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Understanding smoking behavior among young adults in rural Gujarat: determinants and preventive strategies

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Informed consent: both verbal and written informed consent were obtained from all participants prior to their inclusion in the study. Each participant was provided with a Participant Information Sheet, which clearly outlined the study's purpose, protocols, procedures, potential benefits, and their rights—including the right to refuse or withdraw from the study at any stage without any consequences.

Patient consent for publication: written informed consent was obtained from all participants after clearly explaining the objectives of the study and the intention to publish the clinical findings. Participants were informed that their participation was entirely voluntary and were assured that all personal information would be kept confidential in accordance with ethical and publishing standards.

Availability of data and materials: the data and materials supporting the findings of this study will be made available by the corresponding author upon reasonable request.

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Abstract

Youth is a critical developmental stage marked by curiosity, risk-taking, and strong peer and social influences. Tobacco initiation often occurs during this period, making young adults a key target for prevention. Despite national and state-level tobacco control efforts, smoking remains prevalent among rural youth in India. In Gujarat, easy availability of tobacco products, social acceptance, and limited awareness further reinforce smoking behavior. Understanding context-specific determinants is essential for effective prevention strategies.

A descriptive type of qualitative study was conducted in Changa village, Gujarat. Six young adult smokers (aged 19–24 years) and seven parent key informants were selected using snowball and consecutive sampling, respectively. Data were collected through in-depth interviews and a focus group discussion, audio-recorded, transcribed verbatim, and analyzed manually using thematic analysis. Ethical approval was obtained, and informed consent was taken from all participants.

Three major themes emerged: health concerns, influencing factors, and governmental norms. Participants were aware of smoking-related health risks; however, peer influence, emotional distress, curiosity, and parental modeling contributed to continued use. Early signs of dependence, normalization of smoking, and desensitization to health warnings were evident. Structural factors, including easy access to cigarettes, weak enforcement of regulations, and low awareness of cessation policies, further sustained smoking practices. Parents emphasized the role of school-based sensitization and community awareness initiatives.

Smoking among young adults in rural Gujarat is influenced by individual, social, and systemic factors. Comprehensive, multi-level interventions focusing on education, parental engagement, regulatory enforcement, and accessible cessation support are crucial to reduce smoking initiation and promote cessation.

Key words: young adults, smoking behavior, influencing factors, prevention strategies.

Introduction

Young adulthood is a transitional developmental phase marked by identity exploration, increased autonomy, and continued susceptibility to peer and social influences, which can sustain or reinforce smoking behavior [1,2]. Although many individuals initiate smoking during adolescence, patterns often persist or escalate during young adulthood due to greater independence, stress, and social exposure [3]. This age group is therefore a critical period for understanding the behavioral mechanisms that shape smoking practices and for developing targeted prevention strategies.

Behavioral and social theories provide valuable frameworks for understanding smoking among young adults. The Health Belief Model (HBM) suggests that young adults' decisions to continue or escalate smoking are influenced by their perceived susceptibility to health risks, perceived severity of long-term consequences, perceived benefits such as stress relief or social acceptance, and perceived barriers to quitting [4]. Similarly, the Theory of Planned Behavior (TPB) highlights the role of attitudes, subjective norms, and perceived behavioral control, all of which, in young adulthood, are shaped by peer networks, workplace or college environments, parental modeling, and broader socio-cultural norms surrounding tobacco use [5].

Shifts in tobacco consumption patterns, including increased accessibility and diversified tobacco products, have significantly influenced smoking behavior among young adults, particularly in communities undergoing rapid social and economic change [6]. Although global tobacco use has declined due to stronger policies and increased public awareness, India continues to face persistent challenges related to early initiation during adolescence, socio-cultural acceptance of tobacco use, and inconsistent enforcement of tobacco-control legislation, which collectively contribute to continued smoking in young adulthood [7].

In response to rising tobacco use, the Government of India has implemented multiple regulatory measures under the Cigarettes and Other Tobacco Products Act (COTPA) 2003, including prohibiting the sale of tobacco products to individuals below 18 years and restricting sales within 100 meters of educational institutions. Mandatory pictorial health warnings covering 85% of tobacco packaging, along with anti-tobacco messages displayed before and during movies and television programs, aim to strengthen risk perception among the public, particularly younger demographics. National initiatives such as the National Tobacco Control Programme (NTCP) and the Global Youth Tobacco Survey (GYTS) further support enforcement, surveillance, and awareness-building. Although these measures primarily target adolescents, their impact extends into young adulthood, as individuals aged 19–24 often continue behaviors formed at an early age. However, many young adults become desensitized to pictorial warnings over time, reducing their intended influence on risk perception and quitting motivation. Persistent gaps between policy and implementation

—especially in rural areas where accessibility and enforcement remain inconsistent—contribute to the continuation of smoking into young adulthood.

This study aims to explore the determinants that influence young adults to initiate and continue smoking, and to identify practical strategies to reduce this behavior. Through in-depth interviews with young adult smokers and focus group discussions (FGD) with parents, this study provides context-specific insights that can inform targeted, community-appropriate prevention and intervention approaches [8].

Objectives of the study

This study addresses the following research questions:

- What are the key factors that influence young adults to initiate and continue smoking?
- What potential strategies or interventions could help reduce smoking behavior among young adults in the studied community?

These research questions guided the use of in-depth interviews with young adult smokers and focus group discussions with parents to explore both the determinants of smoking and potential strategies for intervention.

Materials and Methods

Study design

A descriptive type of qualitative study was conducted in Changa village, located in the central region of Gujarat. The study aimed to explore the factors influencing smoking behavior among young adults and to identify strategies to mitigate it. Using a qualitative research approach, the study examined the perspectives of young adult smokers as well as parents from the community at large, to understand the reasons for smoking initiation and continuation, and to propose effective interventions for reducing smoking prevalence in this age group.

Sample size

To determine an appropriate sample size, the study followed the principle of data saturation, which guides qualitative inquiry. Data collection continued until no new information or themes emerged from participant responses. Saturation first became noticeable during the fourth interview, where answers to four to five key questions began to repeat. By the sixth participant, almost ten out of twelve responses were similar to earlier interviews, confirming that additional data would not contribute new insights. Therefore, data collection for young adult participants (aged 19–24 years) was concluded after six in-depth interviews. Additionally, seven parents from the community were included as key informants for a FGD.

Sampling technique

The present study employed a combination of snowball sampling and consecutive sampling techniques. Participants were recruited through snowball sampling, wherein initial participants referred additional participants who met the inclusion criteria. This approach was particularly useful for accessing individuals with specific characteristics or experiences relevant to the study. In contrast, key informants were selected using consecutive sampling, where individuals who met the predefined criteria were included in the study as they became available, until the desired sample size was achieved.

Ethical considerations

The purpose of the study was clearly explained to all participants. They were provided with a detailed Participant Information Sheet, and informed written and verbal consent was obtained prior to participation. The study protocol was reviewed and approved by the Institutional Ethics Committee, CHARUSAT University.

Study population

Inclusion criteria

- Young adults aged 19–24 years who reported daily or regular smoking, reflecting consistent tobacco use rather than occasional experimentation.
- Parents of young adults (both smokers and non-smokers), included as key informants to provide socio-environmental insights.

Exclusion criteria

- Young adults who were already experiencing morbidity or clinically diagnosed health conditions directly attributable to smoking.
- Young adults who engaged in occasional or infrequent smoking (e.g., smoking once a month or less), as they did not meet the criteria for habitual smoking behavior.
- Young adults who were using or experimenting with alternative nicotine delivery systems such as e-cigarettes, vapes, or other electronic nicotine devices, as the study focused specifically on traditional combustible tobacco smoking.

Data collection

Data collection was conducted using interview guides developed by the researcher, tailored separately for young adult participants and parents. In-depth interviews were carried out with the young adults, while a focus group discussion (FGD) was conducted with the parents. The interview guides included sections on socio-demographic information, introductory questions, core questions, and closing questions.

Prior permission was obtained from Medical Officer of Primary Health Centre (PHC), Changa to conduct all interviews and the FGD within the facility. All data collection sessions took place in the PHC's demonstration room, which provided a quiet and secluded environment essential for ensuring privacy and confidentiality. Each in-depth interview lasted approximately 25–30 minutes, whereas the FGD with parents lasted around 45–60 minutes. During the FGD, the principal author served as the moderator, facilitating discussion, maintaining flow, and ensuring balanced participation among all members. The second author acted as the recorder, documenting observation notes and managing the audio recording process.

Before beginning the sessions, both verbal and written consent for audio recording was obtained from all participants. All interviews and the FGD were recorded in full. To ensure accuracy and preserve contextual meaning, the principal author carefully listened to each recording and transcribed the participant interviews and FGD on the same day they were conducted.

Unlike some qualitative studies where transcripts are returned to participants for verification (member checking), the transcripts in this study were not returned to the participants due to feasibility constraints and the sensitive nature of the topic. All recordings and transcripts were stored on a password-protected digital platform, with exclusive access restricted to the principal author to maintain strict confidentiality and safeguard participant information.

Development of the interview guide

The interview guide was structured into three main sections:

Section A: Socio-Demographic Tool (Table 1)

This section captured key characteristics of participants, including age, education level, socio-economic status (of both the smoker and parents).

Section B: Participant Interview Guide (Table 2)

This section followed a semi-structured format comprising four types of questionnaire:

- Introductory questionnaire to build rapport, explain the study's purpose, and obtain verbal consent for Audio visual recordings.
- General questionnaire to describe participants' initial thoughts, opinions, and beliefs.
- Specific questionnaire designed to probe deeper based on participant responses and study objectives.
- Terminating questionnaire allowing participants to share final thoughts or seek clarification, followed by expressions of gratitude from the interviewer.

Section C: Key Informant Interview Guide (Table 3)

The format mirrored that of the participant interviews, including introductory, general, specific, and concluding questionnaire. Key informants, typically parents, were encouraged

to express their views openly during focus group discussions. Sessions concluded with acknowledgments and appreciation.

Data analysis

The researcher carefully listened to the recorded interviews and transcribed them verbatim, including all punctuation and relevant contextual details. Each recording was played repeatedly and reviewed multiple times to ensure accuracy and to capture subtle expressions, tone, and dialectal nuances. All in-depth interviews and FGD were transcribed on the same day they were conducted to preserve the authenticity and immediacy of participant narratives and minimize recall bias.

Following transcription, the data were analyzed manually using thematic analysis. This process involved repeated reading of transcripts, generating initial codes through line-by-line examination, organizing similar codes into categories, and subsequently identifying sub-themes and overarching themes. Throughout the analysis, particular attention was given to verbatim expressions and linguistic nuances to preserve the authenticity and depth of participants' experiences.

Results

Following data collection, all individual interviews and the focus group discussion were transcribed verbatim and analyzed through thematic analysis. Line-by-line examination of each transcript enabled the generation of descriptive codes, which were subsequently clustered into broader conceptual categories. These categories were refined into sub-themes and ultimately synthesized to form three central themes that captured the core findings of the study: i) health concerns; ii) influencing factors; iii) governmental norms.

This structured analytical approach—Raw Data → Codes → Categories → Sub-themes → Themes—ensured coherence, depth, and transparency throughout the qualitative analysis.

Socio-demographic characteristics

Six young adult smokers and seven parent key informants participated in the study. Half of the young adult participants were 22 years old, followed by those aged 23 and 24. Their educational backgrounds varied, with 16.66% having primary education, 33.33% higher secondary, and 50% graduation. Most young adults (66.66%) belonged to Below Poverty Line (BPL) households. Among parent informants, 66.66% were male, all belonged to BPL families, and the majority were engaged in farming. These characteristics provide important context for interpreting the themes emerging from the qualitative inquiry.

Theme 1: health concerns (Table 4)

This theme reflects participants' perceptions of smoking-related health risks, early physiological effects, and responses to statutory warnings.

Sub-theme 1: health issues & perception of smoking

Raw Data: "Smoking causes cancer", "Tobacco affects lungs", "I tried bidi, cigarette, gutka."

Codes: cancer, mortality, health danger, multiple products

Category: Health Issues

Participants demonstrated basic awareness of health consequences. One adolescent remarked, "Smoking causes cancer... still we smoke whatever we get," highlighting awareness without **behavioral** change.

Sub-theme 2: substance abuse

Raw Data: "I know it is a bad habit but I smoke daily."

Codes: dependency; habit formation

Category: Substance Abuse

Despite negative perceptions, consistent daily use reflected early dependency.

Sub-theme 3: emergency health conditions

Raw Data: "Breathlessness happens", "My family worries I'll fall sick."

Codes: respiratory symptoms; illness fear

Category: Health Risk

Participants reported signs of physical discomfort, supported by familial concern for their health.

Sub-theme 4: ineffective warnings

Raw Data: "Warnings don't scare me", "Everyone dies one day."

Codes: desensitization; fatalistic attitudes

Category: Resistant Behavior

Statutory warnings had minimal deterrent effect; adolescents **normalized** or dismissed risk messaging.

Theme 2: influencing factors (Table 5)

This theme explores the emotional, social, and **behavioral** determinants that influence smoking **behavior** among adolescents.

Sub-theme 1: peer and social influence

Raw Data: "My friends smoked so I started", "I didn't want to be left out."

Codes: peer pressure; conformity

Category: Peer Influence

Peer dynamics strongly influenced smoking initiation and continuation.

Sub-theme 2: emotional vulnerability

Raw Data: "I was stressed; smoking made me calm."

Codes: coping; emotional stress

Category: Psychological Factors

Emotional distress was a major trigger for smoking, suggesting a maladaptive coping mechanism.

Sub-theme 3: experimental behavior

Raw Data: "I tried it just to see what it feels like."

Codes: curiosity; experimentation

Category: Developmental Behavior

Initial smoking behavior often stemmed from experimentation typical of adolescence.

Sub-theme 4: parental influence

Raw Data: "My parents send me to buy cigarettes."

Codes: modeling; reinforcement

Category: Social Modeling

Household norms indirectly supported smoking, making it accessible and socially acceptable.

Sub-theme 5: perceived reduction experience

Raw Data: "When I smoke less, nothing changes", "Sometimes I feel proud."

Codes: lack of change; self-accomplishment

Category: Motivation

Reduction attempts varied, reflecting inconsistent motivation and lack of structured cessation support.

Theme 3: governmental norms (Table 6)

This theme highlights systemic and structural issues affecting adolescent smoking, with emphasis on enforcement, education, and access to support services.

Sub-theme 1: rule enforcement and government policies

Raw Data: "Children easily buy cigarettes", "Rules should be strict."

Codes: easy access; inadequate enforcement

Category: Regulation

Weak enforcement facilitated adolescent access to tobacco products.

Sub-theme 2: school-based education

Raw Data: "Schools should teach them early."

Codes: educational sensitization

Category: Curriculum

Parents **emphasized** the role of schools in early awareness promotion.

Sub-theme 3: lack of awareness and stigma

Raw Data: "We don't know about de-addiction centers", "People feel ashamed."

Codes: unawareness; stigma

Category: Access & Acceptability

Lack of awareness and social stigma hindered **utilization** of cessation services.

Sub-theme 4: awareness and behavioral prevention

Raw Data: "Awareness campaigns are needed", "Parents should supervise more."

Codes: parental supervision; health education

Category: Prevention Strategies

Both community-level awareness and parental engagement were viewed as critical preventive measures.

Summary

Collectively, the three themes—Health Concerns, Influencing Factors, and Governmental Norms—illustrate the complex and interconnected determinants of adolescent smoking. While adolescents were aware of health risks, peer influence, emotional distress, parental behaviors, and structural gaps collectively sustained smoking behavior. The findings underscore the need for comprehensive, multi-level interventions that integrate individual behavior change, family-based strategies, community awareness, and stronger policy enforcement to effectively address adolescent smoking.

Discussion

This study demonstrated that smoking among young adults in rural Gujarat resulted from the combined influence of health beliefs, behavioral tendencies, social pressures, and

environmental conditions. Although young adults were generally aware of the health risks associated with tobacco use, their perceived personal susceptibility remained low. Behavioral factors such as impulsivity, experimentation, and using smoking as a coping mechanism reinforced continued use, while peer approval, stress-relief motives, and easy access often outweighed long-term health concerns.

The findings align with existing qualitative literature. Previous studies have reported that peer networks, parental smoking, curiosity, and gender norms strongly influence tobacco use in young adults. Similarly, our study found that peer influence and social-network reinforcement played a central role, confirming that smoking was often learned, shared, and normalized within young adult groups. Importantly, this study extended these insights by highlighting how rural socio-economic factors, widespread Below Poverty Line status, community acceptance, and weak enforcement of tobacco regulations further embedded smoking within the daily lives of young adults in the Anand district.

Environmental permissiveness, including unrestricted access to tobacco near schools, workplaces, and local vendors, facilitated initiation and continuation of smoking in this age group. Young adults also exhibited desensitization to media warnings, with repeated exposure reducing the perceived seriousness of anti-tobacco messages and the urgency to quit.

Cessation challenges were evident: limited awareness of de-addiction services, stigma around seeking help, low motivation, social bonding around smoking, and fear of withdrawal all hindered attempts among young adults. These findings emphasize the importance of tailored, young adult-friendly, and community-based cessation interventions.

Overall, the study demonstrates that health beliefs, behavioral tendencies, social and parental modeling, and environmental factors collectively influence smoking behaviors among young adults. These insights underscore the need for multi-level, context-specific interventions that involve families, communities, workplaces, educational institutions, and stricter enforcement of tobacco-control policies to reduce smoking prevalence in this age group.

Conclusions

This study offers significant qualitative insights into the complex, multidimensional determinants influencing smoking among young adults in a rural Indian context. By identifying how peer influence, emotional distress, curiosity, and parental modeling interact with young adults' perceptions of health risks, this study contributes to a deeper understanding of smoking initiation and continuation. The three central themes—health concerns, influencing factors, and governmental norms—highlight the need for interventions

that address not only individual behaviors but also family practices and community-level regulatory gaps.

The findings have significant implications for young adult health policy. Strengthening enforcement of tobacco sales regulations, promoting community and workplace sensitization programs, and improving access to culturally appropriate cessation services may collectively reduce tobacco use in this age group. For nursing education, the study underscores the importance of equipping future nurses with competencies in behavioral counseling, community outreach, and young adult mental health support to enable early identification and guidance for at-risk individuals.

However, the study has certain limitations. Although data saturation was achieved, the findings are derived from participants within a single rural setting, which may limit the generalizability of the results to other contexts. The study included only young adults and parents as key informants; incorporating additional social groups—such as teachers, peers, and community leaders who interact closely with young adults—could have provided broader insights into behavioral influences and preventive strategies. In addition, the study focused solely on cigarette and tobacco smoking, whereas expanding the scope to include other forms of substance use could have offered a more comprehensive understanding of young adult risk behaviors. Future research should therefore explore diverse participant groups, consider a wider range of substance-use behaviors, and include perspectives from multiple community stakeholders to enhance the depth and applicability of findings.

Overall, the study provides a foundation for developing context-specific, multi-level strategies to prevent smoking among young adults and supports the integration of behavioral and community-based approaches into public health policy and nursing practice.

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Table 1. Socio-demographic data.

—	Variable	Details/Options
—	Name of the Participant	_____
—	Contact No:	_____
1	Age of the Participant	_____
2	Education/Occupation of the Participant	1. Illiterate 2. Primary 3. Higher Secondary 4. Graduate
3	Age of the Key Informant	_____
4	Gender of the Key Informant	1. Male 2. Female
5	Occupation of the Key Informant	1. Agriculture 2. Business 3. Government 4. Other (Specify): _____
6	Socio-Economic Status of the Participant	1. Below Poverty Line (BPL) 2. Above Poverty Line (APL)
7	Socio-Economic Status of the Key Informant	1. Below Poverty Line (BPL) 2. Above Poverty Line (APL)

Table 2. Interview guide for participant interview.

Section	Content
Introductory Questionnaire	Greetings: 1. Introduction of self to the participant. 2. Brief about the research: To understand reasons and solutions related to adolescent smoking. 3. Request for open and honest responses.
	Confidentiality Assurance: 1. All data will be kept confidential. 2. No names or personal identifiers will be disclosed. Data used for research only.
Participant Interview Questionnaire	1. What do you know about smoking?
	2. Since how long have you been smoking?
	3. What motivates you to smoke? (<i>Peer group, family influence, cultural aspects, etc.</i>)
	4. What according to you are the solutions to reduce smoking behaviour?
	5. How do you feel when you smoke? (<i>Relaxed, happy, stress-free, etc.</i>)
	6. How much money do you spend on smoking? <i>How could this money be better utilized?</i>
	7. How does willpower influence smoking? <i>Is it a good or bad influence?</i>
	8. How do you feel when you smoke less or not at all? <i>If you feel the same, why continue?</i>
	9. What places do you prefer for smoking? <i>If indoors/outdoors, why?</i>
	10. Are you cautious about people knowing about your addiction? <i>What steps have you taken to hide it?</i>
	11. How can smoking triggers be reduced?
	12. What is your opinion about the picture warnings (oral cancer) on cigarette packs?
Closing Questionnaire	Final Questionnaire: a) Is there anything else you'd like to share about smoking? b) Thank you for your time and participation.

Table 3. Interview guide for focus group discussion.

Section	Content
Introductory Questionnaire	Greetings: 1. Introduction of self to the participant. 2. Brief about the research: To understand reasons and solutions related to adolescent smoking. 3. Request for open and honest responses.
	Confidentiality Assurance: 1. All data will be kept confidential. 2. No names or personal identifiers will be disclosed. Data used for research only.
Participant Interview Questionnaire	1. What do you know about smoking?
	2. Since how long have you been smoking?
	3. What motivates you to smoke? (<i>Peer group, family influence, cultural aspects, etc.</i>)
	4. What according to you are the solutions to reduce smoking behaviour?
	5. How do you feel when you smoke? (<i>Relaxed, happy, stress-free, etc.</i>)
	6. How much money do you spend on smoking? <i>How could this money be better utilized?</i>
	7. How does willpower influence smoking? <i>Is it a good or bad influence?</i>
	8. How do you feel when you smoke less or not at all? <i>If you feel the same, why continue?</i>
	9. What places do you prefer for smoking? <i>If indoors/outdoors, why?</i>
	10. Are you cautious about people knowing about your addiction? <i>What steps have you taken to hide it?</i>
	11. What strategies can be employed to reduce smoking triggers?
	12. What is your opinion about the picture warnings (oral cancer) on cigarette packs?
Closing Questionnaire	Final Questionnaire: a) Is there anything else you'd like to share about smoking? b) Thank you for your time and participation.

Table 4. Theme-health concerns.

Raw Data	Codes	Categories	Sub-themes	Themes
Smoking causes cancer. Tobacco affects lungs. I tried bidi, cigarette, and gutka.	Cancer & mortality; health danger; various forms tried	Health Issues	Health issues & perception of smoking	Health concerns
I know it is a bad habit but I smoke daily.	Habit formation; dependence	Substance Abuse	Substance abuse	
Breathlessness happens. My family worries I'll fall sick.	Emergency symptoms; illness fear	Health Risk	Emergency health conditions	
Warnings don't scare me. Everyone dies one day.	Desensitized; irrational belief	Resistant Behaviour	Ineffective warnings	

Table 5. Theme-influencing factors.

Raw Data	Codes	Categories	Sub-themes	Themes
Friends smoked so I started. I didn't want to be left out.	Peer pressure; Conformity	Peer Influence	Peer & social influence	Influencing factors
I was stressed; smoking made me calm.	Emotional stress; Coping	Psychological Factors	Emotional vulnerability	
I tried it just to see what it feels like.	Curiosity; Experimentation	Developmental Behaviour	Experimental behavior	
My parents send me to buy cigarettes.	Parental modeling	Social Modeling	Parental influence	
When I smoke less, nothing changes. Sometimes I feel proud.	No change; Self-accomplishment	Motivation	Perceived reduction experience	

Table 6. Theme-governmental norms.

Raw Data	Codes	Categories	Sub-themes	Themes
Children easily buy cigarettes. Rules should be strict.	Easy access; no enforcement; strict policy	Regulation	Rule enforcement & government policies	Governmental norms
Schools should teach them early.	School sensitization	Curriculum	School-based education	
We don't know about de-addiction centres. People feel ashamed.	Unawareness; stigma	Access & Acceptability	Lack of awareness & stigma	
Awareness campaigns are needed. Parents should supervise more.	Awareness; parental supervision	Prevention Strategies	Awareness & behavioural prevention	