Smoking Environments in Transition:
Experiences of Chinese Migrants to Edmonton

by

Jia Li

A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Arts

Department of EARTH & ATMOSPHERIC SCIENCES
University of Alberta

Abstract

Globally, both smoking prevalence and protection from secondhand smoke are geographically variable. Substantial differences often exist between high-income countries and low and middle-income countries in terms of regulatory environments as well as social norms around smoking. This research investigated the experiences of migrants from China, a middle-income country where smoking is especially common among men, and relatively unregulated – to Canada, a high-income country where smoking is increasingly denormalized, and spatially restricted. To explore how immigrants experience the transition between these environments, focus groups were conducted in Edmonton, Alberta in August-October 2013 with 58 Chinese migrants, 48 of whom were international students. Participants generally expressed accurate perceptions, supportive attitudes and pleasant emotional experiences regarding the widespread non-smoking environments in Canada. Smokers' cigarette consumption also decreased, which they attributed to well-enforced smoking bans. Stigmatization of smoking and smokers in Canada was less perceived, suggesting limited acculturation. Recent immigrants retained Chinese socio-cultural norms regarding smoking, and sustained the practice of sharing and gifting cigarettes.

Keywords: Smoking bans, smoking prevalence, tobacco denormalization, immigration, immigrant health, Canada, China

摘要

吸烟的流行程度和对于二手烟的保护，从全球看是地理分布不平衡的。高收入和中低收入国家在政策环境和对于吸烟的社会态度上有着显著的不同。在中等收入国家中国，男性吸烟依旧非常普遍，而且这方面的法律规范不够健全；相反，在高收入国家加拿大，吸烟已经日益非正常化，而且受到了无烟环境日益严厉的限制。本研究调查了从中国到加拿大的移居者们在这方面的经验。在2013年5月至8月期间，58名中国移居者（其中48名国际留学生）在艾伯塔省埃德蒙顿市参加了一共8组焦点小组访谈。被访者总体上表达了他们对于加拿大无烟环境准确的认识，支持的态度和积极的情绪体验。得益于严厉的公共场所吸烟禁令，吸烟者在移居后吸烟量明显减少。与不完全的文化融入有关，被访者对于吸烟和烟民在加拿大的恶名化程度并没有一个准确深入的认识。短期移民依旧保留着中国在吸烟方面的社会文化习俗，例如互赠香烟。

关键词：吸烟禁令，吸烟流行程度，烟草非正常化，移民，移民健康，加拿大，中国

Preface

This thesis is an original work by Jia Li. The research project on which this thesis is based received approval from the University of Alberta Research Ethics Board, Project Name "Transitions in Regulatory and Social Environments around Smoking: the Experiences of Chinese Migrants to Edmonton", No. Pro00040103, July 29, 2013.

Acknowledgements

First of all, I would like to convey my special and sincere gratitude to my supervisor, Dr. Damian Collins, for his great help, encouragement and supervision during the whole process. With his helpful guidance and advice, I learned how to conduct academic research, which means a lot to my future career. I am particularly grateful to him for inputting so much time in reading and editing each chapter of my thesis with great patience and dedication. Best of all, I am so fortunate to have a supervisor who is not only a role model in my future research career, but also an impressive friend in my life. Thanks as well to my committee members, Dr. Robert Summers and Dr. Leith Deacon for sparing time from their busy schedules to consider my research and make invaluable suggestions on my thesis.

Additionally, I'm thankful for the generous financial support by Dr. Damian Collins' research grants from the Social Sciences and Humanities Research Council (SSHRC) and the Vice-President Research at the University of Alberta. I would also like to thank each of my research participants for attending my focus groups and contributing ideas to my topic. Special thanks to those who forwarded my recruitment information within their social networks and helped me find more participants. Thank to Igor who works in the department lab for providing me a perfect seminar room to conduct all the focus groups.

Finally, and most importantly, I would like to thank my amazing family and friends. To my grandma, thank you raising me and giving me all the best you have. To dad and mom, thank you for all the selfless support and tolerance in the past 24 years. To my aunt and uncle, thank you two for treating me like your own daughter. To my best friends in

Beijing – Feng and Yi, thank you for always being there whenever it is and wherever I am. Thanks to my friends in Hangzhou and all the beautiful memories of us being together. Thank all my friends in Edmonton - Xuechen, Xiongwei, Yuanjing for helping me overcome the hardest time in a new city. To Wushuang and Zheng, thank you for a lot of company in the lonely and difficult thesis writing and editing months. Last, but not least, to my fellow students – Morgan, Kurt, Qiqi, Fujie, Brian, Léanne, Alison and Jalene, thanks for all the time we spent together sharing our small thoughts about both research and life. I am incredibly lucky to have so many amazing people being there when I need them most.

Table of Contents

List of Tables

List of Figure

List of Abbreviations

ACHA – American College Health Association
CCHS – Canadian Community Health Survey
CDC – Centre for Disease Control and Prevention
CIC – Citizenship and Immigrant Canada
CNTC – China National Tobacco Corporation
CPS – Current Population Survey
CTUMS – Canadian Tobacco Use Monitoring Survey
ETS – Environmental Tobacco Smoke
FCTC – Framework Convention on Tobacco Control
FG – Focus Group
GATS – Global Adult Tobacco Survey
HICs – High-Income Countries
HIE – Healthy Immigrant Effect
IARC – International Agency for Research on Cancer
LMICs – Low- and Middle-Income Countries
NSRA – Non-Smokers' Rights Association
NSRTU – National Strategy to Reduce Tobacco Use
SES – Socio-Economic Status
SHS – Secondhand Smoke
STMA – State Tobacco Monopoly Administration
TID – Tobacco Industry Denormalization
USDHHS – United States Department of Health and Human Services
WHO – World Health Organization

Chapter 1 Introduction

Smoking is a global health concern, but the levels of risk are not equally distributed between countries. Legislation restricting where smoking can occur is increasingly widespread (World Health Organization, 2009), but this form of protection is also geographically variable. As earlier adopters of both the smoking epidemic and smoking bans, high-income countries (HICs) have different contexts from low- and middle-income countries (LMICs) (Ericksen et al., 2011). In general, people in HICs are unable to smoke in most indoor and some outdoor public spaces, while in LMICs, smoking is often still allowed in a large range of indoor public places and is almost completely unregulated outdoors (WHO, 2011). From a social perspective, smoking is less acceptable and tolerated in HICs than in LMICs. Smoking in HICs is increasingly regarded as dirty, unhealthy and tainted – which indicates its denormalization and stigmatization - while in LMICs smoking is often still regarded as normal and socially acceptable, especially for men (Chapman, 2007; United States Department of Health and Human Services, 2006; Wakefield et al., 2000; Abdullah et al., 2011).

Smoking behaviours within a population are influenced by local smoking norms, which can vary significantly between places (Collins & Procter, 2011). Geographical variation in both social norms and regulations around smoking may be experienced directly by people who move between countries, whether as short- or long-term migrants. For example, people who move from LMICs with few smoking bans and high smoking prevalence, to HICs with stringent spatial rules and less acceptance of smoking, will experience transitions in both the regulatory and social environments regarding smoking.

Canada and China were selected for this research as illustrative examples of high-income and middle-income countries, respectively. Canada both leads and reflects the anti-smoking norms in HICs, while China is an example of a middle-income country where smoking still enjoys high prevalence among men and general social acceptance (WHO, 2009). Specifically, this research considered the experiences of immigrants from China currently living in the city of Edmonton in Alberta, Canada.

1.1 Research Question and Objectives

This research addresses the question: 'How do migrants experience the transition from a middle-income country, where smoking remains socially acceptable and relatively unregulated, to a high-income country where it is denormalized and subject to widespread spatial restrictions?' To answer this, the research has four objectives:

1. To examine how Chinese migrants, including smokers and non-smokers, perceive the relatively stringent smoking bans and social status of smoking in Edmonton.
2. To document the ways in which the Edmonton context has led to changes in Chinese migrants' attitudes and behaviours relating to smoking and smoking bans.
3. To understand the emotions that Chinese migrants experience as they adjust to a regulatory and social environment that is less tolerant of smoking.
4. To analyze the ways in which migrants' perceptions, attitudes, behaviours and emotions may be influenced by social factors such as gender and smoking status.

'Perceptions' in this research refer to public awareness of policies and social status of smoking in two countries. This aim is to know how smoke-free regulations, and the social norms around smoking, in Canada are understood by recent Chinese immigrants. 'Attitudes' refer to people's support for or opposition to smoke-free policies, while 'behaviours' are actions, including smoking, which may change or be sustained in response to different contexts. It is important to examine the attitudes and behaviours of Chinese immigrants regarding smoking in order to evaluate the effectiveness of current tobacco control policies for new residents to Canada, and to assist in their future development. 'Emotions' include a wide range of feelings, dispositions and bodily sensations, many of which form in relation to places, and place-based experience (Smith et al., 2012). Concern for emotions is relatively new in the field of human geography, and the relevance of emotions to understandings of place and policy continues to be developed.

1.2 Significance of the Research

With increasing recognition of the importance of geographical knowledge in informing public policies, human geography has undergone a 'policy turn' over recent decades (Martin, 2001: 192). Health geography, focusing on health experiences and outcomes in

place, has an especially close relationship with public policy (Donovan & Duncan, 2009; Andrews et al., 2012). Smoking is the leading cause of illness and preventable death in the world, and as such is a major focus of both geographical research and policy development.

Tobacco control in both HICs and LMICs is a generally well-documented topic. However, very little consideration has been given to the smoking-related experiences of people migrating between these two contexts. The current study seeks to address this gap, and in so doing contribute to knowledge of both tobacco control and migration. It will do so via an examination of the experiences of Chinese migrants to Canada, with a focus on the Edmonton context.

China has one-third of all the smokers in the world and around 3000 smoking-attributed deaths per day (WHO, 2014). By contrast, Canada is an international leader in tobacco control (International Agency for Research on Cancer, 2009). Chinese immigrants are currently the second largest group of newcomers to Canada (after migrants from the Philippines) and people of Chinese ethnicity are the second largest visible minority group in Canada (after South Asians) (Statistics Canada, 2013a). To the author's knowledge, this research is the first to focus specifically on the smoking-related experiences of Chinese immigrants in Canada. As such, it will contribute to the evidence base for tobacco control initiatives in Canada in a way that is sensitive to the high levels of immigration to Canada from China in particular, and from other LMICs more generally. It will also contribute to building knowledge of the contextual differences around smoking between China and Canada.

The field of tobacco control research has generally adopted quantitative approaches. This reflects the strong preference for quantitative methods in health-related research more generally (Andrews et al., 2012). One consequence of this approach is that the voices of smokers and non-smokers are often missing from the record. This is beginning to change, including with several recent qualitative studies in China (e.g. Mao et al., 2012; Zhang et al., 2012). However, there is as yet no consideration of the voices of Chinese migrants to Canada and their experiences of changing contexts around smoking. By using qualitative methods, this research will aim to provide in-depth accounts of the experiences of a relatively small number of participants.

One advantage of this approach is that it allows a consideration of the emotions that accompany smoking and exposure to smoke. Emotions are among the most important ways in which people connect or disconnect with where they live (Davidson & Milligan, 2004). However, they have often been underestimated by scholars and policy-makers (Anderson & Smith, 2001). This research takes emotions as crucial elements of people's experiences. In so doing, it contributes to filling the gap in tobacco control research regarding emotional responses to increasingly widespread smoke-free policies.

1.3 Structure of the Thesis

The remainder of this chapter documents the contexts of the research. First, it considers smoking prevalence, smoke-free environments, and social norms around smoking in both HICs and LMICs. It then moves to consider the contexts of Canada and China more specifically. Overall, it provides the necessary background information for readers to understand the transitions around smoking-related environments that are experienced by migrants from LMICs to HICs.

Chapter 2 reviews previous studies on how people's smoking-related experiences are shaped by smoking bans and social norms. Specifically, it considers people's attitudes towards smoking bans and levels of people's exposure to SHS prior to and after the implementation of smoking bans. Importantly, this chapter also illustrates how smoking bans and social norms can influence people's smoking behaviours, such as where and how much they smoke, and their decisions to initiate or quit smoking.

Chapter 3 introduces past studies investigating immigrants and how their smoking-related experiences are shaped by smoking bans, social norms and demographic characteristics. This chapter also puts extra focus on describing the smoking patterns of college students, as international students constitute a large and critical sub-set of the immigrant population in Canada.

Chapter 4 describes the methodology used in this research. It introduces the rationale for using qualitative research and conducting focus group for data collection. The principal procedures for this research - including ethical review, participant recruitment,

focus group discussions and data analysis are explored. It also describes the participants, many of whom were international students from the University of Alberta.

Chapter 5 presents the results generated from analysis of the focus group discussions. These include participants' perceptions, attitudes, behaviours and emotional experiences regarding smoking and its regulations. Appropriate quotations were chosen from the focus group transcriptions to support those results.

In Chapter 6, the results are categorized with reference to the four research objectives. This chapter also interprets and examines the results by referring back to the literature. It ends with a review of the limitations of this research and provides recommendations for future policy-making and academic studies.

1.4 Research Contexts

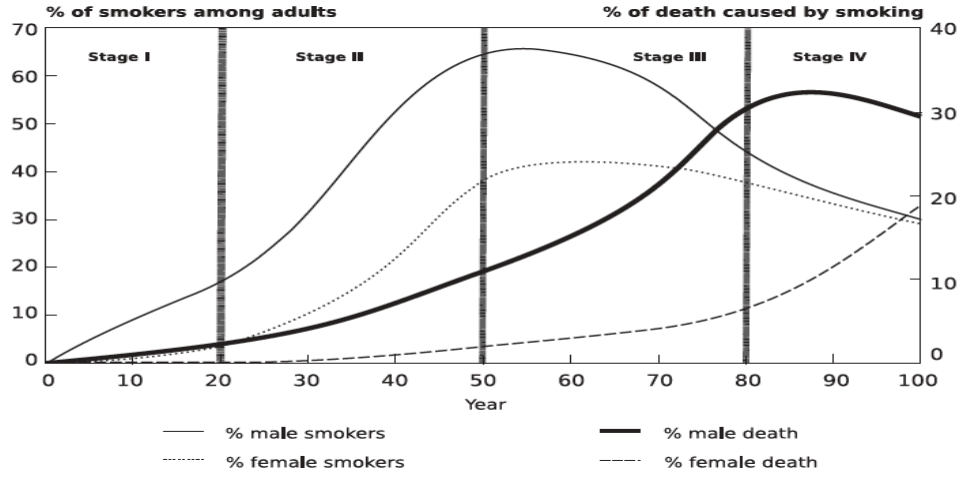
1.4.1 Smoking Prevalence

It is estimated by the WHO that in 2009, there were around 1.1 billion adult smokers worldwide, accounting for 22% of the global adult population (IARC, 2010). Smoking is now a global epidemic, reflecting its historical adoption in HICs, and subsequent spread to LMICs (Abdullah et al., 2012). Since the 1960s, with increasing knowledge and publicity of the adverse health consequences of smoking, smoking prevalence in HICs has been decreasing. However, the total number of global smokers has increased, due mostly to the rising number of smokers in LMICs. It follows that the global burden of disease associated with smoking, including via exposure to SHS, is increasingly shifting to LMICs (WHO, 2009).

Lopez et al. (1994) built a descriptive model to demonstrate the four developmental phrases of the tobacco epidemic in developed countries (see Figure 1.1). In Stage 1, both smoking prevalence and smoking-related death are at a low level, but are increasing for men. In Stage 2, smoking prevalence significantly increases and exhibits a large gender gap, but the deaths increase at a lower rate, especially for females. In Stage 3, smoking prevalence peaks then starts to fall and the gap between male and female smoking is decreasing; however, smoking-related deaths, especially male deaths, increase sharply. In Stage 4, smoking prevalence of both males and females continues to fall and the gap

between smoking rates of the genders decreases to close. Of all deaths caused by smoking, the percentage of deaths of male smokers starts to slightly drop while that of females increases rapidly. The gap between smoking-related deaths for two genders is narrowed at this stage.

Figure 1.1 Four phrases of smoking epidemic in developed countries



Source: Lopez AD, Collishaw NE, and Piha T. (1994). A descriptive model of the cigarette epidemic in developed countries. *Tobacco Control 3*: 242-247.

HICs – including countries in Western Europe, North America and Australasia – have moved into stage 4 with an overall decreasing smoking prevalence and smaller gender differences in both smoking rates and smoking-attributed deaths (Thun et al., 2012). These countries experienced a rapid increase in per-capita cigarette consumption in the beginning of the 20th century, which peaked in the 1960s (Pierce et al., 1991). Public health approaches to reduce the health consequences of tobacco use started in 1960s among HICs (Pierce et al., 2010). Following the release of the first report from the US Surgeon General's office on the adverse effects of cigarette smoking in 1964, the increase in smoking rates slowed, stopped, and eventually reversed in the United States (Crimmins et al., 2011). Smoking prevalence in the United States dropped from 44.1% of men and 31.5% of women in 1970 to 23.1% of men and 18.3% of women in 2008 (Dube et al., 2009). Similar declines – especially marked amongst men – were experienced in other HICs over the same time period, including in Canada (Cutler & Glaeser, 2009; Health

Canada, 2013). HICs also experienced a decreasing gender difference in smoking prevalence. For example, in the United States, in the early 1960s, 34% of women and 80% of men had tried smoking (Hammond & Garfinkel, 1961). By 1980, 83% of women and 72% of men had tried smoking a cigarette (Silverstein et al., 1980). Increasingly prevalent female smoking in HICs was related to tobacco industry's turning its focus to female targets (Elkind, 1985; Fisher, 1976) and the perceived function of smoking in losing weight (Grunberg, 1991).

Ng et al. (2014) reviewed previous survey data and estimated age-standardized smoking prevalence of 187 countries in 1980 and 2012. The findings for a selection of HICs and LMICs are illustrated in Table 1.1. Four key trends are evident in this data. First, smoking rates in HICs such as the US, Canada, New Zealand and Australia decreased between 1982 and 2012, consistent with the model by Lopez et al. (1994). Second, there are some notable disparities in smoking prevalence within the HICs group. Although the smoking epidemic started in the United States, it is now more prevalent in Europe, among both men and women. For example, Greece has a much higher smoking rate than other countries listed in the table. According to the Tobacco Atlas, Greece has the highest smoking prevalence in the world (Ericksen et al., 2011).

Third, the HICs in Table 1.1 have experienced larger declines in smoking prevalence from 1980 to 2012 than LMICs. In most cases, their total smoking prevalence is now lower than that in LMICs. Even though smoking rates have decreased in most of the LMICs included in the table, there are increasing numbers of smokers and smoking-attributed deaths in these countries, due to natural population growth. Over 80% of the one billion smokers in the world now live in LMICs (WHO, 2013). Tobacco use causes around 6 million deaths annually and 80% of these deaths occur in LMICs (WHO, 2011). Among the LMICs, China and countries in East Europe (e.g. Russia) have the highest male smoking rates, followed than countries in South America (e.g. Brazil, Cuba) and then Africa (e.g. Zimbabwe, Kenya) (also see OECD, 2013).

Table 1.1 Estimated age-standardized smoking prevalence for a selection of countries in 1980 and 2012

Smoking Prevalence (%)	1980			2012		
	Overall	Male	Female	Overall	Male	Female
Globally	25.9	41.2	10.6	18.7 (-7.2)	31.1 (-10.1)	6.2 (-4.4)
High-income countries*						
Canada	38.1	42.3	34.1	14.8 (-23.3)	16.7 (-25.6)	12.8 (-21.3)
United States	30.6	33.2	28.3	15.8 (-14.8)	17.2 (-16.0)	14.3 (-14.0)
New Zealand	32.9	34.8	31.0	17.9 (-15.0)	18.4 (-16.4)	17.4 (-13.6)
Australia	30.8	34.3	27.3	16.8 (-14.0)	18.3 (-16.0)	15.4 (-11.9)
Sweden	29.3	30.3	28.7	13.5 (-15.8)	12.3 (-18.0)	14.8 (-13.9)
France	29.9	41.5	18.8	31.0 (1.1)	34.4 (-7.1)	27.7 (8.9)
Greece	39.1	54.7	24.6	37.8 (-1.3)	40.8 (-13.9)	34.7 (10.1)
Middle-income countries*						
China	30.4	53.2	6.0	24.2 (-6.2)	45.1 (-8.1)	2.1 (-3.9)
India	18.9	33.8	3.0	13.3 (-5.6)	23.0 (-10.8)	3.2 (0.2)
Indonesia	29.2	55.8	3.7	30.1 (0.9)	57.0 (1.2)	3.6 (-0.1)
Russia	35.3	57.8	16.9	32.7 (-2.6)	51.0 (-6.8)	16.9 (0.0)
Brazil	20.7	25.9	15.6	13.7 (-7.0)	16.5 (-9.4)	11.0 (-4.6)
Cuba	23.1	30.8	15.3	15.9 (-7.2)	19.9 (-10.9)	11.8 (-3.5)
Low-income countries*						
Zimbabwe	15.5	27.5	4.1	13.2 (-2.3)	24.7 (-2.8)	2.7 (-1.4)
Kenya	12.7	23.4	2.2	10.5 (-2.2)	20.0 (-3.4)	1.3 (-0.9)

Source: Ng, M., Freeman, M. K., Fleming, T. D., Robinson, M., Dwyer-Lindgren, L., Thomson, B., ... & Gakidou, E. (2014). Smoking prevalence and cigarette consumption in 187 countries, 1980-2012. JAMA, 311(2), 183-192. Available from: http://jama.jamanetwork.com/article.aspx?articleid=1812960

* Following the classification of the World Bank (2014). Available from: http://data.worldbank.org/about/country-classifications/country-and-lending-groups

Fourth, Table 1.1 shows another remarkable difference between the patterns of smoking prevalence in HICs and LMICs - the gender difference. In all countries, males are more likely to smoke than females. However, the gender difference is generally much larger in LMICs than in HICs, due in particular to very low smoking prevalence among women in LMICs (Amos et al., 2011). In 2010, half of the world's female smokers were in HICs. The overall smoking prevalence of females over 15 years old is 19% in HICs, while in LMICs it is 3% and 5%, respectively (Eriksen et al., 2010). Ng et al. (2014) found that in 2012, the average gender difference in developing countries is around twice that in developed countries. In Table 1.1, the selected HICs have gender differences between 2% and 6%, while in the selected LMICs the differences are generally much higher (e.g. 43% in the case of China, and 53.4% in Indonesia, 19.8% in India).

With regards to the patterns of smoking prevalence, China and Canada are good examples of LMICs and HICs respectively. Table 1.2 shows the latest smoking prevalence data for Canada, based on the 2012 Canadian Tobacco Use Monitoring Survey (CTUMS) (Health Canada, 2013). While this data differs slightly from that given by Ng et al. (2014), it confirms that general smoking prevalence is less than 20% and that there is a small gender difference.

Table 1.2 Estimated smoking prevalence in Canada in 2012

Smoking Prevalence (%): Current smokers (daily smokers)		All adults	Men	Women
Total		16.1 (11.9)	18.4 (13.2)	13.9 (10.5)
Age	15-19	10.9	18.0	13.6
	20-24	20.3		
	25-44	19.9	18.5	14.0
	45+	13.8		
Region	Newfoundland and Labrador	19.7	23.1	16.5
	Alberta	17.4	17.1	17.7
	British Columbia	13.2	15.2	11.3

Source: Health Canada. (2013). CTUMS. Available from: http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_ctums-esutc_2012/ann-eng.php

Across age groups, smoking in Canada is most prevalent among young adults aged 20-24 (20.3%), followed by people aged 25-44 (19.9%). Among all the provinces and territories, the highest rate is in Newfoundland and Labrador (19.7%) and the lowest is in British Columbia (13.2%). Smoking prevalence in Alberta is 17.4%, slightly higher than the national average. Young adults aged 20-24 in Alberta have a much higher smoking rate (24.4%) than other age groups (all under 20%). It is also notable that the smoking rate of females (17.7%) is slightly higher than that of males (17.1%) in Alberta.

Table 1.3 shows detailed smoking prevalence for China from the Global Adult Tobacco Survey (GATS) (WHO, 2010), which also differs slightly from the Ng et al. (2014) data. It clearly illustrates a higher overall smoking prevalence due to the high rate of male smoking. A stark gender difference is also obvious. Across age groups, the smoking rate in China is highest among males aged 45-64 (63%) and, unlike some HICs, the smoking rate of young adults aged 15 to 24 is the lowest (17.9%). Females aged over 65 have the highest smoking rates among women (6.7%) and smoking is least prevalent in females aged 15-24 (0.7%). With regards to geographic distribution, male smoking prevalence is slightly higher in rural China than in urban areas. Additionally, the

popularity of smoking in China is also reflected in high levels of prevalence in high status professions: 50.2% of male teachers, 47.3% of male physicians, and 61% of male civil servants smoke. Among smoking civil servants, only 37.3% reported willingness to quit (Feng et al., 2011)

Table 1.3 Estimated smoking prevalence in China in 2010

Smoking Prevalence (%): Current smokers (daily smokers)		**All adults**	**Men**	**Women**
Overall		28.1 (24.1)	52.9 (45.4)	2.4 (2.0)
Age	15-24	17.9	33.6	0.7
	25-44	31.0	59.3	1.6
	45-64	33.6	63.0	3.2
	>=65	22.7	40.2	6.7
Region	Urban	26.1	49.2	2.6
	Rural	29.8	56.1	2.2

Source: World Health Organization. (2010). Global Adult Tobacco Survey (GATS) Fact Sheet China: 2010. Available from: http://www.who.int/tobacco/surveillance/en_tfi_china_gats_factsheet_2010.pdf

A related issue to consider is the prevalence of exposure to SHS. According to Canadian Community Health Survey (CCHS), 10% of Canadians reported having been exposed to SHS in public places in the past month in 2009. Also, 5.9% of Canadian non-smokers aged 12 years and older were regularly exposed to SHS at home in 2010 (Statistics Canada, 2013b). SHS is a greater challenge in China. In a typical week, 70% of adults reported exposure to SHS in at least one environment. People are exposed to SHS in public spaces (72%), private homes (67.3%) and workplaces (63%) (Xiao et al., 2010). According to GATS, 88.5% of people in China have noticed smoking in restaurants, 58.4% noticed it in government buildings, and around 35% in medical and health institutions, schools and public transportation.

1.4.2 Smoking Regulations

1.4.2.1 Creating Smoke-free Environments – Article 8 of the FCTC

The World Health Organization's *Framework Convention on Tobacco Control* (FCTC) is the first worldwide-negotiated treaty centred on health. It provides both price-related and non-price measures to reduce the health harms of tobacco through strategies targeting supply and demand. Non-price measures include initiatives to decrease the harms caused by SHS. Specifically, the FCTC requires all ratifying countries to 'adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places' (WHO, 2003, Article 8).

Canada and China were early signatories of the FCTC (both in 2003). The FCTC came into force on February 27th, 2005 in Canada and on January 9th 2006 in China (WHO, 2013). Since then, Canada has been performing as one of the leaders in tobacco control. In contrast, China has failed to make the progress required by FCTC articles. The implementation of and compliance with smoke-free environments, as guided by Article 8, is an important move in the worldwide tobacco control campaign. There is a significant gap between Canada and China in introducing and enforcing smoking regulations in public spaces.

In July 2007, the Conference of the Parties (COP) to the FCTC adopted guidelines for States to 'meet their obligations under Article 8 of the convention' (WHO, 2007: 1). These guidelines emphasize the fundamental human rights to life and health, coupled with governments' obligations to protect these rights against the threat of SHS. Seven principles were identified to guide the implementation of Article 8. These include: that there is no safe level of exposure to SHS; that smoking should be banned completely in all indoor workplaces and indoor public places; that simple, clear and enforceable legislation is necessary; and that voluntary policies are ineffective.

1.4.2.2 Evolution of Smoking Regulations Internationally

Early tobacco control efforts were focused on reducing smoking up-take and encouraging quitting, in order to reduce the health risks faced by smokers themselves. In the 1980s, tobacco control policy took on a broader protective and explicitly geographical mission, via restrictions on where smoking could occur (Collins & Procter, 2011). Some of the earliest smoking bans were for public transport spaces (Bryan-Jones & Chapman, 2006). For example, all domestic and international travel in Canadian aircraft went smoke-free in 1994 (CBC, 2014). Smoking restrictions then spread to other indoor public spaces, such as workplaces in the following ten years (USDHHS, 2006). Finally, by restricting smoking in restaurants and bars, smoking bans in many HICs came to encompass nearly all indoor public spaces (Champion & Chapman, 2005; IARC, 2009; Collins & Procter, 2011). New Zealand first passed national legislation in 1990 to restrict smoking in locations such as workplaces and schools (WHO, 2009). The California *Smoke-Free Workplace Law* in 1994, prohibiting smoking in all indoor workplaces and public places, with bars and taverns included in 1998, was the first smoke-free comprehensive legislation in the world (IARC, 2009). There are now 19 states in the US with unconditional 100% smoke-free restaurants and bars.[1]

On March 29, 2004, Ireland became the first country in the world to implement legislation creating entirely smoke-free indoor workplaces, including bars and restaurants (Champion & Chapman, 2005). In December 2004, a similarly comprehensive ban took effect in New Zealand, while Scotland and England prohibited smoking in bars and pubs from 2006 and 2007 respectively (New Zealand Ministry of Health, 2005; BBC, 2006). In addition, there have been other HICs implementing smoking bans in restaurants and bars, for example Norway and Sweden, as well as every Province and Territory in Canada (Howell, 2005; NSRA, 2012).

With an increase in indoor smoking restrictions, many smokers smoke outdoors, especially at entrances to buildings, which results in concentrations of tobacco smoke at building entrances that can reach hazardous levels (Kaufman et al., 2010). Restrictions on

[1] http://www.smoke-freerestaurants.com/Rest_US.htm

smoking within a certain distance of doorways and windows are becoming increasingly widespread (Kaufman et al., 2010). For example, in Tasmania, Australia, smoking is prohibited within 3m of a doorway to a public building;[2] in Alberta, Canada, smoke-free environments have extended to places within 5m from the doorway, window or air intake of a public place or workplace (NSRA, 2012). Smoking bans also becoming widespread in outdoor spaces such as parks, playgrounds and beaches. For example, during 1993-2011, 843 jurisdictions in the US have banned smoking in parks, and 150 have banned smoking at beaches (Bayer & Bachynski, 2013).

Some LMICs have made progress in the implementation of smoking bans in public places: 154 million people were newly covered by comprehensive smoke-free policies in 2008, and most of these were residents of LMICs. In spite of this progress, only 9% of countries banned smoking in bars and restaurants and 65 countries implemented no 100% smoke-free policies for any type of public place at a national level. Nearly half of HICs and two-thirds of LMICs have very low levels of protection: no smoke-free policies at all or only one or two types of indoor public spaces covered. By 2008, only 17 countries in the world had comprehensive bans in effect.[3] HICs also have a higher level of compliance (80%) with spatial restrictions on smoking than LMICs (lower than 30%) (WHO, 2009). Low level of compliance with smoking bans in LMICs may not lead to significant changes in smokers' behaviours, or reduce SHS exposure for non-smokers.

1.4.2.3 Smoke-free Environments in Canada

On November 26th 2004, Canada ratified the FCTC and made the promise to establish comprehensive protection from SHS in indoor public spaces across the country (WHO, 2009). In Canada, all three levels (federal, provincial/ territorial, and municipal) of government have authority to regulate smoking in public places and workplaces. By December 2008, Canada was one of the 17 countries in the world providing the highest

---

[2] http://www.dhhs.tas.gov.au/data/assets/pdf_file/0003/75486/Tobacco_Discussion_Paper_Submission_-_Action_on_Smoking_and_Health_Australia.pdf

[3] Australia, Bhutan, Canada, Colombia (sub-national legislation), Djibouti, Guatemala, Guinea, Iran, Ireland, Marshall Islands, Mauritius, New Zealand, Panama, Turkey, United Kingdom, Uruguay, Zambia (Framework Convention Alliance, 2008).

level of protection against SHS: i.e. 100% smoke-free in indoor public places and workplaces (CCS, 2010). This was achieved largely through provincial/territorial legislation, which followed earlier federal and municipal actions. The *Non-smoker's Health Act* of 1988, which prohibits smoking in federal government workplaces and on inter-provincial and international modes of transport, was the first federal legislation regulating where smoking can take place (NSRA, 2012). Historically, the majority of smoke-free spaces policies in Canada were at the municipal level. Many municipalities chose to ban smoking in bars and restaurants, contributing to reduced exposure to ETS in these environments (Hahn et al., 2006) and increased cessation and quit attempts among smokers (Bauer et al., 2005).

Many jurisdictions are now going beyond the minimum requirements of Article 8 by providing protection from smoke in some outdoor public spaces and workplaces. At the same time, ways to increase protection in privately-owned spaces, particularly vehicles, are being developed. An increasing number of Canadian jurisdictions implemented outdoor smoke-free legislation that included a 'buffer zone' prohibiting smoking around doorways and windows, etc. – either for specific public buildings, or for all workplaces.. Smoking restrictions are also implemented in a variety of outdoor settings, such as municipal playgrounds, outdoor sport and recreation facilities, parks and beaches, transit properties, patios, and during outdoor public events (NSRA, 2012). Several jurisdictions including Alberta, Nova Scotia, Newfoundland and Yukon Territory, prohibit smoking at restaurant and bar patios (CCS, 2010). Additionally, many municipal governments have outdoor smoking restrictions that exceed provincial/territorial legislation. For example, the latest Public Places Bylaw in Edmonton prohibits smoking within 10m of a playground, seasonal skating rink, skate park, sports field or water spray park (NSRA, 2012).

Smoke-free environments in university and college campuses are becoming widespread, and are an important strategy for prevention and cessation of smoking among post-secondary students. In Canada, smoking is completely banned in all indoor campus property and is often restricted outdoors. Some campuses are governed by legislation that requires smoke-free buffer zones around doorways to all public buildings (Quebec 9m; Alberta 5m; British Columbia, Saskatchewan, Northwest Territories and Nunavut 3m), and one territory requires 100% smoke-free campuses (Yukon) (NSRA, 2012). In

addition, Canadian institutions commonly adopt their own policies regarding outdoor smoking, including complete bans and restricting smoking to designated areas (Baillie et al., 2011; Procter-Scherdtel & Collins, 2013).

Privately-owned spaces that are neither workplaces nor publicly-accessible have generally remained outside the reach of smoking bans. However, this is beginning to change, especially with respect to vehicles. These are confined spaces in which SHS can reach grossly excessive levels (Sendzik et al., 2008). In recognition of this, a number of jurisdictions have enacted laws banning smoking in vehicles when children are present, beginning with Arkansas in 2006 (Saltman et al., 2010). In Canada, this regulation was first enacted by the Town of Wolfville in Nova Scotia in 2007. Subsequently, ten of 13 Canadian provincial/territorial governments passed laws to protect children from exposure to SHS in vehicles. The exceptions are Quebec, Northwest Territories and Nunavut (NSRA, 2012).

In terms of smoke-free housing, some provincial and municipal governments have taken steps to provide smoke-free social housing, even though there is still no legislation restricting smoking in homes more generally (CCS, 2010). The websites 'Smoke-Free Housing BC' and 'Smoke-Free Housing Ontario' were designed to encourage and assist landlords and property managers to create more smoke-free options for tenants (NSRA, 2012). One type of housing in Canada that is commonly smoke-free is University residence buildings; this transition has occurred relatively recently as part of broader initiatives on the part of universities to make many or all aspects of their campuses smoke-free (Procter-Scherdtel & Collins, 2013). However, smoking in homes remains generally free of formal restrictions, and one consequence of this is that domestic space is a major site of exposure for children and youth. Leatherdale & Ahmed (2009) examined the 2006 Youth Smoking Survey (YSS) data and found that 22.1% of youths in grades 5-12 were exposed to SHS in their home in a daily or almost daily basis.

In addition to implementing policies such as those listed above, there must be a high level of compliance so that the population is actually protected in fact and not merely protected on paper. Compliance with smoke-free policies varies greatly among countries and HICs are more likely than LMICs to achieve high compliance with their comprehensive smoke-free legislation (WHO, 2009). However, there are still some flaws

in the enforcement of, and compliance with, outdoor smoking bans in Canada. For example, Baillie et al. (2011) studied four Canadian undergraduate campuses and found that students' smoking behaviours are minimally impacted by outdoor smoking restrictions on campus due to seriously compromised implementation and enforcement. Schultz et al. (2011) found ample observational evidence that people continue to smoke outdoors on hospital property even though policies stated that smoking was banned. This finding was attributed to the absence of designated smoking areas, inadequate treatment for tobacco dependence and poor management of symptoms of withdrawal. Non-compliance at some outdoor sites where smoking is restricted may also be partly due to poorly placed signage and a lack of defined boundaries between smoking and non-smoking areas (Kaufman et al., 2010).

1.4.2.4 Smoke-free Environments in China

China promised to achieve completely smoke-free public indoor spaces requested by the Article 8 of WHO FCTC by January 9, 2011. Efforts have been made at both national and municipal level in China. Four important documents need to be considered in explaining the implementation of smoking bans in China at the national level. In 1987, the Chinese central government issued 'Regulations for the Public Sanitation', where 28 types of space were identified as 'public spaces'.[4] In 1991, the Ministry of Health issued the implementation guidelines for the 1987 document. In those guidelines, 16 of 28 public spaces were designated as smoke-free environments.[5] In 2011, a new implementation guideline document came out, replacing the 1991 document. In the new guidelines, all 28 types of public spaces listed in the 1987 document were requested to be completely smoke-free. The latest regulation at the national level is from December, 2013, when the

---

[4] (1) Hotel, restaurant, hostel guesthouse, motel, cafe, bar, tea house; (2) Pubic bath-taking house, hair salon, facial salon; (3) Movie theater, video theater, game house, dancing house, concert hall; (4) Stadium (gymnasium), swimming pool (swimming hall), parks; (5) Exhibition center, museum, art gallery, library; (6) Shop, book store; (7) Medical waiting room, transportation waiting room, public transportation.

[5] Movie theater, video theater, concert hall, game house, dancing house, music teahouse, stadium, library, museum, art gallery, shopping mall, bookstore, hospital waiting room, public transportation waiting room, passenger cabin of trains, ships and airplanes.

Chinese government issued a document requesting that leaders of the Communist Party and governments at all levels not smoke in those regulated smoke-free areas (CBC, 2013). This was related to the high smoking rates in the Chinese civil servant population, and to the role model effect of political leaders to other smokers.

Rates of compliance with these rules are generally low, in part because they are not genuine laws. They are regulations issued by the Chinese government, and specifically its Ministry of Health, rather than the National People's Congress, which is the only democratically elected legislature in China. Although these rules theoretically have legal effect, they are much weaker than actual legislation. Another difference between 'laws' and 'regulations' in China is that only the agency issuing that regulation should be responsible for it. Other agencies, such as the police office, have no obligations to enforce regulations issued by agencies other than themselves. Second, prior to the latest document banning Party and governmental leaders smoking in public spaces, there was not a single policy specifically focused on banning smoking in public places. With regards to the other three national rules, smoking was mentioned in just several lines in long documents on general public health promotion.

In terms of local level restrictions, by the end of October 2006, 154 towns, cities, and districts across China enacted regulations to ban smoking in public places. This meant about half of all Chinese cities and larger administrative regions had adopted local smoke-free policies (Ministry of Health, 2007). Before 2011, most city-level policies were just a copy of national level regulations, and few were more stringent (Li et al., 2010). Guangzhou's and Shenzhen's local smoke-free laws banned smoking in air-conditioned workplaces and restaurants, which was beyond the scope of the national laws (Ministry of Health, 2007). In March 2008, Beijing released new regulations to restrict smoking in workplaces, although these were not comprehensive and still allowed designated smoking rooms. In addition, the new regulations required restaurants to set up non-smoking areas, which made Beijing the third city in China to implement a partial restriction on smoking in restaurants (Li et al., 2010).

According to the national policies in China mentioned above, 28 types of public place should be 100% smoke-free, including restaurants and bars, as well as parks – which are outdoor spaces. However, those 28 public places do not cover all indoor public places

identified in Article 8 of the FCTC, such as workplaces and government buildings. The workplace is one of the most important sources of SHS exposure for non-smokers (Hammond, 1999). A majority of current smoke-free policies in workplaces in China, especially in private workplaces, are adopted voluntarily and are not enforced by regulations or legislation. Enforcement of voluntary policies is very limited, especially in rural China. A cross-sectional household survey conducted in six counties in 2004 shows that 41.1% of smokers reported that they were non-compliant with smoke-free policies (Ma et al., 2010). The evaluation reports on the compliance with either the national or sub-national smoking bans in China by WHO experts indicated that China failed in providing a complete indoor smoke-free environment at all times (WHO, 2011).

There is still lack of attention to household smoking practices in China and many families have not adopted any voluntary smoking restrictions. A cross-sectional survey in Shanghai in 2006 indicated that only 26% of respondents reported having complete home smoking bans, while among them 68% reported the bans were often/ sometimes broken (Ji et al., 2009). In China, most families prefer to adopt partial smoking restrictions at home rather than complete bans. Women's weakness in social status and their lack of negotiation power contribute to their spouses smoking at home, regardless of concerns for their children's SHS exposure (Abdullah et al., 2011).

A number of articles have discussed the reasons behind the weak enforcement of smoking bans in China. It has been argued that China signed and ratified the FCTC for reasons of international recognition rather public health considerations, and that this presaged weak implementation of FCTC requirements in China (Jin et al., 2012). Moreover, the tobacco industry in China is a government-owned monopoly, which is identified as the most crucial obstacle to the implementation of FCTC in a recent analysis (Lv et al., 2011). In China, the State Tobacco Monopoly Administration (STMA) and the Chinese National Tobacco Corporation (CNTC) have full control over tobacco production, sales and import-export business.[6] This means that the government department that is responsible for the administration, production and sales of tobacco products is also responsible for the tobacco control, contrary to Article 5.3 of the FCTC, which states: 'in

[6] Law of the People's Republic of China on Tobacco Monopoly. Law Library, 1991. Source: http://baike.baidu.com/view/88061.htm

setting and implementing their public health policies with respect to tobacco control, parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law' (Lv et al., 2011; WHO, 2009).

With the absence of democratic elections in China, the ruling party has to ensure its legitimacy by keeping economy growing – a goal to which tobacco industry has been contributing greatly (Liu et al., 2010). In 2010, the Monopoly generated tax and profit of RMB 7530 billion CNY (1.34 billion CAD), equivalent to 7.25% of central government revenue, while the statistics in Yunnan Province is 17.7% (Jin, 2012). The tobacco industry employs about half a million people, 0.06% of total employment in all sectors.[7]

1.4.3 Social Status of Smoking

1.4.3.1 Decreasing Social Acceptance of Smoking in HICs

The social status of smoking has been decreasing over the past few decades in most HICs. In dominant understandings, the cigarette has transitioned 'from an object of pleasure, consumption, autonomy and attraction to a symbol of personal disregard for health, addiction and weakness' (Brandt, 1998: 165). Hammond et al. (2006) investigated 8991 smokers from four HICs (Canada, US, UK and Australia) and found that 80% of Canadian smokers agreed that society disapproves of smoking and smokers - a higher level of social disapproval than in the other three countries.

The decreasing social status of smoking is also reflected in the declining smoking prevalence in HICs (see section 1.4.1). This is most noticeable in high socio-economic status (SES) groups. Before the 1960s there was little disparity between the smoking habits of different social groups (Townsend, 1996). Since that time, in most HICs, the prevalence of smoking has reduced markedly among mid-to-high income groups, while among the lowest SES groups smoking rates have hardly fallen (Barnett et al., 2009). This smoking transition has become more pronounced over time (Pampel, 2002).

Low social acceptance of smoking is also manifested in, and reinforced by, widespread smoke-free environments. According to a qualitative study involving

[7] http://global.tobaccofreekids.org/files/pdfs/en/China_tobacco_taxes_summary_en.pdf

interviews with 25 current and ex-smokers in Vancouver, BC, participants felt that recent legislation, which included efforts to prohibit smoking in a variety of outdoor settings, was overly restrictive and that all public space had increasingly been 'claimed' by non-smokers (Bell et al., 2010: 914). The term "denormalization" was employed to refer to the process to 'remove, or steer away from, what seems to be normal' (Health Canada, 1999). Denormalization is not merely a social process. In the context of tobacco control, it is a strategy actively encouraged by governments, and an intended outcome of interventions and policies. Health Canada (1999) identified tobacco denormalization as a desirable goal to 'reposition tobacco products and the tobacco industry consistent with the addictive and hazardous nature of tobacco products' (Ashley & Cohen, 2003: 396). "Tobacco Industry Denormalization (TID)" was emphasized by the National Strategy to Reduce Tobacco Use (NSRTU) in Canada. This involved telling the public about the tobacco industry's role as disease vector in the development and perpetuation of the tobacco epidemic (NSRA, 2004). Policies and interventions, such as the enforcement of smoking bans and mass media campaigns, have made huge contributions to the denormalization of smoking in the ways, which will be addressed in section 2.3.1.

The decreasing social status of smoking may cause remaining smokers to feel stigmatized. Smoking in HICs is not only increasingly identified as 'not normal', but also as 'not proper' (Voigt, 2013: 51). The latter notion is mostly related to the growing public knowledge of smoking-attributed health risks, especially the health harms of SHS to innocent victims such as children (Bell et al., 2010). Given the emergence of health as 'a pre-eminent social value in Western society', smoking is increasingly regarded as unacceptable, and smokers as irresponsible (Farrimond & Joffe, 2006: 2). It is also increasingly associated with dirt, addiction and despair. As innocent victims, non-smokers' recognition and fear of health harms caused by SHS are also positively related to their perceptions of stigma (Stuber et al., 2008). Smokers' failure to meet normative expectations of behaviour prompts negative social responses, which spoil their identity. Farrimond and Joffe (2006) also point out that the stigmatization of smoking could be reflected in non-smokers' constructions of smokers; for example, with regards to smokers' smell and appearance. A strong inverse relationship between SES and smoking has emerged in most HICs. Smoking-positive sub-cultures remain in low SES communities

where smoking is normal and relatively un-stigmatized (Procter, 2011). Clear social and spatial inequalities in smoking behaviour are evident, with significantly higher rates of smoking among disadvantaged populations and in disadvantaged places (Siahpush et al., 2006b; Marmot, 2006). For some commentators, this raises an ethical concern that stigmatization might exacerbate existing burdens in disadvantaged communities (Voigt, 2010).

1.4.3.2 Part of the culture – Smoking in China

In contrast to the low social acceptance of and tolerance for smoking in HICs, China still largely keeps smoking as an important social custom. The practice of giving and sharing cigarettes remains widespread and generally accepted. Individual cigarettes are exchanged throughout daily life, as people offer cigarettes to each other in casual meetings or chats. Larger packages of cigarettes are exchanged mostly during the holidays, such as Chinese New Year, as gifts for others. There were several tobacco companies having launched holiday-specific packages of cigarettes (Rich et al., 2013), as used to occur in HICs – particularly at Christmas. Also, cigarette exchanges do not necessarily occur only between smokers. It is also normal for non-smokers to offer and receive cigarettes. The reason for this is that non-smokers can accept cigarettes and then sell or re-offer to others.

Related to this social practice of gifting and sharing cigarettes, people are expected to accept offered cigarettes, as to decline would be considered extremely rude, and would result in social isolation. Also, some parents would not mind their male children smoking in the future, because it will help them establish social networks (Abdullah et al., 2011). In addition, even though they are aware of the harmful consequences of smoking, females are not very likely to want their husbands to stop smoking entirely, since smoking is considered helpful in socializing (Mao et al., 2013). This is related to patriarchal families in China rooted in Confucianism, where men are superior to women and family interests are superordinate to those of individual family members. With the widespread belief in China that smoking is an appropriate and effective tool to facilitate social and business contacts, Mao et al. (2013) contend that women support their husbands' smoking as a way to achieve familism and collectivism.

In the practice of sharing cigarettes in China, both price and brand matter. This is because these characteristics are seen as representative of SES (Rich et al., 2013). The brand of cigarettes one offers others is usually related to the status of the giver and his relations with the recipient. For example, he is more likely to offer luxury cigarettes to people such as his boss, other superiors and people he is asking for a favour, in order to show respect and sincerity. The practices of sharing cigarettes are by and large uncommon among women, children and youth. This reflects the fact that smoking remains a largely adult male behaviour in China, and the custom of gifting cigarettes is often associated with masculine workplace and professional cultures (Hu et al., 2012). Rich & Xiao (2012) suggested that sharing and gifting cigarettes generates from the culture roots of China in which people care about the harmony with each other. Gifting exchange is a dominant way to achieve this. This was also originated back to Confucianism.

In addition to the social acceptance of smoking in China, there is limited awareness of its health consequences (Abdullah et al., 2011). In a four-country survey conducted in 2002, the proportion of smokers who knew that SHS causes lung cancer was 76.9% in Canada, 82.6% in the United States, 82.2% in United Kingdom and 72.1% in Australia, while the figure in China in 2006 is 53% (Borland et al., 2006; Li et al., 2010). Also, long-term smokers in China often believe that quitting smoking creates rather than reduces health risks on the basis that they have to keep the concentration of nicotine in their bodies (Zhang et al., 2012). Over two-thirds of 4732 smokers from six cities in China held the false belief that 'light' and/or 'low tar' cigarettes are less harmful - a level of belief that is much higher than for smokers in Canada (16%), the US (28%), the UK (43%) and Australia (27%) (Marshall et al., 2010).

1.5 Summary

This chapter introduced the principal research question, four objectives and significance of this study. The structure of this thesis and contents in each chapter were then outlined. It also addressed, in detail, the different contexts for the work. These include smoking regulations and social norms regarding smoking in two countries – Canada and China, which are broadly representative of HICs and LMICs respectively.

Generally, smoking prevalence in HICs has decreased over recent decades, while the increasing number of smokers live in LMICs. Even though the general smoking rate in HICs is lower than LMICs, HICs have higher female smoking rates and therefore a smaller gender difference. HICs generally go much further than LMICs in the implementation and enforcement of smoking bans in public spaces, consistent with Article 8 of the FCTC. In Canada all indoor public environments are 100% smoke-free, consistent with Article 8 of the FCTC. The focus of regulation is now beginning to shift to outdoor public spaces, and private spaces not specifically covered by Article 8 – especially vehicles in which children are present, but also homes. It is evident that in HICs such as Canada, bans contribute to the denormalization and stigmatization of smoking. Indeed, these processes have been a focus of tobacco control research in HICs. In contrast, smoking regulations in China have limited scope (they do not cover all indoor public places) and enforcement is typically weak. In China, smoking – especially male smoking – is still highly accepted and incorporated into cultural practices. To conclude, there are stark differences between China and Canada with respect to smoking prevalence, behaviours, smoking bans, and norms around smoking. These are likely to have impacts on migrants' experiences.

Chapter 2 Smoke-free Environments, Social Norms and People's Experiences

2.1 Smoking Bans in Influencing Exposure to SHS and Smoking Rates

Smoke-free environments are intended primarily to protect people against exposure to SHS, and are considered highly effective in this regard (Callinan et al., 2010). For example, according to the Canadian Community Health Survey (CCHS), self-reported daily or almost daily exposure of non-smokers to cigarette smoke in public spaces fell from 19.7% in 2003 to 10% in 2009. In addition, the proportion of people who reported exposure to SHS in public places in the past month dropped by 43% during these six years.[8] This occurred alongside the development of comprehensive indoor smoking bans in Canada. Similar findings on reduced exposure to SHS in public places were also found in the US (Abrams et al., 2006), Ireland (Fong, 2006) and Spain (Fernández, 2009). Smoking bans in public places and workplaces have additional benefits by decreasing exposure in private settings, as voluntary restrictions become more widespread (Naiman et al., 2011). In 2010, 14.9% of young Canadians aged 12 to 19 reported exposure to SHS at home, down from 23.4% in 2003 (Statistic Canada, 2013b).

There is no national survey data in China on exposure to SHS prior to and after the implementation of smoking bans. Workplaces, restaurants and bars, and homes are the mostly discussed spaces in previous studies on exposure to SHS in China. For example, Ma et al. (2010) conducted workplace survey in six counties of China and found that non-smokers' exposure to SHS was 3.7 times higher in workplaces without smoke-free policies than those with smoke-free policies. Liu et al. (2010) found restaurants and bars with smoke-free policies had a much better air quality than those without any restrictions. Various levels of restriction on smoking in the home have also been implemented voluntarily by some Chinese families in order to protect children from SHS (e.g. Abdullah et al., 2012).

Smoking bans are directly intended to change smokers' behaviours, by limiting where they can be performed. Even in regulated spaces where people's compliance is very

[8] http://www.smoke-free.ca/factsheets/pdf/cchs/Canada-2009-shs-public.pdf

low, such as recreational venues in China, smokers still report that the presence or absence of smoking bans is a significant predictor of whether they would smoke in these places or not (Li et al., 2010). In addition, smoke-free policies can encourage smokers to reduce smoking quantities and even quit. Fichtenberg and Glantz (2002) reviewed 26 studies including those in Canada on the effects of completely smoke-free workplaces and found that they were associated with a 3.8% reduction in smoking prevalence and an average 3.1 fewer cigarettes smoked per day per continuing smoker. Similar findings were also discovered in recent Chinese contexts. For example, Ma et al. (2010) found people complying with the smoke-free policy in Chinese workplaces smoked 3.7 fewer cigarettes than those reporting no policies or breaking existing policies. Yang et al. (2011) conducted a survey of 4735 Chinese urban residents and found that smoking restrictions, along with gender, age and some other demographic characteristics are all significant predictors of successful quitting attempts. However, the decrease of smoking prevalence is not consistent in all studies (Callinan et al., 2010).

2.2 Attitudes towards Smoke-free Environments

Studies conducted in various settings showed that people generally supported smoke-free environments. For example, 86% of people interviewed in the 2006 CTUMS reported that they support some forms of smoking restricted workplace (Health Canada, 2006). In this survey, 40% of respondents reported that they hoped smoking could be banned in any area of the workplace including both indoors and outdoors. Additionally, 46% agreed that smoking should only be allowed in outdoor smoking areas. High levels of support for complete smoking bans in workplaces were also found in Ireland (Fong et al., 2006), France (Renaud, 2007) and New Zealand (Edwards et al., 2008). Support for workplace smoking bans is smaller in China than these HICs, according to a study in six large cities in 2006, which was 42.8 % for smokers and 52.9% for non-smokers (Li et al., 2010).

Support for bans is stronger for those places with bans already in effect (Borland, 2006). This has been found in both China and some HICs. The survey by Li et al. (2010) also showed that support is highest for bans in public transportation vehicles (93.6%) and schools (93.5%), followed by hospitals (73.7%), conference rooms (73.4%), workplaces (42.8%) and restaurants or bars (21.3%). Support for total smoking bans in bars among

Irish smokers was only 13% before the comprehensive smoke-free law was enforced in 2004, but increased to 46% one year later (Fong et al., 2006). Similarly, Pacheco (2013) argued that people exposed to smoking bans for a longer time might be more supportive of additional smoking restrictions.

The strong support for smoking bans in public transportation vehicles and schools illustrated in the six-city survey in China indicated the significant effects of existing smoking restrictions in those avenues and suggested the feasibility of implementing smoke-free policies in other public places, like restaurants and bars. Other studies in China have examined people's attitudes towards smoking bans in restaurants and bars in particular. People's support for smoking bans may be compromised by other considerations. Liu et al. (2011) conducted a survey among 814 restaurants and bars owners in five Chinese cities. The results showed that 53% of respondents support some smoking bans in their venues. However, only 17% and 11% supported complete bans in restaurants and bars, respectively. These numbers are much lower than the support rate in Ireland in 2005 mentioned above (46%). These relatively low levels of support were linked to the respondents' perception of reduced revenue caused by smoking bans and their belief that indoor air quality depended on ventilation rather than smoking bans.

2.3 Denormalization and Individuals' Smoking-related Experiences

2.3.1 Denormalization as a Process: Spatial Rules and 'Care of the Self'

A social norms approach has been employed as an effective strategy to change people's smoking behaviours. Social norms are characterized as rules known to members of a certain social group, which regulate their behaviours. This regulation is achieved through sanctions for non-compliance from an outside authority or other members of the group and/or their internalization of the rules (Dohrenwend, 1959). In the field of tobacco control, there has been a conscious and multi-faceted effort to develop policies and interventions that will 'change the broad social norms around using tobacco - to push tobacco use out of the charmed circle of normal, desirable practice to being an abnormal practice' (Hammond et al., 2006: 225).

The regulatory function of social norms can be explained by Michel Foucault's concept of "governmentality" (Foucault, 1988). It focuses on the ways in which social control is achieved through the negotiation and balance of power at two levels - government ("technologies of power") and individual ("technologies of the self"). The former notion refers to regulatory strategies developed by government to govern the whole population, while the latter stresses the individual's discipline of the self (Collier, 2009).

Two technologies of power are particularly relevant in the context of smoking. The first is "biopower", which specifically concerns governmental efforts to shape and control biological features of the population. It refers to the 'mechanisms employed to manage the population and discipline individuals to produce or protect a healthy and productive citizenry' (Gastaldo, 1997: 113), such as public health messages regarding the risks of smoking and SHS. The second is "geopower", which includes governmental efforts to restrict individuals' behaviours in certain spaces (Tuathail & Toal, 1996), such as smoke-free rules for enclosed indoor public spaces and workplaces. These two technologies are related, in that geopower is 'a fundamental prerequisite for biopower' (Thompson et al., 2009: 512).

Laws or policies, enacted as technologies of power can generate a top-down norm shift by necessitating the adoption of new behaviours with formal sanctions for breaking the rules (Young, 2008). Formal tobacco control strategies have used biopower and geopower to promote a substantive and wide-ranging norm shift in HICs over the recent decades. Consequently, smoking has been transformed from an accepted and unremarkable behaviour to one that is increasing perceived as abnormal and stigmatized (see section 1.4.3.1). Spatial smoke-free rules, an exercise of geopower, significantly contribute to the denormalization process. Smoking bans construct smoke-free environments as normative by reducing the visibility of SHS exposure, smoking and smokers in publicly-accessible spaces.

Smoke-free environments not only denormalize where smoking is allowed, but also contribute to the reduced social acceptability of smoking and smokers. Smokers are increasingly removed from valued sites of social interaction. For example, by prohibiting smoking in social spaces such as restaurants and bars, smoking is increasingly identified as an anti-social behaviour (Collins & Procter, 2011). In addition, the introduction of

graphic pictures on the packs of cigarettes in some countries, including Canada, not only indicates the health risks of smoking, but also conveys the message that cigarettes are different from other normal consumer products (Chapman & Freeman, 2008). Other examples include prohibition on almost all forms of tobacco advertising and promotion in Canada and implementation of tobacco point of sale display bans (NSRA, 2012).

This process of (de)normalization is reinforced by external forces, but also by individuals' care of the self. The latter concept refers to individuals' efforts to comply with normative expectations around healthy and responsible behaviour. Compliance is encouraged by the social costs of not conforming to a norm (e.g. exclusion from a group) and by more formal mechanisms. When smoking bans extend to new spaces, some people will initially disagree, but comply with them in order to avoid sanctions. However, the normalization process means that their attitudes are likely to change gradually until they come to agree that smoking is neither normal nor social approved (Aronson et al., 2010). When the message conveyed by tobacco control policies (i.e. that smoking is unhealthy and less socially approved) is internalized, individuals are motivated to comply with smoking bans not only to avoid sanctions, but also because they believe it is the right thing to do. At this point, they may undertake other actions consistent with "care of the self", such as quitting smoking to achieve better health. With increasing numbers of people doing so, smoking is progressively denormalized.

When the social unacceptability of smoking is internalized by increasing number of people, a ground-up normative shift can also be generated. For example, with growing concern about the health risks of smoking and SHS, individuals may demand more regulatory efforts from the government, such as the expansion of smoke-free rules into currently unregulated environments (e.g. outdoor public places in HIC contexts, such as playgrounds). Initially, this advocacy will be a minority concern, but over time it may gather support from other members of society who have internalized consistent messages regarding the health risks and unacceptability of smoking (Aronson et al., 2010). For example, opposition to SHS was a minority concern in 1970s, but as public knowledge expanded and smoke-free rules spread, prohibiting smoking in indoor public places obtained much wider support during 1980s and 1990s (Procter, 2011). Initial minority influence thus motivated legal changes at the macro level. The normality of non-smoking

may be continuously reinforced by individual and collective actions (Collins & Procter, 2011). Specifically, anti-smoking norms can be strengthened through the circular interaction of biopower from authorities and care of the self by individuals.

2.3.2 Social Norms and Individuals' Experiences

Social norms are closely connected to various aspects of individuals' experiences, including their behaviours, perceptions, attitudes, and emotions. In the first instance, people are expected to adjust their behaviours in conformity to social norms. As noted above, routine compliance with norms may also lead to changes in attitudes – that is, personal beliefs about the cost and consequences of conducting a certain behavior (Terry & Hogg, 1996), such as the potential health risks of smoking. However, individuals' beliefs can also inform resistance to social norms. In addition, social norms are open to interpretation – particularly when multiple norms co-exist (as when a local norm differs from a global norm). At this point, individuals' perceptions of which norm is most important or relevant becomes important, and influences their behavioural decisions. Also, inaccurate perceptions may compromise the effectiveness of social norms in promoting health-supporting behaviours (Blanton et al., 2008). Social norms also relate to emotions; for example, guilt or shame can be triggered when a social norm is violated (Elster, 1996; 1999); social norms have the function to regulate emotions (Colombo, 2014). Definitions and characteristics of key terms with more details can be seen from Table 2.1.

Table 2.1 Key terms in a social norms approach to understand individuals' experiences

Terms	Definitions and characteristics
Social Norms	A social norm is 'a rule which, over a period of time, proves binding on the overt behavior of each individual in an aggregate of two or more individuals' (Dohrenwend, 1959: 470); Three definitional attributes: collective evaluation; collective expectation; reactions to behavior (Gibbs, 1965).
Normative (mis)perceptions	Individuals' (mis)perception of 'the extent to which others approve, disapprove, or engage in a particular behaviour' (Neighbors, 2006: 291).
Attitudes	A function of individual beliefs about the likely costs and benefits of performing a particular behavior (Berkowitz, 2005); Influenced by normative perception (Oliver & Bearden, 1985; Vallerand et al., 1992); Have predictive effects on behavioural intentions (Terry & Hogg, 1996).
Behaviours	Behaviours are the intentional (coordinated) actions of individuals or groups (Levitis et al., 2009); Predicted jointly by social norms (external) and attitudes (internal) towards the consequences of performing a certain action (Terry & Hogg, 1996).
Emotions	Communicative and expressed feelings, representing a combination of personal experience and social context (Davidson & Smith, 2009; Pile, 2010); Emotions can be triggered by social norms (Elster, 1996); Emotions can motivate individuals to comply with social norms (Colombo, 2014).

The social norms approach to health promotion aims to change people's misperceptions before changing their behaviours (Berkowitz, 2005). Normative misperceptions regarding health behaviours have been observed in college students; for example, studies found that college students systematically overestimate how much their peers drink and the numbers of heavy drinkers (e.g. Lewis & Neighbors, 2004; Perkins et al., 2005). Other correlational studies confirmed that actual drinking behaviours could be related to misperceptions regarding peer alcohol use (Carey et al., 2006;Martens et al., 2006)

With regards to smoking, studies have found that perception of stigma varies between individuals. Farrimond and Joffe (2006) suggested that high SES smokers and

low SES smokers would have different opinions about being stigmatized due to smoking. High SES smokers are less likely to consider themselves to have a negative identity. They also tend to compare their smoking with other behaviours they think even more harmful. By comparison, lower SES smokers are more likely to identify themselves as 'polluters' or 'risky' for others (Farrimond & Joffe, 2006: 485). They are also more serious about the risks their smoking will cause to non-smokers. Similarly, Stuber et al. (2008) found that people's perceptions of stigma were influenced by various factors. Having ever experienced discrimination, low levels of education and holding normative evaluations of family and friends are contributing factors for shaping the perceived smoker-related stigma of current and former smokers. Surprisingly, in this study, those who had greater exposure to smoke-free environments reported lower levels of perceived stigma.

Individuals' needs to belong to groups and intention to avoid informal or formal sanction motivates them to adjust their behaviours in accordance with social norms (Aronson et al., 2010; Anleu, 1998). With the denormalization of smoking, remaining smokers may face potential social consequences, such as being marginalized or discriminated against. It is expected that rational people will choose to quit in order to be involved in non-smokers' group that is increasingly normal. However, quitting does not always happen. Thompson et al. (2009) considered ongoing smoking in unregulated areas as 'a strategic compliance' (p. 513) with some aspects of biopower and geopower, which functions to create the positive identity of the considerate or responsible smoker. Other strategies to avoid being negatively identified included being a secret or social smoker. Social smokers only smoke together with other smokers so as to avoid social withdrawal by their non-smoker peers (Stuber et al., 2008). Other studies emphasize that smokers may understand unwillingness to quit as consistent with care for the self, as smoking is perceived to contribute to their emotional and bodily regulation (e.g. preventing mental difficulties and weight gain) (Christopher et al., 2006; McChargue et al., 2004). To summarize, even though at the macro level, (de)normalization is processed by the mutual power negotiation between government and the population; at the individual level, people exercise 'their own forms' of care of the self (Thompson et al., 2009: 514).

According to Aronson et al. (2010), whether people will behave in adherence to a certain social norm is also influenced by the extent to which they are attached and in

proximity to those who hold it. For example, children's smoking initiation is strongly influenced by parents' habits (Otten et al., 2005). Local norms have more power in influencing people's behaviour than global norms (Blanton et al., 2008): tobacco-related norms are often localized, something that migrants experience and have to negotiate. Another example of this is when smoking rates fall more quickly in high-income neighbourhoods and populations, as has happened during the recent decades in HICs, "smoking islands" can form. This refers to the persistence of high smoking prevalence, as well as smoking-positive social norms, in low-income areas (Thompson et al., 2007). These segregated environments may serve to maintain or even reinforce smoking, as it is not locally denormalized or stigmatized. Influential local norms in these areas continue to support smoking.

2.3.3 Social Norms influencing Behaviours: Understanding Smoking in China

How social norms can influence people's smoking behaviours can also be understood in the context of China. As suggested, while smoking is less acceptable in most contexts in HICs, in China it continues to be positively linked to social status, especially for males. Rich and Xiao (2012) contend that the social norms of sharing and gifting cigarettes in China contribute to high smoking prevalence among men. Studies showed that sharing and gifting cigarettes was considered not only a contributor to smoking uptake, but also an impediment to smoking cessation. For example, male smokers commonly reported receiving their first cigarette from others. Smoking among male adolescents is also taken a symbol of their maturity/adulthood, even by some parents (e.g. Hu et al., 2012).

Hu and colleagues (2012) also found that if someone wants to quit, his smoking friends would not help. Instead, most participants reported that they would try to get their friend to resume smoking. The most common reason for this is that people do not want to smoke alone. Additionally, they held the perception that quitting too quickly would hurt one's health. The most effective way to encourage others to smoke again is to offer them expensive cigarettes. Expensive cigarettes were considered to have a better quality and less harm than cheaper ones. This is associated with the price gap between different brands of Chinese cigarettes and people's pursuit of luxury and vanity.

Given most studies showed that cigarette gifting motivates people to pick up smoking and hinders efforts to quit, Ding and Hovell (2012) argued that appropriate tobacco control efforts in China should break the normality of sharing and gifting cigarettes in socializing. China has made some efforts to change this long-existing association, which has turned out to be effective to some extent. For example, a "giving cigarettes is giving harm" campaign demonstrated short-term effects, especially in urban areas, by advising people that giving cigarettes is not appreciated, but shameful (Alday, 2009; Ding & Hovell, 2012). Malone (2011) suggested that deglamorizing the practice of gifting cigarettes should be particularly effective in China, because Chinese people care more about their image in front of others: 'face'. Ding & Hovell (2012) emphasized that the future tobacco control strategies in China could take advantage of the social culture that social ties ('guanxi') are valued and gift exchange is highly prevalent. Healthy alternatives, such as sports equipment and gym memberships can be promoted as gifts instead of cigarettes to be helpful in people's socializing.

2.4 Emotional Geography and Smoking

Another area of theory informing this research is the emerging field of emotional geography. It acknowledges the presence of emotions in the understandings of the world and emphasizes interactions between places and individuals' emotions (Davidson & Milligan, 2004). Particular kinds of place can transform people's emotional lives to encourage health promotion (Gesler, 1992). It is also notable that individuals' emotions are not only influenced by environments, but also formed by the dynamic relationships between people and places (Davidson et al., 2007).

Smoking bans change the character of places in which people are living and working, as well as the relationships between people and places, by requiring behaviour changes (Collins & Procter, 2011). People's emotions will be influenced by these changes. The stigmatization of smoking prompts emotional responses from both smokers and non-smokers. For example, with an increasingly spoiled identity, smokers can feel guilty and shameful when continuing to smoke, especially in public (Stuber et al., 2008; Thompson et al., 2009; Ritchie et al., 2010). However, they may also feel that smoking plays an important role in their emotional regulation (Bottorff et al., 2006).

Emotional responses of non-smokers to smoking include feelings of 'disgust' and 'hate' (Farrimond & Joffe, 2006: 485). These are related to the perceived health risks and also the smell, which may cause non-smokers' physical distress (Chapman, 2007; Thompson et al., 2009). Non-smokers' negative emotional responses can be heightened by the feeling that innocents such as children are being exposed to SHS (Brandt, 1998; Stuber et al., 2008).

The emotions associating with the implementation and enforcement of smoking bans have received relatively little attention. Procter-Scherdtel & Collins (2013) found that emotive opposition to smoking regulations decreases over time. Weak implementation and/or enforcement of smoking regulations may generate the disappointment and frustration of non-smokers (Baillie et al., 2011; Kaufman et al., 2010). Emotional geography stresses people's sensual experience of places (Davidson & Milligan, 2007), so embodied sensations are also of interest in this research. Here, the smell of smoke is particularly important. For example, the stigmatization of smokers could be reflected in non-smokers' complaints about their smell (Farrimond & Joffe, 2006). This research is also attentive to the positive emotions potentially generated by smoking bans.

2.5 Summary

This chapter has considered how people's smoking-related experiences are influenced by restrictions on where smoking can occur. Smoking bans effectively reduce people's exposure to SHS, and there is also evidence showing that prohibiting smoking in public places can reduce smoking prevalence and the consumption of cigarettes. People's attitudes towards smoking bans were also reviewed. Generally, both smokers and non-smokers report support for smoking bans. Smokers may display more support for partial smoking bans than 100% smoke-free indoor restrictions. People are likely to be more supportive of those smoking bans already in place and implemented for a longer period. Related to this, levels of support in Canada are higher than those in China, especially for bans in restaurants and bars.

Social norms around smoking may also interact with people's smoking-related experiences. Social norms theory emphasizes that people adjust their attitudes and behaviours to meet the standards of the group(s) to which they belong. The notion that

people are more likely to be affected by local norms rather than global norms motivates this research to investigate whether migrants were influenced by the norms of their origins or destinations. There have been studies on both the stigmatization of smoking in Canada and the ongoing socially-desirability of smoking in China, at least among men. How migrants negotiate these very different cultures, and the practices that accompany them, has yet to be considered in the literature.

Denormalizing and stigmatizing smoking effectively encourages some smokers to reduce or quit smoking; however, this does did not work all the time and among all population groups. For example, smoking remains prevalent among low SES groups and in poorer neighbourhoods. These neighbourhoods may form "smoking islands" within which smoking remains normal and free from stigma. Such attitudes remain very widespread in China, where the sharing and gifting cigarettes is a significant contributor to smoking initiation and a barrier to quitting, especially among men. Future tobacco control in China will require efforts to remove the pathway between sharing cigarettes and enhancing social networks.

Previous studies on people's emotional experiences of smoking and its regulation focus mostly on stigmatization. Emotional geography could be applied in a deeper way in tobacco control studies. For example, people's emotional experiences in transitioning to new smoking regulations are insufficiently documented and explored. Addressing this requires increasing use of qualitative methods, so as to understand people's experiences directly, based on their own in-depth reports.

Chapter 3 Immigrants and Smoking

3.1 The Healthy Immigrant Effect (HIE)

This chapter focuses on the principal subjects of this research – immigrants. Immigrants are an increasingly large demographic group in many HICs. As such, it is necessary to take their unique needs and experiences into account in health promotion campaigns. When talking about the health and health behaviours of immigrants, the "Healthy Immigrant Effect (HIE)" is well known. It refers to the fact that immigrants are on average healthier than native-born people in HICs (Bruce Newbold & Danforth, 2003; Perez, 2002). However, the relative health advantage of immigrants diminishes over time. This pattern has been found in several main migrants-receiving countries in the world, including Canada (Chiu et al., 2009; De Maio & Kemp, 2010; Lear et al., 2009), the U.S. (Stephen et al., 1994), Australia (Donovan et al., 1992), and Europe (Domnich et al., 2012).

Explanations for the relatively better health of immigrants include health screening by recipient countries, the healthy lifestyle of immigrants in the home country and immigrant self-selection whereby healthier and wealthier people are most likely to migrate (Jasso et al., 2004; Kennedy et al., 2006). There have also been studies investigating why immigrants' health advantage is short-lived. In some studies, the decline in health status among immigrants was thought to be an outcome of negative acculturation effect. This refers to the ways in which, as immigrants' time in destination countries increases, they increasingly adopt the unhealthier behaviours and lifestyles of those countries (Cunningham et al., 2008; Hill et al., 2012; Nolan, 2012). For example, long-term immigrants will be more likely to have dietary patterns similar to the typical western diet (McDonald & Kennedy, 2005). This explanation could be employed to understand why the obesity rate among longtime immigrants was much higher than their newcomer counterparts, according to the Statistics Canada's national health surveys between 1996 and 2007. Also in this survey, heart health among female immigrants was found to be declining, which could be related to their increasing adoption of smoking (Keung, 2012). In addition, the transition of immigrants' health status is also linked to discrimination,

mental stress, poverty, poor living and working conditions, and barriers to health care and social services in destination countries (De Maio, 2012; Fennelly, 2005; Noh & Kaspar, 2003).

Both the HIE and the health transitions phenomenon may display various patterns in immigrants from different countries of origin. Hyman (2001) found that among immigrants to Canada, non-European immigrants were much healthier than native-born Canadians. Immigrants to the U.S from Central America and the former Soviet Union exhibited significant health disadvantages comparing with those from East and Southeast Asia (Son, 2013). Apart from countries of origin, other demographic characteristics of immigrants – such as age, gender, education, income and employment – also have an influence on immigrants' health condition (Kobayashi & Prus, 2012). Gushulak et al. (2011) summarized that the health of migrants is not only influenced by pre-migration factors such as where and how they lived in their original home country, but also by post-migration factors involving integration into their new place of residence, employment, as well as access to a new health care system.

3.2 Immigrants' Smoking Experiences and Influencing Factors

3.2.1 Smoking Prevalence among Immigrants

While there is a substantial literature on immigration and health, it gives only modest consideration to smoking. In accordance with the HIE, smoking prevalence among immigrants is generally lower than for the locally born population. Kennedy et al. (2006) found that immigrants were less likely to smoke daily than the native-born people in the study conducted in Canada, the U.S, Australia and UK. Georgiades et al. (2006) analyzed data from the Ontario Health Survey (OHS) and found that immigrant youth was less likely to engage in tobacco use than native-born adolescents. In Alberta, about 15.7% of immigrants age 12 and over in 2007-2008 smoked, compared to 23.3% for non-immigrants and this difference was statistically significant (Government of Alberta, 2011). The finding of lower smoking prevalence in immigrants than non-immigrants has been criticized for several reasons, such as the exclusion of non-English proficient Asian immigrants from smoking surveys (Ma et al., 2005).

Within immigrant groups, smoking prevalence varied in different subgroups divided by ethnicity, region and country of origin. According to the data from three cycles of the Canadian Community Health Survey (CCHS) conducted in 2000/01, 2003 and 2005, Asian immigrants were the least likely to smoke, compared with immigrants from Europe, Africa and other regions. Asian immigrants also displayed the greatest variation between country of origin, with Indian immigrants being the least likely to smoke and Vietnamese immigrants the most likely (Newbold & Neligan, 2012). Data from the 1995-1996 and 1998-1999 Current Population Survey (CPS) in the U.S. indicated that, in the case of male Asian/Pacific Islander immigrants, the highest smoking prevalence rates were found among immigrants from South Korea (33%), Japan (29.8%), and Vietnam (28.5%), and the lowest were found among those migrating from India (16.6%) and Hong Kong (9.7%) (Baluja et al., 2003: 645).

Stratification by gender reveals further heterogeneity among immigrants. By calculating the smoking odds ratios amongst women, Newbold & Neligan (2012) found in the CCHS study that, comparing with smoking prevalence among men, certain groups of Asian women were extremely unlikely to smoke, such as China and India-born women. These groups of Asian women were also much less likely to smoke than many European-born women, among whom the smoking prevalence was closely resembled that of the Canadian-born population. In the case of Asian women, according to the CPS in 1995-1998, female immigrants from Japan had the highest smoking rates (16.6%), followed by those from South Korea (10.1%), while those from India and China had the lowest smoking prevalence with 0.9% and 1.7% respectively (Baluja et al., 2003).

In accordance with the health transition phenomenon, according to several studies conducted in Canada, recent immigrants have lower smoking prevalence than long-term immigrants, but their smoking rates increased with length of residence in Canada (McDonald, 2005). O'Loughlin et al. (2010) conducted a cross-sectional study among immigrant children and found that the number of years lived in Canada was related to an increased risk of smoking. However, there were some inconsistent conclusions drawn in other research. For example, several earlier studies on Vietnamese male immigrants in the U.S suggested a decreasing smoking prevalence with increasing duration of staying (Jenkins et al., 1995). There were also other studies where no significant differences

between the smoking prevalence of newcomers and long-term immigrants were found, such as the health survey conducted in Toronto from 2001 to 2008 (Wiecha et al., 1998; Toronto Public Health, 2011).

3.2.2 Acculturation, Smoking Bans and Immigrants' Smoking

One of the transitions that immigrants experience in moving to a new country is a change in socio-cultural contexts. Acculturation is the 'culture change that is initiated by the conjunction of two or more autonomous cultural systems', which is an 'essentially a continuous dynamic process' (Clark & Hofsess, 1998: 37). Gordon (1964) considered the finishing point of this process an eventual and irreversible assimilation of individuals' beliefs, attitudes and behaviours into the dominant culture group (uni-dimensional). More recent sociological theory divided acculturation into two separate processes: maintenance of the original culture and involvement in the new culture (multi-dimensional). Sticking to the two processes, four strategies were introduced to describe different ways individual migrants adapt to the new contexts. An individual moving from one country to another could identify with his or her own ethnic group (separation), with the dominant culture in destination countries (assimilation), with both cultures (integration), or with none of these cultures (marginalization) (Berry, 1980; 1990). Frequent predictors of immigrants' acculturation level include length of stay in hosting countries, socio-economic status and language proficiency (e.g. Barry, 2001; Kuo & Roysircar, 2004).

Public health researchers have increasingly taken acculturation as a variable in influencing people's health outcomes, such as stressing the importance of appropriately defining and measuring acculturation (e.g. Abraido-Lanza et al., 2006; Thomson & Hoffman-Goetz, 2009). One of the health-related contexts to which migrants must adjust is centred on smoking. Smokers who migrate from LMICs to HICs, where smoking is often marginalized and stigmatized, are likely to experience the diminishing social acceptability of smoking (Kim et al., 2005). Consistent with Foucault's theory about technology of power/ the self, people may change their behaviours to avoid being stigmatized, including quitting smoking or restricting their smoking to private places (Thompson et al., 2009). In a qualitative study with Korean Americans, some participants reported that they became very self-conscious about smoking in public and took a careful

read of their surroundings before lighting up to avoid meeting people who dislike smoking. In addition, former smokers among the participants also acknowledged that lower social acceptance of smoking in the U.S motivated them to quit (Kim et al., 2005). However, in this survey, it is also found that Korean male immigrants to the US were less likely to choose assimilation and were more prone to separation. Similarly, Ma et al. (2003) found that about two-thirds of Asian American males tend to preserve their respective social norms, perceptions, beliefs and smoking-related practices. In some Asian countries, like Korea, Japan and China, smoking among men is an accepted social practice and important for socializing (Chen & Unger, 1999). Social norms regarding smoking in migrants' own ethnic group may continue to be influential post-migration (Shin & Seo, 2001).

Conversely, McCleary-Sills et al. (2010) investigated Hispanic young adults in Baltimore and found that exposure to American cultural norms, such as more prevalent female smoking, may encourage females to continue smoking. Gender differences in smoking prevalence among immigrants generally decrease as the length of their stay in destination countries increases. In other words, with acculturation, the smoking rates of male Asian immigrants decrease, while the smoking rates of women increase (Shelly et al., 2004; Maxwell et al., 2005; Weiss & Garbanati, 2006). For example, Juon et al. (2003) and Song et al. (2004) found that length of stay in the US was negatively correlated with smoking among South Korean male immigrants and positively correlated with smoking among female immigrants. Over time, then, acculturation may diminish large gender differences in smoking among immigrant groups, so that they become closer to the relatively small gender difference in the locally born population.

Additionally, immigrants' smoking behaviours were significantly influenced by their social network, for example perceived neighbourhood cohesion and trust have been found to be inversely associated with male immigrants' smoking (Li & Delva, 2012; Kandula et al., 2009). This was related to the potential influence of social involvement on reducing immigrants' depression and isolation. Apart from social norms regarding smoking, tobacco control policy, especially smoke-free environments, is another important factor that may guide and regulate immigrants' smoking behaviours. According to the 2001-2002 CPS Tobacco Use Supplement among US indoor workers, immigrants

were less likely to be employed in workplaces covered by smoke-free policies. This was related to that immigrants disproportionately work in industries and occupations with lower implementation of and compliance with smoking bans (Osypuk et al., 2009).

Tong et al. (2008) argued that smoke-free environments might mediate the acculturation effect, especially for immigrants in HICs who migrated from LMICs, where there are fewer smoke-free environments. Specifically, smoke-free environments are an external structure that reduces smoking opportunities for all people using public spaces – including, e.g., less acculturated immigrant males who keep up smoking, and more acculturated immigrant women with increasing smoking prevalence. In a study conducted in the UK during 2002, Croucher and Choudhury (2007) found that smoke-free environments did contribute to immigrants' giving up smoking, even though immigrants were less likely than non-immigrants to quit. In the study conducted in California, both Chinese and Korean immigrants made quit attempts at a much higher rate than their counterparts in their home countries, partly because of workplace and home smoking bans (Zhu et al., 2007).

Immigrants may have various responses to more stringent smoking bans in destination countries. Current smokers who had never been confronted about smoking in their home countries might see the restrictions as 'an insult or threat to their sense of self' (Kim et al., 2005: 616). However, in the US Current Population Survey data from 1995 to 2002, Osypuk et al. (2010) found that immigrants exhibited stronger support for banning smoking in every venue than native-born respondents, and recent immigrants showed stronger support than long-term immigrants.

Highet et al. (2011) organized two focus groups to explore how male Bangladeshi smokers adapted to smoke-free legislation in England, a topic very similar to that being investigated in the current study. They found that most Bangladeshi smokers in this study had largely adjusted to the smoke-free legislation and reduced their consumption of cigarettes. Importantly, smoking bans also have eroded the social acceptability of smoking in public places. However, smoking still largely remains a social habit among some older Bangladeshi migrants and in private spaces, such as family homes.

3.2.3 Demographic Factors Influencing Immigrants' Smoking Experiences

Higher smoking prevalence and greater tolerance of SHS among immigrants were associated with lower levels of education in some studies (Jenkins et al., 1995; Thridandam et al., 1998). High educational attainment was also related to smoking cessation and quitting (Newbold & Neligan, 2012). The association between smoking behaviour and education varied in different subgroups. In the 2001 California Health Interview Survey, having more than a high school education was a protective factor in all racial ethnic and gender groups with the exception of Hispanic, Chinese female and Filipino male immigrants (Maxwell et al., 2005). Vedoy (2013) found that higher education was associated with lower probability of current smoking among all male immigrant groups in Norway, except Sri Lankans. However in some studies, women immigrants' smoking prevalence did not display a negative correlation with education level. In Vedoy's study, smoking prevalence among women immigrants with secondary education was higher than those with either primary or tertiary education level. Nierkens et al. (2006), in a study with women immigrants in the Netherlands, found that smoking rates were higher among women with higher educational levels.

Studies have also examined the relationship between smoking behaviours of immigrants and other factors, including age, marital and employment status, income and language capacity (Maxwell et al., 2005; TPH, 2011; Ma et al., 2005; Tong et al., 2008). For example, Maxwell et al. (2005) found that smoking rates were higher among male immigrants in the U.S who cannot speak English very well, while being married was associated with lower rates of smoking. A study with Southeast Asian males residing in Ohio indicated that current smokers, compared with never-smokers, tend to be older and not in the labor force (Moescheberger et al., 1997).

3.3 Smoking and International Students

China is the second-largest source country for immigrants to Canada. Both permanent and temporary residents have been significantly increasing over the past decade, especially international students and foreign workers (see Table 3.1). China is the top country of origin for international students in Canada. In 2012, 80,627 Chinese students studied in

Canada – this represented 30.4% of all international students, and was approximately three times higher than the number of students from the next most-common country of origin: India. As such, international students are an important sub-group of Chinese immigrants that merit consideration in this research. In addition, international students are usually young adults (e.g. aged 18 to 24) – the age group with the highest smoking prevalence in HICs like Canada. However, research on immigrants' smoking experiences seldom pays specific attention to international students.

Table 3.1 Chinese migrants* to Canada admitted in 2003 and 2012

Category**/ Year	2003	2012	Change over time	Category as percentage of total in 2012
Permanent Residents	36,251	33,018	-8.9%	51.0%
International Students	10,008	25,346	153.3%	39.2%
Foreign Worker	1118	2929	162.0%	4.5%
Refugee claimants	1798	1735	-3.5%	2.7%
Humanitarian population	1684	1665	-1.1%	2.6%
Total	50,859	64,693	27.2%	100%

Sources: CIC (2013). Canada Facts and Figures: Immigration overview- permanent and temporary residents. Available from: http://www.cic.gc.ca/english/pdf/research-stats/facts2012.pdf

* Hong Kong and Taiwan not included.

** Permanent and temporary residents only; visitor visa holders not included.

3.3.1 International Students' Smoking Experiences

Few studies have looked into the smoking patterns of international students specifically. When mentioned, it is most often explained as an outcome or reflection of psychological factors or adaption difficulty. International students may face homesickness, culture shock, discrimination, language difficulties and so forth (Lee et al., 2004; Mori, 2000). Russell et al. (2010) surveyed 979 international students attending a university in Australia and found that those feeling isolated and unconnected were much more likely to take risky health behaviours, including smoking.

Sa et al. (2013) conducted an online survey at 52 universities in the US with 1021 international students from South Korea. The findings include that the smoking rate of college students from South Korea (43.5%) is much higher than that of US young adults aged 18 to 24 (20.1%) and US college students (16%) in 2010. The smoking rate of female students (29%) is much higher than that of their peers back in South Korea (4%). These increases were attributed to stress, anxiety and depression. Graduate students in this research had a slightly higher smoking rate than undergraduate students, which was linked to extra academic stress.

At the same time, the implementation of smoking regulations can reduce international students' cigarette consumption. Since the prevalence of Korean male smoking is high, and smoking is allowed in most public places in Korea, Sa et al. (2013) argued that respondents who cut back were modifying their smoking behaviours to adjust to the stricter smoking policies in the US. Related to this, students living off-campus have a much higher smoking rate (62%) than those living on campus (25%). The other factor related to reducing cigarette consumption is the cigarette price in the US, which is around twice that in South Korea. Similar to studies on other immigrant groups, the relationship between length of stay and cigarette consumption was negative for male students and positive for females.

3.3.2 Smoking Patterns of College Students

Over half of Chinese international students in Canada are in universities (Statistics Canada, 2011-2012). Campuses are transitional sites where many young adults take up smoking or transfer from occasional to regular smoking (Baillie et al., 2009; Hammond et al., 2005). There is evidence showing that over 20% of students take up smoking in college or university and student smokers are very likely to continue smoking outside of the academic environment after their graduation (Page, 1998; Rigotti et al., 2005; Wechsler et al., 1998). Most college students are at an age when cigarette consumption and brand loyalty may increase (Burrows, 1984).

Smoking rates among general public have been decreasing over recent decades. However, smoking prevalence among university and college students has experienced fluctuations during this time. In the US, the reported 30-day smoking prevalence among

college students fell from 26% to 22% in the 1980s and then increased substantially during the 1990s. It reached the peak of 31% in 1999, before dropping to 14.9% in 2007 (Johnston et al., 2009; American College Health Association, 2008). In addition, students are typically drawn from age groups with the highest smoking rates: such as those aged 18-24 in the US had the highest smoking rates among all age groups in America (23.7%) (Centers for Disease Control and Prevention, 2009). Similarly, smoking prevalence is highest among adults aged 20-24 in Canada (21%) (Health Canada, 2013) and around 51% of these young adults are college or university students (McMullen, 2009). Studies have shown that Canadian postsecondary students have lower smoking rates than their peers in the US: 17.1% vs. 19.3% in 1999 (Johnston et al., 2001).

Studies show that college student smokers tend to smoke on a non-daily basis and smoke fewer cigarettes per day than average adult smokers (e.g. Clark et al., 2005; Levinson et al., 2007). Also, college students primarily smoke together with others (e.g. Moran et al., 2004; Waters et al., 2006). For example, Cronk et al. (2011) found that college students smoked more frequently in weekends than weekdays because they had a higher frequency of parties. Smoking prevalence is higher among fraternity and sorority members because they have more social activities than non-members (McCabe et al., 2005).

The occasional and social patterns of college students' smoking are related to their smoking self-identification. According to Luoto et al. (2000) and Rollins et al. (2002), social and occasional smokers sometimes self-report as non-smokers and this phenomenon was also found in college student smokers. An eight-college longitudinal survey in 1999-2004 found that more than half of students (56.3%) denied being smokers despite having smoked in the previous 30 days, and that deniers were highly likely to smoke infrequently (Levinson et al. 2006). Berg et al. (2010) identified how college students define the term "smokers" from a study conducted in two colleges in Minnesota. A smoker was described in terms of smoking frequency, time since initiation of smoking, whether one purchases or borrows cigarettes; level of addiction, whether smoking is part of a daily routine or habitual, and whether they smoke alone or at parties. These themes provide clues to understand why occasional and social smokers, who tend to smoke infrequently and primarily with others, do not identify themselves as smokers. In addition, the belief of

most college student smokers that they can quit smoking by themselves whenever they want to also influences their self-identification (Morley et al., 2006).

How one defines being a smoker has been proved to have significant influence on the motivation to quit smoking (Butler et al., 2012). Berg et al. (2010) indicated that the idea of quitting smoking would not be applicable to those who did not consider themselves to be smokers. Levinson et al. (2006) claimed that denying being a smoker might be a widespread example of dissonance among college student smokers, which would result in underestimation of smoking prevalence in self-reported surveys. As such, it has both implications and challenges for smoking cessation campaigns and interventions on campus (Levinson et al., 2006).

In terms of gender difference, in Canada and the US, smoking prevalence among female college students was similar to that of males, and some studies have even found that female college students are more likely to smoke in both the US (Berg et al., 2011) and Canada (Adlaf et al., 2002). In LMICs, a stark gender difference is often apparent. For example, in a study conducted in Iran, the prevalence of cigarette use among men college student was nine times higher than that among women (Nakhaee et al., 2011). In Turkey, smoking prevalence was 2.9 times higher among male college students than female college students (Oncel et al., 2011).

3.3.3 Factors Influencing College Students' Smoking

College student smokers are more likely to have parents and siblings who smoke or use other substances (Susan Shur-Fen et al., 2009). In addition, perceived and actual peers' smoking also plays an important role in college students' smoking behaviours (e.g. Nakhaee et al., 2011; Paek, 2009). Importantly, college students often had inaccurate perceptions about their peers' smoking norms, and these misperceptions would influence their self-reported smoking. For example, Arbour-Nicitopouls et al. (2010) found from a sample of college students in University of Toronto that the majority of respondents overestimated their peers' smoking prevalence, and that this encouraged more students to initiate smoking. Students' perception that smoking is normal among their peers motivates their decision to pick up smoking; therefore, correcting students' misperceptions of the smoking norms among their peers can contribute to positive behavioural changes. This is

consistent with the influence of misperceived social norms on people's health behaviours (Branton et al., 2008).

Campus smoke-free policies have achieved some success in reducing students' smoking frequency and prevalence (Dong-Chul et al., 2011; Adlaf et al., 2003). In a study conducted among college student smokers in Taiwan, some participants reported that a smoke-free campus policy forced them to change the sites for smoking and reduced the psychological reward of smoking, for when they got the area where smoking was permitted, 'the desire to smoke had gone away' (Chuang & Huang, 2012: 202). From qualitative research conducted in three universities in Canada, Procter-Scherdtel & Collins (2013) found that smoke-free policy on campus not only restricts college students' smoking spatially, but also decreases the social acceptability of smoking and exposing others to ETS. Conversely, being in a location where smoking is allowed and in the company of smokers can contribute to a feeling of normality and reduced the sense of isolation.

People's beliefs about smoking influence their smoking-related behaviours (Shore et al., 2000). Various studies have examined college students' perceptions about smoking and its health risks. Some studies proved that college student non-smokers reported more perceived negative effects caused by smoking than smokers (e.g. Weinstein, 1999; Seigers & Terry, 2011). However, others showed that college student smokers and non-smokers reported similar perceptions about smoking and its health risks; however, smokers perceived more positive effects (e.g. relieving depression; losing weight; getting involved in social events) than non-smokers and these perceived positive effects might motivate college students to smoke (Christopher et al., 2006; McChargue et al., 2004)

Quite a few studies have explored the relationship between depression and college students' smoking behaviours. Depression and desire to cope with stress are commonly recognized factors influencing college students' smoking (e.g. Brandon & Baker, 1991; Cronk & Piasecki, 2010). Halperin et al. (2010) used regression analyses to indicate that college students who experienced depression had more than double the odds of being dependent smokers. Studies showed that depressed female college students exhibit greater levels of nicotine dependence compared to their male counterparts (McChargue et al., 2004). Morrel et al. (2010) found that the association between vulnerability to depression

and smoking behaviours was significant in females only, and that females were more likely than males to regard smoking as a method to relieve negative affect.

3.4 Summary

The health of immigrants is a generally well-documented topic, although immigrants' smoking prevalence and experiences are not commonly discussed. The Healthy Immigrant Effect (HIE) is commonly cited, and with respect to smoking highlights that prevalence among recent immigrants tends to be lower than that of both the locally-born population and immigrants with a longer strength of stay. Studies of Asian immigrants in the US and Canada show that smoking prevalence of female immigrants is likely to increase with length of stay, while that of males is likely to decrease. In both cases, the smoking prevalence for immigrant women and men moves closer to the local norms, consistent with the concept of acculturation.

International students, with the characteristics of both immigrants and college students, are an important part of the whole immigrant population in countries such as Canada. People of college age are also a focus of the tobacco control movement, because of their relatively high smoking prevalence. Previous studies on international students' smoking experiences are insufficient; therefore studies investigating general college students' smoking were reviewed above. College students' smoking prevalence has not displayed the same consistent declining trend exhibited by the general public in HICs. Most college student smokers tend to be social and occasional smokers and some with these characteristics deny that they are smokers. Factors contributing to college students' initiation and maintenance include individual psychosocial factors, such as depression and body image dissatisfaction. Contextual factors, such as smoking norms formed by those around them, along with the smoking bans in the places where they live and study, also have impacts. Having a smoke-free campus environment is a critical and effective strategy to reduce college students' smoking, not only by restricting where smokers can smoke, but also motivating the transformation of social norms around smoking.

Smoking behaviours among immigrants may show various patterns in different subgroups, for gender, ethnicity and country of origin. Immigrants' smoking behaviours may be the result of complex interactions of multiple factors. Previous research has mostly

used quantitative methods to test statistical associations between demographic variables and smoking, while few studies have employed qualitative methods to hear immigrants' voices and explore how they feel about smoking and its regulation.

Chapter 4 Methodology

4.1 Chapter Overview

This chapter introduces the methodology employed in this research. Unlike most previous studies on smoking, this research uses a qualitative approach, which is explained in Section 4.2. Specifically, focus groups were conducted to collect qualitative data. Section 4.3 addresses the rationale of using focus groups, the process and outcomes of recruiting participants, the details of running the focus groups, and the subsequent data analysis. Ethical considerations and related reflexivity applied in this research are addressed in Section 4.4.

4.2 Qualitative research

Qualitative research is concerned about two fundamental questions: social structures and individual experiences (Winchester & Rofe, 2010). Individual experiences may be determined not only by a person's own characteristics but also by their positions in the social structure (Sayer, 1992). Unlike quantitative research, which employs a set of standardized methods borrowed from natural sciences to test hypotheses and assumptions, qualitative research uses 'a set of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self' to interpret the world and make it visible (Denzin & Lincoln, 1998: 3). It is particularly useful in revealing aspects of human experience that can be difficult to measure, including feelings, emotions, decision-making processes and experiences. A typical application of qualitative methods in human geography involves investigating how people experience places and events, based on the assumption that individuals experience the same places and events differently (Winchester & Rofe, 2010).

In tobacco control research, qualitative approaches has been commonly used, either independently or combined with quantitative methods. Where quantitative research can help researchers know, for example, how many people smoke or how many deaths were caused by smoking, qualitative methods contribute to the understandings of individuals'

experiences around smoking and SHS exposure. The current study focused on migrants' experiences around smoking when they move from one place to another. Qualitative methods in this research are selected as 'a form of systemic empirical inquiry' to help understand how people make sense of their experience (Shank, 2002: 5).

Based on knowledge that Canada and China display significant differences in smoking prevalence and the social environments around smoking, the Chinese immigrant community was selected as a case study. To make the research manageable and affordable, the focus was on Chinese migrants in Edmonton. In broad terms, Edmonton exhibits the general approach towards the spatial regulation of smoking in Canadian cities, with stringent and widespread smoking bans due to the combined effect of provincial laws and municipal by-laws. Chinese migrants in Edmonton represent the second largest visible minority group after South Asians (Statistics Canada, 2011). The Chinese group includes international students, who – for example – make up 10% of all students at University of Alberta.[9]

4.3 Focus groups

Interviews are one of the most commonly used tools in qualitative research, which may either be conducted with individuals or groups (Gill et al., 2008). Focus groups, or group interviews, are widely used by qualitative researchers (Stewart et al., 2007). The basic purpose of focus group is to gather qualitative data from groups of people who have common experience of a 'particular concrete situation' (Merton & Kendall, 1946: 541). In this research, all the participants have experienced the particular concrete situation of moving from China to Edmonton, and experiencing differences in the rules and social acceptance of smoking that apply in these places.

One remarkable difference between focus groups and individual interviews is that in focus group, participants interact with each other. This allows the researcher to observe how group dynamics influence people's perception, information processing and decision-making (Stewart et al., 2007). In smoking-related research, there is evidence that people's perceptions and attitudes around smoking will be influenced by people around them. This

[9] http://www-db.in.tum.de/teaching/ws1213/hsufg/20122013/alberta/website_alberta/uofa.html

could occur in a focus group setting. Simulating interactions among participants is also thought to generate more information in a short period of time than individual interviews (Morgan & Krueger, 1993). Also, it can yield incremental answers, which may go beyond the level of surface explanation (Stewart et al., 2007).

Focus groups are an established approach in studies of smoking and tobacco control. For example, 129 focus groups were conducted across the US in 2002 to explore adolescents' responses to actual and potential tobacco control policy issues (Crawford et al., 2002). In Canada, there have been studies using focus groups to investigate people's perceptions, attitudes, and behaviours related to various tobacco control policies, including the health warning labels and images on cigarette packages and smoke-free locations (e.g. Baillie et al., 2011; Herbert et al., 2011; Health Canada, 1999). In Edmonton, Tymko (2013) held four focus groups with young people to investigate their perceptions of and attitudes towards an Alberta law banning smoking in cars when children under 18 years are present. In China, Hu et al. (2012) conducted six focus groups, organized according to gender and smoking status, to investigate smoking-related social norms. These studies suggest that it is reasonable and effective to use focus groups to acquire the information about people's experience about smoking and tobacco control policies; they also provide detailed insights on procedures for conducting group discussions on these topics.

4.3.1 Recruiting Participants

Involving 8-12 participants in one focus group is appropriate for the moderator to manage and ensure that all the interactions and discussions remain on the topic of interest. In the current study, the original aim was to conduct eight focus groups with eight participants each (total: 64 participants). It was intended that four focus groups would be held with smokers, and four with non-smokers. Potential participants needed to meet several eligibility requirements: adults aged 18 years or older; originally from China, currently residing in Edmonton; and in Canada for less than three years. The three-year cut off was adopted to ensure that participants were relatively recent arrivals in Canada, and so were likely to remain aware of the differences between China and Canada, and not be strongly assimilated into Canadian society. In other words, those with less than three years'

residence in Canada are likely to be still "in transition" to the Canadian regulatory and social environment.

Posters were made to advertise this research and recruit participants. These were displayed on the University of Alberta campus, including in student residences, and other places where Chinese migrants are found, for example the immigrant service center located in the Chinatown of Edmonton. In addition, based on the researcher's experience, many Chinese migrants post and receive information via the Chinese Twitter (Weibo[10]) and a website named "EdmontonChina" [11] which is intended for information sharing within the Chinese immigrant community in Edmonton. Recruitment advertisements were therefore posted on these two social network platforms. Posters and advertisements online included a brief introduction of this research, the eligibility requirements, incentives for potential participants and the contact information of the researcher for receiving further inquiries. The text in the poster was written in three languages: traditional Chinese, simplified Chinese and English. An online sign-up sheet was provided for potential participants to indicate their basic information, their preferred date and time to attend the focus groups and contact information.[12]

Participants were asked to report their smoking status (they are considered current smokers if they have smoked during the past 30 days and the others were non-smokers) in their online sign-up sheet. According to the collected sign-up information, 20 smokers and 38 non-smokers were recruited and they were divided into 8 focus groups (3 for smokers and 5 for non-smokers). The eight focus groups were conducted from August to October in 2013. Some difficulties were encountered in recruiting smoking participants: this may be tentatively related to the lower smoking rates in immigrants, or to smokers having a higher level of discomfort about participation. Some efforts were made to cope with this situation. For example, posters specifically for recruiting smokers were distributed. In these posters, the confidential and voluntary nature of the research was emphasized. Additionally, the researcher used her personal social network to identify smokers, and participants who had already signed up were kindly asked to introduce this research to

[10] http://www.weibo.com/
[11] www.edmontonchina.ca
[12] https://formscentral.acrobat.com/app.html#d=ZHY*mUWdYTCTNpmTgpptgw

smokers they knew. This snowball sampling contributed to the formation of the three smokers' groups.

More detailed demographic information was collected prior to each focus group. Of 38 previously self-reported non-smokers, one participant reporting he/she had smoked during the past 30 days. Therefore, he was re-categorized as current smoker. This inconsistency is probably because that there was a waiting time between the date they signed up and actual focus groups being conducted. Of the 21 current smokers who signed up, those smoked more than one cigarette in average per day were categorized as daily-smokers, while others smoked less than one cigarette were considered occasional smokers. Additionally, three of these participants had picked up smoking after they migrated to Canada, but smoked less than one cigarette per day. Among the daily smokers, most smoked less than five cigarettes per day. Five participants of 37 actual non-smokers reporting that they smoked in China but had not smoked during the past 30 days in Canada were categorized as former smokers (See Table 4.1).

Table 4.1 also outlines participants' immigrant status. The vast majority of participants (84.5%) were international students, all but one of whom studied at the University of Alberta. This might have been due to students being more familiar with the campus environment where the focus groups occurred. Moreover, they may have more interested than other migrants in contributing to a research project. In addition, international students are generally short-term migrants, so most be eligible to participate in this study by virtue of being in Canada for less than three years. By contrast, many permanent residents would not be eligible. The large number of international students registered in undergraduate or graduate programs in University of Alberta also resulted in a high average education level among participants.

The focus group participants included 27 females and 31 males. The great majority of smokers (18/21, or 83.8%) were males. This is generally consistent with the gender difference of smoking prevalence in China. Additionally, related to the high level of student involvement, 37 of 58 were aged 18 to 25, and only two were over 40 years old.

Table 4.1 Focus group participant characteristics

Focus Group (FG)	Number of Participa-nts	Smoking Status				Immigrant Status	
		Smoker		Non-Smoker		International Student	Other
		Daily Smoker	Occasional Smoker	Former Smoker	Never Smoker		
1	9	0	0	2	7	6	3
2	7	0	1	0	6	7	0
3	7	0	0	0	7	5	2
4	7	4	3	0	0	5	2
5	7	0	0	3	4	4	3
6	7	2	5	0	0	7	0
7	8	0	0	0	8	8	0
8	6	5	1	0	0	6	0
Totals	58	11	10	5	32	48 (82.7%)	10 (17.2%)
		21 (36.2%)		37 (63.8%)			

4.3.2 Focus group discussions

The site for conducting focus groups was chosen in a seminar room in the Department of Earth and Atmospheric Sciences at University of Alberta campus. This room was only for the researcher and the participants during the focus groups in order to guarantee the confidentiality of the focus group discussions. To build a safe and comfortable environment for participants to tell their personal experience is a means to develop rapport, which will contribute to a better quality of data (Douglas, 1985). This also includes the 'trust and respect for the interviewees and the information they share' (Dicicco-Bloom & Crabtree, 2006: 40). The researcher made some efforts to achieve this. For example, after each participant entered the room for focus groups, he/she was greeted by the researcher, who had a small talk with him/her. In so doing, all participants might feel welcomed and relaxed before the official start of the focus group discussions. It was also explained that they could chose to participate in Cantonese, Mandarin and/or English, according to individual preference.

All participants were asked to read carefully and sign the informed consent form prior to each focus group. After that, participants were encouraged to fill in a basic

demographic questionnaire, covering their gender, age, former and current smoking status, and immigrant status. It was explained that the purpose of the questionnaire was to assist with data analysis, that answering the questions was voluntary and that their answers would be kept confidential.

Prior to each focus group, an interview guide was prepared with a list of questions on it. Too many questions and exclusively direct questions may lead to the decline in the depth of focus group discussion (Rook, 2003). To avoid this, the guide focused on open-ended questions addressing two overarching themes: smoking bans and social norms around smoking. People's experiences – including their perceptions, attitudes, behaviours and emotions – about these two themes were discussed. The prepared questions were intended as a guide to cover a range of relevant issues, but discussion was not limited to these issues. Questions were slightly different for smokers and non-smokers, mostly in terms of behaviours. To respond to the unanticipated mixture of smokers and non-smokers in two focus groups, questions were adjusted to make sure every participant was asked appropriate questions. Follow-up questions were also prepared for those participants who wanted to share more interesting details with us. At the end of each discussion, the researcher asked participants if they had anything else about smoking to share in order to seek more insights and also end the discussion that empowered the participants. At the conclusion of the focus groups, a $20 gift card was distributed to each participant to acknowledge their contribution.

At the beginning of each focus group, the researcher asked which city in China every participant came from, a question that perhaps seemed irrelevant but was intended as a starting point for participants to know each other and start talking. The next question was about participants' first impression of the differences in the smoking situations of China and Canada. This question is broad and unthreatening, which is a good way to open the topic and build rapport. Also the researcher avoided leading questions in order to encourage each participant to share their personal experiences in their own words unselfconsciously (Dicicco-Bloom & Crabtree, 2006). For example, in terms of the compliance with smoking regulations in China, the researcher did not ask questions like 'do you think the compliance in China is weak?' and instead asked 'how do you think and feel about the compliance with smoking regulations in China?'

4.3.3 Data Analysis

All discussions during focus groups were digitally audio-recorded with all participants' permission. Two recorders were used in case the data in any of the recorder was missing. Only one participant spoke Cantonese during the focus groups, with all others speaking Mandarin. The researcher therefore transcribed participants' words verbatim to Chinese first. After that, the transcriptions in Chinese were translated into English for the following data analysis.

Qualitative content analysis was used to analyze the focus group data in this research. It uses a set of codes to categorize similar materials into data segments (Rothwell, 2010). The data analysis process started with the researcher becoming familiar with data by transcribing the audio files, translating them into English, and reading through all the transcriptions. To reduce the subjectivity of single analyst and also get potentially richer understandings of codes, three transcriptions were randomly selected to be coded collaboratively by two analysts, the researcher and her supervisor (Krueger, 2009). Discussions generally centered on the following aspects: SHS, smoking, smokers, smoking bans and social norms regarding smoking in both countries. According to the frequency of points discussed by participants and their relevance to this research, some initial codes were identified through this approach: non-smoking participants' dislike of smoking and SHS and changes in this after migration, the more extensive smoke-free environments and stronger enforcement in Canada, gifting and sharing cigarettes dominant in Chinese people's smoking, social status of smoking in Canada, reducing smoking after migrating to Canada, and bringing Chinese cigarettes to Canada.

Then the research question and objectives were taken as a template to re-categorize these initial codes into a system of broader themes. Specifically, they were organized into four themes relating to aspects of people's experiences: perceptions, attitudes, behaviours and emotions. Perceptions included their knowledge of smoke-free policies and how they thought about the social status of, and public attitudes towards, smoking in Canadian society. Attitudes included participants' statements regarding their personal preference. Behaviours included the reported behavioural changes that actual happened on participants or people around them after migration, such as reduction of smoking and

importation of Chinese cigarettes. Finally, emotions include direct references to different felt experiences, such as irritation and hate, and being miserable or happy.

After reading through and coding all eight transcripts, the "cut and paste" technique was used to put all excerpts relating to the same theme into one document (Stewart et al., 2007). It was found that some quotes could be categorized into multiple themes. For example, non-smoking participants reported that they felt 'cared and respected' in Canada. This could be understood as people's perception of social norms in Canada that non-smokers' health rights are respected. Also it could be put under the theme of emotional experiences, comparing with feeling 'ignored' and 'bullied' in China. Details of the themes and codes are illustrated in Table 4.2.

Table 4.2 List of focus groups codes categorized into themes

Themes		Codes	
		China	**Canada**
Perceptions	Smoking	Generally higher prevalence. Fewer female smokers.	More female smokers.
		Health harms (physical) and benefits (mental)	
	Smoking bans	No 100% smoke-free indoor places. Weak enforcement and compliance.	Smoke-free indoor places. Restrictions outdoors and on private property. Strong enforcement
	Smoking norms	A social culture. Sharing and gifting cigarettes. Representative of social status. Male smoking is highly accepted. Low acceptance of and tolerance for female smoking.	Smoking is a personal habit and choice. Less social pressure to smoke. Social acceptance low in regulated areas but high in unregulated areas.
Attitudes	Smoking and smokers	Less tolerance for cigarettes going back from Canada. Smokers are irresponsible.	Smokers behave themselves, care for others. Smoking status relates to SES.
	Smoking bans	Weak Understandable Don't criticize China so strongly.	Agree/happy/acceptable Smokers will experience loss of freedom. Smokers may like it as well.
	Smoking norms	Abnormal/ unhealthy. Should be removed.	Support
Behaviours	Cigarettes and smoking	Prevalent smoking contributed by the good taste and relatively lower price.	Loyalty to Chinese brands. Bring cigarettes from China. Gifting.
	Smoking bans	Smoking almost everywhere tolerated by weak smoking bans.	Changes in smoking sites. Decreased and quit.
	Smoking norms	Easy to pick up and hard to quit because of social norms. Smoke more when back in China	No smoking partner. No people offer cigarettes
Emotions	Smoking	Fragrant, taste good, packs are beautiful. Smokers are smelly.	Canadian brands taste bad and are expensive. Packs are disgusting.
	Smoking bans	SHS: annoying, upset, outraged. Smokers: more comfortable.	Non-smokers: happy, comfortable. Smokers: irritated, upset.
	Smoking norms	Imposed, bullied, forced	Understand and respect each other. Free to choose.

4.3.4 Ethics and Reflexivity

This research was approved by the University of Alberta Human Research Ethics Board. To respect participants' rights to privacy and confidentiality, all focus groups were conducted in a room with only the researcher and participants present. Since during the focus group, personal details might be shared among participants, the researcher requested that participants not discuss this information outside the focus group. The discussions were digitally recorded and in the transcription process, all comments were anonymized. Participants' personal information could not be identified in the transcriptions, nor in this thesis. All documents about the research were kept in a password-protected computer in a safe room with authorized entry in University of Alberta.

Participants had full autonomy to decide whether or not like to participate in the focus group, as indicated on the official informed consent form. During the process of focus groups, each participant had the freedom to answer questions or stay silent. Also, there was the potential for both physical and social harms: asking participants about their experience and attitudes towards smoking and its restriction may have been upsetting or potentially psychologically damaging. To cater to this possibility, the researcher explained prior to the focus groups that answering questions was voluntary and that participants could refuse to answer the questions they felt uncomfortable with.

Since research is an ongoing process where there will be something unexpected and uncontrollable, it requires the researcher to keep constant attention and self-critical awareness of ethical research conduct (Dowling, 2010). Reflexivity is defined as 'self-critical sympathetic introspection and the self-conscious analytical scrutiny of self as a researcher' (England, 1994: 82). Power relationship is an important consideration with regards to reflexivity. In terms of power relations between participants and the researcher, questions were worded so as to avoid any impression of authority. For example, participants were asked how they perceived the social acceptance of smoking in Canada; they was no elaboration on the concept of denormalization of smoking in most HICs. The researcher was also conscious about the power disparity between participants. For example, some participants were more talkative than others; she encouraged the quiet participants to talk by asking some questions that were easy to answer.

4.4 Conclusion

This chapter detailed the methods employed in this study. The rationale for a qualitative approach was explained. Focus groups were conducted to collect data. Several approaches were used to recruit participants and during the focus groups. Most of the participants eventually recruited were international students from University of Alberta. Focus group questions focused on participants' perceptions, attitudes, behaviours and emotions regarding smoking and smoking environments in both China and Edmonton, and the transition between them. All the discussions were digitally recorded, transcribed verbatim in Chinese, and then translated to English for further coding and data analysis. Content analysis was used to analyze the qualitative data. A set of codes were identified through reading the transcriptions and categorized into different themes. All aspects of this research were conducted with keeping ethical considerations in mind.

Chapter 5 Results

5.1 Chapter Overview

This chapter illustrates the themes identified in Chapter 4 – perceptions, attitudes, behaviours and emotions around smoking. For each theme, participants' quotations are used to support the results. Section 5.2 introduces participants' perceptions of smoking and smoking-related environments, which are different in China and Canada. People's perceptions may have impacts on their attitudes, which are discussed in Section 5.3. Section 5.4 outlines people's behaviours associated with the changing smoking contexts after they migrated. In Section 5.5, people's emotional experiences in adjusting to the new contexts are illustrated.

5.2 Participants' Perceptions of Smoking

5.2.1 Smoking, SHS and Smokers

The health consequences of smoking were among the most discussed topics in the focus groups. Non-smokers emphasized the perceived harms of smoking to smokers and SHS to non-smokers. For example, one participant working as a doctor reported her experiences with patients having smoking-related diseases:

> In my work, there were some patients with throat-cancer and their throats were too horrible to look at, even for us doctors. Some patients could not speak, because of some complications on their throat caused by smoking. In the final stages, it could not be healed. (FG4, Non-smoker, Female)

> I used to take a part-time job in a fair where there is a casino beside it. After I entered the lobby of the casino, I felt strongly the smell of SHS and I was thinking that if I were to be staying here for the whole day, I would definitely die. (FG2, Non-smoker, Male)

Smokers mentioned perceived health risks of smoking much less frequently than non-smokers did. Instead, they argued that diseases caused by smoking would not necessarily occur to everyone due to individual uniqueness. Additionally, smoking participants were prone to bring up some other lifestyles that were harmful but commonly practiced by people:

> To supplement, I know smoking is harmful to health, but I think there should be a balance for everything. For example, what food is still safe to eat in China? They are all harmful to health. Drinking Coca-Cola is also harmful to health. You have to handle the balance by yourself. (FG5, Smoker, Male)

> When people talk about the adverse consequences of smoking, there are a lot of other stuff harmful to people too, for example going to bed too late at night. (FG8, Smoker, Male)

Moreover, smokers also perceived benefits of smoking centered on mental health, which non-smokers would never feel and understand, such as helping them release pressure, keep a clear mind and get a better mood:

> If smoking can make you feel better in other respects, like your living status, your mental status, your jobs, you will live longer too. If you get a bad mood due to not smoking, it is pointless. (FG8, Smoker, Male)

> [Smoking is] a release of pressure. Maybe it is not actual release from a biological perspective, but there will be effects psychologically. (FG8, Smoker, Male)

Related to non-smokers' negative perceptions of SHS were their understandings of smokers. Some argued that smokers are likely to be less educated, because educated people know better about the adverse consequences of active smoking and SHS:

> I think educational level matters in the decisions on smoking. Students who smoke here [at the University of Alberta] are mostly undergraduates and they dress like 'that kind of person'. I think graduate students may have a better understanding of potential adverse consequences caused by smoking. (FG7, Non-smoker, Male)

> I think the educational level really matters. If the family has a higher family income or educational level, they will have a lower tolerance of smoking …… (FG2, Smoker, Male)

> Among people I know, those with high SES really seldom smoke. Those smokers I have seen before were all dressed in a weird way and less educated. This might be not that accurate but it is the case among people I know. So I may have this 'bias'. (FG3, Non-smoker, Female)

Some others denied seeing the relationship between smoking and SES. This was mostly linked to the noticeable price gap between cigarettes in different brands in China.

> M2: It is hard to say.
> F2: The rich have their pressure and they also need smoking to relieve it.
> M2: You need to look at brands of cigarettes they are smoking.
> F1: It is totally different between a man smoking outside Hilton [Hotel] and another one smoking outside Tim Horton's.
> (FG7, Non-smokers)

5.2.2 Smoke-free Environments

Participants were also asked their perceptions on smoking regulations, using questions such as 'where do you know smoking is banned in China and Canada?' As for smoking bans in China, participants mostly answered by naming certain places. The most frequently mentioned places included hospitals, gas stations, libraries, and shopping malls.

With regards to Canada, they had the knowledge of 100% smoke-free public indoor environment:

> Here [in Canada] you have to go to outside for smoking. (FG2, Non-Smoker, Female)

> I do not know very well about the policy here [in Canada]. Seemingly, you cannot smoke in indoor spaces. (FG3, Non-smoker, Female)

> M2: Sometimes I smoke with my friends and we all have to smoke outdoors in the street and then go back indoors.
> M3: You cannot smoke in all indoor places.
> (FG8, Smokers)

Some participants also addressed their perceptions on outdoor smoking bans in Canada, such as some distances to building entrances and outdoor settings of certain spaces:

> You cannot smoke within 5m of the entrance of restaurants and libraries. (FG4, Smoker, Male)

> I notice on the library door that smoking is not allowed within 5m of the entrance. (FG5, Non-smoker, Female)

> I once took LRT to the stadium station and noticed that even though the station is outdoors, smoking is not allowed there. And there is a sign there saying there will be penalties. (FG6, Smoker, Female)

In contrast with the accurate perceptions of the scope of smoking bans in Canada, only two participants knew of the 2011 rule on smoke-free public places in China. Participants were also asked in which country there are more people breaking smoking

rules. It was a common perception that compliance with smoking regulations in China is weak. For example, when answering where smoking is allowed in China, some participants used words such as ‘everywhere’ and ‘wherever you want’ (e.g. FG6, Smoker, Male) to suggest the weak compliance with smoking regulations:

> That smoking is not allowed in all public spaces has been claimed in China for years but this has never really come true. The rules have been active for years without comprehensive outcomes. (FG3, Non-smoker, Female)

> [In China] there are a lot of no-smoking signs, but no one will comply with them. Smoking is not allowed in hospitals, buses, kindergartens, classrooms and teaching buildings including the hallways, but no one complies with it. (FG2, Non-smoker, Male)

> [In China] I know there are some primary or high schools where smoking is not allowed, but teachers will hide in the classroom for smoking. (FG2, Non-smoker, Male)

Disregard for smoking bans in China was attributed in part to weak enforcement, which was related to the revenue contribution of tobacco industry. Smokers continue smoking in smoke-free environments, which is generally tolerated by not only non-smokers as mentioned above, but also by officials who fail to enforce no-smoking rules:

> In China, the reason that tobacco control is so feeble is that cigarettes contribute large amounts of profits and revenues. Those smoke-free rules are merely for display. Those who ever smoked in Express Trains or domestic airlines were not punished or fined, with only oral education instead. (FG1, Non-smoker, Male)

In contrast, participants perceived that few if any people broke smoking bans in Canada:

So far, I have not seen any people breaking the law here. (FG3, Non-smoker, Female)

M1: I've never seen that.
M2: I think people behave themselves.
M3: I seldom see people smoking indoors.
(FG4, Smokers)

Smokers' compliance with smoking bans in Canada was partly attributed to the perceived consequences:

[In Canada] If you live in a smoke-free environment but you smoke, you will be fined, punished or even kicked out. This is never going to happen in China. People in China will just persuade you verbally again and again like 'Shut the cigarettes off!' However, you will be kicked out if you are here in Canada. (FG8, Smoker, Male)

You'll get a $250 ticket if you smoke in public places. I often see that sign when I am waiting for the bus. (FG3, Non-smoker, Female)

Participants also reported their perception that stringent smoking bans made smoking more inconvenient and complicated, and that this would contribute to reduced consumption:

Here in Edmonton, you are not allowed to smoke in a lot of places and it is inconvenient for smoking. (FG1, Non-smoker, Female)

I think restrictions on where you can smoke are about the complication level of smoking. In China, like the domestic airports or gas stations, tobacco control in those places is performed well. Maybe it is because

> restrictions in those places are strict and you have to go out of the airport to smoke and then go back; if you want to smoke again, you have to go out again. Therefore, for them who are not that eager for smoking, they might not smoke for it is too complicated. This also works for those with smoking addictions. (FG2, Non-smoker, Male)

One participant stressed that the way smoking regulations are considered by smokers eventually depends on their own willingness to quit or not:

> I don't think smokers will like to come here. When my uncle, a heavy smoker, makes a plan to travel abroad, whether he is allowed to smoke without restrictions or not is a major concern of his. …I think, if he indeed wants to quit, he may think the stringent rules a good thing as an external force to quit; but if he doesn't, he will consider how the smoke-free rules influence himself and his habit. (FG1, Non-smoker, Male)

5.2.3 Prevalence, Regulations and Social Status of Smoking

The scope and enforcement of smoking bans contribute to participants' different perceptions of social status of smoking in Canada and China. Some reported that the stricter smoking bans reflect lower social acceptance of smoking in Canada. In this case, the perceived high social acceptance of smoking in China also related to seeing smokers almost everywhere in China, even in regulated places:

> Social acceptance of smoking here is definitely much lower here. In China, you can smoke almost everywhere except some coffee shops, shopping malls or trains. You can smoke in most places. It will take China at least ten years to catch up with Canada. (FG8, Smoker, Male)

> It [social acceptance of smoking] is totally different between Canada and China. I used to enter one restaurant where all the waiters were smoking in it. Then I asked them if they could stop smoking then they got very mad at

> me. It was like you shouldn't expect people not to smoke in places like here. (FG5, Non-smoker, Female)

When smoking bans were broken in China, the silence of non-smokers on the spot also reflected the high social tolerance for smoking and smokers:

> I think Chinese people are more tolerant. Even though they feel uncomfortable about it [smoking], they will not appeal to the law. At most times, they just avoid it instead of taking measures to control or tackle this problem. (FG5, Non-smoker, Female)

While stringent smoking bans contributed to most participants' perception of low social acceptance of smoking in Canada, some reported that these same bans made smoking quite visible in Canada, by requiring it to take place outdoors:

> Here in Canada, you can only smoke outdoors or in several specific concentrated spots. You can always see people smoking in these places so that you will feel that there are a lot of people who smoke here. Actually, the proportion of smokers here is much lower than that in China. In China, you can smoke everywhere including indoor spaces. Most people over 40 years old smoke, mostly in their offices. (FG8, Smoker, Male)

> F1: I think there are also many smokers here [in Canada]. I often see people smoking outside the Cameron Library [at the University of Alberta].
> M4: If you specifically look at that spot, you will definitely see a lot.
> (FG8, Smokers)

Smoking bans influence participants' perception of social acceptance of smoking in another way. Smoking participants who complied with the smoking bans and limited where they smoke in Canada mostly denied being less accepted, or less tolerated, on the

basis of their smoking status. This was because they smoked outdoors and were not perceived to harm others. Some non-smokers also reported similar perceptions.

> The rules here are strict; however, as long as you smoke in certain places, the tolerance is high. (FG6, Smoker, Female)

> Even though I did not see anyone breaking the bans, I do think the tolerance here is pretty high. If you want to smoke, just go to somewhere smoking is allowed. Sometimes there will be others coming to you and asking for cigarettes. (FG2, Smoker, Male)

Participants stressed that smoking following the rules is personal choice and should not be judged:

> Do you want to say that smokers are 'heresy'? I do not feel that. I think it is a place respecting personal choice and freedom here. As long as I do not influence others, that is my own business. I do not think anyone sitting here will have that kind of feelings. (FG8, Smoker, Male)

> I think the acceptance and tolerance in China and Canada are similar. For here, as long as you do not break the rules, it is your personal choice whether you smoke or not. (FG7, Non-smoker, Female)

> Anyway I do not feel shameful about that (FG8, Smoker, Male).

One participant felt himself to be 'an idiot' when he smoked outside; however, smoking together with others alleviated this feeling:

> For example, in winter, when I smoked outside the LRT station, I did think that people inside the station looked at me and thought me as an idiot. Because smoking is bad to health and it was so cold outside. But if I were

> smoking with another one person, I would not feel like that (FG8, Smoker, Male).

Smokers who perceived similar levels of social acceptance for smoking in the two countries also mentioned that locally-born people approached them and asked for cigarettes:

> There are also a lot of people smoking here [in Canada] and there are also people coming up to me and ask for cigarettes. (F6, Smoker, Female)

> Once I was waiting for bus at Southgate Mall and there were four people coming up and asking for cigarettes from me during 20min. (FG6, Smoker, Male)

Other than smoking bans, the perceived number and profile of smokers also contributed to participants' perceptions. Most participants reported that there were fewer smokers in Canada than in China. The perceived lower smoking prevalence contributed to people's perception that smoking is less accepted in Canada than in China:

> In China, smokers account for the larger group. At most times, non-smokers are those who will be isolated and criticized. Here, smokers are in a small group who are criticized. When I was in my undergraduate, I watched 'Friends', in which there was one episode about Chandler being criticized by everyone for smoking. I think this situation will never happen in China. (FG5, Non-smoker, Male)

> I think non-smoking is normal here [in Canada]. Most people hate it. Yes, I think most people oppose smoking here. (FG4, Smoker, Male)

Most participants reported that they perceived a much higher female smoking rate in Canada than in China. The higher visibility of female smoking could contribute to perceptions of higher social tolerance for smokers in Canada:

> I notice that there are lots of females smoking [in Canada]. I often saw middle-aged females standing on the street and smoking. This is uncommon in China. (FG7, Non-smoker, Female)

> After I came here, I was also shocked by the rates of girls' smoking. From this respect, smoking is more accepted and tolerated here. (FG3, Non-smoker, Female)

Perceptions were influenced not only by the number of smokers, but also by the social status of smokers. The perceived high acceptance in China also related to smoking being accepted across the socio-economic spectrum:

> From leaders and managers to ordinary staff in governmental organizations, national enterprises and public-sector organizations, people [in China] smoke. (FG1, Non-smoker, Male)

> In terms of social acceptance and tolerance, I think tolerance [for smoking] here is lower than that in China. In China, bosses in companies and even national leaders smoke when they are in a meeting. This will influence the ordinary people. (FG4, Smoker, Male)

Smokers in China may have various backgrounds, while participants perceived that homeless and Aboriginal people in Canada have higher likelihood of smoking. In contrast with high smoking prevalence in various professions in China, one participant reported that smokers are not welcome in some companies in Canada.

> M5: Those who asked me [for cigarettes] were homeless people.

F2: They are mostly Aboriginals, I guess. They are poorer.
F1: I used to see an interview tip here; it said that actually most companies do not like smokers.
(FG6, Smokers)

5.2.4 Smoking as a Social Practice

Participants' perceptions of the high social acceptance of and tolerance for smoking in China were also generated from the perceived various social functions of cigarettes in Chinese people's everyday life. These functions included smoking being a commonly-expected behaviour when Chinese males get together in daily life and work: refusing others' offers of cigarettes makes a person 'impolite' and disadvantaged them in socializing:

> I think smoking is a social custom. If people offer you cigarettes and you do not take it, the distance between you and them will be extended. If you take it, you two get closer. If you don't, people will say like 'Look at him! He is so good at pretending!' (FG6, Non-smoker, Male)

> Sometimes maybe you do not even like smoking or you hate smoking strongly, but if you do not smoke, you will feel so hard to get involved in this circle. Gradually you will be chased out of the circle and there will be a lot of harms if you are an outsider. (FG2, Smoker, Male)

Cigarettes, usually coupled with drinking alcohol, are routinely used in social contexts including holidays, big events such as weddings, and business talks:

> Occasionally, if there are some holidays or Chinese traditional festival, I will smoke one or two. (FG2, Smoker, Male)

> Smoking is highly accepted in China. Most fields share the agreement that smoking and drinking alcohol are important social customs. In China, smoking and drinking alcohol are 'abilities'. (FG7, Non-smoker, Male)

> It is necessary to prepare both cigarettes and drinks in weddings. Fortunately for now, if you like to smoke, it is fine and cigarettes will still be put on the table and you can take it anytime you want to smoke. (FG2, Smoker, Male)

Additionally, cigarettes are an important gift for building connections in Chinese society regardless of whether the recipients smoke or not:

> Even though there is no one in your family smoking, people still give you cigarettes as gifts. Because cigarettes have been labeled as gifts and I will give you cigarettes anyway, no matter if you have smokers in your family. (FG4, Smoker, Female)

In China, cigarettes were also perceived a sign of people's socio-economic status. This relates to the huge price gap between Chinese cigarettes in different brands:

> Additionally, there are indeed some good cigarettes in China. When you smoke them, you are claiming your social status. There are no such things here. (FG4, Smoker, Male)

> [Offering cigarettes as gifts] It is about the 'face', not the actual demand. This will also contribute to people's vanity in comparing the brands and prices of cigarettes. (FG4, Smoker, Female)

The Chinese norm of sharing and gifting cigarettes was reported to persist among Chinese migrants in Edmonton. Participants conveyed their personal experiences that Chinese cigarettes are still very welcome among Chinese migrants:

> The first time I came here, the guy who picked up me from the airport started our conversation with 'do you bring any Chinese cigarettes with you?' Seemingly Chinese cigarettes are really welcome here. If you want to seek someone for help here, you will not have to pay money, instead you can offer cigarettes. (FG1, Non-smoker, Male)

Some participants suggested that, in Canadian society, smoking sometimes acts as a social custom as well, however this is less common than in China:

> Additionally, cigarette is a social manner as well; sometimes I went to the pub with some White friends and we occasionally smoked too. But I smoked more in China. (FG5, Smoker, Male)

> F3: I think it is the case here that smoking can be a social custom, but it is less common here than in China.
> F4: Yes, in my MBA class here, those who smoke get closer.
> (FG7, Non-smokers)

There were both smoking and non-smoking participants addressing the normality of taking cigarettes as gifts by attributing it to cultural origin and describing it as an important way to maintain the bonds between people in China. This smoking-favourable culture was also considered prior to mandated anti-smoking regulations.

> In China, the cigarette is a tool for socializing and showing your kindness and this is not the case here. I think it is about the culture. When you get together with you friends and classmates, offering others cigarettes makes you look like polite. (FG4, Smoker, Male)

> It is about the cultural image. Coffee is the culture in Europe and America; smoking and drinking are cultures in China. During the short break for a

> cigarette, people can talk with each other. Additionally, in China it is relationship first then law. Law is last in the order. If everyone agrees smoking is beneficial for their relationships with each other, then law could do nothing. (FG5, Non-smoker, Male)

Even though socio-cultural contexts were considered to play a decisive role in forming Chinese smokers' behaviours, one participant borrowed the example of Hong Kong to illustrate that, even though Hong Kong used to have similar smoking-related cultural origins with China, strong enforcement of smoking bans, such as introducing punishment, can effectively reduce smoking:

> To be simple, comparing Hong Kong and the mainland, both two places have large amounts of population and share similar culture…. In Hong Kong, there were large amounts of smokers; but as long as the rule that smoking is not allowed indoors came out, people comply with it. As he mentioned just now, the cost of breaking laws [in China] is so low. (FG5, Non-smoker, female)

In comparison with China, the social force in Canada is much weaker and personal choice of smoking or not is more respected:

> Here nobody will push you and they are straightforward. In China, if people offer you cigarettes and drinks but you turned them down, they would have other bad thoughts of you, mostly they would think you were looking down on them. Here, people will not force you to do anything and you can just speak out yes or no. (FG5, Non-smoker, Male)

Participants reported that sharing cigarettes in China could contribute to smoking uptake and hinder quitting. By contrast, Canada could be helpful for reducing smoking, with fewer people offering smokers cigarettes and pushing them to smoke:

> Environment around people matters. If there is no one offering you cigarettes, you will not think of smoking. (FG6, Smoker, Male)

> There are people influencing others and there are people who are easier to be influenced by others. For the latter, if they want to quit smoking in China and others offer him cigarettes, he will not turn them down; if they are here, there is no one offering cigarettes to them, they will quit naturally. There is no one here pushing you to smoke here, while there are indeed a lot of people forcing you to smoke in China. (FG3, Non-smoker, Female)

> I have an uncle who has business both in China and the U.S. However, he did not have to smoke that much when he was doing business in the U.S. Because in the US, people will respect you and they will not isolate you just because you don't smoke or drink. But in China, if I buy you some good things but you don't eat, you are disrespecting me. (FG3, Non-smoker, Female)

5.2.5 Summary

In summary, participants reported their perceptions on both social and regulatory environments around smoking in China and Canada. It is commonly perceived that smoking is highly accepted and tolerated in China. This is reflected in high smoking rates, less regulated smoking in public spaces, and the various social functions of smoking. Participants recognized that smoking bans in China have a smaller scope, and that in addition there is weak compliance with regulations that do exist.

Although smoking has generally high social acceptance in China, this does not extend to female smoking. The higher prevalence of female smoking in Canada, along with other factors, contributed to some participants' perception of tolerance for smoking in Canada. Importantly, social acceptance of and tolerance for smoking in Canada relates to where smoking occurs and whether it influences others. It was perceived that there was zero tolerance for smoking in regulated places, but that it remained highly accepted and tolerated in unregulated areas. Even though smoking and smokers are less common and

make up a minority of population for both genders, smoking participants barely ever felt being stigmatized. This was attributed to their compliance with smoking bans.

5.3 Participants' attitudes towards smoking and its regulations

One of the key purposes of the focus groups was to examine participants' attitudes towards smoking and its regulation, and whether their attitudes changed after they arrived in Canada from China. Additionally, analysis of focus group transcripts sought to identify differences and similarities between the attitudes of non-smokers and smokers, which were also connected to gender differences.

5.3.1 Smoking and SHS

Generally, non-smoking participants held negative attitudes towards smoking, based on widely perceived harms of smoking to people's health. The negative attitudes related to both the health consequences for smokers and the harms to non-smokers caused by SHS. This was sometimes informed by a view that exposure to SHS causes more harms than active smoking. Therefore, their negative attitudes towards smoking may be exacerbated if SHS could be inhaled almost everywhere. Some non-smoking participants claimed that, as long as others are not forced to inhale SHS, they would and should respect smokers' personal choice and right to smoke:

> I hate SHS strongly because it is even more harmful than the first-hand smoke. … I will not let myself be exposed to the SHS. (FG7, Non-smoker, Male)

> When smokers smoke, they are enjoying it, while it will be more harmful to us non-smokers. … If you can guarantee that your habit will not cause others harms or miseries, then there will be no problem. (FG3, Non-smoker, Female)

> You cannot request everyone to quit. To create a place for them to smoke where we do not have to suffer from SHS at the same time, it is nice. (FG3, Non-smoker, Female)

Some participants reported a higher level of negative attitudes towards smoking and SHS when they went back to China after they had stayed in Canada for a while, because they could smell the SHS almost everywhere. These comments suggested that in Canada they had become acculturated to the norm of smoke-free air, which made exposure to SHS during trips back to China especially unpleasant:

> I did not take smoking seriously and was not that sensitive to cigarettes when I was in China…Yet when I went back to China from here, I found smoking really annoying. (FG1, Non-smoker, Female)

> My tolerance for smoking decreased after I came to Canada. I was insensitive to the smell of cigarettes. Maybe it is due to the better air quality here that when I came back to China, I could easily smell cigarettes my dad left in the home or cars. (FG2, Non-smoker, Female)

> I used to have a lot of people smoking around me and there were only a few places where smoking was not allowed [in China]. After living here for a while, I became very sensitive to the smells of cigarettes, which got more and more unbearable for me. ……My tolerance for smoking is decreasing. In the past, I felt that ten people smoking in front of me was unbearable but I was OK with only one or two, but now I cannot stand even only one person smoking beside me. (FG3, Non-smoker, Female)

Participants reported people held a common negative attitude towards female smoking in China; however, this attitude has changed after they came to Canada. The relative popularity of smoking among women in Canada (14%; Health Canada, 2013), changed their original impression of female smoking. Some participants reported that

female smoking in China is uncommon and often related to low educational level. In contrast, they used words such as 'pretty' and 'fancy' to describe the female smokers they saw in Canada. There was one female participant noting that she would probably have a try:

> There is a little change in my attitude towards girls' smoking. When I was in China, girls who smoke are considered bad kids with bad academic performance … [in Canada] on my way to school, there would be pretty girls smoking lady's cigarettes in one hand with the other hand holding coffee, talking with each other. That's very beautiful and I'm thinking maybe sometimes I can try. (FG2, Non-smoker, Female)

> After going back to China from here, psychologically, my acceptance for smoking of Chinese people may become even higher than before. (FG3, Non-smoker, Female)

> I feel that there are a lot of women who smoke here and the proportion is higher [than in China]. Sometimes I went to the supermarket and might walk across a business-used building, seeing that many women chatting and smoking, which looks like very fancy. (FG1, Non-smoker, Female)

5.3.2 Smoking Regulations

Related to non-smokers' common attitudes towards smoking and SHS, they not surprisingly expressed their disappointment about weak smoking regulations in China. They appreciated and supported stricter smoking bans in Canada, which create a 100% smoke-free indoor public environment for non-smokers and keep them away from SHS:

> I just hope everywhere could be like here in Canada that you can only smoke in some specific sites and smoking is banned in some places. (FG1, Non-smoker, Female)

When non-smokers reported a high level of support for smoking bans, there was one non-smoking participant expressing her worry that too stringent smoking bans may cause the isolation of smokers:

> I think this [strict smoking regulations in Canada] might be creating a gap between different groups. It is not that right generally. I think there will be better methods other than chasing smokers to a restricted place. It looks like, uh, discrimination. I think everyone has habits that may influence others, in different extents. Just imagine that your habit is labeled and ruled and you can only perform it in a certain place, you will feel isolated and discriminated. (FG3, Non-smoker, Female)

Smoking participants displayed various attitudes towards smoking regulations in Canada. Some reported that they do not hate stricter smoking bans in Canada. One of reasons for this is spatial in that they still have somewhere to go for smoking, as it is not completely banned.

> M2: No big difference [between two countries].
> M1: I agree with that. It is similar. You are allowed to smoke in both countries.
> M2: Just go to somewhere smoking is allowed.
> F1: Yes, you can just go downstairs and outdoors.
> (FG8, Smokers)

The other perceived factor influencing participants' attitudes is smoking status. Smoking bans in Canada were understood to force people to reduce smoking frequency and amounts; hence, it was suggested that heavy smokers may encounter more troubles in this process, while lighter smokers may have a much easier time in adjusting to new regulations:

> Our addiction is not so strong that we cannot be significantly influenced by the stricter smoking bans here. I think those heavy smokers may find it is troublesome here. (FG6, Smoker, Male)

> I smoke not very a lot so I did not see many changes. (FG8, Smoker, Female)

Not surprisingly, smoking participants also expressed that smoke-free public indoor environment may lead to their loss of freedom. Especially in cities like Edmonton, being required to smoke outdoors causes particular inconvenience, because of extremely low temperatures in wintertime:

> I think smoking rules here are good for non-smokers. However, for smokers, it'll be inconvenient. Smoking is not allowed in many places and their freedom to smoke may be influenced. If you break the rules here, there will be problems. (FG7, Smoker, Male)

> In China, I could smoke at home whenever I want. Here you have to go out. It is too cold and too long in the winter. You will not want to go outside. Gradually you will smoke less. I hope smoking will be allowed indoors in the winter, such as the stairs. Then we feel better in winter. (FG4, smoker, male)

> I hope smoking can be allowed in bars. There is just that atmosphere in bars but now the rules break this atmosphere. (FG6, Smoker, Female)

Even though smokers' behaviours are restricted, some expressed their support for smoking regulations based on several considerations. Some understood that SHS causes harms to non-smokers, whose health rights should also be respected. Importantly, in Canada, smoking bans are comprehensive in scope, implemented by powerful agencies, and levels of compliance are generally high. For those smokers who want to quit but failed

to do so in China, stricter smoking bans in Canada, as a powerful external pressure, can be supportive:

> M1: I think smoking bans here respect those non-smokers and they are not bad and protect the health of most people.
> M2: Also, they protect myself. These bans make me to smoke less, because you know, you cannot smoke indoors.
> (FG8, Smokers)

> The environment here is more helpful for me to quit and have a healthier life. (FG6, Smoker, Male)

5.3.3 Attitudes Towards Smokers

Non-smokers and smokers reported different attitudes towards smokers. One female non-smoking participant suggested that while smoking status would not be her one and only reference to judge others, it indeed influences her preferences:

> I think I cannot judge a person only according to whether he smokes or not. But whether he smokes or not does have impacts on my decisions on if I should make friends with him. (FG7, Non-smoker, Female)

In contrast, smoking participants displayed more positive attitudes towards smokers. Some reported they were more likely to make friends with smokers. This is related to the perceived positive role of smoking in socializing.

> Smoking influences whether you can get close to others or not. For myself, I prefer to talk with males who smoke. For example, if ten persons hang out together and three of them need to go outside for smoking, they will talk about some deeper and closer topics. That is quite normal and it is the truth. (FG8, Smoker, Male)

Given concerns about the harms of SHS, non-smokers complained that smokers in China disrespect and care less about others, because they continue to smoke almost everywhere. In contrast, they appreciated smokers in Canada who behave themselves and respect others' rights to enjoy a healthy environment, by complying with widespread smoking bans and limiting where they smoke:

> People here care more about the impacts of SHS on their families, especially their children. However, in China, no one cares about it. (FG5, Non-smoker, Female)

> In Canada, I feel respected; while in China, I feel ignored. (FG3, Non-smoker, Female)

As mentioned above, non-smokers felt imposed upon and annoyed in China due to the high prevalence of smoking and insufficient smoking regulations. Some respondents argued that, even though in Canada non-smokers are 'normal' and smoking bans are powerful, there is no tendency to marginalize or discriminate smokers. Instead, smoking bans in Canada contributed to smoothing tensions and promoting mutual agreement or understanding between two groups:

> I don't think they [smokers] are discriminated against by us. Rules aim at keeping the interest of both two groups. If they should be discriminated against, why not completely ban smoking? I think rules protect both two groups and try to avoid conflicts of interest. (FG7, Non-smoker, Female)

> I think different groups should understand each other. Under any circumstance, you should give some understanding and tolerance to those minorities. Policy makers should consider minorities' opinions in policy-making process. (FG3, Non-smoker, Female)

> There are rules here protecting the rights of non-smokers to keep the harmony of non-smokers and smokers. In China, non-smokers are imposed upon to take SHS; therefore the confrontation between two groups will explode. (FG7, Non-smoker, Male)

> It'll be better here. The social environment here decides that smoking is not a common phenomenon. Smokers will get out of the indoor places and go outside. Smokers and non-smokers understand each other. (FG3, Non-smoker, Female)

5.3.4 Social Norms

Participants also expressed their attitudes towards social norms around smoking. The most commonly discussed norm related to cigarettes being offered and accepted as gifts in Chinese society. Some non-smokers acknowledged that this norm was unhealthy, but also realized it is deeply rooted in Chinese society and would be hard to abandon. People's concerns about the health risks of smoking usually yielded to the pressure of social norms:

> Smoking has a deeper root in China and it is of huge difficulty to demolish it completely. For example, taking cigarettes as gifts is abnormal, I think. I think this is an unhealthy norm that should be destroyed. Some healthy norms should be built. (FG3, Non-smoker, Female)

> I had visited to my tutor before I came here. He is a heavy smoker. I knew that it'll be better to give books as gifts but finally I bought two cartons of cigarettes for him. Actually I felt so bad about it and it was like I was killing him. Anyway, he was very happy. For smokers, it is always nice to get cigarettes as gifts. (FG3, Non-smoker, Female)

Participants expressed their support for social norms around smoking in Canada. People are not pushed by others and can decide whether to smoke or not by themselves.

This was related in part to the lower social significance of cigarettes in Canada, with various brands not viewed as status symbols:

> The good thing here is you can choose by yourself. If you want to smoke, do it, as long as others are not influenced by you. If you don't want to smoke, no one will push you … there are no competitions and vanities on the brands of cigarettes as in China. Smokers here smoke only because they really want to, instead of factors related to others. (FG3, Non-smoker, Female)

> Here, people will not force you to do anything and you can just speak out yes or no. Even though you are a smoker, but if you just have no moods for smoking at that exact moment, nobody will push you. Anyway, from all respects, I like the environment here better. (FG5, Non-smoker, Male)

5.3.5 Summary

It is apparent from focus groups that non-smokers had a hard time dealing with the SHS when they were in China, because smoking is prevalent and socially accepted, coupled with the weak spatial smoking regulations. They expressed their appreciation for the Canadian contexts around smoking. Although smokers' behaviours are restricted, they showed their understanding of stricter smoking regulations in Canada, which offered benefits to themselves and non-smokers.

Also, they appreciate the social norms around smoking in Canada. With fewer people offering them cigarettes, it is helpful for them to quit if they want. Also, they had more autonomy in deciding to smoke or not. For smokers, smoking becomes understood as a personal habit or choice in Canada, rather than a social expectation, as in China. Also, non-smokers are not forced to inhale SHS in Canada as they were in China; they expressed their increasing understanding and respect for smokers' smoking, instead of discriminating or isolating them. However, non-smokers and smokers displayed different preference of choosing friends. Most participants, including smokers and non-smokers, embraced both the regulatory and social environment around smoking in Canada.

5.4 Participants' Smoking-related Behaviours

5.4.1 Changes in Smoking Site, Frequency and Quantity

For smokers, stringent smoking regulations in Canada first changed where they smoked. They could smoke almost everywhere in China. Including restaurants and bars, yet all indoor public places are smoke-free in Canada. As such, they can only smoke in unregulated areas, such as outdoors and some private (residential) spaces:

> After I came here, the most impressive thing is that smoking is not allowed in restaurants. When I was in China, I got used to eat and smoke in the restaurants. (FG4, Smoker, Male)

> Smoking is not allowed in bars and you have to go out if you want to smoke. You can smoke at home as long as your roommate does not complain or you two smoke together. (FG6, Smoker, Female)

> You have to go to certain places if you want to smoke. You cannot smoke wherever you want, which makes smoking more complicated. (FG4, Smoker, Male)

While participants were of the view that smokers in Canada generally complied with the rules limiting where they can smoke, several participants reported discussed attempts to smoke secretly in regulated spaces. However, many participants spoke of powerful enforcement of smoking bans when they tried to do this, particularly in University residence buildings:

> I have two friends who used to smoke inside the residence with the windows open; however, there was one day that it was so cold that they had to keep their windows closed. Later on the smell of cigarettes got into the hallway and there were many policemen knocking at the door. They were so scared and sprayed the fragrance trying to cover the smell. After this

> case, they did not dare to smoke indoors anymore. (FG1, Non-smoker, Male)
>
> I used to smoke in the patio of my apartment and the Residence Manager came up to me and told me if there were a next time, I would get punished. (FG8, Smoker, Female)
>
> I have a friend who used to be driven out of [a University residence building] due to his smoking in indoor places. (FG1, Non-smoker, Male)
>
> I used to smoke in the hallway of my apartment on campus. Once two Residence Assistants were hiding somewhere and witnessing me smoking and then caught me on the scene. I was almost kicked out due to that incident. (FG8, Smoker, Male)

As a consequence of effective spatial restrictions smokers' behaviours changed in that they smoked less often, and smoked fewer cigarettes overall. However, participants emphasized that Edmonton's long, cold winters also contributed to this effect – in that the weather discouraged going outside to smoke:

> There will be definitely less than before. The frequency and amount will both be controlled. Here only when I really need to spirit up or the addictions come up, I will smoke. In the winter, only when I am extremely eager to smoke, I go outside. You cannot make it to smoke whenever you want, for it is too cold in the winter. (FG4, Smoker, Male)
>
> The amount will be less, definitely. In China, I can smoke at home whenever I want. Here you have to go out. It is too cold and too long in the winter. You will not want to go outside. Gradually you will smoke less. (FG4, Smoker, Male)

In addition to stringent smoking bans, other factors were also linked to decreasing smoking in Canada. First, smoking participants agreed that people around them mattered in shaping their smoking behaviours. People hanging out mostly with smokers are more likely to pick up and continue smoking.

> I smoke less after I came here. There were people offering cigarettes to others when you hang out in China, but people do not do that here. (FG5, Smoker, Female)

> I smoked more in China for I often hang out with others and when you hang out with your friends, you have to smoke. Here I smoke with my friends as well, but I smoke less here with one or two cigarettes each time. I will smoke more if I go back to China. (FG5, Smoker, Female)

While reducing cigarette consumption was a frequently mentioned consequence, quitting was not. One participant reported that he changed the habit of smoking during meals in restaurants, however, he was not quitting:

> Now I have got used to it that when I eat meals I cannot smoke. However, I am also not very decisive to quit it completely and I do not see the necessity of quitting as well. (FG8, Smoker, Male)

There were other smoking participants who reported that smoking bans would not be helpful in quitting depending on addiction level.

> M1: Yes, they will decrease, they will.
> M3: I agree with that.
> F1: If so, the smoking bans will motivate people to quit?
> M3: No, it is helpless in quitting.
> M4: It depends on your addiction to it. For those heavy smokers who have been smoking for two or three decades, they will not quit definitely

(FG8, Smokers)

> Even though the amount will be less, I do not think it helps when considering quitting smoking. Actually I want to quit, but I know I cannot make it. It is like taking drugs. (FG4, Smoker, Male)

However, with strong personal willingness to quit, one former smoker who used to smoke heavily reported that inconvenience caused by smoking bans in his residential place successfully helped him quit smoking:

> After less than one month I arrived here, I quit smoking, since I lived in a smoke-free apartment and every time I wanted to smoke, I had to go outside. It was inconvenient. (FG1, Former Smoker, Male)

Other three participants reported cases of quitting smoking around them. For example, one participant reported that lack of 'smoking partner' (FG6, Smoker) forced her friend to try to quit:

> He [a friend] attempted to quit in China for several times but failed. After he came here, he could not find people smoking together with him and also there was no one accepting the cigarettes he offered. He took six months to make the decision that he should quit and until now he has been quitting for three months and it is still ongoing. (FG3, Non-smoker, Female)

One participant reported that living in a high-SES neighbourhood with smoking and smokers less visible had also successfully encouraged his friend to quit smoking:

> In addition, the community they lived in was very superior and affluent. There were only a few smokers there and there were no cigarettes butts on the ground. I think this will also have an influence. If you go to some inferior communities, there will be a lot of cigarettes butts on the ground.

> He did not smoke during the nine months he stayed in Canada, which I think is also because the winter in Canada is so cold. (FG5, Non-smoker, Male)

Similarly, one participant reported that her husband quit smoking after he came to Canada in order to match the environment surrounding him:

> My husband had attempted to quit several times in China but failed. After he came here, he noticed that most people around him are non-smokers and if he kept smoking, he might be looked less educated and mismatched with the environment around. (FG3, Non-smoker, Female)

There were other behaviours reported by smokers including that they smoked less in winter and more in summer time, or they smoked shorter cigarettes to reduce their time spent outdoors. While migrating to Canada contributed to an overall decrease in smoking, moving back to China triggered some smokers to pick up smoking again. This was mostly linked to the social norms around smoking in China:

> My father had been staying here for one month. During this period, he did not smoke at all. However, after he went back to China, once others offered him cigarettes or everyone around him was smoking, he could not refuse them due to the politeness consideration. The environment in China strongly dragged him back into deep water again after he went back to China. (FG1, Non-smoker, Female)

During the focus groups, female smokers commonly tended to hide their smoking status from their friends or date partners:

> F2: I think if a girl smokes, her boyfriend will not allow.

> F1: Most of my friends do not smoke and they hate that. Also, I do not smoke much. If you know that most of your friends hate smoking, you will not want to let them know.
> (FG6, Smokers)

> My boyfriend does not smoke and he strongly hates girls who smoke. If he knows that I smoke, he will kill me. (FG4, Smoker, Female)

5.4.2 'Importing' Chinese cigarettes to Canada

Failing to get accustomed to Canadian cigarettes is another critical reason reported by some smokers for reducing smoking and quitting:

> I think if one has got accustomed to the taste of Chinese cigarettes, he/she will not get used to the cigarettes here. Gradually he/she will quit, maybe not right away, just over time. (FG6, Smoker, Male)

> Or if there is one day that cigarettes, or I can say, Chinese cigarettes are not available on the earth, I will stop. I will not buy Canadian cigarettes. (FG8, Smoker, Male)

These Chinese smokers' dislike for Canadian cigarettes was linked to higher prices and perceived worse taste. Some considered the much more expensive cigarettes in Canada one of the most important contributors to reducing their smoking:

> Because there are so many places here where smoking is not allowed, and the price of cigarettes here is very expensive, like $8 for one pack, therefore I gradually quit. (FG1, Former Smoker, Female)

> In China, the cheapest cigarettes could be 5 RMB each pack [approximately 1 CAD]; while the cheapest cigarettes here could be $10. I think someone

> will quit due to the high price. I think the price matters, instead of the environments. (FG5, Smoker, Male)
>
> I think the price factor is more influential too. The guy, who picked me up in the Toronto airport, seemed to have a heavy addiction and he asked me to bring one carton of cigarettes for him. I also asked him why he did not buy cigarettes here; he said the price was really high here. If the supply chain of his Chinese cigarettes breaks, what he could only do is to smoke less. (FG5, Non-smoker, Female)

Expensive and bad-tasting Canadian cigarettes forced Chinese migrants who smoked to either reduce their smoking, or seek out a supply of Chinese cigarettes. This supply involved bringing their own cigarettes when they arrived in Canada, and asking others in Chinese community to do likewise. It was reported that travellers from China often carry Chinese cigarettes into the country with them to use as gifts for friends and associates, and possibly to supply a local market for re-sale:

> I have a classmate who brought a couple of cartons of cigarettes here from China when he came here. He made a smoking plan according to his addiction level and the date he would go back to China next time. (FG1, Non-smoker, Male)
>
> If you only get accustomed to the taste of Chinese cigarettes, you will look for someone to bring cigarettes to you from China. I brought my landlord some cigarettes this time I came back to Canada from China. (FG6, Smoker, Male)
>
> M3: There are Chinese cigarettes for sale on the Edmonton China website.
> M1: Yes, people doing this business have friends bringing them cigarettes from China.

M2: When there are rules, people develop strategies to avoid them. I have a friend who brings ten cartons each time.
M3: People who are doing this specific business may have channels that we do not know. For now, the supply of Chinese cigarettes here is running well. If I want to buy some Chinese cigarettes, I know where to get them. (FG8, Smokers)

5.4.3 Changes in Non-smokers' behaviours

Participants noted that the behaviours of non-smokers towards smoking and smokers were quite different between Canada and China. In China, non-smokers were prone either to endure SHS exposure or escape it by leaving the place where smoking was occurring, instead of speaking out to stop smoking. Even in regulated non-smoking areas, people would usually not try to stop those smokers who broke the rules. This was linked to the normality of smokers and smoking in Chinese society, coupled with the weak formal enforcement of smoking regulations:

> At most times, they [non-smokers] just avoid it instead of taking some measures to tackle this problem. In China, I will not make any effort to report to officers if I see someone smoking in smoke-free environment. I believe people around me will do the same thing like me. We just stay away from them. (FG5, Non-smoker, Female)

> I would take a detour instead of stopping them directly. The environment in China is a little bit dangerous. As a girl, at most times you do not dare to challenge others alone. I don't think most people will challenge others in China, including challenging your friends. (FG3, Non-smoker, Female)

> You have to be tolerant in China. There are some public places where smoking is restricted by rules; however, you will always see people smoking with ignorance of these rules. But you cannot stand up and stop them smoking. (FG3, Non-smoker, Female)

In contrast with people generally keeping silent in China, some reported that, after they migrated to Canada, they got more courage to stop the (relatively few) people who broke the rules:

> Even though you see someone smoking in smoke-free spaces, [in China] you do not have rights to stop him. Here, smokers behave themselves in the first place. Additionally, if you see people breaking the rules, you dare to say. (FG3, Non-smoker, Female)

> In Canada, people value their own right, which has formed a macro environment where people are brave. If people see someone smoking in smoke-free spaces, they will oppose. But in China, you have to be tolerant and you do not dare to speak out. (FG3, Non-smoker, Female)

5.4.4 Summary

In summary, both smokers and non-smokers reported changes on their smoking-related behaviours after they migrated from China to Canada. Benefiting from well-enforced smoking regulations and social norms characterized by mutual respect, non-smokers became braver to protect their own rights to stop those smoking in regulated areas. Also, under the pressure of stringent smoking bans in Canada, smokers were forced to change where they smoked. Smoking outdoors also contributed to the reduction of their smoking frequency and quantity, which was also linked to the loss of 'smoking partners' and less favourable Canadian cigarettes. Effects of smoking bans in reducing cigarette consumption were more than encouraging people to quit. Even though participants expressed more tolerant attitudes towards female smoking, female smokers in this research were prone to hide their smoking status from people around them, especially non-smokers. Another noticeable behaviour is that due to smokers' retaining their strong preference to Chinese cigarettes, it is still very common to bring cigarettes from China to Canada for personal use, gifting and further re-sale.

5.5 Participants' Emotional Responses to Transitions Around Smoking

5.5.1 Non-smokers' Emotions

This research also investigated people's emotional responses to smoking and smoking bans, and how these differed between smokers and non-smokers. In focus groups, non-smoking participants commonly used words such as 'hate', 'dislike', and 'feel sick of' to express their emotional reaction to smoking – and more specifically to the smell of (other peoples') cigarettes. Some reported they felt miserable with SHS around them, especially in enclosed indoor spaces, where smoking continues to occur in China:

> I strongly hate the smell of cigarettes and I can't stand if someone smokes sitting beside me. (FG1, Non-smoker, Female)

> I do not know if it is due to my biological mechanism that if I smell the cigarette, my nose and lungs will be opposed to them and I will stop breathing and feel myself choked. (FG5, Non-smoker, Female)

> When I was in China, my husband and I worked in a university. In my department, 90% of male teachers were smokers. At weekly meetings, smokers smoked with non-smoking female teachers present. Since they smoked in an enclosed space, the smell of cigarettes was always around the room. I was really miserable at that time and my husband and I often had a fight on this issue. (FG3, Non-smoker, Female)

The smell of cigarettes was not only circulating in the air, but also on the bodies of smokers and the people around them:

> M2: Yes, smokers often have bad smells in their mouths.
> F2: And on their bodies.
> M2: Even if you don't smoke by yourself, after staying for a while with smoking people, you will have the smell of cigarettes on your clothes the

> next day. When I was a smoker, I felt the smell of cigarettes from other smokers really good. Now I don't smoke, I feel that smells so bad. (FG1, Non-smokers)

> When I was young, my father smoked. I did not like to be held by him and sleep beside him. I told my dad that he was very smelly. Then he quit. (FG3, Non-smoker, Female)

Non-smoking participants' negative emotional responses to smoking and SHS were also linked to the adverse health consequences. In particular, they were concerned about their personal health, and that of their smoking families and friends:

> When my father was here in Canada, he coughed very strongly and loudly. As his daughter, I should not have felt disgusted; yet it was really annoying and I was very unhappy. He would not be like this if he did not smoke. Smoking makes people around him feel bad and annoyed. (FG1, Non-smoker, Female)

> Because my grandpa (another one) passed away due to diseases related with smoking, I strongly hate people smoking in front of me. (FG3, Non-smoker, Female)

Non-smoking participants' accounts of their emotional responses to smoking often emphasized being exposed to SHS almost everywhere in China. The inability to escape smoke in that context contributed to their distress:

> I think in China, you take SHS everywhere so you hate it very strongly. (FG3, Non-smoker, Male)

F2: I strongly hate people smoking on trains. It is miserable for us non-smokers. However they smokers will be enjoying that and I will be outraged. (FG3, Non-smoker, Female)

In China, smoking continues to occur almost everywhere, and the spatial regulations that do exist are relatively feeble. Smoking in officially smoke-free environments is normalized, and as such non-smokers often felt it was hard to stop others smoking in these places:

M: Sometimes you just feel so hard to speak out.
F: Yes, that'll be embarrassed to stop others smoking.
F: You just felt suppressed and angry but you do not dare to speak out.
(FG2, Non-smokers)

However, in Canada, smoking bans are generally respected, and thus highly effective in removing smoke from shared indoor environments – something non-smokers were 'happy' about. One participant used the word 'heaven' to describe her appreciation for smoking bans limiting where smoking occurs and preventing them from harms caused by SHS:

It is like the heaven here. In China you can smell cigarettes everywhere. (FG2, Non-smoker, Female)

It is more comfortable here, definitely. With those rules, we know where people can smoke and we can avoid these places in advance; while in China there is nowhere for you to escape to. (FG3, Non-smoker, Female)

In Canada, smokers comply with smoking rules and limit where they smoke, which led the non-smoking participants to feel both protected by the regulations and respected by the other group:

> The environment here is more comfortable for me. Smokers and non-smokers respect each other, and psychologically they are more cohesive with each other. In China, you felt suppressed and angry but you do not dare to speak out. People (smokers) here behave themselves therefore you will not strongly hate them smoking. Everyone has different lifestyles and individual uniqueness has been respected here. I love the cohesive environment. In China, I always think that I am the side that being bullied. I have to tolerate time and time again. Here I feel I am respected. (FG3, Non-smoker, Female)

5.5.2 Smokers' Emotions

Smokers' emotions displayed both similar and different patterns of emotions towards smoking. First, social and occasional smokers are similar to non-smokers in their emotions towards the smell of cigarettes:

> I think it is better here. Because I only smoke occasionally, cigarettes are not necessary for me. Sometimes I smelt the cigarettes during a party or something, I felt bad too. Here I can hardly smell the cigarettes, which is good. (FG4, Smoker, Male)

> I like it here and there is no smell of cigarettes here. You know, [in China] we were innocent victims to be exposed to SHS. (FG8, Smoker, Male)

> In China, people got together in the closed room and smoked, which was very miserable. (FG4, smoker, male)

Generally, participants who were regular smokers reported fewer negative emotions towards smoking. Instead, they articulated the benefits of smoking for their own emotional regulation:

> I always know that smoking is harmful to health. For non-smokers, they just cannot understand the excitement smoking can take you. I only smoke when I am extremely upset and helpless. (FG5, Smoker, Female)

> Also, sometimes you feel depressed and smoking is a better way for you to share your feelings with your friends. (FG2, Smoker, male)

Whereas non-smokers enjoyed the positive emotional experiences associated with stringent smoking bans in Canada, smokers reported feelings of being restricted and less free:

> If I want to smoke at this moment and I happen to be in a place where smoking is not allowed, I will be very irritated. (FG4, Smoker, Male)

> I know the environment here will be better for me; but emotionally, I will be more comfortable and free in China. (FG4, Smoker, Male)

One participant reported the resistance of his father who is a heavy smoker towards the smoking bans in Canada:

> I told my dad that smoking is not allowed in indoor public places here. Then he asked me what he could do if he wants to smoke, and then I said, 'you have to go outside', and then he told me he would not come to visit me. (FG6, Non-smoker, Male)

Another significant emotional experience of smokers is their different sense of cigarettes from two countries. This was generated by the qualities of cigarettes as material products/commodities between two countries. This involved differences in both smell and packaging:

M3: In China, cigarettes are called ‘fragrant cigarettes’. When my father held me as he was smoking, I smelled it really nice. There is not any fragrant smell in Canadian cigarettes.
M1: Cigarettes in China are usually with spice.
(FG3, Non-smokers)

Cigarettes here are very bitter and smell bad. In China, there are spice and perfume in the cigarettes. (FG4, Smoker, Male)

Also the packs of cigarettes in China are beautiful while there are disgusting pictures on packs of cigarettes here. (FG3, Smoker, Male)

M5: Pictures on the cigarette packs are so gross.
F1: Yes! They are super gross, such as the oral cancer one.
(FG8, Smokers)

5.5.3 Summary

Generally, the starkly different environments around smoking in China and Canada shaped distinct emotional experiences for people who migrated from one country to another. Non-smokers’ emotional experiences centered on their hatred of the smell of cigarettes and concern about the health risks of SHS. They reported there was no escape from the smell and health risks of cigarette smoke in China, due to the normality of unregulated smoking. While in China they had little choice but to accept exposure, in Canada they enjoyed the protection offered by stringent smoking bans preventing smoking in indoor public places. Non-smokers not only feel protected by smoking regulations, but also cared for and respected by smokers who follow the rules in Canada. The sense of mutual respect and harmony between the two groups generates the positive emotions of non-smokers in Canada. For smokers, smoke-free environments in Canada cause them feelings of being restricted and sometimes isolated, although they remain supportive of more stringent smoking bans overall.

5.6 Conclusions

Analysis of the eight focus groups, with 58 participants in total, was organized around four themes – perceptions, attitudes, behaviours and emotions. One of the most significant findings was that participants, including smokers and non-smokers, were relatively acculturated to the stringent smoking regulations in Canada, and did not view them as unusual or problematic. This could be reflected by their supportive attitudes (Section 5.3.2) and positive emotions (Section 5.5). Additionally, smoking bans in Canada, successfully creating widespread smoke-free air, contributed to the decreasing tolerance for SHS exposure experienced by non-smoking participants (Section 5.3.1). More importantly, regulations also reduced cigarette consumption and encouraged quitting (Section 5.4.1).

Smoking was recognized as less normal in Canada because of the smaller number of smokers and general absence of smoking in regulated areas. However, this perceived denormalization has not extended to smokers (especially males) feeling isolated or discriminated against (Section 5.2.3). Non-smokers also confirmed that they do not discriminate against smokers; instead, they respected smokers' personal choice (Section 5.3.3). This was largely related to the creation of, and smokers' compliance with, smoking bans. By complying with smoking bans, smokers respect the rules as well as non-smokers' rights to enjoy smoke-free indoor air; in return, non-smokers should respect smokers' personal rights to continue smoking. In this way, smoking bans shaped mutual respect between smokers and non-smokers.

While smoking in unregulated areas was considered to make smoking much more acceptable, only a few participants saw the potentially negative identity of smokers in Canadian society (section 5.2.1). Smokers, especially males, still held optimistic opinions on the benefits of smoking to their socializing (section 5.2.4). Some non-smokers have negative constructions of smokers, such as less educated, dressing weirdly and smelling bad, but the inverse relationship between smoking and SES was largely rejected, associating with cigarettes' function of representing SES in China (section 5.2.1 &5.5.1). Additionally, the remarkable difference between female smoking in China and Canada also contributed to shape their perceptions of high social status of smoking in Canada (Section 5.2.3). Despite of less perceived stigma and perceived mutual respect contributed

by smoking bans, non-smokers and smokers have different opinions on how smoking influences one's social network.

There were also other findings in this research. For example, participants were conscious of the different taste and high price of Canadian cigarettes (Section 5.4.2); travelling back to China tended to compromise the achievements of the Canadian context on reducing cigarette consumption by evoking both the regulatory and social environments highly approved of smoking (Section 5.4.1). Some results in the current research are consistent with previous studies and others are considered original findings in this specific setting of Chinese migrants in Canada. Chapter 6 will further interpret the results by referring back to the research objectives and literature.

Chapter 6 Discussion and Conclusion

6.1 Chapter Overview

This research investigated how Chinese migrants to Edmonton perceive and understand changing smoking-related contexts, modify their behaviours to adjust to them, and experience emotions in the process. Additionally, it considered how these experiences of different social and regulatory contexts around smoking are related to their smoking status and gender. This chapter interprets the results presented in Chapter 5 in light of existing literature, and is organized according to the research's four objectives. It concludes by exploring the implications of this research for public policy decision-making and academic research; it also reflects on the limitations of this study.

6.2 Perceptions of Regulations and Social Status of Smoking in Edmonton

The first objective of this research was to investigate how Chinese migrants perceive the spatial regulation and social status of smoking in Edmonton. Regulatory and social environments around smoking can encourage people to modify their attitudes and behaviours to meet with prevailing legal and social standards. However, misperceptions of these standards may compromise this effect (Blanton et al., 2008). For example, college students' misperceived high prevalence of peer smoking may encourage them to pick up smoking (Nakhaee et al., 2009; Paek, 2009). The first objective of this research was to explore participants' perceptions of status of smoking in Edmonton.

Key findings from the focus groups on perceptions include that participants had a generally accurate knowledge of the larger scope and stronger enforcement of smoking bans in Canada than in China. They perceived smoking and smokers as less normal than them in China, consistent with ideas of tobacco being denormalized in HICs. However, this was not associated with experiences of stigmatization: smoking participants did not report feeling discriminated against or isolated. Rather, they emphasized that smoking remains a personal choice in Canada, provided it occurs in unregulated areas and does no harms to others in shared public spaces.

6.2.1 Smoking Bans and Denormalization of Smoking

Generally, Chinese migrants' perceptions of smoking bans were consistent with the actual policies, even though they have been in Canada for less than three years (see section 5.2.2). They perceived effective implementation of smoke-free policies in indoor public places, in regulated outdoor spaces (such as within 5m of building entrances, and at outdoor LRT stations), an in university residence buildings. Their perceptions on this developed from several sources. First, the smoke-free indoor air and seldom seeing others smoking indoors informed participants' perceptions of where smoking is not allowed and people's compliance with the rules. Second, physical signs - such as those stating "No Smoking" on the entrances to university buildings, or advising of a $250 fine for smoking in bus stations – indicated the scope of regulations and potential consequences of breaking them. Additionally, participants' own or others' experiences of ever being punished for smoking in regulated areas also shaped the perceived strong enforcement of smoking bans in Canada.

In terms of social status of smoking in Canada, denormalization of smoking and smokers was perceived. This partly generated from the less visibility of smoking, especially in indoor public spaces, due to the widespread smoking bans. Participants addressed that smoking was abnormal in Canada while it was in the opposite way in China because smoking could be seen almost everywhere. This reflects the way smoking bans function to lower the social status of smoking in HICs such as Canada (Collins & Procter, 2011).

Visibility influenced participants' perception of normal or denormalized smoking in other ways. First, smoking bans forced people to smoke mostly in outdoor environments; this may deliver the information that smoking is common in Canada; second, female smoking was often seen outside university and downtown office buildings (see section 5.2.3 and 5.3.1), which may increase perceived social status of smoking for women; finally, some smokers considered smoking to be also common in Canada because when they smoked outdoors, there were occasionally others asking for cigarettes from them. One smoking participant reported that others might consider him to be 'an idiot' when he was smoking outdoors alone with most others in indoor places. However, he also reported

that if there was someone else smoking together with him on this spot, he would not feel that way. This is consistent with previous studies that smoking with others could make smokers feel normal (Chapman, 2007a; Collins & Procter, 2011). The effect of visibility in influencing people's perceptions of social norms provides the rationale for extending smoking bans to further denormalize smoking in places such as university campuses (Procter-Scherdtel & Collins, 2013) and city streets (Thomson et al., 2013).

Collins & Procter (2011) argued that smoking bans contribute to the denormalization of smoking not only by making it less visible; more importantly, by prohibiting smoking in social spaces such as restaurants and bars, they make smoking an increasingly anti-social act. However, smoking participants, especially male smokers, perceived smoking as helpful in socializing with smokers in Canada, even though social pressure encouraging people to smoke is weaker than that in China. Given smoking bans chase cigarettes out of indoor socializing occasions in Canada, they talked about how jointly smoking outdoors may help them to get involved in smokers' social circles, and how cigarettes worked as money in Chinese immigrant community (see section 5.2.4). When smoking bans contribute to the denormalization of smoking in indoor areas, male smokers still largely remained their focus on the normality and benefits of smoking in outdoor spaces where smoking is unregulated. In other words, when they value that smoking outdoors with other smokers can help them to get closer, they ignored the potential cost. That is smoking would hinder them becoming friends with the larger and more normal group - non-smokers.

Male smokers' optimistic perceptions about social status of smoking in Canada reflect their limited acculturation into Canadian society. These may be contributed by the enduing influence of Chinese smoking culture and result in less awareness of denormalization of smoking in Canada. This is consistent with the empirical study conducted by Ma et al. (2013) in Asian American males that they tended to preserve their original beliefs, perceptions and attitudes about tobacco use. The effect of Chinese smoking contexts in influencing migrants' perceptions in this study is consistent with Shin & Seo (2001) that social norms regarding smoking in migrants' ethnic groups would still be influential post-migration. This is applicable in this research also because the participants were all recent immigrants staying in Canada for less than three years and in

previous studies, length of stay was an important predictor of acculturation level (Kuo & Roysircar, 2004).

Additionally, due to the limited acculturation, they may have not yet fully assimilated to the Canadian community, not only in their understandings of socio-cultural contexts but also their social network. For example, male smokers may still mostly have smokers, especially smokers from China in their social network. For example, having people with the same smoking status and beliefs in their social networks may hinder Chinese smokers' opportunity to perceive the denormalization of smoking. Their judgment of social status of smoking in Canada may be largely influenced by their local norms rather than the global norms. This is consistent with previous studies suggesting that people's experiences are more likely to be influenced by social norms to which they are more close and attached (Aranson et al., 2010; Blanton et al., 2008).

6.2.2 Smoking bans, Stigmatization and Individual Rights

Previous studies in HICs, including Canada, have emphasized the stigmatization of smoking and smokers caused by increasing denormalization. This is reflected by smoking increasingly linked with dirt, despair or low SES (Chapman, 2007a). Consistent with stigmatized smoking from the literature in this study were some non-smokers' constructions of smokers, such as 'dress in a weird way' and 'smelly' (see section 5.2.1 and 5.5.1). The constructed appearance and smell of smokers has been related to the stigmatization in the literature (Farrimond & Joffe, 2006). Also, some non-smoking participants reported that smokers were not preferable as a date partner, friends and employees in Canadian companies (see section 5.3.3). This is consistent with the potential consequence of remaining smokers being socially isolated or discriminated against (Bell et al., 2010).

Large inconsistency with stigmatization of smoking in HICs was found. First, only one participant noted that she considered smokers to have a lower SES, while most participants denied there was an inverse relationship between the two variables. Arguments for this included that it depended on different brands of cigarettes, and smoking helped to release pressure for those with high SES (see 5.2.1). This may also reflect limited acculturation. Participants were still influenced by the cultural context in

China that smoking was prevalent among people from all backgrounds, including national leaders and businessmen. Also there were cigarettes in China too expensive for ordinary people to afford (see 5.2.3 and 5.2.4). A higher level of acculturation may advise to them the cigarette price in Canada different from that in China.

Second, past studies have suggested that in HICs such as Canada and the US, stigmatization has caused remaining smokers to feel shameful or guilt psychologically (Bell et al., 2010). Smoking participants did not report these feelings. One of the tentative explanations for this is as Stuber et al. (2008) suggested, smokers with higher levels of education may be less likely to perceive stigma; this may have been a factor for participants in this study, many of whom were international students attending university. Much more importantly, smoking bans played a critical role in forming their perception. Stigmatization of smoking and smokers is linked to the health risks of SHS exposure for non-smokers. In this research, smokers insisted that as long as they complied with smoking bans and created no harms to non-smokers' health, they would feel neither guilt nor shameful (see section 5.2.3).

Third, even though some non-smokers reported less preference for smokers, some clearly elaborated they had not isolated or discriminated against smokers since smokers behaved themselves and respected others' health rights. Instead, they perceived high mutual respect in Canada between smokers and non-smokers. As a representative of western culture, Canadian society was perceived to value individual right (see section 5.3.3). This can also be related to the ethic concern of stigmatizing smoking. The first reflection of this was forceful smoking bans protect health rights of non-smokers, which were largely ignored in China. The second aspect was respecting smokers' rights to smoke under the circumstance that non-smokers' rights were not interrupted. The implementation of effective smoking bans in Canada, by separating smoking and SHS, put this into practice.

Finally, compared with the social status of smoking in China, the socio-cultural force around people's smoking behaviours was perceived less than that in China. While smoking in China was perceived as a strongly social behaviour, it is mostly perceived as a personal habit in Canada. In China, people label female smokers as less educated and males refusing to smoke as impolite or disrespect. In contrast, participants perceived that

in western culture, people do not judge others over their 'choice' to smoke or not. Participants thought that personal choice plays a larger role than social norms in shaping smoking behaviours in Canada (see section 5.2.4). They do not need to feel guilty to refuse the offer of a cigarette from others, as they did in China. There was no sense that this was disrespectful or impolite in Canada.

6.3 Attitudes and Behaviours towards Smoking and Smoking Bans

The second objective of this research was to document the ways in which the Edmonton context has led to changes in Chinese migrants' attitudes and behaviours relating to smoking and smoking bans. In particular, this research is interested in examining how people's attitudes and behaviours were shaped by their experiences of the spatial regulation of smoking in China and Canada. This may provide indications for future smoking-related policies and strategies both for migrants specifically and the general public.

Key findings from the focus groups include that non-smokers' acceptance of and tolerance for SHS decreased after their migration, reflecting that they have acculturated to smoke-free air in Canada. They also held more tolerant attitudes towards smokers in Canada who complied with smoking bans. In this sense, effective smoking bans relieved the tense relationship between smokers and non-smokers generated from the health risks imposed on the latter, which is commonly ongoing in China. This was appreciated by both smoking and non-smoking participants, who reported a common supportive attitude for the smoking regulations in Edmonton. In terms of behavioural changes, the Edmonton context did reduce their cigarette consumption and smoking frequency, especially for male smokers who used to smoke frequently in China. Chinese contexts still remained in the immigrant community and influenced their behaviours to some extent.

6.3.1 Attitudes towards Smoking, Smokers and Smoking Bans

Related to the perceived health risks of SHS, non-smoking participants held negative attitudes towards SHS. Their acceptance of and tolerance for SHS had decreased since they migrated to Canada (with several expressing their 'hate' for it, see section 5.5.1).

Some found it hard to get re-accustomed to the indoor environment with smoking when they travelled back to China (see section 5.3.1). This indicates that smoking bans, creating smoke-free indoor air, erode the normality of exposure to SHS (e.g. Chapman, 2007a). Also it reflects that they have acculturated to the smoke-free indoor air in Canada.

While non-smoking migrants from China hated SHS more post-migration, they surprisingly became more tolerant for smoking. First, in Canada, non-smokers are separated from smokers and SHS by smoking bans. They were no longer forced to 'suffer' from SHS exposure and their health was protected. Second, related to their perception of individual rights highly respected in western culture, non-smoking participants started to concern the ethical hazards brought by continuous criticism for smokers both from non-smokers and public tobacco control policies (see section 5.3.3). By complying with smoking bans and limiting where they smoke, smokers behaved considerately. This was uncommon in China as reported; smokers in China cared nothing about others' health risks with continuing smoking in regulated areas. As suggested by Poland (2000), consideration of smokers can function to avoid confrontation and reduce criticism from those increasingly hostile to smoking. It not only generates from smokers' management of the health risks smoking impose on others, but also their self-behaviour negotiation with the increasingly disapproving social and cultural contexts around smoking, such as the stringent smoking bans. In this research, considerate smokers in Canada did win the respect and appreciation of non-smokers. In so doing, smoking bans in Canada were perceived to help build mutual respect and harmony between smokers and non-smokers.

Another big change in their attitudes is around female smoking. Female smoking in China is uncommon and socially labeled with negative identities (such as 'bad' and 'less educated') in comparison with the normality of male smoking. Participants' attitudes towards female smoking used to be influenced by Chinese contexts, then they reported their surprise after they migrated to Canada. The perceived tolerance of female smoking in Canada contributed changes in some participants' personal attitudes towards smoking. Some participants described female smokers they had seen in Canada as 'fancy' and 'elegant', which was less likely to hear in China; one even expressed her wish to try a cigarette (see section 5.3.1). The pattern of female smoking in China indicates us the effects of a disapproving social context around smoking in influencing individual's

attitudes and discouraging females to pick up smoking. This mostly comes from traditional gender roles remaining in China and some other LMICs (Ng et al., 2014). Chinese migrants considered this to be changed after migration. However, they put more attention on female smoking much more visible in Canada than in China than the full picture that generally smoking in both genders is experiencing the denormalization. This may also reflect the limited acculturation of recent immigrants.

However, even though non-smokers denied that they would discriminate against or isolate smokers who were respectful of individual rights, they tried to avoid smokers involved in their social network. For example, female participants reported that they were less likely to make friends with smoking males. In contrast, smokers held a mixture of neutral and positive attitudes towards smoking. This was closely related to their perceptions of health consequences of smoking, for example, smoking can release pressure and depression, and contribute to weight loss, while quitting smoking will do harms to heavy smokers. Smoking participants also specifically supported smoking because it brings them perceived benefits in socializing. These 'benefits' have also been found from previous studies, especially in college student smokers (Christopher et al., 2006; McChargue et al., 2004). Smokers also reported that they are more likely to make friends with smokers (see section 5.3.3). The gap between smokers and non-smokers' preferences in making friends according to smoking status is consistent with the increasingly polarized clusters of each group. It has also been found that fewer social ties and increasing distance are between these groups (Christakis & Fowler, 2008). This alerts Chinese male smokers the potential disadvantage in future socializing. Particularly in Canada, where the overall proportion of non-smokers in the population is very high and males, in particular, are much less likely to smoke than in China, it is much more likely than in China to involve non-smokers in their social circles.

A supportive attitude towards smoking bans in Edmonton was observed in the focus group discussions. This attitude of non-smokers is expected, since they perceived the health risks of SHS and hated exposure, which was effectively restricted by smoking bans in Edmonton. Smokers also reported support for smoking bans in Edmonton, based on various considerations. First, policies are more acceptable when there is no serious loss of individual freedom (Steg & Schuitema, 2007). This was reported by participants, who

accepted restrictions provided that they were not completely banned from smoking everywhere. In this case, it was reported that managing such restrictions is easier for occasional or social smokers than for heavy smokers due to different levels of nicotine addiction: for example, one participant reported that his heavy smoking father would not come to Canada partly due to his resistance to the smoking bans (see section 5.3.2).

More importantly, out of health concern, smokers contended that smoking bans protect both the health of themselves by reducing smoking opportunities and non-smokers by creating smoke-free air. Additionally, regulations can also be taken as an external force to help smokers quit. This may indicate that social constraints could also transfer to internalization in smokers of rationale for reducing smoking, which has been found in previous studies on how social contexts influence individual behaviours (Etzioni, 2000). Specifically, stringent smoking bans in Canada not only externally restricted their smoking behaviours, but also contributed to smokers reconsidering their preference regarding smoking, including their concern of health risks and willingness to quit. Regulations in China failed to achieve this due to its high tolerance.

This said, smoking outdoors in Edmonton did become difficult in winter, due to extreme low temperatures, which caused significant discomfort to smokers (see section 5.3.2). Some smoking participants hoped for the introduction of indoor designated smoking rooms or hallways for smoking in wintertime. However, the introduction of smoking rooms is inconsistent with the FCTC and WHO warnings that there is no safe level for SHS (WHO, 2009). Smoking bans were also considered to be too restrictive in some certain environments, including restaurants and bars, where some smokers thought smoking, drinking alcohol and socializing should occur together. This is a social norm in China; and indeed it persisted until relatively recently in HICs, where restaurants and bars were usually the last bastion of indoor smoking (Magzamen & Glantz, 2001).

6.3.2 Behaviours towards Smoking and Smoking Bans

Consistent with people's perceptions, the Edmonton context has indeed influenced people's smoking behaviours. These include changes in the location and frequency of smoking. The most direct effect of smoking bans is that smokers have to change their smoking sites – from smoking almost everywhere in China (including indoor public

spaces), to restricting the behaviour to outdoor areas and some private homes in Edmonton (see section 5.4.1). Smoking participants mostly reported that they have been following the smoking rules, mostly because of the "cost-benefit" consideration (Ajzen, 1991). Specifically, the strong enforcement of smoking bans in Canada create a higher cost for continuing smoking, in the form of fines and other legal penalties, even though smoking outdoors cause them much inconvenience. This proves the effectiveness of strong enforcement of smoking bans.

As said, both the strong enforcement of smoking bans and the denormalization of smoking motivated participants not to smoke in certain places. Several participants reported breaking the rules and trying to smoke secretly indoors in University residence buildings (see section 5.4.1). However, in most cases this was detected and reported, which largely reduced their motivation to try again. This may indicate that Chinese migrants may not get used to the smoke-free environment at first in Canada, and may not acculturate until they experience enforcement and the threat of penalties.

Smoking bans also helped to reduce participants' smoking frequency and cigarette consumption, which has also been found in previous studies (e.g. Fichtenberg & Glantz, 2002; Callinan et al., 2010). Reasons for this include that smoking bans naturally caused the loss of opportunities for smoking when they stayed in regulated areas, such as indoor workplaces. Also, some smokers reported that they preferred to smoke fewer cigarettes rather than go into the low outdoor temperatures of an Edmonton winter.

The other important reason for decreasing smoking after migrating to Canada is that smoking prevalence in the population is lower overall (due to the much lower rate of smoking amongst men), which can lead to a lack of 'smoking partners', and in addition the social practice of 'offering cigarettes' is less common in Edmonton (see section 5.4.1). Smoking prevalence in China is very closely linked to its social functions for men (Hu et al., 2012), and when this is removed – e.g. after moving to Canada – there is less pressure to smoke, and consumption is likely to fall. Similarly, after some smokers reduced or quit smoking when they were in Edmonton, they picked up smoking again when back in China. The normality of smoking, and the related concern of being impolite to refuse others' cigarettes, hinders cessation efforts in China.

While reductions in smoking frequency forced by the stringent smoking bans were common among smoking participants, quitting was not. Among five former smokers, four smoked less than one cigarette per day in China, so it would not be difficult for them to quit. Five cases of quitting smoking after migration, including either participants' own experiences or their friends', were mentioned in the focus groups. One participant used to smoke more than five cigarettes a day, and quit after migrating because of inconvenience caused by residing in a smoke-free apartment (see section 5.4.1). This may suggest the potential effect of implementing smoke-free private residence. The other former smoker reported the reason for her to quit included the joint effect of smoking bans and high price of Canadian cigarettes (see section 5.4.2). The other three examples came from participants' friends or family. The reasons in these three cases for quitting were largely the denormalization of smoking in their neighbourhood and social circle (see section 5.4.1). This may indicate that a better understanding of social norms may contribute to completely drop the identity of smoker by quitting. Reasons for most smokers still keeping it may include that they did not necessarily perceive any stigmatization of smokers in Canadian society or their local circles; rather, they were accepted provided they following the spatial rules (as explained in section 6.2.2). At minimum, widespread and effective smoking bans in Canada changed where participants smoked, and reduced their cigarette consumption; quitting may require a deeper level of acculturation to the smoke-free norms in Canada.

Given that female smoking was perceived more accepted in Canada than in China, Chinese females were more likely to pick up smoking or smoke with more comfort after they migrate to Canada. This was reported by female smoking participants, consistent with previous studies on the smoking patterns of more acculturated immigrant women (Shelly et al., 2004; Maxwell et al., 2005). However, female smokers in the focus groups reported they hid their smoking status from their friends, boyfriends and parents (see section 5.4.1). This may indicate that their behaviours are still influenced by the generally negative views of female smoking that characterize Chinese culture. In their small circles remaining largely connected with Chinese contexts, it is still abnormal and barely unaccepted. They hid smoking status to meet the normative in their local norms, even though female smoking was perceived accepted in the broader Canadian context. This first confirmed

that among Chinese community, the close relationship between smoking and socializing only exists in male smokers. Second, as suggested by Thompson et al. (2009), being a "secret smoker" is a strategy taken to avoid being discriminated against or isolated.

Another notable behaviour around smoking is that people carry Chinese cigarettes from China to Edmonton for personal use, re-sale or socializing. This was linked to the different (inferior) taste and higher price of Canadian cigarettes (see section 5.4.2). The taste of Chinese cigarettes is more acceptable for smokers and the price is generally lower. The higher cigarette price in Canada is consistent with the price-related measures required by the FCTC (WHO, 2003, Article 6). It has been proved that higher prices reduce cigarette consumption, including among college students (Sa et al., 2013). Bringing cigarettes from China remains very popular among the Chinese community in Edmonton. Even though people migrated from China to Canada, they still keep a high loyalty to their original brands.

From a Foucauldian perspective, the Edmonton context, especially strict smoking bans, works as a type of bio/geo power, encouraging changes in Chinese migrants' attitudes and behaviours. Specifically, non-smokers' acceptance of SHS decreases; while a sense of mutual respect between smokers and non-smokers is built by smoking bans. Smoking restrictions in Edmonton also effectively reduce cigarette consumption and smoking frequency among Chinese migrants. However, social norms have less effect on reducing people's smoking than smoking bans. This may be because that smoking bans force people to act in a particular way with implicit consequences for not doing so, while social norms focus more on self-regulation. First, normative misperception may compromise the effect and motivation for Chinese smokers to quit smoking. Interpretations of social norms vary from person to person; moreover, Chinese migrants, who have been in Canada for a relatively short time, retain connections with Chinese norms. Second, as suggested by Thompson et al. (2009), individuals developed their own forms of care of the self, which will not necessarily be quitting smoking. Even though biopower has significantly contributed to the social norms shift regarding smoking among general Canadian society, denormalization and stigmatization of smoking have not yet become widespread within the recent Chinese immigrant community. This indicates that

their acculturation to Canadian norms around smoking is limited. Their smoking behaviours thus still largely influenced by Chinese socio-cultural contexts.

6.4 Emotional Experiences

The third objective of this research is to understand the emotions that Chinese migrants experience as they adjust to a regulatory and social environment that is less tolerant of smoking. People's sensual experience of places has been stressed in the emotional geography literature (Davidson & Milligan, 2007). The 'smell' of cigarettes was frequently discussed emotional experience in the focus groups. The association of SHS with sickness/health risk is known to contribute to people's feelings of 'hate' towards exposure (Tan, 2012; Thompson et al., 2009). In the focus groups, the word 'hate' was used 35 times in total, and in 12 instances referred to non-smoking participants' feelings towards the smell of SHS (as well, there were two usages of 'disgusted' and one of 'feel sick of'). Two participants reported they hate SHS more in China than in Canada because they can smell it in most places, including indoors (see section 5.5.1).

'Smell' also contributes to the separate identity of smokers and non-smoker. Smokers were reported to have smell of cigarettes remaining on their bodies and clothes. Farrimond & Joffe (2006) related non-smokers' complaints about the smell to the stigmatization of smokers. One participant reported that she used to refuse to be held by her 'smelly' smoking father, who later quit smoking due to her complaint. It may indicate how smokers' behaviours could be influenced by stigmatization of smokers related to emotional experiences. Other emotion-related notions in the literature include smokers' feelings such as guilt and shame caused by stigmatization (Stuber et al., 2008; Ritchie et al. 2010). However, in the focus groups, smokers reported they have barely felt stigmatized or isolated in Edmonton; they experienced no particular problems provided they complied with smoking bans.

Smoking bans contribute in changing the relationship between people and places via the changes of smoking sites (Collins & Procter, 2011). 'Smell' is not only a sensuous experience; more importantly, it works as a characteristic of places. People reported that the smell of cigarettes could be felt almost everywhere in China. One non-smoking participant stated that she had 'nowhere to escape' the smell of smoke, which indicated

that smokers claimed most indoor public spaces. By contrast, when the smell of cigarettes mostly exists in outdoor settings and indoor public spaces are completely smoke-free, non-smokers may feel a stronger sense of place in these regulated areas. This change in their relationship with place can influence their emotions (Bondi & Davidson, 2011). They reported they often felt 'bullied' in China; instead, they felt 'respected' (see section 5.5.1). From the perspective of smokers, smoking bans will reinforce their disconnection with those regulated areas (Tan, 2012).

Previous studies put considerable emphasis of individual rights, especially smokers' rights constrained by smoking bans (Keane, 2003); in this research, smokers did not see smoking bans as non-smokers' aggressive claim of extended public spaces. This is probably because most smoking participants in this research were international students, who are often social and occasional smokers. Without a long smoking history and high level of nicotine dependence, they found no big difficulty to adapt to the smoking bans and respect others' health rights. Other than biological response, the high educational level of smoking participants may contribute to a better understanding of the discourses of health and moral responsibility of smoking bans to protect the rights of most people. As indicated in section 5.3.2, smokers held a supportive attitude for smoking bans partly because their freedom to smoke was not completed prohibited. Actually, smoking bans separate smokers and non-smokers respectively and keep each group in independent spaces for claiming their own rights.

Smoking plays an important role in smokers' emotional regulation (Bottorff et al. 2006; Nutt et al. 2007). In this research, for example, participants reported that smoking can help them release pressure or cope with depression. Several studies have suggested that smoking among immigrants is related to depression (Mui, 2000; Sa et al., 2013). Smokers generally also reported they accepted and were 'happy' with smoking bans in Canada, although heavy smokers may resist smoking bans in Canada and face emotional difficulties such as becoming 'irritated' in complying with those restrictions (see section 5.5.2).

There are other important emotional experiences discussed in the focus groups. For example, the different smell and taste of Canadian cigarettes from Chinese ones were recognized as important factors in influencing Chinese smokers' behavior-decisions.

Chinese smokers facing difficulties to get used to the smell of taste of Canadian cigarettes may reduce consumption. This is partly the reason that importing cigarettes from China remains popular among Chinese immigrant community. It was reported by smokers that extra spice was added into cigarettes in China (see section 5.5.2). This may result in the increase of smoking by creating potentially positive emotional experiences.

6.5 Demographic Factors Influencing Experiences

The fourth objective in this research is to analyze the ways in which migrants' perceptions, attitudes, behaviours and emotions may be influenced by social factors such as gender and smoking status. While environmental factors generally influence people's experiences, personal factors may also contribute to different patterns. In this context of this study, smoking status and gender were two demographic characteristics likely to influence participants' perceptions, attitudes, behaviours and emotions.

First, smokers perceived more benefits of smoking than non-smokers. Related to this, they held more positive attitudes towards smoking. Non-smokers highly supported stringent smoking regulations in Canada. Smokers also generally held supportive smoking bans, however, in comparison with non-smokers, some expressed hope for designated indoor smoking rooms. Smoking participants could be divided into occasional smokers and daily smokers according to their smoking status (see Table 4.1). Daily smokers were considered to have a higher level of nicotine addition than occasional smokers. They would face more resistant attitudes and also experience more difficulties in getting accustomed towards smoking regulations in Canada (see sections 5.2.1, 5.3 & 5.5.2).

From the social perspective, previous studies show that college students are more likely to smoke together with others (e.g. Moran et al., 2004; Waters et al., 2006). This may be even more apparent in Chinese international students, which is reinforced by the socio-cultural contexts around smoking in China. Social forces play dominant roles in encouraging people to smoke and hindering them to quit. It was reported that for some smokers in China, the most important reason is to meet the normative of sharing and gifting cigarettes or get closer to other smokers (see section 5.2.4). Differently, there were other smokers smoked because of the perceived benefits in their health (e.g. releasing pressure), or remaining habits of smoking during meals in restaurants or bars. These two

groups of smokers smoke because of different reasons: social forces or personal willingness. For those who were forced to smoke in China, the Edmonton context in a large extent got them rid of this social pressure. They would have more positive attitudes for this, even in the similar level with non-smokers. However, for the latter group, smoking opportunities reduced by stringent smoking bans may generate more negative experiences, such as one smoker's complaint about banning smoking in bars, where she thought to have the atmosphere for smoking (see section 5.3.2).

Gender is another remarkable demographic factor relating to smoking, especially in China. One important notion mentioned in the focus groups is the stark difference in the prevalence of female smoking between Canada and China. The higher female smoking prevalence in Canada may increase Chinese migrants' tolerance for female smoking, and motivate some Chinese women to attempt smoking in Canada. This is consistent with the pattern proved by previous studies that the smoking rate of female immigrants is likely to increase after migration (Maxwell et al., 2005; Weiss & Garbanati, 2006).

Even though the social acceptance of female smoking was perceived higher in Canada that that in China, female smoking participants reported that smoking is not preferred for their date partner, friends and parents. As a result, female smokers are more likely to be secret smokers (see section 5.4.1). They were still influenced by the norm of denormalized female smoking in China. This is coincidently consistent with the observation that stigmatization of smoking may not necessarily lead to quitting; smoking secretly may be another response (Thompson et al., 2009).

Chinese male smokers' perceptions, attitudes and behaviours continue to be influenced by their experience of social norms in China, where male smoking and smokers enjoy big advantages in most fields. For example, they still had the perception that smoking was helpful in their socializing life; they were more likely to make friends with smokers; they were less likely than female smokers to hide their smoking status from others. As previous studies found, male immigrants are less likely to acculturate and more prone to keep their original identity (e.g. Kim et al., 2005). This may contribute to the low level of perceived stigmatization of smoking in Canada.

6.6 Conclusions

6.6.1 Contributions to Health Geography and Tobacco Control

This research is in the first instance an application of health geography, which focuses on the effects of space or place in influencing people's health. Chapter 2 introduced how the health risks associated with smoking and SHS exposure are unevenly distributed geographically, with major differences between HICs and LMICs. This research investigated people experiencing both of these smoking-related contexts. It found that migrating to Canada from China creates new experiences, which are generally accepted and supported. Previous studies have established that spatial smoking bans prevent people's exposure to SHS and also encourage people to reduce cigarette consumption (Chapter 3). This is also one of the major findings in this research.

This research also contributes to tobacco control by covering a specific community – Chinese migrants in Canada. First, people in this group are still influenced by the patterns of smoking in China. Since China remains a huge problem in tobacco control, studies on this population will supplement existing literature on Chinese people's smoking-related behaviours also provide indications for future policy-making by Chinese authorities; such as enforcing smoking bans effectively, and breaking the association between smoking and socializing. Second, Chinese are among the largest migrant groups in the world, and the currently the second-largest group of migrants to Canada. This brings new challenges for Canadian society on tobacco control. This research has investigated how Chinese migrants perceive and cope with smoke-free policies and anti-smoking norms in Canada. It provides a reference for future tobacco control policies not only in Canada but also other high-income destination countries with similar smoking-related patterns; for example, the need to restrict the importation of cigarettes from LMICs, where they are sold at a lower price.

To figure out the cultural origins behind immigrants' smoking can be helpful in making strategies specifically for immigrant smokers. This research found that the remaining influence of Chinese smoking-related norms still play a critical role in shaping Chinese migrants' perceptions, attitudes and behaviours. This largely prevented smoking

participants from quitting. Fortunately, this provided invaluable for future tobacco control strategy. That is, behind the social norms highly disapproving (male) smoking is Chinese societal cherish of social ties and individual image shown in their network. In other words, Chinese people concern more about (the loss of) social cost, which coincidently matched with the core theme of denormalization and stigmatization. However, what should be removed by future strategy is not this Chinese culture root, but the smoking-related part in it. As suggested in previous section that new gifts delivering healthy message need to be developed. In summary, this research indicates that tobacco control, and other public health fields need to investigate the role socio-cultural contexts play in shaping health behaviours of certain population. Heath promotion strategies need to collaborate with cultural specifically measures.

6.6.2 Policy Recommendations

The anti-smoking context in Canada, centred on widespread, effective smoking bans and low social acceptance of smoking, has been proven in past studies to be effective in changing people's smoking behaviours and promoting public health. In this research, the effects this context has on Chinese migrants' smoking-related perceptions, attitudes and behaviours were also observed. The most observable change may be the reduction of smoking motivated by stringent regulations. This confirms the importance of strong enforcement in the effectiveness of smoking policy. Also, it suggests that smoking bans are a structural factor that can apparently generate behavioural changes among an immigrant community. This does not necessarily depend on acculturation; observations of widespread compliance by local residents, combined with the threat of enforcement, are sufficient to change behaviours. In addition to reducing smoking opportunities, smoking bans in Canada generated supportive attitudes and positive emotional experiences.

Concern for the stigmatization of smoking and smokers in Canada has a weaker role in reducing smoking among Chinese immigrants. This could be attributed to people's misperceptions of the identity of smoking and smokers in Edmonton, such as no relationship observed between one's SES and his smoking status, no shame or guilt felt by smokers, high acceptance of smoking in unregulated areas, and benefits of smoking in socializing. Less observed stigma might hinder the motivation for people to quit smoking.

People's interpretations of social norms may be influenced by their personal experiences and cultural background, which mostly refer to their Chinese origins in this research. Future policies in Canada could put more effort into publicizing the stigmatized identity of smoking and smokers. Interventions communicating accurate social norms regarding smoking should target Chinese smokers, following what has been done in some HICs to correct college students' misperceptions of peer alcohol use (Perkins & Craig, 2006). This is considered to be more effective for Chinese smokers because in Chinese culture, people are highly concerned about their image in front of others ('face'). This can be seen in the pursuit of expensive cigarettes in China.

Chinese migrants not only care about 'face', but also their social relations ('guanxi'). Future tobacco control strategies targeting Chinese smokers should put effort into acknowledging the negative influence of smoking for smokers to "fit in" non-smokers' circles. This is more necessary in Canada because non-smokers are a substantial majority of population of both men and women. As their length of staying in Canada increases, immigrants will obtain more awareness and perceptions of the social status of smoking in this HIC. In China, it is critical that policy include efforts to break the associations between socializing and offering cigarettes. As Ding & Hovell (2012) suggested, these may include stigmatize "sharing and offering cigarettes" and possibly develop a new way to hang out with others. For example, as mentioned in the focus groups, drinking coffee is perceived as the dominant socializing style in western culture, and as prevalent as smoking is currently in Chinese society (see section 5.3.4).

Policies could also communicate health risks of smoking to Chinese migrants, who are likely to have relatively low previous awareness (e.g. Borland et al., 2006; Li et al., 2010). It was found in this research that smokers were prone to see the benefits of smoking overweighing the harms (see section 5.2.1). Health risks of smoking and SHS should be routinely publicized in media channels specifically or mostly orientated to immigrants. In the process, common misperceptions of the benefits of smoking should be corrected.

This research also proves that the implementation of price measures (i.e. tax increases) also has a positive role in reducing Chinese immigrants' consumption. This reminds LMICs such as China, having ratified the FCTC, should implement the further

price-tax measures required. Canada has increased the price of Canadian cigarettes (NSRA, 2014), which was reported to reduce cigarette consumption in this research. However, this effect may also be compromised by the phenomenon existing in the Chinese migrant community of bringing Chinese cigarettes to Canada (see section 5.4.2). This availability also prevents some smokers with a deep preference for Chinese cigarettes from reducing or quitting. This may indicate the need for a more restrictive policy for HICs on the importation of cigarettes from LMICs (where they are sold at much lower prices), and on stricter enforcement of existing limits on the number of cartons that travellers can bring with them.

6.6.3 Reflections on Research Methods, Limitations and Implications

To hear Chinese migrants' voices directly regarding smoking, qualitative methods were used in this research. Similar with other studies employing qualitative methods, there may be subjectivity in the data collection and analysis process. For example, the focus group discussions were either in Mandarin or Cantonese so that the researcher had to translate them into English. To lessen the influence of subjectivity in research findings, several measures were taken, such as reading through the original transcribed discussions several times to correct the translations and having two analysts participate in coding the transcripts.

Over 80% of the 58 participants were international students at the University of Alberta; this is partly because of the recruitment information being posted on campus, and the convenience of access to the site the focus groups were conducted. This led to result a high average education level of participants, and an overrepresentation of this single migrant category. However, it also provided a good opportunity to look at the smoking patterns of international students, since college students in general are a key group in tobacco control efforts and also a target of tobacco industry. College students are prone to be social smokers and occasional smokers due to a relative short smoking history. This smoking status may have contributed to the supportive attitudes for smoking bans among participants. Since heavy smokers have more negative experiences with smoking bans, in future studies, participants could be investigated separately according to a more detailed

smoking status. Additionally, a broader range of immigrants (in terms of immigration status, age and educational achievement) could be sought in future studies.

Chapter 2 addressed that smoking bans in China are implemented unequally geographically distributed. Big cities such as Beijing and Shanghai implemented smoking regulations in a broader scope than small cities and rural areas. Because there is no single experience of smoking restrictions in China, future studies may examine Chinese immigrants' experiences of transitions around smoking in light of their previous place(s) of residence in China.

This research involved only recruited immigrants who had been in Canada for less than three years in order to examine the experience of transitioning to a new environment. This research indeed found that as recent immigrants, participants' experiences have been influenced by both their origins and destination. This reflects the limited acculturation of recent immigrants. Future studies may consider how people's level of acculturation changes as their time in Canada increases. This could involve changes in their perceptions of social norms around smoking in Canada, and further changes in behaviours.

The large numbers of Chinese migrants to Canada and the smoking norms embedded in this community present challenges for Canadian tobacco control. In particular, Chinese migrants are likely to see male smoking as normal and acceptable, and gifting of cigarettes as an important social practice. However, these views are subject to change with transition to a new environment. This research indicates that smoking bans can directly reduce Chinese migrants' cigarette consumption by creating physical inconvenience. Strong enforcement increased their compliance with these regulations, relative to previous behaviour in China. One participant suggested that an important reason for Chinese people continuing smoking was that they respected cultural value of 'guanxi' more than legislative regulations (see quotation in 5.2.4). In fact, this is because smoking rules are not forceful enough. Even though smoking culture still exists in Chinese migrants community, they still changed their behaviours under the force of stringent smoking bans in Canada. Chinese authorities should not take culture as the excuse for the failure in enforcing smoking bans. More importantly, the potential effect of smoking bans in changing social norms provides opportunities for tobacco control in China and Chinese immigrants population in HICs.

Referring back to Foucault's concept of governmentality, generally speaking, Canadian society has successfully formed the social norms that smoking is less accepted and desirable, through the implementation of policies and interventions (biopower) and widespread compliance by individuals (care of the self). However, when it comes to the recent Chinese immigrant community in Canada still kept the "sub-culture", in which smoking is un-stigmatized, contributed by the leftover influence of Chinese smoking-positive contexts. Fortunately, the traditional value system in Chinese society ('face' and 'guanxi') is not necessarily obstacles; instead, it is a double-edged sword. In order to increase their social image and keep their connections with others, many Chinese males used to be forced to pick up smoking. However, if the connection between smoking and social status is reversed, then one day they may quit smoking for the same reason.

Moving to Canada provides an opportunity for smoking male immigrants to reconsider what role smoking should play in their lives. Tobacco control in HICs, such as Canada and other popular destination countries, should be attentive to the socio-cultural origins of migrants and how these influence their understandings of smoking. This research has initially touched this point in the Edmonton setting, and found smoking contexts from China still exert a considerable influence on recent Chinese immigrants. Culturally specific strategies need to be taken to change this. In Canada and some other HICs, smoking bans have largely reinforced the social unacceptability of smoking. This effect can be further heightened by spreading the smoke-free environments, such as in outdoor and private settings. Additionally, media plays an important role in influence people's perceptions. For destination countries such as Canada, information indicating less acceptability of smoking should be not only launched in local media, but also those specifically for immigrants. LMICs should also learn from HICs to make multiple efforts to change smoking-related contexts. With various policies including both price-tax and non-price measures listed in FCTC fully enforced, high smoking prevalence in Chinese community, located either in China or other countries, will be effectively reduced in the future. This will be a significant move in the international tobacco control campaign and realizing the global commitment to reducing the harms of smoking.

References

Abdullah, A. S., Hua, F., Xia, X., Hurlburt, S., Ng, P., MacLeod, W., & ... Zhang, Z. (2012). Second-hand smoke exposure and household smoking bans in Chinese families: a qualitative study. *Health & Social Care In the Community*, 20(4), 356-364.

Abraído-Lanza, A. F., Armbrister, A. N., Flórez, K. R., & Aguirre, A. N. (2006). Toward a theory-driven model of acculturation in public health research. *American Journal of Public Health*, *96*(8), 1342.

Abrams, S. M., Mahoney, M. C., Hyland, A., Cummings, K. M., Davis, W., & Song, L. (2006). Early evidence on the effectiveness of clean indoor air legislation in New York State. *American Journal of Public Health*, 96(2), 296.

Adlaf, E. M., Gliksman, L., Demers, A., & Newton-Taylor, B. (2002). Cigarette use among Canadian undergraduates. *Canadian journal of public health. Revue canadienne de sante publique*, *94*(1), 22-24.

Al-Bedah, A. M. & Qureshi, N, A. (2012). Invited commentary. *Tobacco Control*, 21 (2), 198-201.

Alday, J. Survey indicates fewer people in Beijing and Shanghai intended to give cigarettes as gifts after seeing mass media campaign. 2009. Retrieved from: http://www.worldlungfoundation.org/ht/display/ReleaseDetails/i/6253/pid/6858

Anleu, S. L. R. (1998). The role of civil sanctions in social control: a socio-legal examination. *Crime Prevention Studies*, 9, 21-43.

American College Health Association (2008). American College Health Association-National College Health Assessment spring 2007 reference group data report (abridged). *Journal of American College Health*, 56(5), 469–79.

Amos, A., Greaves, L., Nichter, M., & Bloch, M. (2012). Women and tobacco: a call for including gender in tobacco control research, policy and practice. *Tobacco Control*, 21(3), 236-243.

Anderson, K., & Smith, S. J. (2001). Editorial: emotional geographies. *Transactions of the Institute of British Geographers*, 26(1), 7-10.

Andrews, G. J., Evans, J., Dunn, J. R., & Masuda, J. R. (2012). Arguments in Health Geography: On Sub-Disciplinary Progress, Observation, Translation. *Geography Compass*, 6(6), 351-383.

Arbour-Nicitopoulos, K. P., Kwan, M. Y., Lowe, D., Taman, S., & Faulkner, G. E. (2010). Social norms of alcohol, smoking, and marijuana use within a Canadian university setting. *Journal of American College Health*, *59*(3), 191-196.

Aronson, E., Wilson, T. D. & Akert, R. M. (2010). *Social Psychology*. 7th ed. Upper Saddle River, NJ: Prentice Hall.

Ashley, M. J., & Cohen, J. E. (2003). What the public thinks about the tobacco industry and its products. *Tobacco Control*, 12(4), 396-400.

Baillie, L., Callaghan, D., & Smith, M. L. (2011). Canadian campus smoking policies: investigating the gap between intent and outcome from a student perspective. *Journal of American College Health*, 59(4), 260-265.

Baillie, L., Callaghan, D., Smith, M., Bottorff, J., Bassett-Smith, J., Budgen, C., & Federsen, M. (2009). A review of undergraduate university tobacco control policy process in Canada. *Health Education Research*, 24(6), 922-929.

Baluja, K. F., Park, J., & Myers, D. (2003). Inclusion of immigrant status in smoking prevalence statistics. *American Journal of Public Health*, 93(4), 642-646.

Barnett, R., Pearce, J., & Moon, G. (2009). Community inequality and smoking cessation in New Zealand, 1981–2006. *Social Science & Medicine*, 68(5), 876-884.

Barry, D. T. (2001). Development of a new scale for measuring acculturation: The East Asian Acculturation Measure (EAAM). *Journal of Immigrant Health*, *3*(4), 193-197.

Bauer, J. E., Hyland, A., Li, Q., Steger, C., & Cummings, K. M. (2005). A longitudinal assessment of the impact of smoke-free worksite policies on tobacco use. *American Journal of Public Health*, 95(6), 1024.

Bayer, R., & Bachynski, K. E. (2013). Banning Smoking In Parks And On Beaches: Science, Policy, And The Politics Of Denormalization. *Health Affairs*, 32(7), 1291-1298.

BBC News. (2006). *Scotland begins pub smoking ban*. Retrieved from: http://news.bbc.co.uk/2/hi/uk_news/scotland/4845260.stm

Bell, K., McCullough, L., Salmon, A., & Bell, J. (2010). 'Every space is claimed': smokers' experiences of tobacco denormalisation. *Sociology of Health & Illness*, 32(6), 914-929.

Berg, C. J., Parelkar, P. P., Lessard, L., Escoffery, C., Kegler, M. C., Sterling, K. L., & Ahluwalia, J. S. (2010). Defining 'smoker': College student attitudes and related smoking characteristics. *Nicotine & Tobacco Research*, 12(9), 963-969.

Berkowitz, A. D. (2005). An overview of the social norms approach. *Changing the culture of college drinking: A socially situated health communication campaign*, 193-214.

Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. Padilla (Ed.), *Acculturation: Theory, models, and some new findings* (pp. 9-26). Boulder, CO: Westview.

Berry, J. W. (1990). Psychology of acculturation: Understanding individuals moving between cultures. In R. W. Brislin (Ed.), *Applied cross-cultural psychology* (pp. 232-253). Newbury Park, CA: Sage.

Blanton, H., Köblitz, A., & McCaul, K. D. (2008). Misperceptions about norm misperceptions: Descriptive, injunctive, and affective 'social norming'efforts to change health behaviors. *Social and Personality Psychology Compass*, 2(3), 1379-1399.

Davidson, J., Smith, M., & Bondi, L. (Eds.). (2007). *Emotional Geographies*. Ashgate Publishing, Ltd.

Borio, G. (2003). *Tobacco timeline: The twentieth century 1950 – 1999 - The battle is joined*. Retrieved from: http://archive.tobacco.org/resources/history/TobaccoHistory20-2.html

Borland, R., Owen, N., Hill, D., & Schofield, P. (1991). Predicting attempts and sustained cessation of smoking after the introduction of workplace smoking bans. *Health Psychology*, 10(5), 336.

Borland, R., Yong, H., Siahpush, M., Hyland, A., Campbell, S., Hastings, G., & ... Fong, G. (2006). Support for and reported compliance with smoke-free restaurants and bars by smokers in four countries: findings from the International Tobacco Control (ITC) Four Country Survey. *Tobacco Control, 15(Suppl* 3), iii34-iii41.

Bottorff, J. L., Oliffe, J., Kalaw, C., Carey, J., & Mroz, L. (2006). Men's constructions of smoking in the context of women's tobacco reduction during pregnancy and postpartum. *Social Science & Medicine*, *62*(12), 3096-3108.

Brandon, T. H., & Baker, T. B. (1991). The Smoking Consequences Questionnaire: The subjective expected utility of smoking in college students. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *3*(3), 484.

Brandt, A. M. (1998). Blow some my way: passive smoking, risk and American culture. *Clio-Medica-Amsterdam*, 46, 164-170.

Bruce Newbold, K., & Danforth, J. (2003). Health status and Canada's immigrant population. *Social Science & Medicine*, *57*(10), 1981-1995.

Bryan-Jones, K., & Chapman, S. (2006). Political dynamics promoting the incremental regulation of secondhand smoke: a case study of New South Wales, Australia. *BMC Public Health*, 6(1), 192.

Burrows, D. S. (1984, February 29). Younger adult smokers: Strategies and opportunities (Report for RJ Reynolds. Exhibit 12, 579, State of Minnesota and Blue Cross and Blue Shield of Minnesota v. Philip Morris, Inc., et al.).

Butler, K. M., Fallin, A., & Ridner, S. (2012). Evidence-based smoking cessation for college students. *Nursing Clinics of North America*, 47(1), 21-30.

Callinan, J. E., Clarke, A., Doherty, K., & Kelleher, C. (2010). Legislative smoking bans for reducing secondhand smoke exposure, smoking prevalence and tobacco consumption. *Cochrane Database of Systermatic Reviews*, 4.

Canadian Cancer Society. (2010). *Canada's implementation of the Framework Convention on Tobacco Control*. Retrieved from: http://www.smoke-free.ca/pdf_1/FCTC-Shadow-2010-Canada.pdf

Carey, K. B., Borsari, B., Carey, M. P., & Maisto, S. A. (2006). Patterns and importance of self-other differences in college drinking norms. *Psychology of Addictive Behaviours*, 20(4), 385.

CBC News. (2014). *E-cigarettes on planes: legal grey area left up to carriers*. Retrieved from: http://www.cbc.ca/news/canada/calgary/e-cigarettes-on-planes-legal-grey-area-left-up-to-carriers-1.2500896

CBC News. *China bans government officials from smoking in public places*. Dec 30, 2013. Retrieved from: http://www.cbc.ca/news/health/china-bans-government-officials-from-smoking-in-public-places-1.2479367

Centers for Disease Control and Prevention. (2009). Cigarette smoking among adults and trends in smoking cessation-United States, 2008. *Morbidity and Mortality Weekly Report*, 58(44), 1227.

Champion, D., & Chapman, S. (2005). Framing pub smoking bans: an analysis of Australian print news media coverage, March 1996–March 2003. *Journal of Epidemiology and Community Health*, 59(8), 679-684.

Chapman, S. (2007). Public health advocacy and tobacco control: Making smoking history. Oxford: Blackwell.

Chapman, S., & Freeman, B. (2008). Markers of the denormalisation of smoking and the tobacco industry. *Tobacco Control*, 17(1), 25-31.

Chen, X., & Unger, J. B. (1999). Hazards of smoking initiation among Asian American and non-Asian adolescents in California: A survival model of analysis. *Preventive Medicine*, 28, 589-599.

Chiu, S., Redelmeier, D.A., Tolomiczenko, G., Kiss, A., & Hwang, S.W. (2009). The health of homeless immigrants. *Journal of Epidemiology and Community Health*, 63(11), 943-948.

Christakis, N. A., & Fowler, J. H. (2008). The collective dynamics of smoking in a large social network. *New England journal of medicine*, *358*(21), 2249-2258.

Chuang, S., & Huang, S. (2012). Changes in smoking behavior among college students following implementation of a strict campus smoking policy in Taiwan. *International Journal of Public Health*, 57(1), 199-205.

Clark, L., & Hofsess, L. (1998). *Acculturation* (pp. 37-59). Springer US.

Clark, M. M., Croghan, I. T., Reading, S., Schroeder, D. R., Stoner, S. M., Patten, C. A., & Vickers, K. S. (2005). The relationship of body image dissatisfaction to cigarette smoking in college students. *Body Image*, *2*(3), 263-270.

Collins, D., & Procter, A. (2011). Smoking's shrinking geographies. *Geography Compass*, 5(12), 918-931.

Collier, S. J. (2009). Topologies of power: Foucault's analysis of political government beyond 'governmentality'. *Theory, Culture & Society*, 26(6), 78-108.

Colombo, M. (2014). Caring, the Emotions, and Social Norm Compliance. *Journal Of Neuroscience, Psychology, & Economics*,*7*(1), 33-47.

Correia, C. J., Ballard, S. D., Henslee, A. M., & Irons, J. G. (2006). Short communication: perceived consequences of cigarette use among college students. *Addictive Behaviors*, 31, 1490-1495.

Crawford, M., Balch, G., & Mermelstein, R. (2002). Responses to tobacco control policies among youth. *Tobacco Control*, 11(1), 14-19.

Crimmins, E. M., Preston, S. H., & Cohen, B. (Eds.). (2011). *Explaining divergent levels of longevity in high-income countries*. National Academies Press.

Cronk, N. J., & Piasecki, T. M. (2010). Contextual and subjective antecedents of smoking in a college student sample. *Nicotine & Tobacco Research*, 12(10), 997-1004.

Cronk, N. J., Harris, K., Harrar, S. W., Conway, K., Catley, D., & Good, G. E. (2011). Analysis of Smoking Patterns and Contexts Among College Student Smokers. *Substance Use & Misuse*, 46(8), 1015-1022.

Croucher, R., & Choudhury, S. R. (2007). Tobacco control policy initiatives and UK resident Bangladeshi male smokers: community-based, qualitative study. *Ethnicity and Health*, 12(4), 321-337.

Cunningham, S., Ruben, J., & Narayan, V. (2008). Health of foreign-born people in the United States: a review. *Health & Place*, 14, 623e635.

Cutler, D. M., & Glaeser, E. L. (2009). Why do Europeans smoke more than Americans? *In Developments in the Economics of Aging* (pp. 255-282). University of Chicago Press.

Davidson, J., & Milligan, C. (2004). Embodying emotion sensing space: introducing emotional geographies. *Social & Cultural Geography*, 5(4), 523-532.

Davidson, J., & Smith, M. (2009). *Emotional Geographies*. Elsevier, Inc.

De Maio, F. G. (2012). Understanding the health transitions of immigrants to Canada: research priorities. *Journal of Health Care for the Poor and Underserved*, 23, 958-962.

De Maio, F. G., & Kemp, E. (2010). The deterioration of health status among immigrants to Canada. *Global Public Health*, 5(5), 462-478.

Denzin, N.K., & Lincoln, Y.S. (1998). Introduction: entering the field of qualitative research. In N.K. Denzin & Y.S. Lincoln (eds.). *Strategies of qualitative inquiry*. London: Sage, 1-34.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314-321.

Ding, D., & Hovell, M. F. (2012). Cigarettes, social reinforcement, and culture: a commentary on 'Tobacco as a social currency: cigarette gifting and sharing in China'. *Nicotine & Tobacco Research*, 14(3), 255-257.

Dohrenwend, B. P. (1959). Egoism, altruism, anomie, and fatalism: A conceptual analysis of Durkheim's types. *American Sociological Review*, 466-473.

Domnich, A., Panatto, D., Gasparini, R., & Amicizia, D. (2012). The 'healthy immigrant' effect: does it exist in Europe today? *Italian Journal of Public Health*, 9(3), E75321-E75327.

Dong-Chul, S., Jonathan T., M., Mohammad R., T., & Susan E., M. (n.d). The effect of a smoke-free campus policy on college students' smoking behaviors and attitudes. *Preventive Medicine*, 53(Special Section: Epidemiology, Risk, and Causation), 347-352.

Donovan, C. J. and Duncan, R. I. (2009). Situating Politics in Health and Medical Geography, In T. Brown, S. McLafferty and G. Moon *(Eds.), A Companion to Health and Medical Geography* (pp. 173-187), Wiley-Blackwell, Oxford, UK.

Donovan, J., d'Espaignet, E., Metron, C., & van Ommeren, M. (1992*). Immigrants in Australia: A Health Profile*, *Australian Institute of Health and Welfare Ethnic Health Series, No 1.* Canberra: Australian Government Publishing Service.

Douglas, J. D. (1985). *Creative Interviewing*. London: Sage.

Dowling, R. (2005). Power, subjectivity, and ethics in qualitative research. In I. Hay (ed.). *Qualitative Research Methods in Human Geography* (pp. 19-29). Oxford: Oxford University Press.

Dube, S. R., Asman, K., Malarcher, A., & Carabollo, R. (2009). Cigarette smoking among adults and trends in smoking cessation-United States, 2008. *Morbidity and Mortality Weekly Report*, 58(44), 1227-1232.

Edwards, R., Thomson, G., Wilson, N., Waa, A., Bullen, C., O'Dea, D., ... & Woodward, A. (2008). After the smoke has cleared: evaluation of the impact of a new national smoke-free law in New Zealand. *Tobacco Control*, 17(1), e2-e2.

Elkind, A. K. (1985). The social definition of women's smoking behaviour. *Social Science & Medicine*, 20(12), 1269-1278.

Elster, J. (1996). Rationality and the emotions. *Economic Journal*, (438), 1386.

Elton-Marshall, T., Fong, G. T., Zanna, M. P., Jiang, Y., Hammond, D., O'Connor, R. J., ... & Driezen, P. (2010). Beliefs about the relative harm of 'light' and 'low tar' cigarettes: findings from the International Tobacco Control (ITC) China Survey. *Tobacco Control, 19(Suppl 2)*, i54-i62.

England, K. (1994). Getting Personal: Reflexivity, Positionality, and Feminist Research. *The Professional Geographer*, 46(1), 80-89.

Eriksen, M., Mackay, J. L., & Ross, H. (2012). *The Tobacco Atlas*. Atlanta: American Cancer Society. Retrieved from: http://www.tobaccoatlas.org/uploads/Images/PDFs/Tobacco_Atlas_2ndPrint.pdf

Etzioni, A. (2000). Social norms: Internalization, persuasion, and history. *Law and Society Review*, 157-178.

Farrimond, H. R., & Joffe, H. (2006). Pollution, peril and poverty: a British study of the stigmatization of smokers. *Journal of Community & Applied Social Psychology*, 16(6), 481-491.

Feng, G. Z., Jiang, Y. & Yang, Y. (2011). Survey on Smoking-Related Attitudes and Behavior of Civil Servants across China in 2008. *Chinese Journal of Prevention and Control of Chronic Diseases*, 3, 004.

Fennelly, K. (2005). The 'healthy migrant' effect. *Healthy Generations*, 5(3), 1-3.

Fernández, E., Fu, M., Pascual, J. A., López, M. J., Pérez-Ríos, M., Schiaffino, A., ... & Spanish Smoking Law Evaluation Group. (2009). Impact of the Spanish smoking law on exposure to second-hand smoke and respiratory health in hospitality workers: a cohort study. *Public Library of Science One*, 4(1), e4244.

Fichtenberg, C. M., & Glantz, S. A. (2002). Effect of smoke-free workplaces on smoking behaviour: systematic review. *British Medical Journal*, 325(7357), 188.

Fisher, J. M. (1976). Sex differences in smoking dynamics. *Journal of Health and Social Behavior*, 155-162.

Fong, G. T., Hyland, A., Borland, R., Hammond, D., Hastings, G., McNeill, A., ... & Driezen, P. (2006). Reductions in tobacco smoke pollution and increases in support for smoke-free public places following the implementation of comprehensive smoke-free workplace legislation in the Republic of Ireland: findings from the ITC Ireland/UK Survey. *Tobacco Control*, 15(suppl 3), iii51-iii58.

Foucault, M. (1988). *Technologies of the self: A seminar with Michel Foucault*. University of Massachusetts Press.

Foucault, M. (1994). The politics of health in the eighteenth century, In J. Faubion (ed.), *Power, the essential works* (Vol, 3, pp. 90-105). New York: New Press.

Gastaldo D. (1997). Is health education good for you? Re-thinking health education through the concept of bio-power. In: A. Petersen and R. Bunton (Eds.), *Foucault Health and Medicine* (pp. 113-133). Routledge, London.

Gau, S. S. F., Lai, M. C., Chiu, Y. N., Liu, C. T., Lee, M. B., & Hwu, H. G. (2009). Individual and family correlates for cigarette smoking among Taiwanese college students. *Comprehensive Psychiatry*, 50(3), 276-285.

Georgiades, K., Boyle, M. H., Duku, E., & Racine, Y. (2006). Tobacco use among immigrant and nonimmigrant adolescents: individual and family level influences. *Journal of Adolescent Health*, *38*(4), 443-e1.

Gesler, W. M. (1992). Therapeutic landscapes: medical issues in light of the new cultural geography. *Social Science & Medicine*, 34(7), 735-746.

Gibbs, J. P. (1965). Norms: The Problem of Definition and Classification. *American Journal of Sociology*, (5). 586.

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, *204*(6), 291-295.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.

Gordon, M. M. (1964). *Assimilation In American Life: The Role Of Race, Religion And National Origins.* Publisher: Oxford.

Government of Alberta. (2011). *Immigrant Health in Alberta*. Retrieved from: http://www.health.alberta.ca/documents/Immigrant-Health-Alberta-2011.pdf

Greco, M. (1993). Psychosomatic subjects and the 'duty to be well'. personal agency within. *Economy and Society*, 22(3), 357-372.

Grunberg, N. E., Winders, S. E., & Wewers, M. E. (1991). Gender differences in tobacco use. *Health Psychology*, 10(2), 143.

Gushulak, B. D., Pottie, K., Roberts, J. H., Torres, S. & DesMeules, M. (2011). Migration and health in Canada: health in the global village. *Canadian Medical Association Journal*, 183(12), E952-E958.

Halperin, A. C., Smith, S. S., Heiligenstein, E., Brown, D., & Fleming, M. F. (2010). Cigarette smoking and associated health risks among students at five universities. *Nicotine & Tobacco Research*, 12(2), 96-104.

Hammond, D., Fong, G. T., Zanna, M. P., Thrasher, J. F., & Borland, R. (2006). Tobacco denormalization and industry beliefs among smokers from four countries. *American Journal of Preventive Medicine*, *31*(3), 225-232.

Hammond, D., Tremblay, I., Chaiton, M., Lessard, E., Callard, C., & the Tobacco on Campus Workgroup. (2005). Tobacco on campus: industry marketing and tobacco control policy among post-secondary institutions in Canada. *Tobacco Control*, 14(2), 136-140.

Hammond, E. C., & Garfinkel, L. (1961). Smoking habits of men and women. *Journal of the National Cancer Institute*, 27, 419-442.

Health Canada. (1999). *Office of Tobacco Control qualitative (focus group) report regarding health warning labels and images on cigarette packages / prepared by Environics Research Group Limited*. Ottawa: Office of Tobacco Control, Health Canada.

Health Canada. (2013). *Canadian Tobacco Use Monitoring Survey (CTUMS)*. Ottawa: Office of Tobacco Control, Health Canada. Retrieved from http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2012-eng.php

Health Canada. (2006). *Canadian Tobacco Use Monitoring Survey (CTUMS)*. Ottawa: Office of Tobacco Control, Health Canada. Retrieved from: http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/ctumsesutc_2006_e.html.

Herbert, R., Gagnon, A., O'Loughlin, J., & Rennick, J. (2011). Testing an empowerment intervention to help parents make homes smoke-free: A randomized controlled trial. *Journal of Community Health*, 36(4), 650-657.

Highet, G., Ritchie, D., Platt, S., Amos, A., Hargreaves, K., Martin, C., & White, M. (2011). The re-shaping of the life-world: male British Bangladeshi smokers and the English smoke-free legislation. *Ethnicity & Health*, 16(6), 519-533.

Hill, T. D., Angel, J. L., Balistreri, K. S., & Herrera, A. P. (2012). Immigrant status and cognitive functioning in late-life: An examination of gender variations in the healthy immigrant effect. *Social Science & Medicine*, 75, 2076-2084.

Howell, F. (2005). Smoke-free bars in Ireland: a runaway success. *Tobacco Control*, 14(2), 73-74.

Hu, M., Rich, Z. C., Luo, D., & Xiao, S. (2012). Cigarette sharing and gifting in rural China: a focus group study. *Nicotine & Tobacco Research*, 14(3), 361-367.

Hyman, I. (2001). *Immigration and Health*. Health Canada: Ottawa.

Häkli, J. (2009). Governmentality. *In Kitchin, Rob & Thrift, Nigel (eds.). International Encyclopedia of Human Geography* (Volume 4, pp. 628-633). Oxford. UK: Elsevier.

International Agency for Research on Cancer. (2009). *Evaluating the effectiveness of smoke-free policies [electronic resource]*. Lyon, France.

International Agency for Research on Cancer. (2010). *A Review of Human Carcinogens: Personal Habits and Indoor Combustions*. Retrieved from: http://monographs.iarc.fr/ENG/Monographs/vol100E/mono100E.pdf. Lyon, France.

Jasso, G., Massey, D. S., Rosenzweig, M. R., & Smith, J. P. (2004). Immigrant health: selectivity and acculturation. *Critical perspectives on racial and ethnic differences in health in late life*, 227-266.

Jenkins, C. N., McPhee, S. J., Ha, N., Nam, T. V., & Chen, A. (1995). Cigarette smoking among Vietnamese immigrants in California. *American Journal of Health Promotion*, 9, 254–256.

Ji, M., Ding, D., Hovell, M. F., Xia, X., Zheng, P., & Fu, H. (2009). Home smoking bans in an urbanizing community in China. *American Journal of Preventive Medicine,* 37(2), 132-136.

Jin J. (2012). FCTC and China's Politics of Tobacco Control. *The 4th GLF Annual Colloquium*. Retrieved from: http://www.princeton.edu/~pcglobal/conferences/GLF/jin.pdf

Johnston, L. (2010). *Monitoring the future: National results on adolescent drug use: Overview of key findings (No. 9)*. DIANE Publishing.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2009). Monitoring the Future: National Survey Results on Drug Use, 1975-2008. Volume I, Secondary School Students. NIH Publication No. 09-7402. *National Institute on Drug Abuse (NIDA)*.

Juon, H., Kim, M., Han, H., Ryu, J. P., & Han, W. (2003). Acculturation and cigarette smoking among Korean American men. *Yonsei Medical Journal*, 4, 875-882

Kandula, N. R., Wen, M., Jacobs, E. A., & Lauderdale, D. S. (2009). Association between neighborhood context and smoking prevalence among Asian Americans. *American Journal of Public Health*, *99*(5), 885.

Kaufman, P., Griffin, K., Cohen, J., Perkins, N., & Ferrence, R. (2010). Smoking in urban outdoor public places: Behaviour, experiences, and implications for public health. *Health & Place*, (5), 961-968.

Kennedy, S., McDonald, J.T., & Biddle, N. (2006). *The Healthy Immigrant Effect and Immigrant Selection: Evidence from Four Countries*. Hamilton, Ontario: SEDAP Research Program.

Keung, N. (2011). *Canadian lifestyle hazardous to immigrant health*. Retrieved from: http://www.thestar.com/life/health_wellness/news_research/2011/08/09/canadian_lifestyle_hazardous_to_immigrant_health.html

Kim, S. S., Son, H., & Nam, K. A. (2005). The socio-cultural context of Korean American men's smoking behaviour. *Western Journal of Nursing Research*, 27(5), 604-623.

Kobayashi, K.M., & Prus, S.G. (2012). Examining the gender, ethnicity, and age dimensions of the healthy immigrant effect: Factors in the development of equitable health policy. *International Journal for Equity in Health*, 11(8), 1-6.

Krueger, R. A. (2009). *Focus groups: A Practical Guide for Applied Research*. Sage.

Kuo, B. C., & Roysircar, G. (2004). Predictors of acculturation for Chinese adolescents in Canada: Age of arrival, length of stay, social class, and English reading ability. *Journal of Multicultural Counseling and Development*, *32*(3), 143-154.

Lear, S.A., Humphries, K.H., Hage-Moussa, S., Chockalingam, A., & Mancini, G.B. (2009). Immigration presents a potential increased risk for atherosclerosis. *Atherosclerosis*, 205(2), 584-589.

Leatherdale, S. T., & Ahmed, R. (2009). Second-hand smoke exposure in homes and in cars among Canadian youth: current prevalence, beliefs about exposure, and changes between 2004 and 2006. *Cancer Causes & Control*, 20(6), 855-865.

Lee, J. S., Koeske, G. F., & Sales, E. (2004). Social support buffering of acculturative stress: A study of mental health symptoms among Korean international students. *International Journal of Intercultural Relations*, *28*(5), 399-414.

Levine, J. M., & Moreland, R. L. (1998). *Small groups. In D. Gilbert, S. Fiske, & G. Lindzey (Eds.)*, Handbook of social psychology (4th. ed., Vol. 2, pp. 415-469).

Levinson, A.H., Campo, S., Gascoigne, J., Jolly, O., Zakharyan, A., & Tran, Z.V. (2007). Smoking, but not smokers: Identity among college students who smoke cigarettes. *Nicotine and Tobacco Research*, 9, 845-852.

Lewis, D. K. (1969). *Convention: A Philosophical Study*. Cambridge, MA: Harvard University Press.

Lewis, M. A., & Neighbors, C. (2004). Gender-specific misperceptions of college student drinking norms. *Psychology of Addictive Behaviors*, 18, 334–339.

Li, Q., Hyland, A., O'Connor, R., Zhao, G., Du, L., Li, X., & Fong, G. T. (2010). Support for smoke-free policies among smokers and non-smokers in six cities in China: ITC China Survey. *Tobacco Control, 19(Suppl 2)*, i40-i46.

Li, S., & Delva, J. (2012). Social capital and smoking among Asian American men: An exploratory study. *American Journal of Public Health*, *102*(S2), S212-S221.

Liu, R., Yang, Y., Travers, M., Fong, G., O'Connor, R., Hyland, A., & ... Jiang, Y. (2010). A cross-sectional study on levels of second-hand smoke in restaurants and bars in five cities in China. *Tobacco Control, 19(Suppl 2)*, i24-i29.

Lopez, A. D., Collishaw, N. E., & Piha, T. (1994). A descriptive model of the cigarette epidemic in developed countries. *Tobacco Control*, 3(3), 242.

Luoto, R., Uutela, A., & Puska, P. (2000). Occasional smoking increases total and cardiovascular mortality among men. *Nicotine & Tobacco Research*, 2, 133-139.

Lv, J., Su, M., Hong, Z., Zhang, T., Huang, X., Wang, B., & Li, L. (2011). Implementation of the WHO framework convention on tobacco control in mainland China. *Tobacco Control*, 20(4), 309-314.

Ma, G. X., Fang, C. Y., Tan, Y., & Feeley, R. M. (2003). Perceptions of risks of smoking among Asian Americans. *Preventive Medicine*, 37, 349-355.

Ma, G. X., Shive, S. E., Tan, Y., Toubbeh, J. I., Fang, C. Y., & Edwards, R. L. (2005). Tobacco use, secondhand smoke exposure and their related knowledge, attitudes and behaviours among Asian Americans. *Addictive Behaviours*, 30, 725-740.

Ma, J., Apelberg, B. J., Avila-Tang, E., Yang, G., Ma, S., Samet, J. M., & Stillman, F. A. (2010). Workplace smoking restrictions in China: results from a six county survey. *Tobacco Control,* 19(5), 403-409.

Malone, R. E. (2011). China's chances, China's choices in global tobacco control. *Tobacco Control*, 19, 1-2.

Mao, A., Bristow, K., & Robinson, J. (2013). Caught in a dilemma: why do non-smoking women in China support the smoking behaviors of men in their families. *Health Education Research*, 28(1), 153-164.

Marmot, M. (2006). Smoking and Inequalities. *Lancet*. 368(9533), 341-2.

Martens, M., Page, J., Mowry, E., Damann, K., Taylor, K., & Cimini, M. (2006). Differences between actual and perceived student norms: An examination of alcohol use, drug use, and sexual behavior. *Journal of American College Health*, 54, 295-300.

Martin, R. (2001). Geography and public policy: the case of the missing agenda. *Progress in Human Geography*, 25(2), 189-210.

Maxwell, A. E., Bernaards, C. A., & McCarthy, W. J. (2005). Smoking prevalence and correlates among Chinese- and Filipino-American adults: Findings from the 2001 California Health Interview Survey. *Preventive Medicine*, 41, 693-699.

McCabe, S. E., Teter, C. J., Boyd, C. J., Knight, J. R., & Wechsler, H. (2005). Nonmedical use of prescription opioids among US college students: Prevalence and correlates from a national survey. *Addictive Behaviors*, *30*(4), 789-805.

McChargue, D. E., Cohen, L. M., & Cook, J. W. (2004). The influence of personality and affect on nicotine dependence among male college students. *Nicotine & Tobacco Research*, 6(2), 287-294.

McCleary-Sills, J. D., Villanti, A., Rosario, E., & Bone, L. (2010). Influences on tobacco use among urban Hispanic young adults in Baltimore: findings from a qualitative study. *Progress in Community Health Partnerships: Research, Education, and Action*, 4(4), 289-297.

McDonald, J., & Kennedy, S. (2005). 'Is migration to Canada associated with unhealthy weight gain? Overweight and obesity among Canada's immigrants'. *Social Science and Medicine*, 61, 2469-2481.

McDonald, J. T. (2005). *The Health Behaviors of Immigrants and Native-born People in Canada*. SEDAP Research Program, McMaster University.

McMullen, K. (2009), 'College and university graduates with low earnings in Canada: Demographic and labour market characteristics', *Education Matter*, 6(2). Ottawa: Statistics Canada.

Merton, R.K. & Kendall, P.L. (1946). 'The Focused Interview', *American Journal of Sociology*, 51, 541-557.

Ministry of Health. (2005). *The smoke is clearing: Anniversary report 2005*. Wellington: Ministry of Health. Retrieved from: http://www.moh.govt.nz/moh.nsf/wpg_index/Publications-Smoke+is+Clearing:+Anniversary+Report+2005

Ministry of Health. (2010). *Tobacco use in New Zealand: Key findings from the 2009 New Zealand tobacco use survey*. Wellington: Ministry of Health.

Moeschberger, M. L., Anderson, J., Kuo, Y., Chen, M. S., Wewers, M., & Guthrie, R. (1997). Multivariate profile of smoking in Southeast Asian men: A biochemically verified analysis. *Preventive Medicine*, 26, 53-58.

Moran, S., Wechsler, H., & Rigotti, N. A. (2004). Social smoking among US college students. *Pediatrics*, *114*(4), 1028-1034.

Morgan, D. L., & Krueger, R. A. (1993) 'When to use focus groups and why' in Morgan D.L. (Ed.), *Successful Focus Groups*. London: Sage.

Mori, S. C. (2000). Addressing the mental health concerns of international students. *Journal of Counseling & Development*, *78*(2), 137-144.

Morley, K. I., Hall, W. D., Hausdorf, K., & Owen, N. (2006). 'Occasional' and 'social' smokers: Potential target groups for smoking cessation campaigns? *Australian and New Zealand Journal of Public Health*, 30, 550-554.

Morrell, H. E., Cohen, L. M., & McChargue, D. E. (2010). Depression vulnerability predicts cigarette smoking among college students: Gender and negative reinforcement expectancies as contributing factors. *Addictive Behaviors*, *35*(6), 607-611.

Naiman, A. B., Glazier, R. H., & Moineddin, R. (2011). Is there an impact of public smoking bans on self-reported smoking status and exposure to secondhand smoke?. *BMC Public Health*, 11(1), 146.

Nakhaee, N., Divsalar, K., & Bahreinifar, S. (2011). Prevalence of and factors associated with cigarette smoking among university students: a study from Iran. *Asia-Pacific Journal of Public Health*, 23(2), 151-156.

Neighbors, C., Dillard, A. J., LEWIS, M. A., Bergstrom, R. L., & Neil, T. A. (2006). Normative misperceptions and temporal precedence of perceived norms and drinking. *Journal of studies on alcohol*, *67*(2), 290-299.

Newbold, K. B., & Neligan, D. (2012). Disaggregating Canadian immigrant smoking behaviour by country of birth. *Social Science & Medicine*, 75, 997-1005.

Ng, M., Freeman, M. K., Fleming, T. D., Robinson, M., Dwyer-Lindgren, L., Thomson, B., ... & Gakidou, E. (2014). Smoking prevalence and cigarette consumption in 187 countries, 1980-2012. *Journal of the American Medical Association*, 311(2), 183-192.

Nierkens, V., Vries, H. De., & Stonks, K. (2006). Smoking in immigrants: do socioeconomic gradients follow the pattern expected from the tobacco epidemic? *Tobacco Control*, 15, 385-391.

Noh, S., & Kaspar, V. (2003). *Diversity and Immigrant Health*. Toronto: University of Toronto.

Nolan, A. (2012). The 'healthy immigrant' effect: initial evidence for Ireland. Health Economics, *Policy and Law*, 7, 343-362.

Non-Smokers' Rights Association. (April, 2014). *Cigarette prices in Canada*. Retrieved from: https://www.nsra-adnf.ca/cms/file/files/140401_map_and_table.pdf

Non-Smokers' Rights Association. (March, 2012). *Provincial and territorial smokefFree legislation*. Retrieved from http://www.nsra-adnf.ca/cms/file/all_jurisdictions_Mar_2012.pdf

Oliver, R. L., & Bearden, W. O. (1985). Crossover effects in the theory of reasoned action: A moderating influence attempt. *Journal of Consumer Research*, 324-340.

O' Loughlin, J., Maximova, K., Fraser, K., & Gray-Donald, K. (2010). Does the 'Healthy Immigrant Effect' extend to smoking in immigrant children? *Journal of Adolescent Health*, 46, 299-301.

OECD. (2013). *Health at a Glance 2013: OECD Indicators*. OECD Publishing. Retrieved from: http://dx.doi.org/10.1787/health_glance-2013-en

Öncel, S. Y., Gebizlioğlu, Ö. L., & Alioğlu, F. A. (2011). Risk factors for smoking behavior among university students. *Turkish Journal of Medical Sciences*, 41, 1071-80.

Osypuk, T. L., Subramanian, S.V., Kawachi, I. &Acevedo-Garcia, D. (2009). Is workplace smoking policy equally prevalent and equally effective for immigrants? *Journal of Epidemiology and Community Health*. 63(10), 784-791.

Otten, R., Engels, C. M. E. and van den Eijnden, R. J. J. M. (2005). Parental smoking and smoking behavior in Asthmatic and nonasthmatic adolescents. *Journal of Asthma*, 42 (5), 349-355.

Pacheco, J. (2013). Attitudinal policy feedback and public opinion the impact of smoking bans on attitudes towards smokers, secondhand smoke, and antismoking policies. *Public Opinion Quarterly*, 77(3), 714-734.

Paek, H. (2009). Differential effects of different peers: further evidence of the peer proximity thesis in perceived peer influence on college students' smoking. *Journal of Communication*, 59(3), 434- 455.

Page, R.M. (1998). College students' distorted perception of the prevalence of smoking. *Psychological Reports*, 82, 474.

Pampel, F. C. (2002). Inequality, diffusion, and the status gradient in smoking. *Social Problems*, 49(1), 35-57.

Perez, C. E. (2002). Health status and health behaviour among immigrants. *Health Reports*, *13(Suppl.)*, 1-12.

Perkins, H., & Craig, D. W. (2006). A successful social norms campaign to reduce alcohol misuse among college student-athletes. *Journal of Studies on Alcohol and Drugs*, 67(6), 880.

Pierce, J. P. (1991). Progress and problems in international public health efforts to reduce tobacco usage. *Annual Review of Public Health*, 12(1), 383-400.

Pierce, J. P., Messer, K., White, M. M., Kealey, S., & Cowling, D. W. (2010). Forty years of faster decline in cigarette smoking in California explains current lower lung cancer rates. *Cancer Epidemiology Biomarkers & Prevention*, 19(11), 2801-2810.

Pile, S. (2010). Emotions and affect in recent human geography. *Transactions of the Institute of British Geographers*, *35*(1), 5-20.

Poland, B. D. (2000). The 'considerate' smoker in public space: the micro-politics and political economy of 'doing the right thing'. *Health & Place*, *6*(1), 1-14.

Procter, A. (2011). *De-normalizing tobacco on campus: the spatial regulation of smoking in three Canadian university environments / by Amy Leigh Procter*. 2011.

Procter-Scherdtel, A., & Collins, D. (2013). Social norms and smoking bans on campus: interactions in the Canadian university context. *Health Education Research*, 28(1), 101-112.

Renaud, T. (2007). *Smoking Ban in Public Areas*. Paris: Institut de Recherche et Documentation en Economie de la Santé (IRDES). Retrieved from: http://www.hpm.org/fr/a9/2.pdf

Rich, Z. C., & Xiao, S. (2012). Tobacco as a social currency: cigarette gifting and sharing in China. *Nicotine & Tobacco Research*, 14(3), 258-263.

Rich, Z., Hu, M., & Xiao, S. (2013). Gifting and sharing cigarettes in a rural Chinese village: a cross-sectional study. *Tobacco Control*, 1-5.

Rigotti, N. A., Moran, S. E., & Wechsler, H. (2005). US college students' exposure to tobacco promotions: prevalence and association with tobacco use. *American Journal of Public Health*, 95(1), 138.

Ritchie, D., Amos, A., & Martin, C. (2010). 'But it just has that sort of feel about it, a leper'—Stigma, smoke-free legislation and public health. *Nicotine & Tobacco Research*, 12(6), 622-629.

Rollins, S., Malmstadt Schumacher, & J.R., Ling, P.M. (2002). *Exploring the phenomenon of social smoking: why do so many young adults social smoke?* Paper presented at: National Conference on Tobacco or Health; November 20, 2002; San Francisco, CA.

Rook, D. W. (2003). Out-of-focus groups. *Marketing Research*, 15 (2), 11.

Rothwell, E. (2010). Analyzing focus group data: content and interaction. *Journal for Specialists in Pediatric Nursing*, *15*(2), 176-180.

Russell, J., Rosenthal, D., & Thomson, G. (2010). The international student experience: three styles of adaptation. *Higher Education*, *60*(2), 235-249.

Sa, J., Seo, D. C., Nelson, T. F., & Lohrmann, D. K. (2013). Cigarette Smoking Among Korean International College Students in the United States. *Journal of American College Health*, *61*(8), 454-467.

Saltman, D., Hitchman, S., Sendzik, T. A. R. Y. N., & Fong, G. (2009). The current status of bans on smoking in vehicles carrying children. *A Canadian Perspective, Report Card on Cancer in Canada*, 10.

Sayer, A. (1992). *Method in Social Science: A Realist Approach.* Routledge: London.

Schultz, A. S., Finegan, B., Nykiforuk, C. I., & Kvern, M. A. (2011). A qualitative investigation of smoke-free policies on hospital property. *Canadian Medical Association Journal*, 183(18), E1334-E1344.

Seigers, D. K., & Terry, C. P. (2011). Perceptions of risk among college smokers: Relationships to smoking status. *Addiction Research & Theory*, *19*(6), 504-509.

Sendzik, T., Fong, G. T., Travers, M. J., & Hyland, A. (2009). An experimental investigation of tobacco smoke pollution in cars. *Nicotine & Tobacco Research*, 11(6), 627-634.

Sepe, E., & Glantz, S.A. (2002). Bar and club promotions in the alternative press: Targeting young adults. *American Journal of Public Health*, 92, 75-78.

Shank, G. D. (2002). *Qualitative Research: A Personal Skills Approach*. Retrieved from: http://www.clarku.edu/~mbamberg/class%20material/107/Qualitative%20Research,%20A%20personal%20sills%20Approach.pdf

Shaw, M. E. (1976). *Group Dynamics: the Psychology of Small Group Behavior*, 2nd Ed. McGraw-Hill Book Company: New York.

Shelley, D., Fahs, M., Scheinmann, R., Swain, S., Qu, J., & Burton, D. (2004). Acculturation and tobacco use among Chinese Americans. *American Journal of Public Health*, 94, 300–307.

Shin, K. H., & Seo, H. C. (2001). The introduction of tobacco and the diffusion of smoking culture in Korea [Abstract]. *Uisahak*, 10(1), 23-59.

Shore, T. H., Tashchian, A., & Adams, J. S. (2000). Development and validation of a scale measuring attitudes toward smoking. *The Journal of Social Psychology*, 140(5), 615-623.

Siahpush, M., McNeill, A., Hammond, D., & Fong, G. T. (2006). Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. *Tobacco Control*, 15(suppl 3), iii65-iii70.

Silverstein, B., Feld, S., & Kozlowski, L. T. (1980). The availability of low-nicotine cigarettes as a cause of cigarette smoking among teenage females. *Journal of Health and Social Behavior*, 21, 383-388.

Smith, M., Davidson, J., Cameron, L., & Bondi, L. (2012). *Emotion, Place and Culture*. Ashgate Publishing, Ltd.

Son, J. (2013). Are immigrants from Asia healthier than immigrants from other regions?: self-reported health status and functional difficulties of immigrants in the USA. *Migration & Integration*, 14, 19-38.

Song, Y. J., Hofstetter, C. R., Hovell, M. F., Paik, H. Y., Park, H. R., Lee, J., & Irvin, V. (2004). Acculturation and health risk behaviors among Californians of Korean descent. *Preventive Medicine*, *39*(1), 147-156.

Statistic Canada. (2011). *Immigration and Ethnocultural Diversity in Canada*. Retrieved from: https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm#a4

Statistics Canada. (2013a). *Immigration and Ethnocultural Diversity in Canada*. Retrieved from: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm

Statistics Canada. (2013b). *Exposure to Second-hand Smoke at Home*, 2010. Retrieved from http://www.statcan.gc.ca/pub/82-625-x/2011001/article/11460-eng.htm

Stephen, E., Foote, K., Hendershot, G., &Schoenborn, C. (1994). Health of the foreign-born population: United States, 1989-90. *Advanced Data*, 241, 1-12.

Stewart, D.W., Shamdasani, P.N., & Rook, D.W. (2007). *Focus Groups: Theory and Practice*, 2nd edition. Thousand Oaks, CA: Sage.

Stuber, J., Galea, S., & Link, B. G. (2008). Smoking and the emergence of a stigmatized social status. *Social Science & Medicine*, 67(3), 420-430.

Terry, D. J., & Hogg, M. A. (1996). Group norms and the attitude-behavior relationship: A role for group identification. *Personality and Social Psychology Bulletin*, *22*(8), 776-793.

Thompson, L., Pearce, J. & Barnett, J. R. (2007). Moralising geographies: stigma, smoking islands, and responsible subjects. *Area*, 39 (4), 508–517.

Thompson, L., Pearce, J. and Barnett, R. (2009). Nomadic identities and socio-spatial competence: making sense of post-smoking selves, *Social & Cultural Geography*, 10 (5), 565-581.

Thomson, M. D., & Hoffman-Goetz, L. (2009). Defining and measuring acculturation: a systematic review of public health studies with Hispanic populations in the United States. *Social Science & Medicine*, *69*(7), 983-991.

Thridandam, M., Fong, W., Jang, M., Louie, L., & Forst, M. (1998). A tobacco and alcohol use profile of San Francisco's Chinese community. *Journal of Drug Education*, 28, 377–393.

Thun, M., Peto, R., Boreham, J., & Lopez, A. D. (2012). Stages of the cigarette epidemic on entering its second century. *Tobacco control*, 21(2), 96-101.

Tong, E. K., Nguyen, T. T., Vittinghoff, E., & Perez-Stable, E. J. (2008). Smoking behaviors among immigrant Asian Americans rules for smoke-free homes. *American Journal of Preventive Medicine*, 35(1), 64-67.

Toronto Public Health. (2011). *Toronto's Health Status Indicator Series: Smoking by Immigrant Status*. Ontario, Toronto: Toronto Public Health.

Townsend, J. (1996). Price and consumption of tobacco. *British Medical Bulletin*, 52(1), 132-142.

Tuathail, G. Ó., & Toal, G. (1996). *Critical geopolitics: The politics of writing global space* (Vol. 6). University of Minnesota Press.

Tymko, M. A. (2013). *When you smoke, they smoke [electronic resource]: children's rights and opinions about vehicular smoking bans / by Morgan Anne Tymko*. c2013.

United States Department of Health and Human Services. (2006). *The health consequences of involuntary exposure to tobacco smoke: a report of the surgeon general*. Atlanta, GA: US Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Vallerand, R. J., Pelletier, L. G., Deshaies, P., Cuerrier, J., & Mongeau, C. (1992). Ajzen and Fishbein's Theory of Reasoned Action as Applied to Moral Behavior: A Confirmatory Analysis. *Journal Of Personality & Social Psychology*, *62*(1), 98-109.

Vedøy, T. F. (2013). The role of education for current, former and never-smoking among non-western immigrants in Norway. Does the pattern fit the model of the cigarette epidemic? *Ethnicity & health*, *18*(2), 190-210.

Voigt, K. (2013). 'If You Smoke, You Stink.' Denormalisation Strategies for the Improvement of Health-Related Behaviours: The Case of Tobacco. *Ethics In Public Health & Health Policy*, 47.

Voigt, K. (2010). Smoking and social justice. *Public Health Ethics*, 3(2), 91-106.

Wakefield, M. A., Chaloupka, F. J., Kaufman, N. J., Orleans, C. T., Barker, D. C., & Ruel, E. E. (2000). Effect of restrictions on smoking at home, at school, and in public places on teenage smoking: cross sectional study. *British Medical Journal*, 321(7257), 333-337.

Waters, K., Harris, K., Hall, S., Nazir, N., & Waigandt, A. (2006). Characteristics of social smoking among college students. *Journal of American College Health*, *55*(3), 133-139.

Wechsler, H., Lee, J.E., & Nelson, T.F. (2002). Underage college students' drinking behavior, access to alcohol, and the influence of deterrence policies. Findings from the Harvard School of Public Health College Alcohol Study. *Journal of American College Health,* 50(5), 223-36.

Weinstein, N. D. (1998). Accuracy of smokers' risk perceptions. *Annals of Behavioral Medicine*, 20(2), 135-140.

Weiss, W. J. & Garbanati, J. A. (2006). Effects of Acculturation and Social Norms on Adolescent Smoking Among Asian-American Subgroups. *Journal of Ethnicity in Substance Abuse*, 5(2), 75-90

Wiecha, J. M., Lee, V., & Hodgkins, J. (1998). Patterns of smoking, risk factors for smoking, and smoking cessation among Vietnamese men in Massachusetts (United States). *Tobacco Control*, 7, 27-34.

Winchester, H. P. M., & Rofe, M.W. (2010) Qualitative research and its place in human geography. In Hay, I. (Ed.), *Qualitative Research Methods in Human Geography, 3rd Ed.* Oxford University Press: Toronto.

World Bank. (2014). *Country and Lending Group*. Retrieved from: http://data.worldbank.org/about/country-classifications/country-and-lending-groups

World Health Organization. (2003). *Framework Convention on Tobacco Control.* Geneva: WHO.

World Health Organization. (2007). *Guidelines on Protection from Exposure to Tobacco Smoke*. Retrieved from: http://www.who.int/fctc/cop/art%208%20guidelines_english.pdf?ua=1

World Health Organization. (2009). *WHO Report on the Global Tobacco Epidemic, 2009, The Mpower Package.* Geneva: WHO.

World Health Organization. (2011). *WHO Report on the Global Tobacco Epidemic, 2011, The Mpower Package.* Geneva: WHO.

World Health Organization. (2013). *Tobacco Factsheet*. Geneva: WHO.

World Health Organization Western Pacific Region. (2014). *Tobacco in China*. Retrieved from: http://www.wpro.who.int/china/mediacentre/factsheets/tobacco/en/

Xiao, L., Yang, Y., Li, Q., Wang, C. X., & Yang, G. H. (2010). Population-based survey of secondhand smoke exposure in China. *Biomedical and Environmental Sciences*, 23(6), 430-436.

Yang, M. (2007). Passive tobacco smoking and health research. In N.A. Jeorgensen, ed. *Passive Smoking and Health Research*. New York: Nova Science Publishers, 43-64.

Yang, T., Xu, X., Rockett, I. R., Guo, W., & Zhou, H. (2011). Effects of household, workplace, and public place smoking restrictions on smoking cessation. *Health & Place*, 17(4), 954-960.

Zhang, J. Y., Chan, S. S. C., Fong, D. Y. T., Malone, R. E., & Lam, T. H. (2012). The social context of smoking cessation in China: An exploratory interview study. *Tobacco control*, 21(1), 57-58.

Zheng, P., Fu, H., & Li, G. (2009). Smoke-free restaurants in Shanghai: Should it be mandatory and is it acceptable? *Health Policy*, 89(2), 216-224.

Zhu, S. H., Wong, S., Tang, H., Shi, C. W., & Chen, M.S. (2007). High quit ratio among Asian immigrants in California: implications for population tobacco cessation. *Nicotine & Tobacco Research*, 9(3), 505-514.

Appendix A: Email of Initial Contact and Attached Letter of Initial Contact

Dear [Name of Contact / Name of Organization],

My name is Jia Li and I am a Master of Arts student in Human Geography at the University of Alberta. For my thesis research, I am looking at the differences in rules and attitudes towards smoking between China and Canada. To examine this, I am interested in the perspectives of people who have moved from China to Edmonton.

I am conducting this study because Canada and China have different regulatory and social environments around smoking. I want to understand what Chinese immigrations to Edmonton think about these differences. This study will contribute to the better understanding of people's experiences of different rules and attitudes around smoking when they move from one country to another.

To understand how people adjust to different rules and attitudes towards smoking here in Edmonton, I am conducting focus groups with Chinese people here in Edmonton.
Anyone who is an adult (aged 18+ years) originally from China but now resident in Edmonton, and who has been in Canada for less than three years, is eligible to participate. Both smokers and non-smokers are welcome.

I would like to include people from [Name of Organization] in my focus groups. I can arrange a time that is convenient for everyone who is interested. A focus group would last 45-60 minutes. Everyone who participates will receive a $20 gift voucher.

Participation of people from [Name of Organization] is entirely voluntary. If any individuals would like to be involved, we will provide them each with a consent form with further details on our study.

If they do chose to be involved in the focus group discussions, their comments will be audio recorded. However, they will not be identified personally, and we will not record names during focus groups.

Please do not hesitate to contact me with any questions you may have about my study, or the details of participation. You can also contact my supervisor, Dr. Damian Collins.

This research is funded by the University of Alberta. I look forward to talking with you about whether people from your organization would be interested in joining my focus groups.

Sincerely,

Study Investigator:
Jia Li
MA Student
Human Geography Program
Dept. of Earth & Atmospheric Sciences
University of Alberta
jia5@ualberta.ca
(780) 263-0883

Supervisor:
Dr Damian Collins
Associate Professor
Human Geography Program
Dept. of Earth & Atmospheric Sciences
University of Alberta
damian.collins@ualberta.ca
(780) 492-3197

The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615.

Appendix B: Focus Group Questions

Background:

1. [For each participant]: Can you tell us when you came here from China and why?
2. [For each participant]: Can you tell us your smoking status and other experience related with smoking– e.g. never smoker, former smoker, occasional/social smoker, and regular smoker; do you have any close friends or relatives smoking?

Perceptions:

1. Thinking about Edmonton in particular, what are the main rules about smoking?

    How about for indoor places?

    How about for outdoor places?

    Anything else?

2. How do these rules compare to those from where you were in China?

3. How is the social acceptance and tolerance of smoking in China?

4. What do local people in Edmonton think about smoking and smokers here? Is there less social acceptance of smoking here? How can you tell?

    FOR SMOKERS ONLY: Does this cause you any discomfort?

Attitudes

1. After coming to Edmonton, have your attitudes towards smoking changed? How and why?

2. How do you think of existing smoking bans in Edmonton? (Completely agree, partly or disagree) Why or why not?

3. Gender roles: How do you think the role that non-smoking wives play in the smoking behaviours of smoking husbands?

Behaviours

1. Do you think most people comply with the smoking bans in Edmonton?

    When/where do some people not comply?

    How about in China?

2. Do you think smokers' behaviours (e.g. smoking frequency, amount, places etc) change after coming to Edmonton from China? Why?

3. Has your personal smoking status changed since you came here? If YES, why?

Emotions

1. How would you describe your feelings about the differences around smoking between China and Edmonton?

    Are you generally happier or unhappier with the rules here?

    How might the feelings of smokers be different from the feelings of nonsmokers?

2. If your behaviours and/or attitudes towards smoking have/has been changed, how did you feel during this adjustment process? Did your feelings change over time?

    Was it hard to adjust to the rules in Edmonton?

3. Which set of ***approach*** around smoking do you feel is better – the Edmonton approach or the Chinese approach? Why?

Concluding Comments

1. Before we finish the focus group, is there anything related to your experience around smoking before and/or after coming to Edmonton from China you want to share?

Appendix C: Demographic Survey Questions

1. Are you Male or Female?

___Male ___Female

2. Which is your age?

___18-25 ___25-40 ___40-55 ___over 55

3. What is the highest level of education you have completed?

___Less than high school ___High school ___BA ____Master's or Doctoral degree

4. How long have you been in Canada?

___Less than 6 months ___6 months to 1 year __1 to 2 year __2 to 3 year

5. How long have you been residing in Edmonton?

___Less than 6 months ___6 months to 1 year __1 to 2 year __2 to 3 year

6. Did you smoke during the past 30 days?

___Yes ___No (To 8)

7. How many cigarettes for average did you smoke per day during the past 30 days?

____<= 1 ____1-5 ____5-10 ___>= 10

8. Did you smoke when you were in China?

___Yes ___No (To 10)

9. How many cigarettes for average did you smoke per day when you were in China?

____<= 1 ____1-5 ____5-10 ___>= 10

10. Do you have plans to stay in Canada permanently?

____Yes ____No ____Not Sure

Thank you for your contribution!