RESEARCH ARTICLE

Smoking Initiation and Continuation - A Qualitative Study among Bruneian Male Adolescents

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Abstract

Background: Cigarette smoking is one of the leading global causes of premature and preventable death. In Brunei Darussalam, smoking-related diseases have been a primary cause of mortality for the past three decades. Despite the increasing efforts that have been made in recent years to reduce the consumption of tobacco products in Brunei, the prevalence of adolescent smoking cigarette, however has risen alarmingly, from 8.9% in 2013 to 11.4% in 2014, with a higher prevalence found in males (17.8%) than in females (4.8%). In response to the need for more effective smoking prevention programmes in Brunei, this study sought to explore factors that influence Bruneian male adolescents to start and continue smoking. Materials and Methods: A qualitative study using focus group discussions (FGDs) as the data collection method was conducted from October to November 2015. A total of 43 studentss, comprising 31 smokers and 12 non-smokers, aged 13-17 years, from two government secondary schools in Bandar Seri Begawan, participated in six FGDs. Discussions were recorded and translated. Transcripts were entered into NVivo10, before thematic analysis was conducted. Results: We identified three themes under the core construct of 'factors influencing smoking initiation' (*'family as teachers', 'overt pressure from peers' and 'perceived smoking has many advantages'*) and three themes under the core construct of 'factors influencing smoking continuation' (*'craving and addiction', 'smoking as a 'social activity' and 'easy accessibility of cigarettes'*). Conclusions: Based on the findings, it is recommended that future prevention activities should be embedded in a comprehensive approach, involving all stakeholders within a community, and should be focused towards bringing a change in smoking and parenting behavior of parents, social norms within the culture towards all population levels, and at strengthening the existing non-smoking policies in schools and other public places where young people congregate.

Keywords: Smoking initiation - smoking continuation - qualitative study - adolescents - Brunei

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Introduction

Cigarette smoking is one of the leading global causes of premature and preventable death (World Health Organization, 2012). It is well known for causing a number of cancers, cardiovascular diseases and chronic obstructive pulmonary disease (COPD) (World Health Organization, 2014). According to the World Health Organization (WHO), around 5.4 million of mortalities per annum are attributed to smoking-related diseases, 70% of which occurred in "developing" countries, and that a very high burden of mortality was reported in the Southeast-Asian region (World Health Organization, 2012).

One of those developing countries in the Southeast-Asian region suffering from such epidemic is Brunei Darussalam. Smoking-related diseases has been the primary cause of mortality in the past three decades (Ministry of Health, 2013). A number of efforts have been made in the recent years to reduce the consumption of tobacco products in Brunei such as the dissemination of information regarding the dangers of smoking to the public, introduction of tobacco control regulations, such as designation of smoke-free areas in government buildings and public areas, increase taxation and fines, and legality of smoking age (Ministry of Health, 2013). In spite of that, the prevalence of cigarette smoking, particularly among the adolescents remained increasing at an alarming rate. There was a significant increased from 8.9% in 2013 to 11.4% in 2014, with higher prevalence found in male (17.8%) than in female (4.8%) (World Health Organization, 2015). This suggests that there remains much room for improvement and urgent needs for more effective smoking prevention or interventions.

However, in order to develop effective interventions beneficial in preventing young adolescents from initiating cigarette smoking and helping those who have acquired the habit of smoking to stop; knowledge on factors associated with smoking behaviors among the adolescents is essential (Lantz et al., 2000). Numerous studies worldwide have examined the influencing factors of smoking behaviors.

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Some of these include: genetic factors, peer influences, social norms, stress and depression, parental attitudes and behaviors, and broader environmental factors such as media influences (Tyas and Pederson, 1998; Das et al., 2011; Freedman, 2012; Bagchi et al., 2014; Lim et al., 2014). Unfortunately, there is a limited number of study that has been carried out on cigarette smoking behaviors among Bruneian male adolescents. As such, knowledge on their perspectives on smoking remains an ideal. This lack of awareness meant that many current smoking interventions strategies for adolescents have been developed without the foundations of basic research to inform the public health professionals and health policy makers. This might provide some explanation on why the existing health programmes has been short in reaching their goals.

There is a dire need for smoking prevention programmes in Brunei to be more affective in reaching its goal. This study hopes to shed some light on the determinants of smoking initiation and continuation, particularly among male adolescents in the country. It is hoped that the findings from this study can be further utilized in redesigning smoking prevention approaches that can ultimately reduce prevalence in the future.

Materials and Methods

Study Design

A qualitative study design using focus group discussion (FGD) as data collection method was conducted from October to November 2015. Through the use of qualitative methods, it enables us to discover and collect in-depth information about their views and the meanings associated with smoking. Such findings will create a comprehensive picture how adolescents conceptualize smoking in the context of their lives (Corbin and Strauss, 2014). In addition, FGD was chosen as it is a naturalistic, interpretative approach that helps to provide an in-depth, better understanding of how people interpret their situation, attitude, behaviour and belief (Agar and MacDonald, 1995).

Participants

Participants are consisted of adolescent males who are currently smokers and non-smokers. Non-smoker in this context is defined as someone who, at the time of interview, does not smoke cigarette at all. While smoker is defined as someone who, at the time of interview, smokes cigarette, either daily or occasionally.

Using a convenience sampling, smokers and non-smokers from Year 7, 8, 9 and 10 from two government secondary schools in Bandar Seri Begawan were invited to participate in this study. The schools were selected based on convenience sampling according to their voluntary participation in the study. All potential participants and their parents were given a letter that comprised of participant information sheet (PIS) and consent form requesting their permission to participate in the FGD.

Data Collection Instrument

A pre-tested consisting of semi-structured open-ended questions were used to obtain information from participants on areas related to smoking: *i)*. knowledge on smoking, *ii)*. smoking behaviour (initiation and continuation), e.g. factors that predispose them to start smoking and/or continue smoking, or protect them from taking up this behaviour, *iii)*. place of smoking and with whom they usually smoke, and *iv)*. accessibility of cigarettes.

Data Collection Procedure

The discussions were conducted at a time and date convenient for participants' schedules and were held at their respective schools, without revealing their smoking status information to anyone including the school personnel. All discussions were conducted in Malay language, the most widely used language in Brunei, to allow participants to comfortably express their ideas. In every discussion, the moderator (T.T) was assisted by a scriber who took field notes throughout the discussions. Before start of FGDs, demographic details were collected. The researchers then introduced themselves to the participants and started ice-breaking session requesting each participant to briefly introduce themselves. The session proceeded with the introduction to the study explaining the aims and rules in the focus group. The participants were also informed that the discussion would be audio-taped for the purpose of data analysis and they were re-assured regarding the anonymity and confidentiality of the outcome from the discussion.

The discussion started with the introductory questions designed to build up a degree of familiarity among participants and to reinforce the feelings of being in a 'group' (Ritchie et al., 2013). At this stage, the researcher used the information shared to steer the conversation towards more specific questions until data saturation has been achieved (i.e. no new information emerged). Probing questions were also projected to elicit further discussion. Before closing the FGD, all the main points raised were concluded and participants were invited to add or clarify on their opinions. Each discussion lasted approximately 45-60 minutes.

Data Analysis

All recorded discussions were transcribed verbatim while referring to the field notes and translated into Standard English. Translated verbatim were checked for accuracy by second researcher (Z.M) who went through the recordings while reading the transcripts. Data analysis was assisted by the use of NVivo 10 software for data management. The SIX phases of thematic analysis was used for identifying, analyzing and reporting themes within data (see Figure 1).

In establishing the trustworthiness of our study, T.T and Z.M met several times during the analysis. Transcribed data were re-read several times individually and coded, list of codes that had been produced was screened thoroughly and for this purpose; codes that appeared under one common thread were grouped together and themed. Once all themes were identified, all researchers reviewed and compared their codes and themes, enabling the development of refined themes.

Ethical Considerations

The study protocol was approved by the Pengiran Anak Puteri Rashidah Institute of Health Sciences Ethics Committee, Universiti Brunei Darussalam. Permission was also obtained from the Department of School Ministry of Education (MoE) Brunei Darussalam and school principals, prior to the commencement of this study. Considering the potential influence of the sensitive nature of the topic, reassurance regarding confidentiality, anonymity and their right to withdraw from the study at any time was re-emphasized to participants before the discussion.

Results

In total, forty-three (*N=43*) participants participated in six focus group discussions. Four focus groups (FG1, 2, 3, 4) (*N*=31) were conducted among smokers, consisting of 6 to 10 participants per group and two focus groups (FG 5,6) (*N*=12) were conducted among non-smokers, consisting of 4 to 8 participants per group. The characteristics of participants are presented in Table 1.

All participants are Bruneian and aged between 13-17 years. Of the 43 participants, twelve (*n=12*, 28%) reported that have never smoked in their lifetime, seventeen (*n=17*, 40%) reported that they usually smoke 1-5 cigarettes per week, six (*n=6*, 14%) reported that they usually smoke 6-10 cigarettes per week and eight (*n=8*, 19%) reported that they usually smoke 11-15 cigarettes per week. The mean age of initiation among smokers is 11. 3 years.

Table 1. Socio-demographic Characteristics of Participants (N=43)

Variables	n	%
Age (years)		
13	13	30.2
14	11	25.6
15	9	20.9
16	8	18.6
17	2	4.7
Year in School		
7	10	23.3
8	10	23.3
9	18	41.9
10	5	11.6
Marital status		
Single	43	100
Married	0	0
Race		
Malay	42	97.7
Chinese	1	2.3
Smoking status		
Smoker	31	72.1
Non-smoker	12	27.9
Age for initiation (Years old) (Among smokers)		
8	2	6.5
9	7	22.6
10	4	12.9
11	3	9.7
12	5	16.1
13	4	12.9
14	5	16.1
15	1	2.3
Number of cigarettes smoked/per day		
0	12	27.9
1 - 5	17	39.5
6 - 10	6	14
11 - 15	8	18.6
>15	0	0

Knowledge about Health Hazards of Smoking

All participants in this study were generally aware of the many dangers and harmful effects of smoking. They learned such knowledges from schools, mass media messaging as well as through interpersonal interactions with family members. They were also able to cite many illnesses, diseases and symptoms associated with smoking including lung cancers, liver, heart and throat diseases, as well as minor health problems such as headaches and coughing. Some have also discussed the non-lethal consequences of smoking such as the reduction in physical capacity resulting from shortness of breath, and its impact on appearance, such as stained teeth and skin. They also proved to have knowledge that smoking is an addiction, poisonous, smells and pollutes the environment.

P1: *Smoking is harmful to our body health* (Smoker, 15 years old, FG3)

P1: *It [smoking] can cause cancer lung cancer* (Smoker, 13 years old, FG1)

P4: *It can cause shortness of breath* (Smoker, 14 years old, FG2)

P2: *It can turn your teeth yellow* (Non-smoker, 13 years old, FG6)

While all participants have had considerable knowledge on the health hazards of smoking, it failed to prevent them from initiating and continuing smoking. Our data analysis revealed three themes that influenced them to initiate smoking ('family as 'teachers', 'overt pressure from peers' and 'perceived smoking has many advantages') and three themes that influenced them to continue smoking ('craving and addiction', 'smoking as a 'social activity'' and 'easy accessibility of cigarettes').

Factors Influencing Smoking Initiation

Theme 1: Family as 'teachers'. This theme describes that family smoking behavior especially that of parents, has been strongly associated with adolescent smoking initiation.

This study revealed that smoking habits within a household as well as extended networks of family (e.g. cousins and uncles) was prevalent among smokers. Majority of them emphasized that family played an important role in their development of smoking behavior,

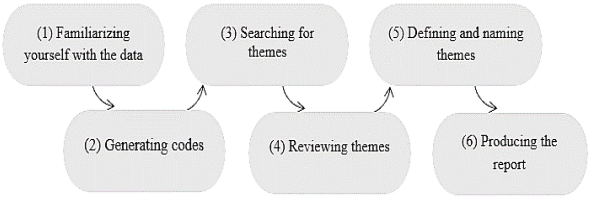

Figure 1. Phases of Thematic Analysis According to Braun & Clarke (2006)

through implicit influences such as through observation or modeling, and through direct influences such as verbal persuasion to smoke from family members. Level of parental control of adolescent behavior and the way in which parents dealt with smoking at home were also known to have impacted their child smoking behavior.

Two of the participants shared their experiences on how they were influenced by their parents:

P1: *I got influenced from my parents after seeing them smoking, it made me wonder about the taste, was it good or not. I was curious about how does it feels too when you smoke, so I decided to try, initially I struggled to puff but then after few times of trying I became addicted to it*! (Smoker, 15 years old, FG3)

P6: *I saw my parents smoked at home. I felt like I wanted to try it too. I felt Jealous. I felt curious. So I just took the cigarette. Moreover, they like to place the cigarettes everywhere, so I just took it and tried it.* (Smoker, 15 years old, FG4)

Some have also reported that they were asked directly by their family members to smoke cigarette:

P4: *I was asked by my mother. She asked me to smoke. It will be a waste if I didn't try it, my father and my brother smoke too! All of them and they're okay if I smoke. Actually after that, I've tried to stop smoking but only able to stop for a short while. Then I continue to smoke to master it. I want to be a pro*! (Smoker, 16 years old, FG1)

P7: *It was my grandmother who offered me the cigarette, she said, "do you want to try this?' I said, yes. She let me smoke. But my parents didn't know about this.* (Smoker, 14 years old, FG3)

In some instances, we found that some smoker parents sometimes tend lenient on smoking among their own children. Some regarded smoking as 'normal' and acceptable behavior in their families.

P5: *Both my father and mother smoke. They knew about me smoking. Thank goodness I'm legal [allowed to smoke] already! They didn't stop me from smoking, they just let me. Same goes to my siblings. My parents didn't care nor forbid me from smoking.* (Smoker, 17 years old, FG1)

In contrast, we found that some smoker participants were scared that their parents would find out that they were smoking. Nevertheless, this study revealed that anti-smoking culture or beliefs within a family was effective in preventing the members to start smoking in the first place. Restrictions especially by parents such as disallowing smoking, imposing home as a smoking free zone, strong messages of disapproval, as well as clear and informed consequences that will fall upon them if they take up smoking; consequences that are both future health-related and punishment by the family such as scolding, beating and having their pocket money cut. In some instances this 'fear' was what stopped some participants from taking up smoking.

P1: *I don't dare to smoke because I'm afraid of getting scolded by my father* (Non-smoker, 13 years old, FG2)

P8: *I will never smoke as my father didn't allow me.* (Non-smoker, 16 years old, FG1)

However, the advice offered by families was considered by some participants to be hypocritical. As two participants said:

P6: *I don't understand, both my father and my mother smoke around me but they forbid me from smoking* (Smokers, 16 years old, FG1)

P6: *Both my father and my brother always mad at me whenever they saw me smoking, but I always said to my father 'if he [his brother] can smoke why can't! I?' My brother started smoking since childhood. I feel unfair.* (Smokers, 15 years old, FG4)

Theme 2: Overt Pressure from Peers. This theme describes that pressure from peers to try smoking is another important influence in leading adolescents to take up smoking. In some instances, smoker participants reported that they were often put under pressure from their peers to take up smoking. They reported to be feeling 'forced' into trying it on a number of occasion.

P5: *First, I got influenced from my friends. When I think back, my parents smoke too! Both my father and mother smoke, and my cousins, they smoke too, so I decided to try it. At first I didn't know how to smoke, but my friend provided me on the smoking technique, so I tried and yeah it felt good. Since then I started to ask for more cigarettes.* (Smoker, 17 years old, FG1)

P3: *It started when I was in primary school, my friend gave me a cigarette and asked me to smoke. I became addicted after trying it the first time.* (Smoker, 14 years old, FG3)

P10: *My friends forced me. I have no choice, I just took it! At first, I coughed but then it tasted really good. I became addicted after that, I couldn't help anymore.* (Smoker, 16 years old, FG4)

In many instances, some participants reported experiencing difficulties to withstand peer pressures from friends (i.e. lack of refusal skill).

P5: *It happened after we played football. I was offered a cigarette by my friends. [They said] 'Just try this!' It was inevitable. I didn't know how to reject them! So I just took it.* (Smoker, 14 years old, FG2)

Theme 3: Perceived Smoking Has Many Advantages. This theme explains that participants initiated smoking as they perceived smoking was beneficial to them.

Some participants have indicated that they started smoking as they believed smoking has many perceived advantages. Some viewed smoking as fun and contributed to positive image, such as to look cool and mature. Additionally in the discussions, participants reported that they frequently watched movies and they told stories of smoking scenes and stars doing cigarette smoking.

P3: *Saw actors smoking in the movie. They look so cool. I want to become cool like them too!* (Smoker, 15 years old, FG4)

P2: *Saw someone's smoking, in Google, in Instagram, Facebook, Telegram, Video, and YouTube. I can see enjoyment.* (Smoker, 15 years old, FG4)

In comparison, participants who were non-smokers described the act of smoking in unpleasant terms, perceiving smoking as "disgusting" and "gross", thus will portray bad image to oneself. Some non-smoker participants also reported that the smell of cigarette smoke

is unpleasant and therefore should be avoided.

On the other hand, some have reported that they initiated smoking to relieve boredom (mainly to kill the time) and to overcome stresses caused by personal and relationship problems with family and girlfriend.

P7: I always got stressed because of my family problems. They always fight, I couldn't stand, and that made me wanted to try smoking to release my tension (Smoker, 14 years old, FG3)

Factors Influencing Smoking Continuation

Theme 1: 'Craving and Addiction'. This theme explains that smoker participants' difficulties in quitting smoking was due to cigarette cravings and nicotine addiction.

Most of the smoker participants in this study reported that they have attempted to quit smoking at some point but have failed to overcome the difficulties in the process. They reported themselves to be in a state of addiction to the habit. However, the nature of which they were addicted was perceived to have varied from one to another. Some of the participants argued that they developed a biological need to continuously crave for nicotine; while the others acknowledged that their addiction to the act in itself is more psychological.

P5: *It feels weird if I don't smoke, whenever I wake up and get out of my bed, I used to look for my cigarettes. It's already become part of my habit*. (Smoker, 17 years old, FG1)

P3: *I always 'crave' for it, I can't stop the feeling. I really can't!* (Smoker, 16 years old, FG1)

P6: *It feels like I'm looking for something, something is missing if I don't smoke*. (Smoker, 16 years old, FG1)

In addition, smoker participants also claimed that seeing others smoking have also triggered their cravings to smoke, thus making them difficult to quit smoking.

Theme 2: Smoking as a 'Social Activity'. This theme describes smoker participants' difficulties to quit smoking as smoking has already became part of their 'social activity'.In the discussions, they reported that smoking provided them a medium for socializing and 'hanging out' with friends and cousins. Despite their age, they admitted to have been smoking in public especially with their friends and cousins. However, it is of their safety interest that they do so out of view of their parents or teachers. As such they prefer to smoke at secluded areas within the public such as shopping complexes and restaurants. More commonly, smoking in school despite the strict policies is a norm among their peers. Participants from both schools also shared stories of known smoking sites at schools, which includes toilet, bus stand and under the school bridge.

P3: *Most often when we were in football field, near my home area. We smoked after we played football*. (Smoker, 14 years old, FG4)

P1: *With my friend at school, at the school's toilet during break time* (Smoker, 15 years old, FG4)

Theme 3: Easy Accessibility of Cigarettes. This theme describes that participants continued cigarettes smoking due to the way in which they are readily available and can be found almost everywhere. They reported that cigarettes are very accessible whenever they felt they want to smoke. Smoker participants reported that they have access to cigarettes through a variety of means, however peers and family members remain as common route for participants to access cigarettes.

Most of the time, participants reported peer bought packs and resell them for profit in schools. Cigarettes can also be bought individually as a single stick at a very high price.

P2: *I got it from my friend, he and his father are our agent here, our supplier. Initially, he gave me one, then after that I bought the cigarettes myself. Sometimes I bought it in packet, around BND $ 3-5, and sometimes as single stick for 50-80 cents* (Smoker, 13 years old, FG2)

Some participants also reported that in some instances, friends who have access and obtained cigarettes will share among their group of friends.

P3: *I got it from my friend. The cigarettes he got from his older friend, he usually share it with us*. (Smoker, 13 years old, FG2)

Meanwhile, some stole and were supplied cigarettes directly from their family members (father, brothers, cousins, uncles) at home.

P8: *I got the cigarettes from my father. I can just asked from him*. (Smoker, 16 years old, FG3)

P7: *I usually bought it, but if I saw my father bought the cigarettes, I just steal it from him* (Smoker, 14 years old, FG3)

P4: *I can just ask it [the cigarette] from my brother. [He's] 21 now*. (Smoker, 14 years old, FG2)

Some have also reported to have purchased their cigarettes pack from their neighbors. This occurrences were mainly reported by participants living in public housing.

P6: *Bought it from my neighbor. They are selling cigarettes*. (Smoker, 15 years old, FG4)

P2: *Bought it from the terrace house, our neighboring house*. (Smoker, 15 years old, FG1)

P3: *I also bought it from my neighbor, they are selling cigarette too! Many people come to buy cigarettes there*. (Smoker, 16 years old, FG1)

In addition, some participants also reported purchasing it from the nearby outlets or stores. They mostly perceived banning of selling of cigarettes to minors (aged <18 years) often have little effect on them. Because confirmations of legal age were rarely sought by shop owners, it has not been difficult to purchase cigarettes directly at shop outlets.

P8: *Sometimes I also bought it from the grocery store, never they asked for identification or age*. (Smoker, 16 years old, FG3)

In addition, when asked about their source of money to buy cigarette, majority stated that they obtained them from their monthly pocket money (given by their parents) while reported to have obtained them from their salary working at the food stalls.

Discussion

To the best of our knowledge, this study is the first qualitative study in Brunei designed to increase our understanding on cigarette smoking behavior among the Bruneian male adolescents.

This study revealed that although all participants have considerable knowledge about the adverse health consequences of smoking, it did not prevent them from taking up cigarette. This is in contrast with some studies findings that argued that knowledge about smoking is one of the most significant protective factors against cigarette smoking initiation (Ho et al., 2007; Karimy et al., 2013b). As proven by Hoyt (2002) and Niknami et al. (2008), even though delivering information about cigarettes has been shown to increase knowledge, it may not help in changing the behaviour. Consistent with a number of other studies, our findings revealed that family and peers played a central role in smoking initiation and continuation among the Bruneian male adolescents (Das et al., 2011; Mak et al., 2012; Jeganathan et al., 2013; Pradhan et al., 2013).

We found that adolescents who are exposed to family members who smoke are the most susceptible to take on smoking. As established by Bricker et al. (2006) and Leonardi-Bee at al. (2011), a strong predictor and risk factor for initiation of smoking within children and young people is their role models including parents and siblings. Furthermore, such cultures within a family facilitates the act of smoking into a 'norm'. Subsequently, their behaviour and perception towards the act itself will have been difficult to change. They see smoking as an 'acceptable' habit especially after growing up in such environment. Such occurrences have been reported in a number of studies (Ozawa et al., 2008; Mak et al., 2012; Lim et al., 2014). In such circumstances, parent would have poor credibility and empowerment to restrict their children from smoking cigarettes because they would be giving contradictory messages in regard to smoking prevention or cessation. In agreement, a study reported the relationship between parenting style and adolescents smoking behavior was inconclusive, however permissive parenting styles may be associated with independent predictor for adolescent smoking initiation (O'Byrne et al., 2002; Chassin et al., 2005).

Contrary to the above context, this study found that non-smoker participants were not exposed to a culture of smoking at home within their family members. Furthermore, anti-smoking cultures actually reduced their inclination to try smoking. Jackson and Henrikson (1997) described that families who frowns upon smoking or "anti-smoking socialization" are comparatively more successful in establishing a healthy culture and as a result, more successful in protecting their children against the smoking habit. The researchers highlight the importance of knowledge dissemination to provide their children with the right attitudes and skills in resisting social pressure to smoke (Jackson and Henriksen, 1997). There are a number of strategies that can be put in place on top of expression of anti-smoking messages such as effective monitoring of the family members' behaviors and setting a defined negative consequences if any of them tries smoking. Several robust epidemiological studies have upheld the hypothesis that anti-smoking socialization is protective against youth smoking (Jackson and Henriksen, 1997; Waa et al., 2011).

Peer is another major factor that has significantly influenced smoking behaviors, both initiation and continuation, of participants in our study; through imitation, direct pressure, socialization and facilitating easy access of cigarettes. These findings are consistent with a study conducted by Simons and Farhat (2010) who argued that peer pressures acts further beyond the initiation of the habit. Peers play a major role in making it difficult for a smoker to cease their habit. This is particularly prominent in the adolescent stage, where the youths are trying to emancipate themselves socially from their parents (Simons-Morton and Farhat, 2010). Most often, the values, attitudes and behaviors of peers tend to be more important for them when compared with their own family; where a choice is to be made, the adolescent would prioritize the peers' value (Lim et al., 2010; Sawyer et al., 2012; Hock et al., 2013). Nevertheless, it also appears that smoking refusal skills was another important factors influencing the smoking initiation behavior of the adolescents. This finding supported study conducted by Karimy et al. (2013) that showed refusal skills as the significant predictors of smoking uptake (Karimy et al., 2013a).

Besides that, our study also demonstrated that stronger positive beliefs about smoking were associated with smoking uptake. This result is in agreement with study conducted by Ho et al., (2007) where adolescents initiated smoking as they perceived smoking can improve self-image to help them look 'cool' and elegant. This was somehow associated with the media exposure. Participants in this study reported were influenced by messages and images portrayed on the Internet and satellite television. As Ho et al. (2007) has stated, exposure to movie has a considerable impact on adolescent smoking initiation. Through persuasive, multiple and attractive role model, it could promote favorable smoking beliefs and intentions (Ho et al., 2007). On the other hand, in a study conducted among Malaysian schools adolescents by Kuang et al. (2014) and Eun Sun So and Ji Young Yeo (2015) among Korean adolescents; most adolescents reported to have taken up cigarette smoking as a mean of dealing with stress, facing the usual pressures from family, schools, peers or may be experiencing uncertainty and worries about the future or unsuccessful adjustment to life changes.

Additionally, because the nicotine contained in cigarettes is a highly addictive chemical (Jha et al., 2006), and adolescents are at a critical period and age who faces accelerated growth are even more vulnerable to the effects of the chemicals obtained from cigarette smoking (General, 2014), these provide evidence why smokers who started smoking at such age are less likely able to resist cessation of smoking.

Finally, apart from family and peers as important sources of access of cigarettes among participants in this study, we have found that adolescents have virtually unimpeded access to obtaining cigarettes directly from stores and illicit sources, despite the existing laws that prohibited the sale of cigarettes to minors under 18, increased enforcement (including sting operation),

increased penalties, and increased sales price. This suggests that the enforcement on smoking had little effect unless strongly enforced.

Strengths And Limitations Of The Study: This study utilized a qualitative approach obtaining its result. Through such method, the researcher is able to explore and understand the experiences from the participants' point of view. Because their frames of reference differ, their perception of the world as experienced would also vary from on to another. As such, through in depth interviews, this study was able to obtain richer information and description on their beliefs on smoking.

However, the limitations of this study include; first, the findings have limited generalizability as only two government schools were selected. Secondly, the qualitative nature of the study limits the strength to make definite conclusions on the causality between the discussed factors and adolescents in taking up smoking. In addition, social desirability as well as preconception may have actually have biased participant's responses and led them to self-censor their actual opinions.

Implications For Research And Future Prevention Programs: The findings in this study have shed some lights regarding the causality of individuals to have participated in smoking behaviors in the first place. Through first hand experiences and view, the study was also able to obtain information from their perspective. This paves some way for governmental health organizations in providing support for a smoking prevention programme that is relative to the population. Within a school setting, knowledge and health information can be disseminated. However, simply doing this might not be enough. This study suggests that related organizations or authorities should establish appropriate norms and beliefs about cigarette smoking within peer groups, and harness the power of positive peer influences to reduce smoking. Intervention programmes should also put emphasis on cultivating self-value and assertiveness to help youths in protecting themselves from social pressure of the habit.

To help improve the effectivity of anti-smoking school-based programmes, a wider scope of the community should be considered and improved upon. For example, the environment in which the adolescents grows up should be highlighted. It is imperial that parents themselves should attempt to stop or reduce their habit. Further, through encouragement of positive parenting, parents can be given a great tool to maintain bonds within their family. This, coupled with parenting strategies such as setting definite rules and proper monitoring of their children's activities can help protect them from initiation of smoking. In addition, mass media efforts in health promotion are also particularly relevant and appropriate. We live in an era with information at the tips of our fingers and as such, the influence of media upon the public must not be overlooked. Finally, it is suggested that school and public bans of smoking should be strongly enforced in reaching the goal of smoking reduction.

In conclusion, our study suggested family and peers played a major role in smoking initiation and continuation among the Bruneians male adolescents. The findings from this study can be utilized further in developing cigarette smoking prevention programmes that are more effective towards the Bruneian population. This study suggests that prevention activities organized by health organizations should involve all stakeholders within a community, focused towards bringing a change in parental behaviors, social norm within the culture towards all level of population. This, coupled with the existing policies in schools and public places might bring about a better result towards the nation's aim to reduce smoking among the populations.

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References

Agar M, MacDonald J (1995). Focus groups and ethnography. *Hum Organ*, **54**, 78-86.

Bagchi N, Ganguly S, Pal S, et al (2014). A study on smoking and associated psychosocial factors among adolescent students in Kolkata, India. *Indian J Public Health*, **58**, 50-3.

Bricker J, Peterson J, Leroux B, et al (2006). Prospective prediction of children's smoking transitions: role of parents' and older siblings' smoking. *Addiction*, **101**, 128-36.

Chassin L, Presson CC, Rose J, et al (2005). Parenting style and smoking-specific parenting practices as predictors of adolescent smoking onset. *J Pediatr Psychol*, **30**, 333-44.

Corbin J, Strauss A (2014). Basics of qualitative research: Techniques and procedures for developing grounded theory, Sage publications.

Das S, Ghosh M, Sarkar M, et al (2011). Adolescents speak: why do we smoke? *J Trop Pediatr*, **57**, 476-80.

Freedman K (2012). Smoking initiation among young adults in the United States and Canada, 1998-2010: A systematic review. *Prev Chronic Dis*, **9**, 5.

General S. The health consequences of smoking-50 years of progress: a report of the surgeon general. US Department of Health and Human Services, 2014. Citeseer.

Ho M, Shi Y, Ma S, et al (2007). Perceptions of tobacco advertising and marketing that might lead to smoking initiation among Chinese high school girls. *Tob Control*, **16**, 359-60.

Hock L, Ghazali S, Cheong K, et al (2013). Correlates of susceptibility to smoking among secondary school students in Kota Tinggi district, Johor, Malaysia. *Asian Pac J Cancer Prev*, **14**, 6971-8.

Hoyt A (2002). Delivering primary substance abuse prevention in primary care. *Clin Excell Nurse Pract*, **6**, 31-7.

Jackson C, Henriksen L (1997). Do as I say: parent smoking, antismoking socialization, and smoking onset among children. *Addict Behav*, **22**, 107-14.

Jeganathan P, Hairi N, Al Sadat N, et al (2013). Smoking stage relations to peer, school and parental factors among secondary school students in Kinta, Perak. *Asian Pac J Cancer Prev*, **14**, 3483-9.

Jha P, Chaloupka FJ, Moore J, et al (2006). Tobacco addiction.

Karimy M, Niknami S, Heidarnia A, et al (2013a). Refusal self efficacy, self esteem, smoking refusal skills and water pipe (Hookah) smoking among iranian male adolescents. *Asian Pac J Cancer Prev*, **14**, 7283-8.

Karimy M, Niknami S, Heidarnia A, et al (2013b). Prevalence and determinants of male adolescents' smoking in iran: an

explanation based on the theory of planned behavior. *Iran Red Crescent Med J*, **15**, 187-93.
Lantz P, Jacobson P, Warner K, et al (2000). Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tob Control*, **9**, 47-63.
Lim K, Chong Z, Khoo Y, et al (2014). Parental smoking status, stress, anxiety, and depression are associated with susceptibility to smoking among non-smoking school adolescents in Malaysia. *Asia Pac J Public Health*, **26**, 81-90.
Lim K, Sumarni M, Kee C, et al (2010). Prevalence and factors associated with smoking among form four students in Petaling District, Selangor, Malaysia. *Trop Biomed*, **27**, 394-403.
Leonardi-Bee J, Jere M, Britton J (2011). Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis. Thorax, thx. 2010.153379.
Mak K, Ho S, Day J (2012). Smoking of parents and best friend-independent and combined effects on adolescent smoking and intention to initiate and quit smoking. *Nicotine Tob Res*, **14**, 1057-64.
Ministry of Heallth (2013). Brunei Darussalam National Multisectoral Action Plan for the Prevention and Control of Non-Communicable Disease (BruMAP-NCD). Bandar Seri Begawan.
Niknami S, Akbari M, Ahmadi F, et al (2008). Smoking initiation among Iranian adolescents: a qualitative study. *East Mediterr Health J*, **14**, 1290-300.
O'Byrne K, Haddock C, Poston W, et al (2002). Parenting style and adolescent smoking. *J Adolesc Health*, **30**, 418-25.
Ozawa M, Washio M, Kiyohara C (2008). Factors related to starting and continuing smoking among senior high school boys in Fukuoka, Japan. *Asian Pac J Cancer Prev*, **9**, 239-45.
Pradhan P, Niraula S, Ghimire A, et al (2013). Tobacco use and associated factors among adolescent students in Dharan, Eastern Nepal: a cross-sectional questionnaire survey. *BMJ Open*, **3**, 2123.
Ritchie J, Lewis J, Nicholls C, et al (2013). Qualitative research practice: A guide for social science students and researchers, Sage.
Sawyer S, Afifi R, Bearinger L, et al (2012). Adolescence: a foundation for future health. *Lancet*, **379**, 1630-40.
Simons-Morton B, Farhat T (2010). Recent findings on peer group influences on adolescent smoking. *J Prim Prev*, **31**, 191-208.
Tyas S, Pederson L (1998). Psychosocial factors related to adolescent smoking: a critical review of the literature. *Tob Control*, **7**, 409-20.
Waa A, Edwards R, Newcombe R, et al (2011). Parental behaviours, but not parental smoking, influence current smoking and smoking susceptibility among 14 and 15 year-old children. *Aust N Z J Public Health*, **35**, 530-6.
World Health Organization (2012). WHO global report on mortality attributable to tobacco.
World Health Organization (2014). World Health Organization Tobacco fact sheet. 2014 [Online]. Available: http://www.who.int/mediacentre/factsheets/fs339/en
World Health Organization (2015). WHO Report on the Global Tobacco Epidemic, 2015. Country Profile: Brunei Darussalam. *WHO June*.