A major focus of the NSW Cancer Plan 2011–15 involves developing culturally appropriate tobacco control programs for culturally and linguistically diverse (CALD) communities. Three priority communities to target with anti-tobacco messages are identified: Chinese (Mandarin and Cantonese-speakers), Vietnamese and Arabic-speaking communities. Previous research has indicated that there is a need for consistent and tailored messages to address smoking in these communities.

Given this, research and communication advice was required to inform the development of a series of culturally-specific anti-tobacco messages. To inform a comprehensive approach to tobacco control, the Cancer Institute NSW commissioned qualitative research in 2011, with the aim of exploring smoking-related knowledge, beliefs, and attitudes in Arabic, Chinese, and Vietnamese communities of Sydney.

Two rounds of research were conducted, comprising 27 focus groups in total. Both current smokers and recent quitters (quit in the last 12 months) were included in the research. The first round was exploratory in nature, covering smoking behaviours and related attitudes and knowledge.

The second round focused on identifying culturally appropriate anti-smoking messages. Groups were conducted with smokers and recent quitters (quit in the last six months) aged 25–44 years (except Cantonese) across the three communities (see Table). Women were not included in the Chinese and Vietnamese groups because of the very low smoking prevalence in women in these communities. Cantonese-speaking smokers were aged 40–49 years to reflect the community’s earlier migration to Australia, compared to Mandarin speakers. All except two groups in Round 1 (one Arabic and one Chinese) were conducted in-language.

The report draws upon findings from this research, with a focus on smoking behaviours, attitudes, knowledge, and beliefs. It is hoped that these insights will help to inform tobacco control initiatives within these communities.

March 2013
SMOKING BEHAVIOURS AND ATTITUDES

In Australia, smokers were thought to be a minority, with smoking behaviour disapproved of by the community as a whole. In contrast, smoking was thought to be common place and traditional in the country of origin. This association has largely carried across to the individual communities now in Australia with CALD smokers aware that smoking prevalence is greater in their communities than in the general population. However, for most, this was not a concern as smoking was viewed as an integral part of their culture.

“But it is the Vietnamese culture that men and young men smoke. They have grown up this way. Most of the men in the family smoked, grandfathers, fathers, uncles, older brothers, so it’s just the way it is.”
(Vietnamese, male, 25–44 years).

Smoking was generally a highly emotive issue, with smokers associating their habit with feelings of guilt, affection, ostracism, relaxation and helplessness. It was also perceived by smokers as being a very social behaviour.

“Yeah, you feel cool. It helps with socialising and helps with communication, breaking the ice with new people. It’s a bond between people. A cigarette is something you have in common with other people, brings you together.”
(Mandarin, male, 25–34 years).

“Life is very boring here, we have nothing to do here, there are no pleasures. Smoking becomes something to ‘lift’ you, and a habit too!”
(Arabic, female, 35–44 years).

For Arabic smokers, particularly women, sheesha (waterpipe tobacco) was seen as a very social activity with strong cultural relevance. Sharing sheesha was seen as a good way of facilitating familial and social interactions and was not often seen in the same light as smoking cigarettes. Some participants believed that if you only smoked sheesha, then you were not a smoker. Similarly, there was some confusion about the health risk posed by sheesha in comparison to other tobacco smoking.

“Whenever we got together it [sheesha] was more of a social thing to have together than cigarettes. I didn’t even think it was unhealthy. I only found out about it being a health risk recently.”
(Arabic, female, 25–44 years).

HEALTH EFFECTS OF SMOKING

Participants generally accepted that smoking causes health problems, with lung cancer, heart disease, stroke, and emphysema all commonly recalled. However, it was clear that health consequences were not readily accepted as relevant to the individual smoker; very few people claimed to have modified their behaviour due to concern for their own health.

Indeed, most smokers were reluctant to acknowledge that their own smoking may cause them harm, instead preferring to believe that they were generally healthy and that the more serious smoking-related conditions would occur late in life, if they occurred at all.

“Lung cancer is the worst. This does play on your mind a bit if you are a long-time smoker!”
(Mandarin, male, 35–44 years).

In contrast, significant concern was directed at the potential health effects on their families, particularly children. This elevated concern about the health effects of second-hand smoke was in direct contradiction with the level of concern about themselves. Many parents expressed a desire to not see their children smoke.

“The most important reason which might make me want to quit smoking would be my children and family. I fear smoking would harm the health of my children.”
(Vietnamese, male, 25–44 years).
SMOKING CESSATION

Most participants readily acknowledged that quitting smoking was something that they should do, and many expected that at some stage in their life they would successfully quit. Most had already attempted to quit, though quitting was commonly seen as very difficult and something to be tackled in the long term. Even among recent quitters, many conceded that the habit was hard to break and that they still get tempted to smoke when stressed or in particular social situations or settings. In general, the benefits of smoking were seen to outweigh the negatives. This meant that quitting was not a priority, especially not for younger smokers in the Asian communities.

Quitting motivations varied, with aspects such as negative health effects, rising costs, and role modelling for children all frequently mentioned. Smokers tended not to dwell on the potential harm from smoking, with younger smokers denying that it has any undesirable physical effects on them. Recent quitters were more aware of the negative consequences of smoking and were more likely than smokers to accept concern about health as a reason to quit.

For most participants, children and family were the prime motivation to quit. Changes in life stage (for example, starting a new relationship or planning a pregnancy) may also trigger serious consideration of quitting.

“I feel I let my family down when I am not quit or take it up again.”
(Cantonese, male, 40–49 years).

Barriers to quitting included: denial; lack of willpower; personal problems; fear that social life will be lost; addiction; and poor awareness of support options available. While family was often cited as a reason not to smoke, there was also some sense that the stress of being a parent would actually be a barrier to quitting.

“Even after I had kids, it [smoking] was actually my time out. I looked forward to the cigarette and had even more.”
(Arabic, female, 25–44 years).

QUITTING SUPPORT

Those who had quit most commonly reported going ‘cold turkey’; that is, without quitting aids. Some reported adopting specific coping strategies such as avoiding or minimising contact with smokers and smoking situations, seeking support from family and friends, and engaging in other activities when cravings occurred. Arabic smokers were especially likely to mention seeking support from friends or family.

Willpower was considered an essential factor in quitting successfully, and without it smokers felt they would most certainly fail.

“...no-one can really push me to quit except myself.”
(Mandarin, male, 25–44 years).

Only a few reported having success with quitting aids such as nicotine replacement therapy and prescribed medications. These sorts of aids were often considered too expensive, ineffective or laden with side effects.

While some had thought of using Quitline, very few had actually used it. There was poor knowledge of what it offered, including that the service is available in their language, and a general perception that the service would not be very helpful.

ANTSMOKING MESSAGING

Mass media campaigns and graphic health warnings on packaging were frequently mentioned as being motivating to quit, although the most effective style of message varied between the different communities, and even within the communities. Graphic imagery, for example, was perceived as being effective by some, particularly in the Vietnamese community.

“Like, we still smoke now, but those images keep lurking in our background, in our minds. It will make us stop sooner or later.”
(Vietnamese, male, 25–44 years).

For others, especially Arabic smokers, testimonial-style advertising was perceived as being the most effective. These ads engendered a strong sense of personal relevance and were thought to be emotionally involving. For those in the Chinese community, there was a stated preference for ‘hard’ facts and educative approaches. However, it was evident that care needs to be taken when delivering these types of messages as there was a strong tendency among smokers to try and poke holes in any messaging that contained statistics. For example, when shown a message stating that 20% per cent of all cancer deaths are due to smoking, some participants viewed this with scepticism:

“If you stop smoking, you might die from other causes anyway.”
(Cantonese, male, 40–49 years).

While both English-language and in-language advertising were mentioned, in-language advertising was clearly less top-of-mind. However, it was apparent that a mix of English and in-language advertising would be most effective at reaching smokers in these communities as there was some sense of increased personal relevance when advertising was presented in this way.
From this research, it is clear that more needs to be done to address tobacco smoking in the Sydney Arabic, Chinese, and Vietnamese communities.

Quitting smoking, while something many participants thought they should do, appeared not to be a priority because of a lack of understanding of personal susceptibility to smoking-related diseases and because the cultural and social benefits of smoking outweighed the perceived negatives. However, the messages tested as part of this research showed that providing more information on the health effects of smoking to smokers in these communities could have considerable impact.

Care needs to be taken to ensure that appropriate styles of message delivery are used but if delivered effectively, in conjunction with mainstream messaging, and with appropriate support in place, it was apparent that the motivation of many smokers could be dramatically increased.

**SMOKING FACTS: MALE SMOKERS IN NSW**

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<th>NSW GENERAL</th>
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**THE LANGUAGE SPECIFIC QUITLINE TELEPHONE NUMBERS ARE:**

- ARABIC: 1300 7848 03
- CHINESE (CANTONESE AND MANDARIN): 1300 7848 36
- VIETNAMESE: 1300 7848 65
- KOREAN: 1300 7848 23