



African-born women's and children's exposure to secondhand smoke

*A research report funded by ClearWay
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Summary

Exposure to secondhand smoke has been proven to cause serious health risks. As a result of legal settlements against tobacco companies in the 1990s, substantial funding is now available in Minnesota to study ways to reduce these health risks among diverse populations.

From January 2008 to July 2009, Wilder Research and the Minnesota African Women's Association (MAWA) conducted a study of exposure to secondhand smoke among African women and children, sponsored through a Developmental Community-Academic Research Award by ClearWay Minnesota. The study involved immigrants and refugees from twelve African countries, including Somalia, Nigeria, Togo, Cameroon, Ethiopia, Liberia, and Kenya living in the Minneapolis/St. Paul Metropolitan Area, where most of the state's African populations are concentrated.

In August 2008, ten in-person key informant interviews were conducted with female leaders representing Cameroon, Congo, Ethiopia, Liberia, Somalia, and Togo. In November 2008, four focus groups were conducted with African adolescent girls age 15 to 18. The adolescents identified themselves as Somali, Liberian, and Nigerian. Finally, the findings from the key informant interviews and the focus groups with youth were used to develop a self-administered survey, which was administered to 223 African women in February and March of 2009. The survey was offered in English, Somali, Oromo, and French. Although the survey participants reported being from 12 different countries, two-thirds of the women participating in the survey were from Somalia.

Findings

The women participating in this study were asked about: rates and contexts of secondhand smoke exposure, social norms around smoking, personal attitudes toward smoking, awareness of health risks associated with tobacco smoke, and strategies for increasing awareness.

Secondhand smoke exposure

- Over one-quarter of women surveyed reported being exposed to smoke from cigarettes or small cigars in the past day or the past week. This number increased to almost a third reporting exposure to cigarette smoke in the past month.
- Women from African countries other than Somalia are significantly more likely to report exposure to cigarette smoke in the past month.
- About 1 in 10 women reported exposure to shisha smoke in the past day.

- Exposure to shisha smoke is significantly more common for Somali women daily and weekly, but not monthly.
- According to surveys, common contexts where this exposure occurs include: visiting friends, community events, parties, and work. According to focus groups with adolescents, exposure usually occurs around family and friends, from neighbors, at school, and in public.

Social norms around smoking

- Religion emerged as a powerful social constraint to smoking, particularly for women. However, other social norms may overpower the role of religion.
- Many participants reported that smoking behaviors have increased, particularly for women and youth, since immigrating to the United States. This is attributed to a desire to fit into the culture and to glamorization of smoking in the media.
- Peer pressure is seen as a catalyst for youth smoking, though parents can either protect youth from peer pressure by monitoring friends and behaviors or unintentionally encourage youth smoking by further role modeling the behavior.
- Smoking, especially shisha, often serves as a means for or artifact of smoking. Smoking is prevalent at community-based social gatherings, and, for women, shisha smoking is often a core component of get-togethers.
- African women and adolescents acknowledged the role of addiction in perpetuating smoking. This is a significant barrier to smoking cessation and can be especially triggered with the stress of living in America.
- Participants discussed social differences by age and gender in smoking behaviors. In Africa, smoking was more traditionally done by adult men. In America, more women and youth are beginning to smoke, and the differences are more present in what and where people are smoking than in the behavior itself.
- Shisha smoking emerged as an unanticipated theme in which certain groups of women had experience with shisha and other groups were unaware of what shisha is. Overall, shisha tends to be viewed by community members as a safer, cleaner alternative to cigarette smoking and in many cases is thought of as a food product rather than a tobacco product.

Personal attitudes toward smoking

- Most of the women and youth participating in this study reported having rules restricting smoking in their homes and around vulnerable people, such as children, pregnant women, and the elderly, though these rules may be flexible and may have exceptions.
- Somali women are more likely to have rules in their homes and around vulnerable people restricting smoking, and are more likely to have those rules apply to everyone.
- The majority of survey participants reported that they had asked people to stop smoking near them in the past six months, and Somali women were significantly more likely to report doing so.
- Women are more likely to ask extended family, friends, acquaintances, and strangers to stop smoking than immediate family members or co-workers.
- Women are particularly likely to ask someone to stop smoking around them out of concern for their own health, the health of a child, the smoker's health, or the symptoms they experience in their eyes, nose, or lungs.
- Some community leaders and focus group participants reported being comfortable asking others not to smoke near them, while others only felt comfortable asking certain people, and others were more comfortable simply moving away from the smoker.

Awareness of health impacts of smoke

- The women participating in this study demonstrated a high level of personal awareness of the health impacts of smoke, especially: secondhand smoke risks, asthma, allergies, lung cancer, and heart disease. However, some of their knowledge was uncertain, tenuous, or inaccurate.
- Women from Somalia tended to be more likely to respond that they were unsure of an answer to a knowledge question on the survey than women from other African countries.
- Some areas of knowledge were particularly uncertain for survey participants including: dangers of light-cigarettes, dangers of shisha smoke, and risks for cancers other than lung cancer.
- African adolescents had a high degree of awareness of general health concerns, but seemed less confident in their knowledge of specific health risks.
- Many participants were able to share personal experiences with smoke exposure and its associated symptoms, which also demonstrated awareness.

- Finally, participants were inconsistent about the level of awareness of the health risks of tobacco smoke in their communities. Some participants felt that their community members were unaware of the dangers of tobacco smoke. Other participants felt that their community members are aware of the dangers, but may be in denial or unconcerned.

Strategies for building awareness

- Community leaders identified key groups of people who should be included in efforts to raise awareness in their communities. These key groups include: women, parents, community leaders, medical professionals, schools, government, non-profit organizations, and “everyone.”
- Survey participants reported that broad information about all of the risks and strategies for addressing smoking are needed in their communities. Of the nine topics of information specifically asked about in the survey, all had over 80 percent of women requesting additional information in their communities about the topics.
- Specific strategies for delivering this information to community members include: talking individually, hosting small group discussions, attending large events, using the media, providing visual images and examples, developing interactive activities, providing alternatives to smoking, and personally relating to the priorities of people, including protecting their children. Many of these suggested strategies also included the use of scare tactics, such as gruesome visuals or shocking stories.

Conclusions

Because smoke exposure is prevalent in African communities, but not necessarily in any particular microenvironments, a broad systems approach to decreasing the health risks of smoke exposure may be needed. There are many social norms in African communities, and from American culture, that coincide to promote smoking. Smoking while socializing is one especially powerful norm, including among women. While individuals participating in this study have identified personal strategies for limiting secondhand smoke exposure, including creating rules in their homes about smoking or asking others not to smoke around them, these strategies are insufficient given the levels of exposure across multiple settings.

One of the reasons women may be particularly likely to use personal strategies to avoid smoke exposure is that the women in this study had high levels of awareness and concern regarding secondhand smoke health risks. However, based on women’s perceptions of awareness in their communities, this high level of awareness and concern may not be representative of others. The women in this study tended to report that either people in

their communities did not know about the health risks associated with tobacco smoke, or knew about the risks and were in denial or did not care. These perceptions indicate that greater emphasis will need to be placed on building awareness and motivation for change within the community.

African women who participated in this study shared their suggestions for strategies to increase awareness and motivate change in their communities. These strategies included making “everyone” part of the mission and connecting with people in a variety of ways to help maximize the saliency of the messages for individuals. Specific strategies for delivering this information include: talking individually to smokers; hosting small group discussions to share information and experiences; attending existing large events to create conversations about risks; using the media to demonstrate positive messages; providing visual images and examples of the health risks; developing interactive learning activities; providing alternatives to smoking; and personally relating to the priorities of people, including protecting their children.

Another essential path of action that emerged is to conduct additional exploratory research to answer some of the very basic questions that could not be addressed in this initial study. Some key points of interest for future research include:

- Assessing secondhand smoke exposure in greater detail in African communities beyond the Somali community;
- Further investigating secondhand smoke exposure and health impacts for children across different age groups, and;
- Specifically exploring the prevalence and perceptions of shisha use in African communities and among African women.

Background

Since 1990, Minnesota has become home for thousands of African immigrants that either came directly from Africa or came here after initial settlement in other parts of the United States. The majority are from Somalia, with Ethiopians making up the next largest group; smaller numbers come from other East African countries such as Kenya, Tanzania and Uganda, and West African countries such as Cameroon, Ghana, Liberia, Nigeria, and Sierra Leone. In 2004, the Minneapolis/St. Paul area was ranked the top metropolitan area for Somali refugee resettlement and second largest for Ethiopian resettlement (Singer & Wilson, 2006).

The Minnesota Demographic Center estimated in one study (2004a) that 25,000 Somalis lived in the state in 2004, and in a second (2004b) estimated the number of Ethiopians in Minnesota at 7,500 people. In 2006, the Minnesota Demographic Center reported 2,233 additional new immigrants from Somalia, 1,303 from Ethiopia, 713 from Liberia, and 502 from Kenya. Other data sources, including immigration data and reports by African community organizations, indicate that approximately 50,000 African immigrants and refugees currently live in the Minneapolis/St. Paul Metropolitan Area. East Africans (particularly Somali) are most heavily concentrated in south Minneapolis and in Rochester, while the largest concentrations of Liberian, Ghanaian and Sierra Leonean immigrants and refugees are concentrated in Brooklyn Park and Brooklyn Center, with immigrants and refugees from Kenya, Eritrea, Nigeria and Cameroon more broadly residing throughout Hennepin and Ramsey Counties.

Exposure to harm from commercial tobacco

The U.S. Centers for Disease Control and the Federal Drug Administration predicted in 2001 that over the next 20 years tobacco use would cause more deaths among African-born people worldwide than AIDS, malaria, tuberculosis, maternal mortality, motor vehicle accidents, homicides and suicides combined (Medical Letter on the CDC and FDA, November 19, 2001). In 2006, the U.S. Surgeon General reported the Public Health Service's current conclusions on the health consequences of exposure to secondhand smoke, based on 20 years of scientific research (U.S. Department of Health and Human Services, 2006):

1. Secondhand smoke causes premature death and disease in children and in adults who do not smoke;
2. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome, acute respiratory infections, ear problems, and more severe

- asthma, and smoking by parents causes respiratory symptoms and slows lung growth in their children;
3. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer;
 4. The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

Exposure to secondhand smokes occurs in “microenvironments,” definable locations that have a constant concentration of environmental smoke during the time that a person is there (National Research Council, 1991). Some key microenvironments include homes, social gathering places, and cars, the areas of primary concern for the proposed research (Klepeis, 1999). A Canadian study on exposure to secondhand smoke found that non-smokers age 12 and older were exposed to environmental tobacco smoke most frequently in public spaces (23% of males and 17% of females), followed by workplaces (about 16% of males and 6% of females) private vehicles (about 11% of males and 9% of females) and homes (11% of males and 10% of females). Youth were most at risk; at age 12, 37 percent were regularly exposed to environmental tobacco smoke (ETS), and by age 20, the proportion rose to 55 percent (Pérez, 2004).

Research on a probability sample of 152 children in South Minneapolis schools involved surveying caregivers and testing the children’s urine cotinine concentrations in winter and spring of the same school year. The researchers found that Southeast Asian children had moderately high concentrations compared to Somali and Hispanic children. Unlike the other groups, Somali children showed higher concentrations in Winter than in Spring. Most exposure occurred in the home; 22 percent of children had caregivers that smoked in the home, and 21 percent lived in homes where others smoked indoors. Fourteen percent of caregivers reported that their child had at least some exposure to environmental tobacco smoke in vehicles, and 13 percent acknowledged that their child was exposed to secondhand smoke in other indoor environments besides the home (Sexton et al., 2004). The lower ETS exposure of Somali children in this study is consistent with findings from a Developmental CARA project by the African Assistance Program and Wilder Research (Pierce et al., 2007), which involved in-depth interviews with 136 current and former West African smokers, primarily men. The study found that men from specific African immigrant groups tend to smoke away from their families, and African-born women in general rarely smoke.

A recent report on the Global Youth Tobacco Survey, originally initiated in 1999 by the World Health Organization, the Canadian Public Health Association, and the Centers for Disease Control, provides some information that can help estimate ETS exposure within

various African immigrant groups (Centers for Disease Control, 2007). Based on 103,906 surveys completed by youth ages 13 to 15 across Africa, 22.6 percent of those whom had never smoked had been exposed to secondhand smoke in their homes, 38.2 were exposed in places other than their home. Though no studies have effectively established smoking among African immigrants in the U.S., research in some African nations provides rough estimates for those most represented in Minnesota:

	Prevalence	Group	Year of study
Cameroon	35.7%	Adults	1994
Ghana	10.8%	Males 25+	1997
	4.0%	Females 25+	1997
	19.5%	Male youth	2000
	18.8%	Female youth	2000
Ethiopia	4.7%	Adult current smokers 15+	2000
	1.8%	Regular smokers 15+	2000
	9.6%	Lifetime smokers	2000
Kenya	66.8%	Males 12+	2000
	31.9%	Females 12+	2000
Nigeria	15.4%	Males 15+	1990
	1.7%	Females 15+	1990
	23.9%	Male youth	2001
	17.0%	Female youth	2001
	17.4%	Senior executives (male)	2001
	18.5%	All adults 15+	1998
	3.2%	Ages 10-27	1994
Sierra Leone	18.5%	Adults	1998
	3.2%	Ages 10-27 (tobacco and cannabis)	1994
Tanzania	23.0%	Males 25-64	1998-1999
	1.3%	Females 25-64	1998-1999
Uganda	52.0%	Adult males	1995
	17.0%	Adult females	1995

Source: World Health Organization, 2003.

Similar to the variation in smoking prevalence rates seen in various African countries, research on other immigrant groups in the U.S. shows wide variation in smoking prevalence. One study found that smoking rates in Asian immigrant communities were higher than the national rates (Le, 1998); while others found the opposite among Hispanics (Acevedo-Garcia et al., 2005; King et al., 1999). However, immigrants from countries having high smoking rates (such as those from China, Korea, Vietnam, and Cambodia) have similarly high rates after immigration (Asian-Pacific Tobacco-Free Coalition of Minnesota et al., 2006; Ma et al., 2005).

There is some evidence that, for immigrant groups with relatively low smoking rates (when compared to U.S. rates), smoking increases as immigrants acculturate to life in the United States. For instance, researchers have found that the longer that Latinos live in the U.S., the more likely they are to smoke regularly (Roman, 2007). The African Assistance Program/Wilder Research Developmental CARA study described earlier included extensive interviews with 136 West African smokers and former smokers, and a high percentage of those that smoked before immigrating to the U.S. reported that their smoking increased significantly after settling in Minnesota (Pierce et al., 2007). The study also found that male West Africans are much more likely than African women to be smokers, which respondents reported to be a result of strong social prohibitions against women smoking. A number of other studies have found that African-born men are much more likely to smoke than African-born women (e.g., Adelekan et al., 1993; Kurtz, Azikiwe, and Kurtz, 1993; Omoluabi, 1995). Research with other immigrant groups have found similar gender disparities, with immigrant men's average smoking rates similar to those of U.S. men but much lower rates for immigrant women (Ivey and Faust, 2001).

Despite the helpfulness of the research literature in describing the secondhand smoke risks of African immigrants, it is important to note that prevalence rates are based upon smokers' self-report. The African Assistance Program/Developmental CARA research with West African smokers and former smokers encountered an immense reluctance within these communities to acknowledge being a smoker. A 2003 focus group study in DeKalb County, Georgia, of immigrant and refugee populations' views on tobacco use in their communities, found that Somalis (which researchers have identified as a group with very low smoking rates) identified exposure to secondhand smoke as a serious problem in their community. Other groups highlighting secondhand smoke as a serious community problem in focus groups were Bosnian and Chinese immigrants, whom have very high smoking rates in their home countries and in the U.S., and Latino immigrants, whose U.S. rates have been rising (PATCH Secondhand Smoke Committee, 2003).

Tobacco studies have found that many African people are not aware of the negative health effects associated with smoking (Kurtz et al., 1993; Martin, Steyn, & Yach, 1992; Pobee et al., 1984). The findings from the African Assistance Program/Wilder Research Developmental CARA project described earlier are consistent with those of these earlier studies. Study participants reported general awareness about the relationship between smokers' risk of cancer, heart disease, and low birthweight in newborns; however, they were much less knowledgeable about the links between tobacco use and diabetes, the risks of "all natural" tobacco products, and the impacts of secondhand smoke exposure (Pierce et al, 2007).

Higher smoking rates among men are often linked to higher levels of secondhand smoke exposure among non-smoking women and children living in the smoker's household (Ivey and Faust, 2001). Women have been found to impose restrictions on smoking behavior on specific spaces within the home in an attempt to create a smoke-free environment for their children, but these can be restricted by the limitations of the physical environment of their homes (Robinson and Kirkcaldy, 2007).

Linguistic barriers and cultural influences may also limit African immigrant women's awareness about the risks of secondhand smoke and options for reducing their own and their children's exposure. Research among Asian and other immigrant groups has found that even though women do not smoke and are not likely to start, they and their children may have difficulty avoiding high exposure to secondhand smoke by men in the home (Ivey and Faust, 2001; Le et al., 2002). In focus groups with Asian women, researchers found that participants did not feel that they could ask men to stop smoking around themselves or their children, and were generally hesitant to appear disrespectful of smoking male elders or employers (Le et al., 2002).

When translating health awareness and disease prevention materials, some experts note that it is important to not only provide a literal translation, but to also translate the messaging itself to be culturally appropriate (Bhopal et al., 2004; Brugge et al., 2002; National Heart, Lung, and Blood Institute [NHLBI], 1987). Others strongly suggest that simply translating materials into English does not make the materials or the approaches behind them culturally appropriate. Individualized, culturally appropriate approaches are described as essential for promoting smoking cessation and informing immigrant populations about the risks of smoking and exposure to secondhand smoke (Ma, 2006). One team of researchers seeking to inform a Latino heart disease prevention and education campaign concluded that the community itself should develop educational materials and interventions that address language preferences and cultural values (Moreno et al., 1997). A second research team used focus groups to develop linguistically and culturally appropriate "message concepts" for reducing Asian women's and children's exposure to secondhand smoke, which were well-received by the target communities (Brugge et al., 2002).

Description of the research project

This collaboration between Wilder Research, a research organization known for its high-quality, community-based research, and the Minnesota African Women's Association, which provides multiple programs and services to African immigrant women and girls, builds on the strengths of both organizations. An earlier Developmental CARA completed by the African Assistance Program and Wilder Research found that though there are powerful social constraints against smoking in many African immigrant communities, African men frequently smoke at social events and with peers and relatives. The responses from African men and women at two community meetings for that project indicated that more African immigrants are probably more willing to report being exposed to secondhand smoke than are willing to admit being smokers.

This study can expand knowledge about eliminating tobacco-related disparities in priority populations by assessing African women's and girls' exposure to secondhand smoke in their homes, cars, and social activities; the number of smokers in their households; their own and household members' health conditions that have been previously associated with exposure to tobacco smoke; and attitudes and beliefs about secondhand smoke and its dangers. The findings can be compared to what is known about secondhand smoke exposure in other immigrant groups, thus increasing knowledge that can lead to more effective tobacco control communications and policy interventions for immigrant populations. The long-term goal of the research is to reduce harms from tobacco in these communities. ClearWay Minnesota accepted the proposal and funded an 18-month project.

To ensure cultural competency in the research design and interpretation of the findings, MAWA convened an Advisory Committee of women leaders and immigrant community organizations representing and serving diverse East and West African immigrant communities. Advisory Committee members were selected based on their involvement in their communities, identification by their communities as trusted and respected leaders, their awareness about tobacco harms, and their interest in reducing the harms caused by exposure to secondhand smoke. The Advisory Committee provided ongoing feedback and support to the study team, especially around issues such as cultural barriers and interpretations of social and cultural influences concerning tobacco use among Africans who have moved to the United States.

To provide technical support and tobacco research expertise, Dr. Richard Hurt, Director of the Mayo Clinic's Nicotine Dependence Center, was contracted as a consultant to the project. Additional technical assistance was provided to the research team by Paula Keller from the University of Wisconsin Medical School's Center for Tobacco Research and Intervention.

Methods

The research was designed by Wilder Research in consultation with staff from MAWA and Dr. Richard Hurt, a consulting tobacco expert for the project.

At the beginning of the project, African women leaders that represent East and West African immigrants and organizations were identified to make up an advisory committee to guide and oversee the project in partnership with MAWA and Wilder Research. They were selected based on their status of respect in their communities, community involvement, awareness of tobacco harms, and interest in reducing the harms of secondhand smoke within their communities. The advisory team, along with project leaders, reviewed and provided feedback on key informant interview questions, focus group questions and sampling methods, and survey questions and sampling methods. Their input provided Wilder Research staff with cultural insight and considerations relative to participant engagement. Other activities for the advisory team were to inform the community about the project and its goals, identify and recruit potential participants for the data collection methods, assist with survey administration, and invite the African immigrant community to events to learn about the research results.

MAWA developed a page on their website for the purpose of introducing the research project and its goals, keeping the community informed of activities, events, and progress of the project, recruiting participants, and disseminating information. This information was also communicated through a newsletter distributed by MAWA programs and its partner organizations.

The research methods used in the project included: key informant interviews with African women leaders, focus groups with African adolescent girls, and a survey of African women. Methods for each are described below:

Key informant interviews

MAWA staff conducted key informant interviews with 10 community leaders during July and August of 2008. The primary purpose of the interview was to assess the community's readiness to address secondhand smoke. Wilder Research provided MAWA staff with training on interviewing methods and on protecting the rights of the interview participants. Advisory committee members and representatives from partnering organizations were trained as well, in case any of the participants required interviewing in their native language. All interviews were conducted in English because of participants' proficiency and comfort with the language. MAWA staff scheduled and conducted face-to-face interviews with the African women leaders who had either previously worked with

MAWA, or who had been recommended. The interview asked the leaders specifically about things being done to improve health in their communities; if smoking tobacco is perceived as an important health problem; if people understand what secondhand smoke means; what would motivate people to address secondhand smoke; and who they would get involved to address it. All of the key informant interviews were digitally recorded and transcribed by MAWA staff. Wilder Research staff provided MAWA with a transcription template and written instructions on how to transcribe the conversations of the leaders. Wilder Research analyzed the interview data using the Atlas TI computer program to microcode qualitative responses into themes.

Focus groups with African adolescents

Four focus groups were conducted in November of 2008 with African adolescent girls ranging from 14 to 18 years old. Wilder Research provided focus group training to MAWA staff who facilitated the groups. Wilder trained the facilitators on informed consent procedures, sampling, and focus group administration. Wilder also provided technical assistance for the recruitment of participants, ensuring they were the appropriate age; were from the targeted groups who spoke English, French, Oromo, and Somali; and had signed consent from parents prior to participation.

The MAWA Project Coordinator worked with leaders from MAWA's African Girls Initiative for Leadership Empowerment (AGILE) program to recruit eligible girls and to schedule the focus group dates and locations. AGILE is a program for girls 9 to 18 years old designed to build their social and leadership skills and their self-esteem, and to reinforce cultural identity. The groups were conducted in English because of the girls' proficiency in the language. Many of the participants represented different language groups, particularly Somali; however, they felt comfortable with English as the interview language. Everyone in each group received a \$25 cash incentive for their participation.

The focus group questions asked the adolescents about their knowledge of the impacts of secondhand smoke on people's health; if others' cigarette smoke was bothersome; about any rules regarding smoking in their home environments; if they have seen smoking at social events in their community; if they have been exposed to cigarette smoking; if they have friends or family who smoke; and whether or not smoking and secondhand smoke were topics they could easily discuss in their communities.

All of the focus groups were digitally recorded and transcribed by MAWA staff. Wilder Research staff designed a protocol and transcription template for MAWA's staff to transcribe all the conversations. Wilder Research staff analyzed the transcripts to identify key concepts. These concepts were coded into categories according to how the concepts were mentioned in the groups.

Survey with African women

Sub-themes from the key informant interviews and youth focus groups were used to develop survey questions and response categories for the 43-item self-administered survey. The survey specifically asked women about breathing problems of people in their lives; if they ever approached someone who was smoking to stop; if they inhaled smoke from family or friends; their opinions about gender and smoking; their knowledge about the harms of smoking and secondhand smoke; and information about tobacco and its health effects that is needed in their community. The survey was translated into French, Oromo and Somali.

In order to build the sampling framework for this community-wide survey, MAWA staff created a sample list of 300 African immigrant women who could potentially complete the survey. This process made it easier to know the country of origin, age, and educational background of the targeted women. It also helped to determine if the goal of surveying 250 women and girls was realistic.

MAWA's community partners and staff recruited women to complete the self-administered survey in February and March of 2009. MAWA hosted a community breakfast in February 2009 to launch the survey and provide an opportunity for participants to fill out the surveys. To broaden their outreach, MAWA staff also attended community gatherings and recruited women from African organizations throughout Twin Cities college campuses. Advisory members assisted with recruitment by identifying and referring potential participants to MAWA staff, or by administering surveys themselves at community meetings.

Surveys were proctored in French, Oromo, and Somali and in English by MAWA staff and advisors for those participants who could not read proficiently. Wilder Research provided training to MAWA staff and proctors on how to administer the surveys and maintain confidentiality. A total of 223 surveys were completed by African immigrant women. As an incentive for their participation, all participants were eligible to enter into a lottery to win a prize at a \$10, \$20 or \$50 dollar value.

Wilder Research staff entered, cleaned, and analyzed the survey data using SPSS (frequencies, chi-squares, and t-test analyses). Data were analyzed both in aggregate and by whether or not the women identified themselves as Somali. The group of Somali women was the only country-specific group large enough to analyze separately. The remaining survey participants were grouped together to allow for statistical comparisons. Throughout this report, the comparison group of women is referred to as "other respondents."

Participant characteristics

It is important to note that the participants in the key informant interviews, focus groups, and surveys in which data were collected for this project were not randomly selected and therefore cannot be assumed to be representative of all African immigrants living in Minnesota. Their information serves as an example of issues African women and children may be facing, but is not exhaustive and may not reflect the experiences of other African families.

Ten in-person key informant interviews were conducted in August 2008 with female leaders representing the following countries: Cameroon (N = 2), Congo (N = 1), Ethiopia (N = 2), Liberia (N = 2), Somalia (N = 2), and Togo (N = 1). Each woman is native to the country she represents and serves in an advocate role within her specific community in Minnesota.

Four focus groups were conducted with adolescent girls age 15 to 18 (Average = 16 years). Two of these groups were facilitated in St. Paul, and two took place in suburbs that have large populations of African families. The size of the groups ranged from six to nine participants, with two groups having seven participants. The youth primarily identified themselves as Somali (N = 14), Liberian (N = 11), and Nigerian (N = 5). One participant identified herself as both Liberian and Nigerian.

Surveys were completed by 223 African women. When asked what African country their families were from, most of the women were from Somalia (67%), though 11 other countries were represented as well, including: Nigeria, Togo, Cameroon, Ethiopia, Liberia, Kenya, Ghana, Congo, Eritrea, Sierra Leone, and Cote D'Ivoire. The over-representation of Somali participants in this study is not surprising given that they are the largest African immigrant group in Minnesota.

Most of the women originally were from Africa (88%), and have lived in the United States from one to 47 years (Average = 9 years). The majority of the surveys were completed in English (75%), followed by Somali (21%), French, and Oromo (2% each), though most of the women who took the survey said that they do not usually speak English at home (58%). Of the women who do not speak English at home usually, the most common language spoken is Somali (53%). The women who completed the survey were age 18 to 81 (Average = 35 years, Median = 25 years). Over one-third of the women have children under the age of 18 living in their home. Homes with children had one child on average, though women reported having up to seven children living with them.

1. Survey interview respondent characteristics (N=223)

	Number	Percent
Participant age		
18-25	126	57%
26-35	18	8%
36-45	14	6%
46-65	41	18%
65+	24	11%
<i>Not reported</i>	6	7%
Average age	35.4 years	
Median age	24.5 years	
Country participant is from		
Africa	196	88%
United States	14	6%
Somewhere else	0	-
<i>Not reported</i>	13	6%
Length of time in the U.S.		
Less than 5 years	120	54%
6 - 10 years	70	31%
11-20 years	25	11%
Over 20 years	8	4%
Country family is from^a		
Somalia	149	67%
Nigeria	17	8%
Togo	13	6%
Cameroon	12	5%
Ethiopia	12	5%
Liberia	9	4%
Kenya	4	2%
Ghana	3	1%
Congo	1	<1%
Eritrea	1	<1%
Sierra Leone	1	<1%
Cote D'Ivoire	1	<1%
<i>Not reported</i>	3	1%

1. Survey interview respondent characteristics (N=223) (continued)

	Number	Percent
Language(s) spoken at home^b		
English	95	43%
Somali	42	19%
French	6	3%
Mina	6	3%
Oromo	5	2%
Arabic	4	2%
Ewe	3	1%
Amharic	3	1%
Lingala	1	<1%
Tigrinya	1	<1%
Yoruba	1	<1%
Swahili	1	<1%
<i>No language reported</i>	<i>73</i>	<i>35%</i>

^a When reporting which country their family is from, three women reported being from two different countries.

^b When reporting languages usually spoken at home, 13 women reported two languages, one woman reported three languages, and one woman reported four languages.

Exposure to secondhand smoke

In order to assess exposure to secondhand smoke in African women and youth, questions about personal experiences with exposure to smoke in multiple contexts were asked in the survey of African women and the focus groups of African youth. Overall, the rates of exposure to secondhand smoke were notable. However, the locations or contexts of that exposure was varied. While some patterns emerged, it was clear from both African women and African youth that exposure to secondhand smoke occurs across multiple contexts, with none of them particularly prominent.

Rates of exposure to secondhand smoke

Women participating in the surveys were asked about the frequency of their exposure to friends' or relatives' cigarette or cigar smoke. Two-thirds (69%) reported that their friends and relatives do not smoke around them at all. However, nearly one in five women reported that their friends or relatives smoke around them “often” or “sometimes.” Somali and other respondents reported similar rates of exposure to smoke from friends and relatives.

2. Rates of secondhand smoke exposure from friends and relatives

		Total (N=223)	Somali (N=146)	Other respondents (N=77)
I have friends or relatives who sometimes smoke cigarettes or little cigars around me.	Often	4%	4%	4%
	Sometimes	13%	14%	10%
	Seldom	10%	9%	13%
	Not at all	69%	69%	69%
	Missing	4%	3%	4%

When asked about exposure across different contexts or locations, the surveyed women reported greater rates of exposure than just from relatives or friends smoking. In the week prior to completing the survey, one-quarter of Somali women and one-third of women from other African countries were exposed to secondhand smoke in any location. In the month prior to completing the survey, almost one-third of the women overall reported being exposed to secondhand smoke. Somali women were less likely than other respondents to report exposure to secondhand smoke (23% versus 46%).

In general, women’s reports of exposure to shisha were lower than their reports of exposure to cigarettes or little cigars. About 10 percent of surveyed women were exposed to smoke from shisha in any location. However, a significantly greater percentage of women from Somalia reported being exposed to shisha smoke in the past 24 hours or the past seven days (14%) than other respondents (5%).

3. Exposure to secondhand smoke in any location

		Total (N=223)	Somali (N=146)	Other respondents (N=77)
Exposure to smoke from cigarettes or small cigars in any location	Past 24 hours	27%	27%	27%
	Past 7 days	27%	23%	33%
	Past 30 days	31%	23% ^c	46% ^c
Exposure to smoke from shisha in any location	Past 24 hours	11%	14% ^b	5% ^b
	Past 7 days	11%	14% ^b	5% ^b
	Past 30 days	9%	9%	9%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Contexts of exposure to secondhand smoke

Women appear to be exposed to secondhand smoke in a large variety of “microenvironments.” Exposure to smoke in any particular location was relatively low for participants, with 13 percent or less reporting exposure in any specific location. Locations that women appear to be slightly more likely to be exposed to smoke from cigarettes or small cigars include: while visiting friends, at community events, at parties, and at work. However, when examining differences between Somali women and women from other African countries, it is clear that some women are more likely than others to be exposed to smoke in specific locations.

Somali women were more likely than other respondents to be exposed to tobacco smoke in a car within the 24 hours prior to completing the survey (10% versus 3%). Somali women were significantly less likely to report smoke exposure at work than other respondents both within the last week (5% versus 18%) and the last month (3% versus 17%). It should be noted, though, that approximately one-third of Somali women reported not having a job at the time of the survey, and none of the other respondents reported not having a job at the time of the survey. Similar to the finding about exposure

to smoke at work in the past 30 days, other respondents were over five times more likely to be exposed to smoke at a club or café in the past 30 days than women from Somalia were (3% versus 17%). Again, approximately one-third of Somali women, and about 10 percent of other respondents, reported not being at a club or café in the past 30 days, which may account for some of the discrepancy.

4. Location of exposure to smoke from a cigarette or little cigar over time

Location of exposure	Past 24 hours			Past 7 days			Past 30 days		
	Total (N=223)	Somali (N=146)	Other respondents (N=77)	Total (N=223)	Somali (N=146)	Other respondents (N=77)	Total (N=223)	Somali (N=146)	Other respondents (N=77)
Visiting friends	11%	10%	13%	9%	8%	10%	7%	4%	10%
Community event	9%	10%	9%	7%	5%	10%	13%	11%	17%
Party	9%	8%	13%	5%	3%	8%	9%	6%	16%
Home	7%	8%	4%	7%	6%	8%	5%	4%	5%
Car	7%	10% ^a	3% ^a	5%	6%	4%	5%	6%	5%
Visiting relatives	7%	8%	7%	4%	5%	3%	7%	8%	4%
Work	7%	4%	12%	9%	5% ^b	18% ^b	8%	3% ^b	17% ^b
Club or cafe	7%	6%	9%	5%	4%	7%	8%	3% ^c	17% ^c

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

A significantly greater percentage of Somali respondents than other respondents reported exposure to shisha smoke while visiting friends in the week prior to the survey (9% versus 1%). However, the rate of exposure while visiting friends became equal when the timeframe expanded to the month prior to survey completion.

Situations in which shisha smoke exposure appeared to be particularly prominent include: while visiting friends or relatives, at home, at parties, and at clubs or cafes. However, no more than 9 percent of women total reported exposure to shisha smoke in any particular context.

5. Location of exposure to smoke from shisha over time

Location of exposure	Past 24 hours			Past 7 days			Past 30 days		
	Total (N=223)	Somali (N=146)	Other respondents (N=77)	Total (N=223)	Somali (N=146)	Other respondents (N=77)	Total (N=223)	Somali (N=146)	Other respondents (N=77)
Visiting friends	6%	7%	4%	6%	9% ^b	1% ^b	3%	3%	3%
Home	4%	4%	3%	3%	3%	1%	2%	2%	1%
Visiting relatives	4%	4%	1%	2%	3%	-	3%	3%	1%
Party	2%	3%	-	2%	2%	3%	3%	2%	3%
Car	1%	2%	-	1%	2%	-	<1%	1%	-
Work	1%	2%	-	1%	1%	1%	2%	2%	1%
Community event	<1%	1%	-	1%	1%	1%	2%	3%	1%
Club or cafe	<1%	1%	-	2%	2%	3%	2%	1%	3%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

In the focus groups with young African women, the youth were able to identify four primary situations in which they are exposed to secondhand smoke. These situations are when: spending time with family or friends, passing by neighbors, at school, and in public.

Most of the young women could identify either a friend or family member who has smoked around them. These findings mirror those of the women who completed the surveys. The women surveyed reported that smoke exposure while visiting relatives and friends was among the more common contexts of exposure. Some of the quotes in which the focus group participants described exposure to smoke from friends or family members are included here.

Only my aunt [smokes] and she is the only one I live with. And it just used to be two of us.

I grew up mostly with boys, when I was little, but now seeing them smoke, and I look at them like this (made a reaction of disgust with her face) so they know not to come near me.

My step dad smokes and he is never going to quit.

My dad smokes even in the car and when we are in it. He puts the window down a little bit, but still you can smell it.

Neighbors smoking around the focus group participants was also a prevalent theme. Many of the young women identified smoke entering their living space due to neighbors smoking, and they felt like they were unable to remedy the situation. Some specific accounts of this are included below.

A lot of [smokers] just sit, like, by my window and smoke and stuff. And there is nothing you can do about it.

When I am at home, like, my neighbors they are right there standing in front of my house smoking.

Everyday whenever we see like people smoking we just hold our breath, we will be like “this dumb [person] is smoking again.” We walk past them and we just hold our breath.

People upstairs [smoke] with their friends and stuff.. I don’t have no right to go and tell them not to. I don’t have no right to do that because it is not my business. But at least I still have rights to tell them to stop smoking by my window.

Participants described smoking occurring in and around the school and a lack of discipline for smoking in school. They also mentioned smoking at school bus stops. While this context is not necessarily applicable to adult survey participants, it may mirror the prevalence of exposure in a workplace context given that participants tend to spend a great deal of time in both locations and may be less able to avoid smoke in both locations. Focus group participants’ accounts are included here.

I actually don’t smell much smoke at home, but at school I smell smoke a lot.

My school, if you go outside, you can just smell the smoke everywhere.

When I am like waiting for the school bus, kids just smoke until the school bus comes.

Even next to the school bus, they smoke there.

They’re smoking even in the hallways of my high school. There was once that boy was smoking in the hallway and he smoked it and passed it on to his friends and they are walking thinking they look cool.

They did that at [school] and the teacher walks into the bathrooms and comes out and says, they are smoking in there, and the teacher will go back to do what they were doing before. They will not even try to say you are not supposed to smoke on school grounds. Because they know that even if they say it, they will like go right back and do it again.

Participants discussed a great deal of exposure to secondhand smoke in public areas, such as streets, bus stops, and restaurants. This was one of the most commonly reported contexts in which the youth reported being near others smoking, and it is described below.

I think they should stop people from like smoking on the street or at the bus stop.

Like most people just walk and smoking stuff and you pass by them and they smell really nasty.

I know of restaurants where people go and just smoke there.

I work in downtown, so every time I am going there it is lunch time and you see people smoking everywhere you look. It's like they are taking a break to smoke.

Every time you get up, wake up in the morning and you are walking you see people who are smoking.

Social norms around smoking

Findings from interviews with African women leaders, focus groups with young African women, and surveys of African women all revealed strong social norms around smoking or abstaining from smoking. Some of these social norms come from within African communities, and some come from the American culture, but all contribute, positively or negatively, to rates of smoke exposure within these communities.

Religion

Religion is one powerful social norm that contributes to certain African populations abstaining from smoking. While this was not addressed in the surveys with African women, it emerged as a significant theme in the focus groups with young African women. Particularly, there was debate around whether or not the Quran prohibits smoking. The role of religion in the gender disparities was also presented, particularly with greater barriers to women smoking. Some key statements around the role of religion in smoking are presented here.

But it is. If you read the Quran carefully our holy book, it is, because it is kind of taking your mind way for God.

To me, the way I see my religion, I see that shisha is even against the religion but they try to say oh, its not.

It's against our religion but the guys do it.

Anything that can hurt your body or do any damage to you or could like put you in danger is like against our religion. And we are not supposed to do it. Because we are supposed to be healthy and have a life.

Alcohol and smoking are two things that are really against our religion.

Also smoking is against our religion. It just is.

No, it says in the Quran that you are not supposed to do anything that hurts your life.

Reasons for smoking

Despite the powerful role of religion in prohibiting smoking, study participants reported many powerful reasons that encourage or perpetuate smoking in African communities. These reasons for smoking have cumulatively created numerous barriers in addressing secondhand smoke exposure within African communities.

Immigration

The role of immigrating to the United States in smoking behaviors of African people was discussed in the interviews with community leaders, the focus groups with young women, and the surveys of women.

In surveys of African women, one-third of the women felt that people from their country smoke cigarettes or little cigars to be American and fit into the culture. Almost 1 in 10 women felt this was “often” the case. Somali women were significantly less likely than other respondents to feel this way sometimes or more often (14% versus 35%).

6. American culture and smoking behaviors

		Often	Sometimes	Seldom	Not at all	Missing
People from my country who live in the US smoke cigarettes or little cigars to be American and fit into the culture.	Total	9%	11%	9%	66%	5%
	Somali ^c	8%	6%	6%	77%	4%
	Other respondents ^c	13%	22%	16%	44%	5%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Community leaders who were interviewed also discussed the role of immigration in increasing smoking behaviors within their communities. Several respondents commented that in Africa, their community members did not smoke, but they began smoking in the United States because it appeared to be a “fun” activity that didn’t have any risks. Some people also noted that it is more socially acceptable for women to smoke in the United States than it was in Africa, but these women emphasized that most African women smoke only shisha and only at home (if they smoke at all). Community leaders also commented on a lack of power to prevent secondhand smoke exposure in the United States because of the rights-based culture. For instance, smokers have the “right” to smoke at a bus stop or in public, so others have no ability to stop them or comment on their smoking. Some key quotes pertaining to the impacts of immigration on smoking behaviors are presented here.

Back home they are not much of smokers, but I saw that they learn it here, they get desperate and stressed and then all of them are smoking the shisha pipe at home.

Because of the awareness in America, in Africa I wouldn’t have known that if you are sitting next to me and you are smoking next to me, I am at danger... so you know with the awareness here, because they keep saying it on the television, on the radio.

For now, I think both men and women [are smoking in my community], for now. Before it used to be only men, but you know here it's both men and women.

Many of our people don't smoke back home, but is a shame that they do here. Since I came here, I saw most of them smoke. They think it is fun right now. They use this at get-togethers for fun. They think it is fun. Also some of them are getting desperate and they are using that. So that is the problem. It is two things. One of them for fun, one of them for depression.

In the focus groups with young women, some of the youth also discussed changes in smoking behaviors after immigrating to the United States. These changes were centered on increases in smoking behaviors and decreases in concern about smoking. A sample of quotes that illustrate this phenomenon is included below.

Everything happens more [in the United States].

In Africa is like if an older person sees you smoking or doing the wrong thing, they will actually talk to you and you will be afraid of them and then you stop. But here, nobody got respect for anybody.

A lot of them, when they come here, a lot of them start smoking.

The younger people started smoking here.

The media is a specific aspect of the American culture that may account for some of the changes in smoking behaviors after immigrating to the United States. Participants of the focus groups pointed to the American media as a catalyst for smoking. They believe that celebrities and commercialization have increased smoking behavior within their communities.

Also on TV celebrities will smoke. You know on TV when you are watching a movie, you see somebody smoking and the person is playing a cool part or the hero part, so it looks like it this is an American style.

Like my brother, he just thinks it is cool, so it is something that they see on TV. They just copy it from the celebrities.

The advertisements, the celebrities, the games, there is more of those things here.

I don't think America is serious about it. [Celebrities] talk about it every day on the TV that smoking is bad, but after that when they go home or go somewhere else, they actually smoke.

Role modeling and peer pressure

Within the African community, many respondents reported that role modeling and peer pressure also contribute to increased smoking behaviors. This theme was particularly prevalent when discussing smoking among African youth. However, when reporting on pressure they have personally experienced, surveys of African women indicate that personal experiences with peer pressure are limited. In fact, the majority of the women who completed the survey reported that their friends or relatives don't want them to smoke with them at all. These findings indicate that this is likely a phenomenon participants in this study have observed rather than experienced personally, or that it is more prevalent for younger African women than for African adults.

7. Family or friend peer pressure around smoking

		Often	Sometimes	Seldom	Not at all	Missing
I have a friend or relative who wants me to smoke cigarettes or little cigars with them.	Total	2%	8%	5%	81%	4%
	Somali	3%	9%	6%	77%	3%
	Other respondents	-	4%	3%	88%	5%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

The focus on peer pressure in the community leader interviews and the youth focus groups pertained almost entirely to pressure youth experience from their peers. Among community leaders who were interviewed, most assumed that parents would have an active role in countering peer pressure for youth smoking, particularly by staying alert to “bad friends” that could pressure youth to smoke. The respondents also recognized the role of peer influence in the proliferation of smoking and other bad habits in their communities. In a more holistic, community-based approach to the problem, some respondents described the solution as encouraging not just their own kids not to smoke, but also their kids' friends. These descriptions are included in the quotes below.

Young people seem to follow their peer group and who knows they might be attempting to smoke too and so parents have to be very alert and very educating to their children.

You know there is no parent that wants his or her kids being a tobacco addict, you know so like if a kid is smoking the parents will not let friends that smoke hang around their children. So I think what people are worried about is their friend influencing their children to smoke.

Let the mothers inform their children. Because I am sure those girls started smoking because they had a bad friend that influenced them to smoke. So we should also be friends with their friends and tell them that smoking is not good for them. And that might be helpful to all not just for our own kids.

It is an addiction and a lot of people know that. That is why myself I don't let people smoke around my kids so they don't get that idea. And when they are old enough, I am going to start talking to them about it.

Adolescent female participants in the focus groups identified a strong peer influence on smoking for people their age. They emphasized a desire to be “cool” or “get attention” as a primary catalyst for smoking in youth. Some examples of these statements are included here.

You kind of notice that people get influenced by their friends and they start smoking to get popularity I guess.

Some of them do it just to be cool.

Most of the time, they just want to be cool...because I want to be cool, my friends are doing it. If I don't do it, I will feel left out.

If you are around your peers who do it, who are smoking, you try to be yourself, but they will try to convince you to smoke.

If you see other people doing it and you think what they are doing it is cool. Like most of the time, when I was like 10, 11 all I wanted to do was like smoke, because everyone around me was smoking. My cousin was doing it. I tried it like one time and I saw that it was so nasty.

Many of the young female participants also believed that youth begin smoking because they see adults, especially parents, modeling the behavior. This indicates that not only do friends provide pressure for smoking, but adults in their lives implicitly do as well. This is contrary to the preventative role of adults in youth smoking that community leaders referenced. Community leaders tended to view parents as protection against peer pressure rather than a source of modeling themselves. Key quotes from the youth focus groups pertaining to parental role modeling are included below.

I think the parents need to stop doing it around the kids, because the kids will take after them and do it later.

I get upset, like my dad started smoking since he was 16, and now he is 50, and I have been trying to make him stop. The whole family now smokes, but I guess I am used to it.

That is how they get you to start, even at a young age. When older people around you are doing it, then when they get big, they want to start smoking.

I tried a cigarette like once, because my dad used to smoke... I was like I want to try what this tastes like, so I tried it and I spit it out, because it so nasty.

For smoking, I think the way people get into it and stuff; it is from their family members. They first try it, and that triggers it. I don't really know how to explain it.

Socializing

The prominence of smoking as a means for or artifact of socializing is one of the culturally-based reasons for smoking that emerged in surveys, interviews, and focus groups.

Smoking was mentioned as a common activity in community-based social situations.

In the survey of African women, the majority of women reported that smoking was not a regular part of the social lives of men or women from their countries. However, almost one-third of women reported that smoking cigarettes or little cigars is a regular part of socializing for men. Over one-fifth of women reported that smoking shisha is a regular part of men's socializing. Just under 15 percent of women reported that smoking cigarettes or shisha are regular parts of socializing among women. Women from Somalia were significantly more likely to agree that smoking was a regular part of social lives of people in their community, with the exception that fewer Somali women reported that men smoked cigarettes or little cigars as part of their social lives (24% versus 42%).

8. Smoking as a regular part of socializing by gender and tobacco product

		Strongly agree	Agree	Disagree	Strongly disagree	Missing
For men from my country, smoking cigarettes or little cigars together is a regular part of their social life.	Total	15%	15%	14%	55%	2%
	Somali ^c	16%	8%	6%	70%	1%
	Other respondents ^c	13%	29%	27%	27%	4%
For men from my country, smoking shisha together is a regular part of their social life.	Total	12%	9%	11%	66%	3%
	Somali ^a	16%	6%	6%	71%	1%
	Other respondents ^a	4%	13%	21%	56%	7%
For women from my country, smoking cigarettes or little cigars together is a regular part of their social life.	Total	8%	5%	10%	73%	4%
	Somali ^b	11%	6%	6%	75%	3%
	Other respondents ^b	3%	4%	20%	69%	5%
For women from my country, smoking shisha together is a regular part of their social life.	Total	8%	6%	11%	74%	2%
	Somali ^b	11%	6%	7%	76%	-
	Other respondents ^b	1%	5%	18%	70%	5%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Community leaders commented on the role of smoking in socializing within their communities as well. These women tended to report that smoking was an integral part of social exchanges, and that shisha smoking was particularly prominent at social gatherings. Key quotes describing smoking while socializing are included below.

I think it's just cigarettes and cigars. And it is more of a social thing. Most of the people that smoke will drink and smoke. So it's more in a social gathering.

When we go for funeral or when we have a get together, and after wedding ceremonies, when we go together to chat with friends, all the time they are using that [shisha], so if one day we visit them as a visitor, I see four or five pipes. Everybody sits around and has a pipe of their own and then you see fire and smoke everywhere.

They use shisha to get together and chat with each other and socialize, and they socialize and smoke shisha.

Many young women participating in the focus groups also discussed the prevalence of smoking in social situations, both within the African community and within the youth community. The role of smoking as a social exchange is likely linked with the peer pressure and role modeling youth experience as well. Some examples of this include:

I think a lot of [teenagers] smoke, especially the boys; they think it is so cool. They think women will want to hang out with them a lot.

Like, one of my friends is having a party next month, and I know there is going to be smoking and drinking there. Of course it's bad, but there is nothing you are going to do about it. It is not like it is your business or something.

It's like they smoke in the shopping malls, and at like get togethers, during the holidays or weddings and something like that. Anything where people like come together, you will see or always see like more than one person with a cigarette in their hands.

I noticed that at [school]'s graduation, at my friend's graduation, and my brother's graduation, these guys as soon as they took their diplomas, they went out there and started smoking. I saw them smoking the big ones.

I have like family members that always use it when they have a get together party.

Yes. I know a lot of the older ladies, like my friend's parents do stuff like that. They have those little gatherings and they like talk about life and how they were and they just smoke and catch up.

Addiction

Addiction to smoking was one of the most prevalent causes for smoking or barriers to smoking cessation that emerged in the focus groups with African youth. The participants demonstrated an understanding of the addictiveness of smoking and referenced this as a barrier to quitting that was commonly viewed as outside of the smoker's control. Some of the statements pertaining to the role of addiction are included here.

Sometimes they don't want to, but they are addicted to it.

Well I don't know, but some people are saying they have to stop smoking because it is bad for their health. But some people still smoke. They can't get away from it.

You know people are addicted to Nicotine, and that is why people are addicted to cigarettes and stuff. Like you take it away and like they go crazy. I think it is something that we could try to ban. I don't know how well that will work.

I don't think they can ban it. One, the United States makes a lot of money off of it. And it is like something that makes a lot of money for them, so they are going to keep it. And when you are addicted to it, it is not something you can just like say I don't need any more. It is like something that is stuck with you. So we can get rid of it, but maybe a little at a time.

The youth also discussed stress as a trigger for smoking among those who are addicted. The participants believed that stress relief was a significant reason for smoking, and like addiction, it was a barrier to smoking cessation that was, to some extent, beyond the smoker's control. Below are some examples of quotes from the focus groups.

It calms them down when they are mad; they just grab a cigarette and start smoking.

That is why most people do it. It is when they are stressed out and stuff. Like if they lose their jobs, they will start smoking like all the time.

There is this lady that used to live by us, before she moved. The last time she was smoking on the porch. I asked her, 'why are you smoking?' She said 'I don't like to smoke, but I smoke because I am frustrated.'

I think a lot of people use [smoking] as a stress relieving thing.

It is kind of a relaxation thing when the kids are going through a hard time they will get out of the house and start smoking; it is like something that makes them lower their anger.

I have an uncle who smokes, but I think he quit but I am not sure because I don't see him much, but like when he was like smoking, he will say that smoking takes the stress away. When he gets stressed, he will go outside and smoke and that will calm him down.

Social norms in smoking behaviors

In addition to describing social norms as reasons for smoking, study participants also described social norms in who smokes and what type of product they smoke, with apparent differences in smoking behaviors and shisha use related to age and gender.

Age differences

Based on interview, focus group, and survey data, there appear to be age differences in smoking behaviors. Overall, it appears that younger people may be more likely to smoke than older people, but this is not always the case, and it may be that both generations are equally likely to smoke, but for different reasons and in different contexts.

Women surveyed tended to disagree with the statement that younger men and women were more likely to smoke cigarettes or little cigars than older men and women. This implies that it is the older generation that is slightly more likely to smoke cigarettes or little cigars. Surveyed women also tended to disagree with the statement that older men and women smoke shisha more often than younger men and women. This indicates that it may be younger men and women who are more likely to smoke shisha. These findings reveal that there may be age differences based on the tobacco products being smoked. Perhaps the younger generation is more likely to smoke shisha, while the older generation is more likely to smoke cigarettes or small cigars.

Somali women were more likely than other respondents to “strongly disagree” that younger men (65% versus 29%) and younger women (71% versus 49%) from their country smoke cigarettes or small cigars. Somali women were significantly more likely than other respondents to “strongly agree” that older women (12% versus 1%) and older men (12% versus 7%) from their country smoke shisha.

9. Smoking behaviors by age, gender, and tobacco product

		Strongly agree	Agree	Disagree	Strongly disagree	Missing
More of the younger men from my country smoke cigarettes or little cigars than the older men.	Total	19%	17%	9%	53%	3%
	Somali ^c	19%	11%	5%	65%	1%
	Other respondents ^c	20%	29%	17%	29%	7%
The older men from my country smoke shisha more often than the younger men.	Total	10%	11%	9%	66%	4%
	Somali ^b	12%	8%	6%	72%	2%
	Other respondents ^b	7%	17%	16%	55%	7%
More of the younger women from my country smoke cigarettes or little cigars than the older women.	Total	13%	12%	9%	64%	2%
	Somali ^c	14%	12%	3%	71%	-
	Other respondents ^c	10%	13%	21%	49%	7%
The older women from my country smoke shisha more often than the younger women.	Total	9%	8%	8%	73%	3%
	Somali ^a	12%	8%	5%	73%	1%
	Other respondents ^a	1%	9%	13%	71%	5%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Community leaders also reported that smoking behaviors varied by age and tobacco products. The leaders reported that although younger people are smoking shisha and cigarettes, some older people were also trying shisha, or smoking in general, since coming to the United States. Also, community leaders inferred that youth smoking behaviors transcend tobacco smoking and include smoking of other drugs. Some key statements around this issue are included below.

Shisha has become more popular more than a few years ago, and it is mostly done by the younger generation.

I have never seen any of our young children smoke. None of them smoke at all. The only ones that I know that smoke so far are men over 35 years.

The younger people are smoking the cigarettes, every kind of cigarette. They smoke anything, they smoke everything.

I know the older people smoke the regular cigarettes, but I do hear that the young people will begin with regular cigarettes, and then it doesn't seem to be enough for them.

Snuff is considered for old generations...like an ancestral thing, but a lot of people smoke cigarettes, or different brands of cigarettes.

The focus group participants also tended to report that younger people were more likely to smoke than older people, especially for women. However, there were focus group participants who contended that people of every age smoke, as can be seen from the examples provided.

Mostly young people smoke.

I see young people nowadays smoking shisha.

Like adolescents and adults, but mostly like 15, 16 year old boys who are just learning it, and are doing it because they think it is cool. And like older people who have been doing it, is like they cannot stop, because they are addicted.

Gender differences

In addition to age differences in smoking behaviors, gender differences also emerged. In general, participants reported that smoking is more common among men than women, but smoking by women seems to be increasing and there appear to be differences in the tobacco product being smoked.

According to community leader interviews, men are socially allowed to smoke, and they are able to do so in both public and private locations. In Africa, women generally did not smoke, except in specific regions. Yet even in those areas only some women smoked, usually shisha, and usually it was in private. In the United States, community leaders still describe men being the primary smokers, though women are beginning to engage in more smoking activities, and again it is often in private and often smoking shisha. Some key statements community leaders offered are included here.

In my area, it was a taboo when women smoke, but in the Muslim areas around Arab and some other areas, it is okay for the women to smoke this shisha. I found out that it is okay for women to smoke here since I came here. When I was back home, it was not okay for women to smoke. Equality.

The Muslim areas, and other parts of [country] itself, the women use this smoking tobacco and shisha that is what they smoke.

When I was growing up, even as a young woman in [country], men smoked, it was not common for women to smoke. And if women did smoke, they were the so called, women of the high class (chuckles). Yeah but you know, middle class and, you know, poor women, so to speak, we didn't smoke.

I would say the men [smoke more], because in our culture it is considered degrading to see a woman smoking or drinking in public. So if they are doing that in private, I don't know (Laughs), but in public you don't really see that often. But men have a tendency to smoke whether in public or in private, but not a lot with women.

I have never seen a woman smoke a cigarette outside. It is always on the inside with shisha.

The males, they smoke cigars and cigarettes, but most of the females, 99 percent, smoke the shisha.

To delve deeper into the idea that status may influence gender differences in smoking behaviors, survey respondents were asked whether there were differences in smoking by gender and status. Most respondents disagreed that higher status in general was associated with increased smoking. However, over one-fifth of Somali women agreed that higher status was associated with increased cigarette or small cigar smoking for both men and women. For other respondents, almost 40 percent agreed that higher status was associated with smoking for men, but only 9 percent agreed that this was the case with women. This means that there may be fewer gender differences with regard to smoking and status among Somalians in Minnesota.

10. Smoking behaviors by gender and status

		Strongly agree	Agree	Disagree	Strongly disagree	Missing
Men from my country who have higher status often smoke cigarettes of little cigars.	Total	14%	14%	14%	55%	4%
	Somali ^c	15%	7%	7%	69%	2%
	Other respondents ^c	12%	26%	19%	27%	7%
Women from my country who have higher status often smoke cigarettes of little cigars.	Total	8%	9%	11%	69%	3%
	Somali ^c	12%	9%	5%	74%	1%
	Other respondents ^c	1%	8%	23%	60%	8%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Focus group participants reported that there are gender differences in smoking behaviors as well. Overall, men tend to be the ones smoking, though younger women are as well. The focus groups revealed a great deal of taboo around women smoking, and many may do it in private rather than in public like men. This is reflected below in some quotes from focus group participants.

Mostly men smoke.

Actually, for me, it is 50/50. But I think there are more girls smoking then they were before. More girls smoke nowadays than before.

I think teenagers that are girls from my community are starting to smoke right now, but boys have been smoking for a long time. Like I know a lot of boys that have been smoking since I was like littler and they are still going at it.

But you mostly don't see women do it. They might do it in the house during like a get together or something like that. But out in public, I think they don't do it because they feel ashamed.

Honestly in our community, no one really talks about smoking amongst young women and stuff like that. It is all hush hush. They pretend not to notice. Like elderly women and stuff, they do not want to get into it, they don't want to like say anything. They will rather talk about another person's kids and say look at that girl she is smoking, instead of focusing on their family member that smokes.

Mainly the boys [smoke]. If the girls do it, they keep it on the down low but mostly it is the boys that do it.

Shisha smoking

The prevalence of shisha smoking was an unanticipated theme that emerged in the community leader interviews. Shisha smoking tends to be the type of smoking preferred by women and by younger men. In the interviews, respondents expressed some confusion around whether shisha counts as tobacco, with one respondent stating that some people were trying to connect shisha to fruit because of the fruit flavored varieties. Shisha was also seen by some as a social activity, particularly with women from Muslim communities. Some respondents did not know what shisha was; while others referenced it without prompting. Some comments about shisha smoking can be found below.

I have never seen a woman smoke a cigarette outside. It is always on the inside with shisha.

I think they actually smoke what we call shisha. They think and say that it is not tobacco, but I believe that there is something in there that they don't know. They tell you that it is a fruit flavor and that it's basically combined with fruits and so it is food. I know they know it's wrong, but they keep hiding it that it is a fruit flavor...I was like no, there has to be something in there. You cannot just be addicted to fruits.

Shisha has become more popular more than a few years ago, and it is mostly done by the younger generation. So I really don't think they do it every day because it costs money. But I know it is been done more than it was done a few years ago when we just came into the country.

Focus group participants also discussed the prevalence of shisha smoking and about what shisha smoking is. Again, some participants mentioned it without prompting, and others did not know what the product was. Here are some examples of what focus group participants said about shisha smoking.

When I was in Kenya, these Africans, right, [shisha] is like their hobby that is what they smoke all the time. I think that is like worse than cigarettes, because cigarette has just a little bit of smoke, but shisha fills the whole house and the smoke will not go away for like couple of hours. Because they use charcoal too and that makes the smoke even worse.

I know that Muslim people, or Somali people in general, we have like this thing that makes the house smell good. And it has a lot of smoke.

I have a neighbor who has like a really sick baby that they keep taking back to the hospital and they smoke shisha in their house and they keep saying the baby is just sick. But I think it's from the shisha.

And the water is boiling and they put like put tobacco in it and they have it in like restaurants.

Personal attitudes toward smoking

Both adult and adolescent African women participating in this study expressed strong opposition to people smoking near them. Some of the women explained that smoking around others, or in general, is a sign of disrespect. Overwhelmingly, women reported that they had self-imposed rules and restrictions on others smoking around them. These include rules about smoking in their homes or cars and strategies for avoiding others who are smoking.

Respect

Many of the focus group participants described how smoking can change the respect they feel for another person and, specifically, how they felt smoking around them was disrespectful. The disrespect appeared to be rooted in the potential dangers and unwanted negative impacts of secondhand smoke exposure, as is demonstrated below in a few quotes.

To me it is disrespectful. The person smoking next to me is being disrespectful, because if they...they obviously know that I am not smoking, I think they should like you know leave and go somewhere else and go smoke. And it is not like I want to get any disease because they are smoking. I don't want to get affected by that. So I am offended if a person smokes by me because again I feel like it concerns my health a lot.

It gives them like a bad name. When I see people who smoke, generally to me I don't look at them in a better way. I kind of lose respect for them.

I lose respect for them. Like before, when I was little, I thought it was cool. Like everybody though, that they looked cool. But now I think it is kinda of dumb, because when I think of all these stuff that comes along with it, I think it is kind of dumb to do that.

If you smoke you don't respect your parents and the older people who are around you, you just think it is cool or you are cool, no one cares for you and you don't care for anyone. And that is bad.

While community leaders did not raise the issue of respect as much as the focus group participants, they implied it throughout the interviews. The comment below reflects the common theme that women have the right to protect their children and smoking is disrespectful of that right.

So I basically tell them to step outside, or not in front of my kids, respect my house or don't smoke in my car. But they have not hurt anyone to the extent that we tell them that we don't want them to be our friends because you are harming me and my kids.

Rules and regulations

Previous studies have shown that women at risk for secondhand smoke exposure often impose restrictions on smoking behaviors in specific spaces in their homes in an attempt to create a smoke-free environment (Robinson and Kirkcaldy, 2007). The majority of survey participants reported that they used such strategies by having universal rules about smoking in their homes and around vulnerable people. Over 70 percent reported that each of these rules applied to everyone. Somali women were significantly more likely to have rules about smoking in their homes. Over 84 percent of Somali women reported that they have rules that apply to everyone about smoking in their homes and around vulnerable people. By contrast, 48 to 70 percent of other respondents reported that they have universal rules about smoking in any of these contexts. In total, 80 percent of Somali women reported that they had rules about smoking in certain rooms of their homes, smoking in their homes in general, smoking around children, smoking around pregnant women, and smoking around older people and applied all of these rules to everyone. Forty-two percent of other respondents had all of the rules and applied them to everyone; while 16 percent did not have any rules about smoking in their homes.

11. Rules about smoking in homes and around vulnerable people

In your home, are there rules about...		Rule applies to everyone	Rule for family only	No rule	Missing
Smoking in certain rooms?	Total	71%	3%	14%	12%
	Somali ^c	84%	3%	8%	6%
	Other respondents ^c	48%	3%	25%	25%
Not smoking in the house?	Total	80%	3%	10%	6%
	Somali ^a	86%	3%	6%	6%
	Other respondents ^a	70%	4%	18%	8%
Not smoking around children?	Total	79%	3%	11%	8%
	Somali ^b	86%	2%	6%	6%
	Other respondents ^b	65%	4%	20%	12%
Not smoking around pregnant women?	Total	78%	2%	12%	8%
	Somali ^c	86%	2%	6%	6%
	Other respondents ^c	62%	3%	22%	13%
Not smoking around older people?	Total	76%	3%	13%	9%
	Somali ^c	85%	2%	7%	6%
	Other respondents ^c	60%	4%	23%	13%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Focus group participants were asked to discuss rules in their homes about smoking. The majority of the young women reported that their families had rules about smoking in their homes, most of which banned anyone from smoking in the home. Many of these rules were flexible and applied only to certain individuals or situations. These exceptions to the rules were likely not included in the reports of rules provided by women in the survey because the survey question focused on the presence of rules rather than the application of them. Below are some key quotes presented by the young women who participated in the focus groups about smoking rules in their homes.

My mom told my dad not to smoke in the house, it is the rule. Even in our apartment they said no smoking in the house.

There are rules against smoking in my house too. My dad stopped smoking. And his friend, the one that still smokes, when he comes to our house and wants to smoke...but when he is in my house, my mom tells him to go outside and smoke. But they have stopped coming to our house because there is no smoking in our house.

In my house you have to be like – my mom says you have to be 21 and if you want to smoke that is your own problem. If you want to die, that is your own problem. You have your responsibility to the rest of us not smoke around us.

The only person in my house that smokes is my uncle. And he comes around once in a while. But we always tell him that whenever he smokes, he has to stay outside... Whenever he comes we make sure he smokes outside and stays there, because you know the smoke is very strong. But then sometimes my mom, when she has her friends over, she will just let them smoke in the house. I get really upset and then she tells me to leave.

In my house, no one like smokes, at least that I know of. And no one comes to our house and smokes. My aunt lives with us and she has like asthma, so that is one reason why they can't.

I have brothers who smoke and my mother is against smoking in the house, or near where we live and I feel like she does not like to see my brother or any of our family members smoke at all. And we have rules against that.

Strategies for avoiding secondhand smoke

Women who participated in the surveys, focus groups, and key informant interviews all reported strategies they personally use to avoid exposure to secondhand smoke. In particular, women reported that they are likely to ask someone not to smoke around them as a strategy. Other strategies that emerged included walking away from a smoker or embarrassing a smoker.

Over two-thirds of the women surveyed (68%) reported that in the past six months, they asked someone not to smoke around them. The people they tended to ask were extended family, friends, acquaintances, or strangers, but not immediate family or co-workers. When asked why they requested others to not smoke around them, over half of the women did so because of concerns about their own health. Other common reasons for asking someone not to smoke include: smoke bothering their eyes or breathing, not liking the smell of smoke, concerns about the health of a child, and concerns about the smoker's health.

Somali women (78%) were more likely than other respondents (51%) to ask someone not to smoke around them in the previous six months. Somali women were also more likely to ask a relative not to smoke (42% versus 11%), but less likely to ask a co-worker not to smoke around them (4% versus 26%). In terms of reasons for asking someone not to smoke, Somali women were more likely to ask because of a child's health concerns (47% versus 24%) and less likely to ask because they do not like the smell of smoke (36% versus 66%).

12. Respondents reports of asking others not to smoke near them

	Total (N=147)	Somali (N=109)	Other respondents (N=38)
Percent who asked this person not to smoke around them			
Friend	40%	43%	29%
Other relative	34%	42% ^c	11% ^c
Someone you do not know	33%	34%	29%
Other person you know	32%	30%	37%
Co-worker	10%	4% ^c	26% ^c
Boyfriend or husband	5%	6%	-
Parent	3%	4%	-
Son or daughter	3%	3%	3%
Percent who requested not smoking for this reason			
Concerns about your own health	79%	81%	74%
Smoke bothered your eyes or breathing	50%	52%	45%
Did not like the smell	44%	36% ^b	66% ^b
Concerns about the health of a child	41%	47% ^b	24% ^b
Concerns about the smoker's health	35%	33%	40%
Think smoking is poor behavior	28%	24%	37%
Other	6%	5%	11%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Community leaders reported that the avoidance of secondhand smoke exposure is pervasive within their communities. The women reported that while there is little they can do to eliminate smoking in general, if it is near them or their children, then they feel comfortable asking someone to refrain from smoking. Also, this aversion to smoking is so strong that one community leader described how people in her community put effort into camouflaging the smoke smell when they go to social gatherings. This idea is illustrated in the quotes included here.

Nothing much can be done, unless it comes to the point where that person is doing it near us at a party, inside a room where we are, and then definitely people will say something.

There are not a lot of smokers so...trust me the women in my community that I know, if somebody is smoking where their kids are sitting, they are the first people that say you need to leave here now. So they are so ready to embarrass you.

I can't stand the cigarette smell...A lot of my community members can't stand that. That is why those that smoke, when they come to gatherings, they make sure they don't smell of smoke and they are well perfumed, so that they don't have that bad smell. So they understand that secondhand smoke is a very, very, very powerful thing. So they will not go around where people are smoking.

These statements about discussing smoking were not universal though. Some community leaders reported that barriers such as fear of infringing on peoples' rights and social taboos prevent them from talking about smoking, especially with groups such as Americans and men. Some examples of this include:

People are worried, but you are in a country where people have their rights. So as much as my worry may be serious to me, there is nothing I can do. I take the bus to go downtown, because I don't like driving downtown. And If I am waiting at the bus stop and a guy is smoking, I can't go to him and say "stop smoking." I can do it in Africa...but can I do that here, no. It is his right, so I can only walk away from there.

And culturally that [smoking] is not even a subject of discussion in the family...usually in my culture, because of the dominance of the male, it is quite hard for a woman to address that.

It is some form of denial. It is a taboo you know... you don't find many people sitting around and talking about you know "I have cancer" or stuff like that or you know "I have HIV" or you know "I have something." The most people will talk about is common cold so there is still some level or some form of taboo lingering in our community.

The young women participating in the focus groups had even greater ambivalence about asking someone not to smoke around them. Some young women were comfortable asking anyone to stop smoking, while others were conditionally comfortable, and some were more comfortable employing other strategies instead.

When asked how comfortable the young women felt about asking others to stop smoking around them, some of the women said they were completely comfortable. These women tended to feel that they were entitled to be free of secondhand smoke. Key examples from the focus groups are shown here.

I will like try to tell you, and I will shout if I have to.

I am comfortable to tell people not to smoke near me because it is going to be my problem too when it comes, so I will tell them right away.

I don't have no respect for anybody except for my mom, so I will tell you that 'you need to go somewhere else and smoke, because ain't no body smoking here.' I will make a big deal out of it, and if they get tired of me talking, they will move away.

Me, I don't care, if you are smoking in front of me and I don't like it, I will tell you to stop smoking in front of me.

I am very comfortable. I tell my brothers all the time that that is just wrong and they should not smoke near me or around the house.

Some of the other young women said they were comfortable in certain circumstances. They tended to be more comfortable when talking to a peer or friend. Also, they may not feel comfortable directly asking someone to stop smoking, but they may indirectly communicate this message or may opt to simply leave the situation, as described below.

What I do when like somebody is smoking, I can't like tell the person to stop. If the smoke is affecting me, I will start doing some things, like I will start coughing a lot, so that the person knows that I am affected by it.

No. If it's like someone I know, like my uncles and my aunties, maybe I will, but if it is my dad's friends, I don't know how I will do that.

I will just walk away.

I will not tell them to stop smoking around me, but if they do, I am not going to make a big thing or a big fuss out of it or anything about it. I will just leave.

If the person who is smoking is not someone I know, I won't say anything. But if it like my friend or somebody close to me, I will tell them to stop or I will go somewhere else.

If I see that the person looks kind of like a good person, and they look like they know that they are doing something wrong, then yeah I will confront them and I will tell them, but if it is like somebody that looks tall or really mean or looks like they can hurt me, I will like back away and not say anything.

Finally, some of the young women said they were not at all comfortable asking someone to stop smoking near them because they do not feel like they are in a position to say anything, feel scared, and feel like nothing will change. Below are a couple of examples of this lack of comfort.

I am not comfortable, especially if it is an adult, I feel like it is not my place to say anything.

Like I said, I don't say anything (laughs). Especially if it like my dad's friends, it is kind of like weird if I tell them not to, you know. But they don't like come inside to smoke. So, but if they did, I would not know how to handle it.

I don't feel comfortable telling people not to smoke, so if they are, I will just walk away.

Awareness of the health impacts of smoke

The women participating in this study were asked about three aspects of awareness of the health impacts of secondhand smoke. They were asked about their own awareness of health impacts, about their experiences with health impacts, and about their perceptions of community awareness of health impacts. Personal awareness of and experience with health impacts of tobacco smoke were explored in the surveys of African women and in the focus groups with African adolescents. Community awareness of the health impacts of tobacco smoke were assessed in the community leader interviews and in the focus groups with young women.

Personal awareness of health impacts

The women participating in the surveys and the young women participating in the focus groups demonstrated a high level of personal awareness of the health impacts of tobacco smoke. However, this awareness was often couched in uncertainty. In the surveys, a large number of women reported being unsure of the answers to a set of knowledge questions, and in the focus groups some of the adolescents used tentative terminology, such as “I think,” “I heard,” or “they say.” So while the awareness of these two groups is extensive, their knowledge could be affirmed and reinforced.

General knowledge of health impacts

Of the 14 knowledge questions about the health impacts of tobacco smoke asked in the survey of African women, respondents answered from 0 to 13 correct (Average = 7 correct answers). However, only 6 of 14 questions had more than half of the respondents answering the questions correctly. The questions that had the highest percentage of correct responses include: both smokers and non-smokers need to worry about tobacco health risks; babies whose parents smoke are more likely to be hospitalized, and smoke in a house can hurt you even if it is in a different room. The questions that had the lowest percentage of correct responses include: tobacco smoke can cause cancers beyond lung cancer; shisha smoke is just as dangerous as cigarette smoke; smokeless tobacco is as dangerous as cigarette smoke, and menthol cigarettes are as dangerous as regular cigarettes.

For many of the questions, a larger percentage of women responded that they did not know the answer than responded with the correct answer. The specific questions in which this was the case include: light cigarettes are as dangerous as regular cigarettes; secondhand smoke can cause heart disease; menthol cigarettes are as safe as regular cigarettes; smokeless tobacco is as dangerous as cigarettes; shisha smoke is as dangerous as cigarette smoke, and tobacco smoke can cause more than just lung cancer.

Women who were from countries other than Somalia answered significantly higher numbers of questions correctly (Average = 9.1) than women from Somalia (Average = 6.2). Women from Somalia were significantly more likely than other respondents to respond that they did not know the answer to the questions. Somali and other respondents differed significantly in the percentage answering many of the questions correctly. In all but one of these questions with a statistically significant difference, the women from Somalia were less likely to correctly answer the question. The one question in which a significantly higher percentage of Somali women correctly responded was that smoking does not relieve stress (67% versus 53%).

13. Exposure to smoke knowledge questions: percent correct and “don’t know”

		Total (N=205)	Somali (N=130)	Other respondents (N=75)
Only smokers have to worry about health risks from tobacco smoke. (A: False)	Correct response	85%	84% ^a	88% ^a
	“Don’t know”	10%	15%	3%
If a baby has a parent that smokes, she is more likely to end up in the hospital. (A: True)	Correct response	85%	88%	78%
	“Don’t know”	12%	10%	16%
If someone is smoking in the house, their smoke will not hurt you as long as you are in a different room. (A: False)	Correct response	84%	81%	89%
	“Don’t know”	12%	16%	5%
Children can get asthma from breathing an adult’s cigarette smoke. (A: True)	Correct response	81%	80%	84%
	“Don’t know”	11%	14%	7%
As long as a pregnant woman does not smoke tobacco herself, her baby cannot be hurt by other people smoking in the home. (A: False)	Correct response	72%	60% ^b	93% ^b
	“Don’t know”	22%	31%	4%
Smoking tobacco relieves stress. (A: False)	Correct response	62%	67% ^a	53% ^a
	“Don’t know”	29%	23%	41%
If a person only smokes 5 cigarettes a day, their risk of getting cancer is about the same as someone who does not smoke at all. (A: False)	Correct response	47%	35% ^b	68% ^b
	“Don’t know”	44%	57%	20%
Light cigarettes are safer than regular cigarettes. (A: False)	Correct response	42%	28% ^b	67% ^b
	“Don’t know”	55%	70%	28%
Non-smokers can get heart disease from someone else’s cigarette. (A: True)	Correct response	36%	18% ^c	69% ^c
	“Don’t know”	38%	50%	16%
Menthol cigarettes are safer than regular cigarettes. (A: False)	Correct response	32%	15% ^a	61% ^a
	“Don’t know”	64%	81%	35%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

13. Exposure to smoke knowledge questions: percent correct and “don’t know” (continued)

		Total (N=205)	Somali (N=130)	Other respondents (N=75)
Using smokeless tobacco like snuff or chew tobacco is safer than smoking cigarettes or little cigars. (A: False)	Correct response	31%	15% ^c	62% ^c
	“Don’t know”	61%	76%	33%
The smoke from a shisha pipe is safer than smoke from cigarettes. (A: False)	Correct response	28%	17% ^b	47% ^b
	“Don’t know”	62%	71%	46%
The only kind of cancer caused by tobacco smoke is lung cancer. (A: False)	Correct response	28%	9% ^c	62% ^c
	“Don’t know”	30%	39%	15%
Average number correct (range is 0-13)		7.3	6.2 ^c	9.1 ^c

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

The adolescents who participated in the focus groups demonstrated a general awareness of the negative impacts of smoking on health, appearance, and life. The young women also had a great deal of awareness of the dangers of secondhand smoke exposure. However, some of the awareness they demonstrated was not as accurate or certain as it could be. Also, the teens believed that smokers may not share the awareness that they possess, as can be seen in the quotes below.

They say that is bad for your health.

When I see somebody smoking the first thing that comes to my mind is that the person is going to get sick and if they don’t stop they are going to die.

Smoking can destroy your life.

Smoking is bad for your health and it gives you all kinds of diseases.

Just like if you are around the person too much, like the smoke goes in your lungs too. It is like if you are smoking and someone around you is also smoking, it affects you both the same way as it affects the person that is not smoking. Yeah, they kind of talk about it a little bit. I heard it is actually worse than “smoking smoking.”

I know that secondhand smoke, you have the same diseases as the regular smoker, but it is more like less, but you get the same diseases, like heart diseases, lung diseases, throat, bad teeth, and bad breath.

I don’t know if this is true, but I heard like during secondhand smoke, if you are around that person, your lung is going to turn black.

I think secondhand smoke is very bad, because if you smoke, and somebody else breathes in that smoke, there is a 25 to 50 percent chance that you might get cancer, if like you are really near the person. And I think some people don't realize that secondhand smoking affects other people.

Knowledge of specific risks

Some of the focus group participants identified specific health risks, such as cancer and heart disease associated with smoke exposure. Again, some of these statements could have been more certain.

I know that it could give you cancer, like lung cancer. It could also give you breathing cancer.

If the person that is driving a car is smoking and the people sitting around and in the back and they have kids, they could have lung cancer.

The effects of secondhand smoke could just be as bad as for the person smoking it. Like the commercials and stuff that you, like "I never smoked before, but then I have cancer" and things like that. So you can sometimes, maybe not all the time get sick from that stuff. Just the same as the person who has been smoking for a while.

I heard that it is more riskier for a person to get cancer for the person who breaths someone's smoke than the person who smokes.

I think there's a 50 percent chance that somebody can get sick from another person's smoke. They can get diseases from the smoke and the smoke can hurt their heart, or they get heart diseases from it.

It could give you like a bad heart, like your heart can be bad.

I think it gives you heart problems.

It will also spoil your heart.

Knowledge of risks of smoke exposure and pregnancy

In Figure 13, the majority of surveyed women knew that secondhand smoke exposure while pregnant can harm the baby. This knowledge was echoed by participants in the focus groups, who discussed their knowledge of the dangers of smoke exposure while pregnant, particularly if the pregnant woman is smoking.

If you are pregnant, it could affect the child, you know.

My [family member] works in the hospital with like little babies and she tells me all these little stories of babies that are born and their mom had been smoking and stuff and I think that is really bad because when they grow up they are going to have problems already that are not their fault. So I think that it is really bad for women to smoke.

I know like a pregnant woman. She is smoking and I know that is going to affect how her baby comes out. And the baby's breathing and stuff like that.

I have noticed that there are some teenagers who are pregnant or are married or get married early and are pregnant and are smoking, you know like their child, like I have seen some babies that I have helped baby sit, like when they are breathing when they are sleeping they are wheezing. They come out with some disability and the kids are just sick and the parents say, this is just the way God made them, and they know that it is their fault for smoking and they don't seem to care about it. And after the child is born, they like regret doing what they did, but they keep doing it.

Community leaders also described the risks associated with smoke exposure during pregnancy, though this awareness may be more recent and not widespread throughout the community.

Now, secondhand smoking is as dangerous as you know whatever you think out there. You know, especially with the younger children and you know unborn babies. You know they are still in the developmental stages. So they would grow or they may grow up with you know breathing complications like asthma or you know some other complications in that.

For the pregnant women, including myself, I didn't know that anything that I could take in could harm my child. Nobody told us about that back home. I didn't have that kind of knowledge to know. Therefore nobody thinks that anything you take could harm your baby.

Despite this perceived lack of community awareness of the risks of smoke during pregnancy, most women surveyed reported that pregnant women from their country do not smoke cigarettes, cigars, or shisha while pregnant. This does not reflect the prevalence of secondhand smoke exposure during pregnancy, which could potentially be greater.

14. Rates of smoking during pregnancy

		Strongly agree	Agree	Disagree	Strongly disagree	Missing
Pregnant women from my county smoke cigarettes, cigars, or shisha.	Total	6%	6%	9%	78%	1%
	Somali ^a	8%	6%	6%	80%	-
	Other respondents ^a	1%	5%	16%	74%	4%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Personal experiences

In the surveys completed by African women, two-thirds of women reported that their eyes, throat, or lungs hurt from smoke from cigarettes, little cigars, or shisha. Somali women are significantly more likely than other respondents to report that their eyes, throat, or lungs hurt from smoke (79% versus 47%, $p < 0.001$).

The majority of women surveyed said that no one in their home has asthma or breathing problems (79%). The 37 women who do have at least one person in their home with a breathing problem or asthma were asked who experiences these symptoms; 43 percent said they do; almost one-fourth said that their child or another adult relative does (24% each); 14 percent reported their parent does, and 8 percent reported a grandparent does. For mothers of children with a breathing problem or asthma, the children who have these problems were age 2 to 15, with an average age of 9 years old.

Focus group participants shared stories or first-hand accounts of health impacts they experienced when someone smokes near them. The young women discussed asthma reactions, breathing problems, allergies, and odors associated with smoke exposure. Some of the examples shared were:

I know that when someone else smokes in front of me, right after I leave them, like I don't know why, my chest starts hurting really badly. I don't know if it is because I have been around that person for less than five minutes, but I know I get very uncomfortable. I am not saying everyone else is like that.

If somebody is smoking by me, I can't breathe.

When someone is smoking next to me, and I smell the scent, I start coughing, and I cannot breathe.

I get allergies.

If I smell cigarette my nose will be blocked because I am not used to smoking, or secondhand smoke, so it affects me like that.

My eyes burn from the smoke.

My eyes get watery.

I don't like the smell of it. It like make me nauseous. I just don't like being around it.

I just hate the smell of it.

Community awareness

Previous studies have found that there tends to be a low level of awareness of health effects associated with smoking (Kurtz et al., 1993; Martin et al., 1992; Pobee et al., 1984). Community leaders, discussing their perceptions of awareness of the harms of tobacco smoke in their communities, expressed a great deal of ambivalence around whether or not community members are aware of the health risks associated with tobacco smoke. Many community leaders believed that members of their community do not know about these risks.

Because they don't know. They don't know the risk involved. It is not about the enjoyment. They don't know the issues involved, the serious issues involved.

What we are saying to them is that there is no good cigarette (laughs). You know I hear sometimes I hear people say this cigarette is better than the other cigarette. No, there is no good cigarette. It's like pollution, when a place is polluted, it is polluted. So what we tell them is that no matter what it is has the same effect. So your best bet is to keep away from it.

Because they don't think they are ingesting it, so they don't think they can get affected. They don't see the extent of how bad it could be bad for them. Because they are not physically taking the cigarette.

They don't know. They tell me if you are not smoking, then why are you complaining? So they don't know that I complain because it will make me sick. Like I told you, those people...in my country, there is nothing to teach people or explain. There is no opportunity like that there like here. That is why they don't have any knowledge about it.

If they knew that the secondhand smoking would have that kind of effect on their kids, I don't think they will smoke. I don't think they are aware.

For example, back home, most people used to have lung diseases. They try to take care of it because if that kid gets the lung disease, tuberculosis, he starts coughing, and starts bleeding. Therefore it is easily noticeable, but when it comes to tobacco, even around them, people are smoking 30, 40 years and nothing has happened to them, you know, outward. Therefore they believe that people cannot get sick. But you know it is affecting them from the inside. Therefore they don't understand and it is hard for them to understand that.

Focus group participants had similar impressions of a lack of community awareness around the health impacts of tobacco smoke.

I think there is lack of knowledge about it. That is why it is not a big deal.

I just heard about secondhand smoke. I didn't know it existed. I just thought that a person who smoked was the only one affected and others were not. So if I didn't know, I don't think my parents know either.

However, some community leaders argued that it is difficult to be unaware in the United States where the health messages are so prevalent.

In this country, it is very, very easy to know that it does, when you hear all the promotions on nicotine and the addiction to nicotine and quitting and all that, so people know.

I am saying this from my own view is that this country is very very much educating and the TV says it, hum... the radio says it, and I mean we have an ad of the smoke going up in the air and this young child thinking that the shadow he is seeing was his grandfather, but he had already died from smoking. So yes, they do.

So you know with the awareness here, because they keep saying it on the television, on the radio, that secondhand smoke, secondhand smoke, you know... so now we are getting to know the awareness.

They are saying to people, it is not good for your health. It will give you cancer and we know what cancer does.

Finally, many community leaders described a general lack of concern or denial about the dangers of smoking, despite being taught about these dangers.

They are aware of all the bad effects of smoking. Even the smokers make comments like, "I know this will kill me one day." So they know, but they can't quit. They are aware of this.

You can't imagine how much they know about bad things about cigarettes... even the educated ones. They know what damage it does to them, they hear it everywhere. They get their information from the Internet, from their schools, from their community, wherever, but still they are in denial. They think that the doctors are saying all this to sell them medicine.

They know everything they just keep doing it.

Yes, and also women when they are pregnant, they smoke and they know that something is going to be wrong with their kid you know, but they keep doing it.

I pretty much think they know [smoking tobacco] is not good. But it is like part of the culture.

We tend to have that bad habit that whatever is happening is happening to others and not to us. So it really has to strike home, unfortunately, having somebody die (laughs) from the effects of second smoke, because that person would be exposed to it then somebody like me who has asthma been constantly exposed to secondhand smoking and ending up at the hospital. Something that is definitely happening close to home will make them pay attention.

This belief that community members are aware of the health impacts but are not concerned about them was echoed by focus group participants.

I don't think they look at it as a problem or stuff like that. I think that when they came here, they heard that smoking is bad for you, you should stop, but I don't think they really care about it more than as a problem.

They basically don't pay attention.

Some people will say, "I don't care about that."

It is like it goes in one ear and comes out of the other.

Strategies for building awareness

In order to continue to help community members learn more or care more about the health impacts of secondhand smoke, this study explored strategies for building awareness in African communities. Three aspects of awareness building were assessed: who should be involved, what information should be shared, and how that information could be distributed. Community leaders were asked specifically about who should be involved in community efforts to build awareness. Survey participants were asked about how great the need was for specific types of information. And both community leaders and focus group participants were asked for suggestions on how to disseminate information within their communities.

Who should be involved

When asked specifically who should be involved in building awareness within African communities, community leaders provided a list of many different people. Initially, many of the leaders said “everyone” because they felt that this issue was significant enough to get everyone in the community involved. When probed further though, certain groups of people emerged as potential leaders, including: women, parents, community leaders, medical professionals, schools, government, and non-profit organizations. Some of the responses are included here:

I think everybody should be involved...I think it is everybody’s job.

Everybody, everyone, not just leaders, everybody from the grass roots to the high mountains, everybody should be involved.

So everybody has a role to play and parents at home should be talking to their children about the effect of secondhand smoke.

Anybody concerned, anybody that has a person that or knows a person that smokes and cannot help themselves should be involved to find out how to help that person to beat the habit.

I think it has to start with the community leaders starting a conversation about it because we tend to listen to our leaders.

I think [women] should just take the lead. Because they are our children.

Clinics, hospital, you know they really believe in what they hear from their doctors and nurses and stuff like that.

The Department of Health could air public health announcements over the effects of secondhand smoke.

We have a lot of non-profit organizations that deal with this, obviously including MAWA.

Types of information needed

In order to determine the types of information African women felt were most important to share in their communities, a series of questions in the surveys asked women to rate the need for specific types of information. A large majority of women (83% or more) reported that each of the different types of information were very needed in their communities. This high level of need was reported by both Somali and other respondents. These findings demonstrate the high level of need for general information about the risks associated with tobacco smoke within African communities and suggest that that needs may be broad and not necessarily targeted on any specific topic, population, or risk.

15. Kinds of information about tobacco use needed in communities

Type of information		Very much needed	Needed a little	Not needed at all	Missing
Health risks for smokers	Total	87%	3%	3%	6%
	Somali	88%	1%	3%	8%
	Other respondents	86%	7%	4%	4%
Health risks for non-smokers	Total	85%	5%	4%	6%
	Somali ^b	89%	2%	3%	6%
	Other respondents ^b	78%	10%	7%	5%
Secondhand smoke health risks for pregnant women and their babies	Total	88%	4%	2%	6%
	Somali	87%	3%	3%	8%
	Other respondents	90%	5%	1%	4%
Secondhand smoke health risks for children	Total	89%	2%	3%	5%
	Somali	88%	2%	3%	6%
	Other respondents	91%	3%	3%	4%
How tobacco companies design their products to get people “hooked” quickly	Total	83%	6%	4%	8%
	Somali	84%	5%	3%	8%
	Other respondents	79%	9%	4%	8%
How tobacco companies market their products to certain communities	Total	83%	5%	5%	7%
	Somali	85%	5%	3%	8%
	Other respondents	81%	7%	8%	5%
Strategies other communities have used to prevent youth from starting to use tobacco products	Total	87%	3%	3%	7%
	Somali	87%	3%	3%	8%
	Other respondents	88%	4%	3%	5%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

15. Kinds of information about tobacco use needed in communities (continued)

Type of information		Very much needed	Needed a little	Not needed at all	Missing
Ways that doctors can help people quit using tobacco	Total	88%	3%	2%	7%
	Somali	88%	3%	3%	7%
	Other respondents	88%	4%	1%	7%
Strategies other communities have used to help people quit using tobacco	Total	88%	3%	3%	7%
	Somali	87%	3%	3%	8%
	Other respondents	90%	3%	3%	5%

^a Indicates a statistically significant difference between Somali and other respondents at the $p < .05$ level.

^b Indicates a statistically significant difference between Somali and other respondents at the $p < .01$ level.

^c Indicates a statistically significant difference between Somali and other respondents at the $p < .001$ level.

Strategies for sharing information

In addition to gathering information about who should be involved in disseminating information about risks of secondhand smoke and what types of information should be disseminated, this study sought to learn strategies for sharing this information with the people who need it. Both community leaders and young women were asked for suggestions about strategies for helping build greater awareness in the community. The strategies shared include how to reach people and how to deliver the information to those people to truly engage them.

Talking individually

When asked about potential strategies for increasing awareness of the dangers of exposure to smoke, the focus group participants suggested talking to smokers they know individually. The respondents tended to believe that this individual approach would be effective if delivered in an appropriate way.

Even at the bus stop, if you see anyone smoking, you can walk up to them and tell them. Be bold to them, but don't do it in like a rude way. You just tell them in a way that they will understand.

I think you can explain to them and make them listen. Just tell them that it is not good.

Just talk to them.

Community leaders also felt that an individual approach might be particularly effective with some people, especially if they want the information. One of the community leaders emphasized that persistence is important with this one-on-one approach.

This kind of information cannot be a mass education, it can be a one to one...and you have to do it again and again, without giving up. Without losing hope.

Language will not really play a role to somebody that is interested in knowing more. Just going ...to their buddies and looking up the information together and having that person interpret the results for them. So my stand is that it takes somebody that is interested in the topic to get information.

Small group discussion

Another potential strategy for increasing awareness of the dangers of exposure to smoke described by focus group participants was having small group discussions, like the focus groups, in which people can relate to one another.

We can talk to them like the way you are talking to us here [in the focus group].

Like what we are doing now, to get people's feelings and thoughts.

Like this type of group. We could invite other girls and people sit in front of us and other people talk about people that smoke and how it affected them or like talk about people that died from it, or people that smoke. Or just tell them how you can die from smoking.

I just don't think a large group is the way to go. I think a smaller group is better.

Large events

The focus group participants also suggested events for large groups of people, such as at community events, churches, parties, or in the classroom, to help increase awareness of the dangers of exposure to smoke.

At the mosque, we talk about religious stuff, but we also talk about general stuff like smoking and how it is bad for you.

Church events, community gatherings and stuff.

Do you know something called [program]? It is for girls in my school, and they do the same thing and the talk about cigarettes and stuff. It is like a gym class.

If it is more than like five people and you know them, you can try to talk to your teachers to bring some information to help them. Or bring in a spokesperson to talk about smoking.

Large events were also mentioned by community leaders as a forum for sharing information about the health risks of secondhand smoke. Community leaders emphasized sharing information at existing large gatherings, rather than hosting gatherings for the purpose of sharing information.

I know sometimes they have health fairs at most of the public housing buildings, so most Somali people who live there attend, so they have that and they have that at most of the clinics, they have most of the Somali speaking staff who talk to them about health.

Everyone is busy, everyone wants to go out and get something free and relax, so if you know where their parties are, go there with your information. If you can attend a party and just take about five minutes, not too long, because when you talk beyond five minutes, they start getting bored. So talk to them and just you know catch up. You know where their parties are, go there. Take just five minutes or less, just show a picture and say secondhand smoking kills, say something and show something graphic that is short and simple, that stays with them a lot longer.

Also in parties, or in a get-together, so more word of mouth in our parties.

Media

A commonly mentioned strategy for increasing awareness of the dangers of exposure to smoke was using the media to get the messages out. In particular, the focus group participants talked about using radio, TV, internet, newspapers, and other printed materials.

Like the internet, like use MySpace. A lot of people go on MySpace and stuff and Facebook too. You could just put the information there

Mostly on You Tube. People do a lot of things on You Tube; you can make some videos on what smoking can do to you and stuff.

You can use BET. Most of the people watch BET.

You can use kids' favorite TV shows. Like the [name of show], where people are talking about the smoking, you can just put it on there.

There are many articles in the newspaper and also on the internet.

Northwest community TV.

Or you can call B96 to talk about it.

You can put it on TV, like a commercial.

Community leaders also described the role that media could have in building awareness in their communities. The leaders compared these proposed strategies to the media campaigns used to build awareness about HIV and AIDS or other public health issues.

There is nothing out there, you know in your face telling pay attention to this happening, like you see billboards about HIV or breast cancer everywhere, you know or suicide prevention, you don't see such things for secondhand smoking. So for me it would take really attracting people's attention before they get the information that they need. Because if they don't think of it as their priority, they are not going to look for it.

So talk about it, like the AIDS program. We keep talking about it. When I lived in [country], it was on the radio, it was on the television, it was on the news, parents talk about it, teachers talk about it, you know, especially at school.

Really seeing it happening now really getting a public announcement on the TV or whatever, because we tend to have that bad habit that whatever is happening is happening to others and not to us.

I know a lot of people read, and I know they watch TV all the time.

Visual messages

The young women also mentioned that a potential strategy for increasing awareness of the dangers of exposure to smoke includes using visual images or examples, including speakers who have experienced health impacts of smoking. By helping inform people about how smoke affects their bodies inside and outside, the focus group participants believed that it would inspire people to stop smoking or prevent people from starting to smoke.

I think it will be nice to bring somebody to speak to them. Like somebody who had experience with smoking when they were younger or like a person who had cancer and like survived it but got cancer because of smoking, by bring in those kinds of people, they might see how they might be in the future, and when they see this they will be like oh snap I don't want to be like that.

People like me represent people that look like us, and when they start smoking, they start to look different, that is what "take a look at my face" means.

A really good example, I think it to bring people who smoke and have that little whole in their neck or have to use those machines to breath, like bring one of those people and tell them this could be you in 50 -40 years if you don't quit.

You know how sometimes, people show you the bad lungs and the good lungs. You should show them that kind of stuff.

I think for the young people, if you just tell them, they don't listen to you...I think what we should is like show them what happens to you when you smoke and what your heart will look like when you smoke and when they see that, they will not want to smoke.

Community leaders also strongly emphasized the need to use visual images to help build awareness. Most of the leaders reported that visuals are far more effective in their communities than written text is. They discussed using print media to get the message out to the community, but this print media must include pictures in order to have an impact.

I am a visual person and you know, Africans... Africans are very visual people. When I was growing up, if you ask me 1 + 1 I will look at you like a fool. But if you show me one mango + one orange, I will quickly tell you it is 2. Same thing there.

I believe also, we need to hand out books that show pictures of this is what your lungs will look like if you smoke. We need handouts, we need awareness. For example like in my shop now, I could have like a poster that says smoking is bad for your health, please don't smoke. Something that will flash in the minds of people you know will help.

They need to see it to believe it, putting it on paper and giving it to them to read, they are going to read it as if they are reading another story, from another continent. Show them these pictures, it will mean. A picture is worth a thousand words, so show them those pictures.

Activities

Focus group participants felt that their peers would respond well to hands on activities like games, dances, and incentives for education. They believed that a "fun" activity would increase engagement and understanding of the material.

Maybe they should have a game of who can hold their breath longest and then like tell them whoever wins gets a prize. You know prizes always gets people motivated, especially candy or maybe money, you know what I mean? And then say for all of you who smoke, one week stop smoking and see how it helps. Just help them get through it. Set a goal for them and support them. That could sound a little cheesy but I think it will work.

We could educate them, and play games such as jeopardy to make it fun, and say in the game what causes this and this and more.

So it is like if we dramatize, you know in an African dance, or something, children understand.

Alternatives

Focus group participants also recommended offering distractions or alternatives to smoking to people who currently smoke, particularly physical activities and stress relievers.

You could give them ways to like deal with their stress especially for teenagers and stuff.

Probably acting, anything, like sports, anything could help. So instead of smoking that day, you can do something else. I am not going to say it is easy, it does take time

Replace smoking. Like every single community should have something for the kids to get involved in.

You know how someone when they are stressed out, they want to smoke, like take them shopping or something that takes their mind off of it.

Relating to people

When asked about potential strategies for increasing awareness of the dangers of exposure to smoke, the young women suggested trying to relate to people and work with them to help them understand the health risks. These suggestions primarily centered around persuading people by figuring out what information is important to them.

I think like, to get people focused, you can't tell them it is wrong for you, you can say, you can't do this, you can't do that. Kind of do it in a mocking way, you know tell them what it does. They don't like the truth, they are not going to listen. So use more humor and stuff.

I think to connect with people, tell them something they can relate to. That is important. I don't know how you would do that but, something that they can relate to, that people usually think about.

Make them feel comfortable. Like hear their views and stuff like that. Not make it look like we are judging them or saying anything wrong about them.

I will try to find out why they smoke in the first place, like what led them to smoke.

Community leaders also described ways to relate to what is important to people in their communities. In particular, community leaders discussed focusing on children because they believe that people's concern for their children will be a powerful motivator.

Use children (laughs), yeah children, because right now, I am a new mother, and I cannot think of anything without putting my child first...So to get women involved, get the children involved, because it affects them the most, more than the smoker. Secondhand smoking will affect a one year old more than a 30 year old mother, and even way more than the smoker. Yeah so, get the children involved, because every mother's heart is their children.

Smoking is cool until it just so happens that your child gets a debilitating disease or ends up dying from the effects of smoking. They would then stand up. Unfortunately we tend to be conditioned by traumatic events. Instead of preventing we want to cure.

Discussion

Smoke exposure of women and children reported in this study is on par with findings from previous studies. In this study, exposure to secondhand smoke was reported to be between 27 percent and 31 percent, depending on the timeframe. Existing literature estimates that around 22 percent of Somali youth in South Minneapolis schools are exposed to secondhand smoke (Sexton et al., 2004) and between 23 percent and 38 percent of youth living in Africa are exposed to secondhand smoke (Center for Disease Control, 2007). Our findings are within the range of exposure estimated both among African immigrants in Minnesota and among Africans living in their native countries.

The current study identified, however, that exposure to secondhand smoke does not appear to occur in any particular microenvironment, but rather spans multiple contexts. This finding demonstrates the necessity for broad prevention efforts that target general smoking behaviors rather than strategies for addressing exposure in specific circumstances, like in the home. One of the reasons that smoke exposure may cut across multiple contexts is that smoking tends to be a core facet of socializing in African communities. Social gatherings can occur in many different contexts, including at home, at community gatherings, at clubs or restaurants, and at parties. If the smoke exposure is linked to the activity rather than the location, it could account for the dispersed reports of exposure across locations.

Based on information from community leaders, adolescents, and survey participants, African women tend to already have rules in place to restrict exposure to secondhand smoke in their homes, vehicles, or around vulnerable people. However, exposure in these locations does not appear to be lower than found in other studies. This may be because the rules tend to be conditional or flexible. Also, study participants individually have developed strategies for avoiding the smoke including asking others not to smoke around them and simply walking away from a smoker. However, there were varying levels of comfort reported for using these strategies, and these strategies may not address the community-wide dangers of secondhand smoke exposure. Again, a broader systems approach may be necessary to combat exposure despite having personal rules and strategies in place.

Study participants reported that in recent years, smoking among women and young people in African communities has increased. Based on data collected in this study, smoking while socializing may be the most common reason that women smoke, despite the fact that women smoking was traditionally not condoned. While socializing may be the primary catalyst for the increase in women smoking, study participants attribute increases in youth smoking primarily to American cultural influences, peer pressure, role

modeling by adults, and the media. Each of these factors relate to the idea that youth learn behaviors and adopt those behaviors from others. Participants discussed how each of the influencing factors on youth also have the potential to function as protective factors through positive parent and peer role modeling and media messages. The key is to make the positive messages more frequent, salient, and relatable than the negative messages.

One of the limitations of this study is that the women and youth participating tend to be the community members who are already connected, engaged, and concerned about community health issues. Because the survey was not distributed using a random sample, the community leaders were nominated by advisory committee members, and focus group participants were recruited through youth groups, these participants may have a clearer understanding and concern for secondhand smoke issues than the broader community. Therefore, it is not surprising that participants in this study had a high level of general understanding of health risks associated with secondhand smoke exposure. However, when information about more specific risks were requested, such as heart disease, cancers beyond lung cancer, or dangers of different types of tobacco products, there was a great deal of tentativeness, hesitation, and uncertainty, even among our relatively aware participants. It may be that general awareness is more accessible, but as information becomes more specific or nuanced, community members may not be provided with or able to retain the information.

Because we recognized the uniqueness of this sample, the participants in this study were asked to also reflect on their perceived awareness of tobacco health risks in their broader communities. Participants were relatively divided on the levels of awareness they perceived in their communities. Some participants felt that their community members were completely unaware of the health risks of tobacco smoke and that if community members had the awareness they would probably not engage in the smoking activities. However, other participants believed that, in America, there was no way to avoid information about the health risks and that their community members were aware, but were in denial or did not care. These opposing viewpoints indicate that, depending on the level of current awareness, the strategies used may need to be altered to either provide basic, broad information or more targeted information. Regardless of current level of awareness though, either more information or information disseminated in more effective ways is required in order to motivate community members to change their behaviors and decrease smoking risks in the broader community.

Study participants offered a number of strategies that could be used to engage community members and increase their awareness of the risks associated with secondhand smoke. Specific strategies for delivering this information include: talking individually to smokers; hosting small group discussions to share information and experiences; attending existing large events to create conversations about risks; using the media to demonstrate

positive messages; providing visual images and examples of the health risks; developing interactive learning activities; providing alternatives to smoking; and personally relating to the priorities of people, including protecting their children. Many of these suggested strategies also included the use of scare tactics, such as gruesome visuals or shocking stories. Community leaders emphasized the importance of “everyone” being engaged in these efforts to build awareness, though they felt that women, parents, community leaders, medical professionals, schools, government, and organizations could take a proactive role. Overall, participants in this study overwhelmingly reported that there is a significant need for information and conversation around the risks of smoke in their communities. The women participating in this study are likely the people who already have a concern about this issue, and they clearly believed that other community members need to have a better understanding and a greater concern as well.

One essential path of action identified through this research is to conduct additional exploratory research to investigate secondhand smoke exposure in African families beyond what is included in this initial study. This further exploration is particularly important in the following areas:

- The sample was by necessity a convenience sample, and there was an overrepresentation of Somali women included in the sample. Future research should include a more generalizable sample of community members from diverse African communities or a series of target investigations within several other communities. Because these populations are highly mobile and access is a significant challenge, greater efforts to increase representation of multiple tribal or ethnic groups within the sample is essential.
- This study focused primarily on secondhand smoke exposure of women. While exposure of children was asked about, and adolescents were included in the data collection, more specific information about rates of secondhand smoke exposure and associated health impacts for children, including across different age groups, should continue to be gathered. This is particularly important because this study revealed that the health of children is a motivating factor for many community members to alter their behaviors. By better understanding the risks for children, appeals to community members on behalf of the health of their children can be better informed.
- Finally, further investigation is needed to better understand the prevalence and impact of shisha smoking in African communities. Smoking shisha appears to be particularly prevalent for women. Both smoking by women and smoking of shisha could be underreported because of social constraints on women smoking and a lack of understanding of shisha as a tobacco product. The prevalence of shisha smoking that emerged in this study is likely a glimpse of what may be a larger issue that warrants continued research and intervention.

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Appendix

Key informant interview questions

Focus group protocol

Survey of African women (English version)

Key informant interview questions

One of the goals of this research project is to understand the ways that the different African communities are ready to address smoking as a community health problem, and the ways that they are not ready.

1. Would you please tell me a little bit about what is happening in your own community to improve health?
 - a. Is there a special focus on the health of girls and women in your community?
 - b. Why do you think this is happening?
 - c. What kinds of health problems are the main focus for health improvement in your community?
2. Do you think most people in your community believe that smoking tobacco is an important health problem in the community?
 - a. What do people say about smoking tobacco in your community?
 - b. What kinds of tobacco products are they smoking? (**Don't probe until they answer**)
 1. Do most people think of "smoking tobacco" as just cigarettes and cigars?
 2. What about shisha? Smoking tobacco in a water pipe?
 - c. Who is doing most of the smoking?
 1. Men—type of tobacco product? (Cigarettes, cigars, shisha/water pipe)
 2. Women—type of tobacco product? (Cigarettes, cigars, shisha/water pipe)
 3. Older people—type of tobacco product (Cigarettes, cigars, shisha/water pipe)
 4. Younger people—type of tobacco product (Cigarettes, cigars, shisha/water pipe)
 - d. Do you think most people understand that tobacco contains chemicals that are meant to make it very hard to quit smoking?
 - e. Do you think most people understand that those chemicals can make not only the smoker sick, but also the nonsmokers who breathe the smoke from the smoker's cigarette, cigar, or shisha/water pipe?

3. A lot of the health information about smoking talks about “secondhand smoke”—do you think people in your community understand what this means?
 - a. **[IF NO]** What would help people understand that this information is about breathing the tobacco smoke from another person who is near them.
[Ex. standing next to them, in a room where there is smoke from tobacco]
 - b. Do people talk about breathing the tobacco smoke from another person as something that can make a person sick?
 1. That can cause children to get asthma?
 2. **[IF NO ONE IS TALKING]** Why do you think this is not something that people are worried about?

4. What do you think would make your community want to do something about this?
 - a. Who should be involved? What types of organizations, which leaders?
 1. Schools?
 - b. What steps/actions would get women involved?
 - c. What kind of information needs to be available?

Focus group protocol

Young African-born women ages 14 to 18

Introduction:

Thank you all for coming to talk with us today. You were invited to participate in this conversation because you are all young women between the age of 14 and 18, and your families came to the U.S. from Africa. Altogether, we are having four conversations like this one with young women from Africa.

Tonight we will be talking about how much smoking happens around you and what you think about smoking in your community. Being a part of this group conversation is voluntary, and you don't have to do it if you don't want to. If you choose not to, you and your family will still receive the exact same information and support from the Minnesota African Women's Association and their programs that you would receive if you decide you do want to be in the conversation. We don't want to miss anything you have to say, so we will be recording the conversation, but after we type up the notes, we will erase the recording. Your names will not be on the notes or listed in any report about these conversations, and MAWA staff will not talk with anyone, even your parents, about what you personally had to say in this group. Everyone who is part of the group conversation will receive \$25 in cash, which will be given to you at the end of the meeting.

When we write our report, all of your comments will be put together so that no one will know what any one person said. If you are willing to be part of this conversation, would you please sign both of the consent forms in front of you? One copy is yours to keep and it has the contact information for our research partners at Wilder Research and for the Minnesota Department of Health committee that reviewed our plans for this conversation to be sure that your rights are protected. The other copy will be kept at Wilder Research in their files, but MAWA will not have a copy. So, as soon as we have consent forms signed, we can begin. If you have decided not to participate, please feel free to leave now.

<Do not proceed until everyone has either signed the consent or left the room. Once you have all signed forms, go to next page.>

Does anyone have any questions before we begin? Okay, let's get started.

1. This research we are doing is about breathing someone else's cigarette smoke, what health professionals call "secondhand smoke." How much do you know about the ways that breathing smoke from someone else's cigarette or little cigar can affect a person's health?
 - a. [Probe to ask them to name specific diseases/health impacts]
2. Does smoke from cigarettes bother you?
 - a. Physical irritation [eyes, breathing, throat]
 - b. Other things [smell, disgust triggers]
3. Are there any rules against smoking in your house?
 - a. In the car?
 - b. How comfortable are you with asking someone not to smoke when they are with you? [Probe for reasons]
 1. An adult family member
 2. A family member your age
 3. A friend
 4. Someone you do not know very well
4. Do you see much smoking at social events in your community?
 - a. Are people in your community talking about smoking as a problem? What do they say?
 - b. Do you hear people talking about breathing someone else's smoke as a problem? What do they say?
5. In the past month, has anyone smoked a cigarette or little cigar when they are with you? The past week?

Probe questions if people don't mention these things:

 - a. Where did this happen? [Probe to see if it occurs at home, in the car, at social events, or when visiting a relative or friend.]
 - b. Mostly men, women too? [Probe for gender differences]
 - c. What ages?
 - d. How often are you around people who are smoking, close enough to be breathing the smoke from their cigarette or little cigar?
 - e. Are there usually smaller children around who are also breathing the smoke?
 - f. Do any of the children in your home have asthma or breathing problems?
6. Do you have any friends or family members who smoke?
 - a. [Probe to identify whether the young woman are talking about their own community or Americans in general]
 - b. How do you feel about that? Does smoking make a person look more American, more sophisticated?
 - c. Is this something that is happening more often, or has it always been this way?

7. If you wanted to plan community education for girls your age about smoking and secondhand smoke, what would you focus on first?
 - a. Health impacts of smoking
 - b. Health impacts of secondhand smoke
 - c. How to keep people from starting to smoke
 - d. Why tobacco is addictive and hard to stop using once you start

8. How would you get this information to young women like you?
 - a. MAWA programs—which ones?
 - b. Community newspapers—which one(s)?
 - c. Community events—which one(s)?
 - d. Churches or mosques?
 - e. Other ways?

9. Is there anything else you think we should know about how smoking is affecting young women and children in your community?

Thank you for your help! Please see [consultant] now and she will give you your cash. We really appreciate the time you have spent with us. Thank you!!

Survey of African women (English version)

Experiences of African Women and Girls Exposure to Tobacco Smoke

The Minnesota African Women's Association (MAWA) is concerned about the effect that tobacco smoke is having on the health of African women and girls. They are interested in smoke from cigarettes, little cigars, and pipes as well as smoke from shisha (a fruit and tobacco mixture that is smoked in a water pipe). Wilder Research is helping MAWA with this study, which is funded by ClearWay Minnesota.

The questions in this survey are intended to show how often African women and girls themselves are smoking tobacco or shisha, and how often they are breathing tobacco smoke from other people who smoke near them. We hope that you will help us better understand this issue by offering your opinions and experiences. Your name will not appear on this survey and you will be identified by this survey. What you tell us will help MAWA create community education about secondhand smoke for African people.

If there are any questions that you do not want to answer, that is okay. What you write on this survey is confidential, so please do not write your name on it.

1. Please tell us what African country your family is from.
¹ Cameroon ⁶ Nigeria
² Ethiopia ⁷ Sierra Leone
³ Ghana ⁸ Somalia
⁴ Kenya ⁹ Togo
⁵ Liberia ¹⁰ Other (Specify: _____)
2. Were you born in Africa or in the U.S.?
¹ Africa ³ Somewhere else (Please write in: _____)
² The U.S.
3. What is your age? _____ years
4. How many children under the age of 18 live in your home? _____ children
5. Does your family usually speak English at home?
¹ Yes
² No, we speak _____ language
6. How many years have you lived in the U.S.? _____ years
7. Do your eyes, throat, or lungs hurt from smoke from cigarettes, little cigars, or shisha (tobacco and fruit smoked in a water pipe)?
¹ Yes
² No
8. Does any person in your home have asthma or breathing problems? **(CHECK ALL THAT APPLY)**
¹ No one ⁴ A parent
² Yourself ⁵ Another adult relative
³ A grandparent ⁶ A child Age of child: _____
9. In the past 6 months, have you asked a person not to smoke around you?
¹ Yes
² No **(GO TO QUESTION 12)**

10. In the past 6 months, who have you asked not to smoke around you? (CHECK ALL THAT APPLY)

- ¹ Boyfriend or husband ⁵ Friend
² Parent ⁶ Co-worker
³ Son or daughter ⁷ Other person you know
⁴ Other relative ⁸ Someone you do not know

11. Why did you ask them not to smoke? (CHECK ALL THAT APPLY)

- ¹ Smoke bothered your eyes or breathing ⁵ Concerns about the smoker's health
² Did not like the smell ⁶ Concerns about the health of a child
³ Think smoking is poor behavior ⁷ Other: _____
⁴ Concerns about your own health

12. Have you breathed smoke from someone's cigarette or little cigar...

	In the past 24 hours?		In the past 7 days?		In the past 30 days?	
	Yes	No	Yes	No	Yes	No
a. At home	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
b. In the car	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
c. When visiting friends	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
d. When visiting relatives	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
e. At a community event	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
f. At a party	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
g. At work	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
h. At a club or café	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²

13. Have you breathed smoke from someone smoking shisha (a fruit & tobacco mixture, using a pipe)...

	In the past 24 hours?		In the past 7 days?		In the past 30 days?	
	Yes	No	Yes	No	Yes	No
a. At home	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
b. In the car	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
c. When visiting friends	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
d. When visiting relatives	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
e. At a community event	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
f. At a party	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
g. At work	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²
h. At a club or café	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ¹	<input type="checkbox"/> ²

	Often	Sometimes	Seldom	Not at all
14. I have friends or relatives who sometimes smoke cigarettes or little cigars around me.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
15. I have a friend or relative who wants me to smoke cigarettes or little cigars with them.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
16. People from my country who live in the US smoke cigarettes or little cigars to be American and fit into the culture.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
Men from my country who live in the US...				
17. Men from my country who have higher status often smoke cigarettes or little cigars.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
18. More of the younger men from my country smoke cigarettes or little cigars than the older men.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
19. For men from my country, smoking cigarettes or little cigars together is a regular part of their social life.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
20. For men from my country, smoking shisha together is a regular part of their social life.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
21. The older men from my country smoke shisha more often than the younger men.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
Women from my country who live in the US...				
22. Women from my country who have higher status often smoke cigarettes or little cigars.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
23. More of the younger women from my country smoke cigarettes or little cigars than the older women.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
24. For women from my country, smoking cigarettes or little cigars together is a regular part of their social life.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
25. For women from my country, smoking shisha together is a regular part of their social life.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
26. The older women from my country smoke shisha more often than the younger women.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴
27. Pregnant women from my county smoke cigarettes, cigars, or shisha.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ⁴

Do you think these statements are true or false?	True	False	Don't know
28. Only smokers have to worry about health risks from tobacco smoke.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
29. If someone is smoking in the house, their smoke will not hurt you as long as you are in a different room.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
30. Light cigarettes are safer than regular cigarettes.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
31. Children can get asthma from breathing an adult's cigarette smoke.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
32. As long as a pregnant woman does not smoke tobacco herself, her baby cannot be hurt by other people smoking in the home.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
33. The smoke from a shisha pipe is safer than smoke from cigarettes.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
34. Smoking tobacco relieves stress.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
35. Menthol cigarettes are safer than regular cigarettes.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
36. Non-smokers can get heart disease from someone else's cigarette.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
37. The only kind of cancer caused by tobacco smoke is lung cancer.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
38. Using smokeless tobacco like snuff or chew tobacco is safer than smoking cigarettes or little cigars.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸
39. If a person only smokes 5 cigarettes a day, their risk of getting cancer is about the same as someone who does not smoke at all.	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ⁸

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3

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Do you think these statements are true or false?

True False Don't know

40. If a baby has a parent that smokes, she is more likely to end up in the hospital.

¹

²

⁸

41. In your home, are there any rules about...

	Rule applies to everyone	Rule is for family members only	No, we do not have a rule
a. Smoking in certain rooms only?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
b. Not smoking in the house?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
c. Not smoking around children?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
d. Not smoking around pregnant women?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
e. Not smoking around older people?	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³

42. What kinds of information about tobacco use are needed in your community?

Type of information	Very much needed	Needed a little	Not needed at all
a. Health risks for smokers	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
b. Health risks for non-smokers	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
c. Secondhand smoke health risks for pregnant women and their babies	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
d. Secondhand smoke health risks for children	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
e. How tobacco companies design their products to get people "hooked" quickly	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
f. How tobacco companies market their products to certain communities	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
g. Strategies other communities have used to prevent youth from starting to use tobacco products	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
h. Ways that doctors can help people quit using tobacco	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
i. Strategies other communities have used to help people quit using tobacco	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³

43. What is the most important thing that we should know about people from your home country who now live in the US, if we want to help protect your women and girls from the health problems caused by tobacco smoke? **(PLEASE WRITE YOUR ANSWER)**
