers smoke, their grandfathers smoke, so they think it is part of being a man" (non-smoker; participant 2, focus group of Bangladeshi women aged 18-22, English)

"I think from the old days going back hundreds of years, it was a man thing to do . . . you remember watching Indian films and you watch the hero smoking" (non-smoker; participant 1, focus group of Bangladeshi women aged 18-22, English)

"If you went somewhere and if you didn't smoke a cigarette . . . you are not considered to be a manly man" (non-smoker; participant 3, focus group of Bangladeshi men aged 30-49, English)

"I think I smoke more when I am sitting around with friends who are smokers because you are offered one and you are offered another one and you get on talking, and you smoke more when you are socially with smokers" (current smoker; participant 1, focus group of Bangladeshi men aged 30-49, English)

"I can have a period where I go from Monday to Friday and not smoke one cigarette . . . and then on a weekend because I am going out with friends . . . 10 cigarettes could be smoked over two days" (current smoker, Pakistani man, aged 30-39, interview in English)

minority thought that the trend was now changing, however, that it was becoming more sociable not to smoke. For a minority of young men, smoking in peer groups was also linked with drinking alcohol.

Stress was also thought to influence smoking in men. Both men and women viewed Bangladeshi and Pakistani men as having stressful lives owing to pressures associated with being separated from family and to poorly paid work. Participants thought that Bangladeshi men working in the catering industry suffered particularly severe stress as a result of unsocial and long working hours in restaurants.

In contrast, participants often regarded smoking in Bangladeshi and Pakistani women with a sense of taboo, stigma, and non-acceptance, using such words as "bad," "labelled," "tainted," "shamed," and "disrespectful." Smoking was also perceived to affect the chances of a woman marrying. Women were regarded as having fewer opportunities to smoke, both culturally and economically (box 3).

However, some men and women (and especially the younger participants) held the view that the prevalence of smoking in young Bangladeshi and Pakistani women is increasing as they become more westernised, influenced by white women and peer pressure from white children at school. Most of the female smokers who participated in the study were under 30. Motivation for young women to smoke often centred on "rebellion" or expressing independence from family members (box 3). Although smoking in women was usually viewed as a covert activity, some younger Bangladeshi and Pakistani women seemed to smoke in peer groups (box 3).

Age and generation

Age seemed to influence the cultural acceptability of smoking. Because of elders' respected status in South Asian society the participants viewed it as more acceptable for older men and, to a lesser degree, older women

to smoke openly. In contrast, smoking in young people tended to be regarded as "disrespectful," particularly in front of elders. Thus, smoking in young people tended to be hidden from older members of the community (box 4).

Elders who smoked were perceived to lack knowledge of the health effects of smoking and have a more fatalistic approach to life. Younger people were viewed as being more likely to smoke because of influence of peer pressure, image, and rebellion (box 4). However, if a participant's peer group comprised predominantly non-smokers, this sometimes resulted in that person being less likely to start smoking.

Religion

Unlike alcohol, tobacco is not specifically banned or prohibited in the Islamic faith. The Koran does prohibit intoxicants and addictions, however. Most participants agreed that it was religiously unacceptable to smoke in a mosque and that the potential for women to smoke was reduced as they have a protected status in the Muslim religion.

Participants held conflicting perspectives on how religiously acceptable it is for men to smoke and to what degree smoking is permitted in the Muslim religion. Many believed that, although smoking is not banned or prohibited, it does not fit comfortably within the Islamic religion, that it "isn't right" or is "makroo." This argument was used in two contradictory ways.

Box 3: Women and smoking

"In our culture smoking is not accepted for women. It is very bad, especially from a good family" (non-smoker, Bangladeshi woman, aged 20-29, interview in Bengali/Sylheti)

"They are always frightened of their husband. No husband likes their wife smoking. Our women do not maintain a smoking habit, because women smokers are hated in our society. It is not a prestigious thing at all; rather it is a scandal in our society" (former smoker, Bangladeshi man, aged 40-49, interview in Bengali/Sylheti)

"Lads can knock about and play footie and that but girls aren't allowed. They have always been protected by Islam and parents. So they haven't got enough opportunity to go out and smoke outside" (non-smoker; participant 1, focus group of Pakistani women aged 18-29, English)

"I think more women are starting to smoke, only they are hidden whilst the men are very open about it" (non-smoker; participant 2, focus group of Bangladeshi women aged 18-29, English)

"Women smoke in the bedroom, [behind] locked doors" (non-smoker, participant 1, focus group of Bangladeshi women aged 18-29, English)

"I don't smoke like an everyday thing. I smoke when I'm with bad people . . . I do it often when I am angry. I do it in front of my husband more because I make him angry because he doesn't smoke and he hates seeing people smoke" (current smoker, Bangladeshi woman, aged 30-39, interview in English)

"I take the occasional puffs with my friends, just for the fun of it because they are doing it in front of me" (current smoker; participant 4, focus group of Bangladeshi women aged 18-29, English)

Box 4: Influence of age

“Older people, they can smoke in the house because [they] are allowed. Because of their age they can smoke” (current smoker, Bangladeshi man aged 40-49, interview in English)

“These elderly women do smoke in front of their sons . . . my dad’s mother, my grandmother, they smoke in front of their sons” (current smoker; participant 1, focus group of Bangladeshi women aged 18-29, English)

“They [young people] will sneak out of the house or they will just say they are going out . . . It’s a cultural thing. It’s like respect for your elders if you don’t smoke in front of them” (former smoker, Pakistani man aged 20-29, interview in English)

“I think there’s an image that if you smoke you’re cool, you’re stylish, you’re in with your friends. I think that’s what [young] people think when they smoke” (current smoker, Bangladeshi woman aged 20-29, interview in English)

“When there is five of them [young people] together they think ‘oh, let’s have a fag’ . . . I think a lot of them, being rebellious, they think ‘do something hidden’ ” (non-smoker; participant 1, focus group of Bangladeshi women aged 18-29, English)

Box 5: Influence of religion

“Islam, He said if anything is damaging your health, it is haram [banned or prohibited], which is sinful . . . the reason Mohammed allowed smoking and banned drinking is that, [drinking] was damaging people’s health at that time. Nowadays smoking is no different from drinking: it is more dangerous. So if you could get that to the people’s knowledge then I think most of our majority may just stop smoking” (non-smoker, Bangladeshi man, aged 30-39, interview in English)

“Alcohol has a substance that makes you . . . lose your senses . . . you don’t know what you are doing. You lose that control over yourself. So that’s why it becomes unlawful . . . when you smoke you still know what you are doing. You don’t lose your senses” (non-smoker; participant 2, focus group of Bangladeshi women aged 18-29, English)

“I have read many [religious] books. It doesn’t say smoking is unlawful. But it does say if you feel that you have become addicted to something and rely on that to make you a better person or make you feel more comfortable, then it becomes unlawful. So in other words, smoking does become unlawful to those who become addicted to it” (non-smoker; participant 1, focus group of Bangladeshi women aged 18-29, English)

Some used it to justify the need to ban smoking; others used it to justify the acceptability of smoking in the Muslim religion as long as the smoker was not “addicted to” or “intoxicated by” cigarettes (box 5). Non-smokers (particularly women) thought that many smokers who are addicted to cigarettes do not realise or admit to this.

Only a small number of participants felt that smoking was unacceptable in the Islamic religion because it damaged health (although the Koran states that

Muslims should not allow their hands to contribute to their own destruction) (box 5).

Tradition, culture, and family

Tradition and culture also seemed to play a role in creating, perpetuating, and regulating cultural norms, acceptance, and “fashion” around smoking (box 6).

Views on why smoking levels in Bangladeshi and Pakistani men differed focused on socioeconomic differences and social disadvantage; the more recent arrival of Bangladeshis into the United Kingdom; stressful jobs and working long unsocial hours in unregulated environments (particularly restaurants); and the fact that smoking has traditionally been viewed as macho among Bangladeshi men.

The family was felt to be an important medium through which cultural norms and values associated with smoking were shaped and negotiated. Young boys often learnt to smoke by observing male elders smoking (box 6), whereas opportunities for women were limited owing to the cultural restrictions imposed on a Muslim woman by her parents. There were strong rules and standards surrounding what was expected of a “good family.”

Our analysis also suggests generational changes in acceptability of smoking. Several participants described how their children—who had learnt at school about the risks to health from smoking—criticised their fathers for smoking (box 6). This had sometimes led to changes in behaviour, such as starting to smoke outside the house or in a different room from their

Box 6: Influence of tradition, culture, and family

“My uncle smokes and he’s in his 50s. He’s come from Pakistan, so he started from there. So my cousins are in Glasgow and they have started smoking and they are my age. It’s from working in a shop and, like I say, the fascination is there. They see old people buy cigarettes and they think what’s the fascination of it?” (non-smoker; participant 1, focus group of Pakistani men, aged 18-29, English)

“I suppose because my dad smokes as well, when you see someone else smoking in your family when you are young you kind of think that it is okay ‘cause they are doing it” (former smoker; participant 3, focus group of Pakistani men, aged 18-29, English)

“I’ve seen that teenagers, young people . . . put a lot of pressure on parents and aunties and uncles about smoking. They say that smoking is so bad for you. And the example they give is from awareness in school. I can sort of say that with my two kids, and the children I mix with in other families, there are very strong feelings, ‘stop smoking dad! It does this and that and that.’ They feel very strongly. It’s the teenagers, the young children who are telling the parents” (non-smoker; participant 5, focus group of Pakistani women aged 20-59, Punjabi/Urdu)

“When I used to smoke, my children used to complain ‘dad we can’t breathe.’ They used to cough and say ‘dad is a stinky’ and ‘we can’t breathe. Dad smokes and it smells.’ This is why I can understand that it does affect those people who don’t smoke. They feel they can’t breathe” (former smoker; participant 3, focus group of Bangladeshi men aged 20-49, Bengali/Sylheti)

children or trying to give up smoking altogether. In some families, however, criticism of elders was not acceptable.

Other traditional practices involving tobacco (smoking hookahs, Pakistanis; and chewing “paan” (betel leaf and areca nut), Bangladeshis) were viewed as being less common today among younger people. Cigarette smoking was often viewed as becoming the modern equivalent of smoking hookah for young people.

Discussion

Although our results show some similarities with those of studies of smoking behaviour in predominantly white populations,^{18 19} they also highlight important differences, particularly the influence of a person’s gender and religion. The findings must be interpreted with regard to the characteristics of our sample and the participatory nature of the research. We had a broad range of participants in terms of age, sex, occupation, socioeconomic status, educational level, and smoking status. By working with members of communities at all stages of the research, we used our participatory approach to increase the validity of our findings.¹¹ The socioeconomic characteristics of Bangladeshi and Pakistani people living in Newcastle upon Tyne are broadly typical of Bangladeshi and Pakistani people nationally.¹³ Thus, although we must be guarded, our findings are likely to be generalisable to other Pakistani and Bangladeshi communities in the United Kingdom, although local variations reflecting differing regional origins within Bangladesh and Pakistan may exist.

Comparing Bangladeshi and Pakistani populations

Despite smoking being less common in Pakistanis than in Bangladeshis³⁻⁵ we found few differences in beliefs or attitudes between these two groups. Differences in smoking levels between Pakistani and Bangladeshi men may be explained largely by socioeconomic factors and social disadvantage,^{3 5 13} which, although acknowledged by several participants, are difficult to confirm in qualitative research. However, our data suggested that compared with Pakistani men, smoking in Bangladeshi men may be more deeply socially ingrained, contributing to group cohesion and identity.

Gender and age

Our analysis shows that in Pakistani, and particularly Bangladeshi, men smoking is central to socialising and identity and is an antidote to stress. In women, smoking has been traditionally regarded as disreputable, and cultural restrictions have reduced opportunities for women to smoke. However, both male and female participants said that smoking, which was often private and covert in women, seemed to be increasing among young women.⁷ This increase was attributed to westernisation, peer pressure, and rebellion.

Smoking was viewed as more acceptable in male elders and, to a lesser degree, in female elders. Young people smoking in the presence of elders was deemed disrespectful. Peer pressure and image were viewed as powerful influences on young people starting to smoke.

Islam, tradition, and family

As others have found in relation to diabetes and heart disease, religion plays an important but contested role

What is already known on this topic

Smoking is common among Bangladeshi and Pakistani men in Britain but rare among the women

Smoking is particularly common in Bangladeshi men

Socioeconomic status is thought to influence smoking uptake in Bangladeshi men

Influences on smoking in South Asians in Britain are poorly understood

What this study adds

Smoking among Pakistani and Bangladeshi men is strongly seen as socially acceptable—a “normal” part of being a man

Smoking in Bangladeshi men is more deeply socially ingrained than in Pakistanis, contributing to group cohesion and identity

Smoking in Bangladeshi and Pakistani women is associated with a strong sense of cultural taboo, stigma, and non-acceptance

Islam forbids addiction and intoxicants, but opinions differ on whether the Muslim religion allows smoking

Culturally sensitive smoking cessation interventions for Bangladeshis and Pakistanis are needed

in influencing attitudes and behaviour.^{20 21} Islam forbids addictive substances, intoxicants, and those that harm health but does not expressly forbid tobacco (which was unknown in the Old World when the Koran was written). There were conflicting interpretations of how religiously acceptable it is for Muslim men to smoke. These conflicting interpretations were linked with participants’ understanding of whether smoking is an addiction or intoxication.

The family was viewed as an important medium through which traditional norms, rules, and values associated with smoking were shaped and negotiated.

Implications for smoking cessation

Currently ethnic minority groups are not given special mention in national policies on smoking cessation,^{22 23} although the Department of Health has recently launched the NHS Asian tobacco education campaign, and local smoking cessation services are increasing. Our findings and those from other studies^{4 10} suggest that substantial effort and investment is needed in culturally sensitive smoking cessation interventions for South Asian people, involving the government and national and local health agencies (in particular, primary care trusts). The Race Relations (Amendment) Act 2000, which obliges public authorities, including the NHS, to promote racial equality in access to services will underline and add urgency to this requirement.²⁴

Appropriate targeting and involvement of ethnic minority groups and respect for cultural norms is essential.¹⁰ Work with Muslim religious leaders should clarify the religious acceptability of tobacco use in the Islamic faith and support the dissemination of an agreed policy nationally. Further work should develop and evaluate culturally sensitive smoking cessation interventions with South Asian communities.

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