

Better
Health
Briefing

22

**Tobacco use
among minority
ethnic
populations
and cessation
interventions**

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Key messages

- 1 While smoking rates have decreased within the general population, this pattern does not seem to be reflected among black and minority ethnic communities
- 2 Lower socio-economic status can influence tobacco usage, which may account for the prevalence of smoking among some minority ethnic groups
- 3 Use of different tobacco products, including shisha and smokeless tobacco, is more common among minority ethnic groups
- 4 Compliance with and enforcement of regulations on labelling and packaging of smokeless tobacco products need to be improved to protect minority ethnic communities from the health risks associated with using these products
- 5 Regulation and cessation outreach work must acknowledge these different products, and adapt to the specific needs of different ethnic groups.

Introduction

According to the 2001 Census, England's black and minority ethnic community makes up 9 per cent of the total population, nearly half (48 per cent) of whom live in the London region. Tobacco smoking is the biggest cause of preventable death and ill health in England, with over 80 000 tobacco-related deaths each year and half the difference in life expectancy between the highest and lowest social classes ([The Information Centre for Health and Social Care, 2008](#); [Gruer *et al.*, 2009](#)). Since 1998, overall smoking prevalence has declined by 7 per cent in the general population ([Robinson and Bugler, 2008](#)). However, there is evidence that changes in smoking prevalence among minority ethnic groups have failed to show a similar pattern. Tobacco use among these groups has important implications when planning health services, tackling health inequalities and reducing the burden of ill health from lifestyle-related disease ([Sproston and Mindell, 2004a](#)).

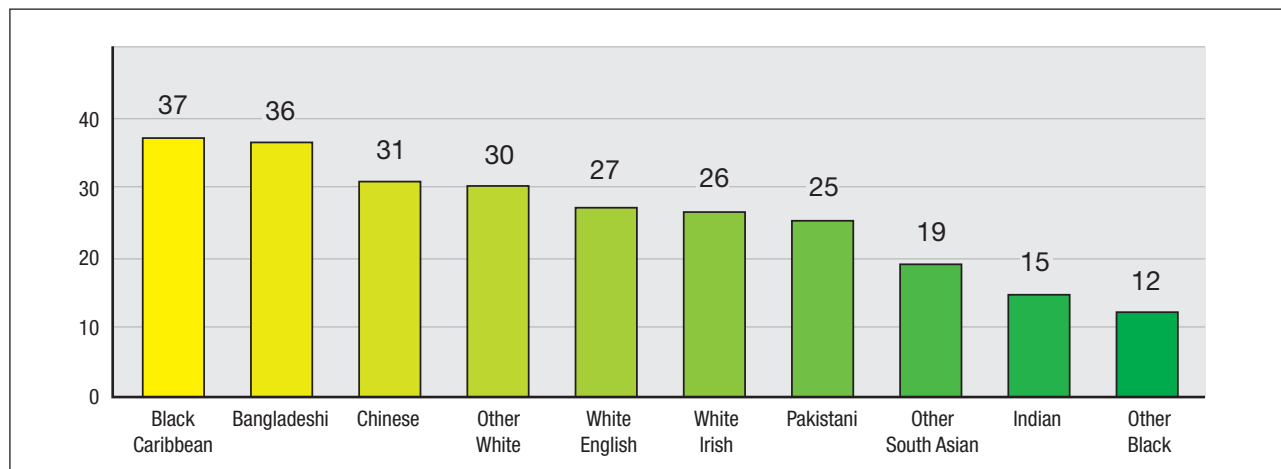
1 Smoking among minority ethnic groups

Smoking prevalence varies greatly between ethnic groups. Smoking rates among minority ethnic groups are generally lower than those of the general population. However, there is great variation in the smoking rates among different minority ethnic groups and between men and women within them. Adherence to religious traditions, which discourage tobacco use, may account for part of these differences.

Ethnic differences in the smoking rates of men

Findings from age-standardised analyses of combined data from the Health Surveys for England 2006, 2007 and 2008 suggest that among men, Black Caribbeans (37%) and Bangladeshis (36%) have the highest smoking rates, followed by Chinese (31%) and Other White men. Indian (15%) and Other Black men (12%) had the lowest smoking rates among the ethnic groups explored ([Health Survey for England 1999, 2004, 2006, 2007, 2008](#): authors' analysis).

Figure 1 Current regular smoking rates among men (England)



(Source: Health Survey for England 1999, 2004, 2006, 2007, 2008: authors' analysis)

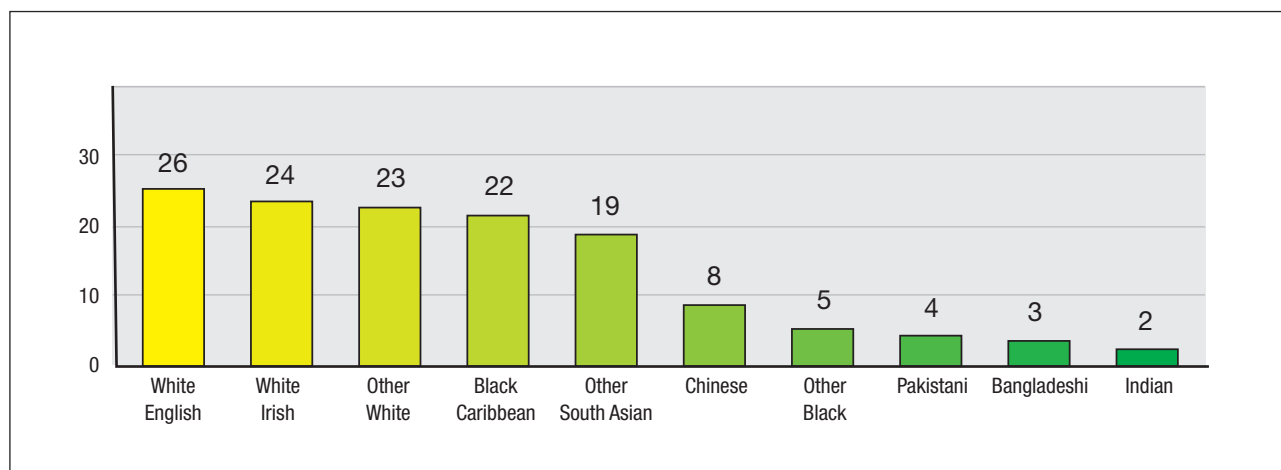
Between 20% and 25% of White Irish, White English and Other White men were ex-regular cigarette smokers, compared with between 15% and 20% of Bangladeshi, Black Caribbean and Other South Asian men and 12% or fewer of Pakistani, Indian, Chinese and Other Black men. Bangladeshi, Black Caribbean, White English, White Irish and Other White men reported never having been a regular smoker less frequently than men in the other groups explored.

Ethnic differences in the smoking rates of women

These analyses also identified striking differences between the cigarette smoking rates of Black Caribbean, White English, White Irish and Other White women and those of women in the other ethnic groups explored. Almost all Indian (96%), Pakistani (96%) and Bangladeshi (95%) women in the sample reported that they had never regularly smoked cigarettes. Twenty-six per cent of White English, 24% of White Irish, 23% of Other White and 22% of Black Caribbean said they were regular cigarette smokers.

White English (21%), White Irish (21%) and Other White (24%) women said they were ex-smokers more often than women in the other groups explored (where 11% or fewer women said the same).

Figure 2 Current regular smoking rates among women (England)



(Source: Health Survey for England 1999, 2004, 2006, 2007, 2008: authors' analysis)

The relatively high rates of current regular cigarette smoking show some consistency for both men and women in the Black Caribbean and different White groups. However, there are important differences in the smoking rates of men and women in different South Asian (and Chinese) groups. While there are extremely low rates of current or ex-smoking among women in each of the South Asian groups explored, over twice as many Bangladeshi than Indian and almost 50% more Bangladeshi than Pakistani men said they regularly smoked cigarettes.

However, there have been changes to the profile of the minority ethnic population in the UK which are not accounted for in these data. Over the last decade there has been an increase in political and economic migration from certain areas of Africa, Asia and Central and Eastern Europe. Figures from December 2008 suggested a fivefold increase in the number of UK residents born in Poland since the 2001 Census ([ONS, 2009](#)). The shifts in migration and settlement patterns and the variation of tobacco use among these groups have important implications when planning health services, tackling health inequalities, reducing the burden of ill health from lifestyle disease and delivering stop smoking services. Unfortunately, at present insufficient empirical evidence exists to understand these requirements.

2 Health inequalities

A disproportionate number of people in lower social classes continue to smoke and use tobacco. A recent report by the Equality and Human Rights Commission (EHRC) found that poverty through low income is higher among minority ethnic groups. The highest rates were among Bangladeshi and Pakistani communities, with almost two-thirds living in low-income households ([EHRC, 2010](#)).

Differences in the smoking rates of Bangladeshi and Black Caribbean men and White English men are explained by the variation in the socio-economic position of the groups. However, this does not explain the lower rates of current cigarette smoking between Indian, Pakistani, Other South Asian, Other White and Other Black men, compared with White English men.

Among women, the lower rates of current cigarette smoking between Indian, Pakistani, Other South Asian, Chinese and Other Black compared with White English are not explained by socio-economic differences. However, Black Caribbean women had significantly lower smoking rates than White English women after adjusting for socio-economic effects. Improving the socio-economic position of certain minority ethnic groups may offer an important opportunity to reduce their smoking rates, and the negative health consequences.

Data from the Health Survey for England 2004 show that minority ethnic groups are more likely to report ill health than the general population ([Sproston and Mindell, 2004b](#)). The survey showed that compared with the general population:

- Bangladeshi and Pakistani people and Black Caribbean women are more likely to report bad or very bad health;
- Pakistani women and Bangladeshi men are more likely to report limiting longstanding illness;
- Pakistani men are at more risk of ischaemic heart disease;
- Bangladeshi, Pakistani and Indian people and African Caribbean women are more at risk of Type 2 diabetes.

Since 1998, overall smoking prevalence has declined by 7% in the general population ([Robinson and Bugler, 2008](#)). However, changes in smoking prevalence among minority ethnic groups have failed to show a similar pattern. The combined data from the Health Surveys for England 2006, 2007 and 2008 found fewer self-reported ex-smokers among these groups, which suggests that tackling tobacco use among minority ethnic groups needs to be addressed if health inequalities are to be reduced.

Guidance by the National Institute for Health and Clinical Excellence noted that reducing tobacco consumption among minority groups would reduce health inequalities more than any other measure ([NICE, 2008](#)).

3 Other types of tobacco used by minority ethnic populations

Smokeless tobacco

Smokeless tobacco is a broad term that refers to over thirty different tobacco products, which include chewed, sucked or inhaled products. Chewing tobacco is a popular form of smokeless tobacco that is particularly prevalent among South Asian and Asian communities. These products traditionally contain tobacco, areca nut, betel leaf, flavourings and spices.

In England, the highest proportion of self-reported use of chewing tobacco products is among Bangladeshi women (19%), followed by Bangladeshi men (9%), Indian men (4%) and Pakistani men (2%) (Sproston and Mindell, 2004a). However, it is important to note that there may be a degree of under-reporting among these groups. For example, a study that investigated under-reporting among Bangladeshi women found that 15% of women under-reported their personal tobacco use (Roth *et al.*, 2009). Findings from the Health Survey for England suggested similar levels of under-reporting. Self-reported use of all tobacco products was 44% and 17% among Bangladeshi men and women respectively. However, when respondents with a saliva cotinine level indicative of personal tobacco use were also included, the estimates rose to 60% and 35% respectively (Sproston and Mindell, 2004b).

Chewing tobacco is embedded in many aspects of South Asian culture and traditions. It has many symbolic implications at social and religious ceremonies. However, there are many misconceptions regarding the health risks associated with using chewing tobacco, which are reinforced by manufacturers who continue to promote misleading health claims, such as betel quid having curative effects for dental pain (WHO Framework Convention on Tobacco Control, 2010).

Chewing tobacco is highly addictive and studies have found that users have blood nicotine levels that are as great as or greater than cigarette smokers (Benowitz *et al.*, 1988). These products are also associated with a range of diseases that are prevalent among the UK's Asian population, including:

- oral disease and cancer;
- cardiovascular disease;
- diabetes.

Oral cancer is largely a lifestyle disease, with almost 90% of oral cancers being associated with tobacco use. Case control studies in India found that men who chewed betel quid with tobacco had relative risks of oral cancer varying between 1.8 and 5.8, and risks for oesophageal cancer of 2.1–3.2. Furthermore, pregnant women in India who used smokeless tobacco had a threefold risk of still birth and a two- to threefold increased risk of having a low birth weight infant (Gupta and Ray, 2003).

A study by the International Agency for Research on Cancer (IARC) reported that areca nut and betel quid, which are common ingredients added to smokeless tobacco products, are both carcinogenic and place users at an increased risk of developing oral cancer (Sharma, 2003). Researchers also found an even higher risk of cancer of the oral cavity when it was combined with tobacco. These findings have important implications for local health providers when planning cessation interventions and campaigns. The study demonstrates the need to warn users of the harmful health risks of popular chewing tobacco products, as well as providing appropriate local cessation services and support in communities with a high South Asian and Asian population.

Chewing tobacco is also prevalent among teenagers and children in these communities due to the easy availability of these products (Longman *et al.*, 2010). The brightly coloured packaging and sweet flavours of some products suggest that they are targeted at young consumers.

Waterpipes

Waterpipes, also known as hookah or shisha smoking, have traditionally been used to smoke tobacco in the Middle East and parts of North Africa. However, there has been a recent global resurgence of waterpipe smoking, particularly among young adults ([Maziak *et al.*, 2004](#); [American Lung Association, 2007](#)). There is a common misconception among users of waterpipes that the water filters out the harmful impurities in tobacco smoke. In fact, there is a growing body of evidence demonstrating that harm from using waterpipes is similar to, if not greater than, smoking cigarettes. For example, one study found that compared to a single cigarette, 45 minutes of waterpipe smoking doubles carbon monoxide and triples nicotine exposure ([Eissenberg and Shihadeh, 2009](#)). Further health risks include communicable disease, such as hepatitis A and tuberculosis, due to sharing the mouthpiece of the waterpipe ([Maziak *et al.*, 2004](#)). The use of waterpipes in any indoor public place is illegal in the UK and new guidance has been issued for local authority officers on dealing with non-compliance in shisha bars ([Local Government Regulation, 2011](#)).

Box 1 Common tobacco products used by minority ethnic groups

Smokeless tobacco products

Betel quid (paan)

Usually mixed with tobacco and includes lime and sliced areca nut and is wrapped in a leaf from a betel vine. Areca nut and betel quid are carcinogenic ([Sharma, 2003](#)).

Gutkha

Contains areca nut, spices and powdered tobacco and is prepackaged. Gutkha, which is imported from South Asia, is a mixture of betel nut and chewing tobacco.

Paan masala

A balanced mixture of betel leaf with lime, areca nut, clove, cardamom, mint, tobacco, essence and other ingredients. It is used as a mouth freshener.

Snus

A moist powder tobacco product originating from Sweden. Users place it under the lip for extended periods of time. The sale of snus is illegal in the EU, but it is still available in Sweden due to exemptions.

Zarda or Khaini

A smokeless tobacco leaf product. It is an integral part of the Indian culture as a mood enhancer.

Other tobacco products

Bidis

Small thin hand-rolled cigarettes. They are popular among Indian and Southeast Asian men and boys. Bidis are available in a range of flavours, including chocolate, vanilla, mint and cherry, and are particularly attractive to young people. Bidi cigarettes contain higher concentrations of nicotine than conventional cigarettes, which make them more addictive and increase the risk of bidi smokers becoming nicotine dependent at a faster rate ([Malson *et al.*, 2001](#)).

Waterpipes

Also known as hookah or shisha. Traditionally, they are smoked in the Middle East and parts of North Africa, but usage has spread to the UK, North America and Europe in recent years.

4 Regulation of smokeless tobacco products

Under the terms of the 2001 EU Tobacco Products Directive 2001/37/EC, smokeless tobacco products (other than snus, which is banned) are required to have health warnings. However, many of these products, which are readily available in local communities with large South Asian and Asian populations, fail to comply with the law ([Longman *et al.*, 2010](#)).

A recent study on the accessibility of chewing tobacco products in England found that less than half (48%) of chewing tobacco purchased had any form of health warning, while only 15% of products complied with the current legislation of health warnings for smokeless tobacco products ([Longman *et al.*, 2010](#)). The evidence of non-compliance with current regulations on labelling and packaging requirements suggests a need to challenge retailers selling smokeless tobacco to ensure they comply with the current UK and EU labelling and health warning regulations.

The EU is currently consulting on a possible revision of the Tobacco Products Directive, which may lead to a tightening of the law.

5 Tobacco cessation among minority ethnic groups and limitations in current services

People who use NHS stop smoking services are up to four times more likely to quit smoking than those who try to give up alone. Despite evidence showing that minority ethnic groups in England are as ready to quit smoking as the general population, fewer have made an attempt to stop through using professional support, with only 6% of total NHS stop smoking services uptake coming from minority ethnic groups ([The Information Centre for Health and Social Care, 2007](#)).

There have been few robust evaluations of stop smoking programmes aimed at minority ethnic groups in the UK ([Aspinall, 2007](#)). A study of smoking among a Somali community identified a number of limitations and shortcomings within local stop smoking services, which, despite the availability of a one-to-one Somali stop smoking adviser, resulted in poor uptake of cessation services ([Straus *et al.*, 2007](#)). Findings from the study showed that within the community there was a low awareness of local stop smoking services, a lack of knowledge of nicotine replacement therapy (NRT) and an apprehension to speak to a stranger alone, with a strong preference for group counselling.

There have been some successes. For example, STOP!, a Leicester NHS stop smoking service, increased uptake among minority ethnic groups from 14% in 2007–08 to 21% in 2010. This was achieved through developing partnerships with key advocates, such as local GPs, Pfizer, community colleges and traditional allies such as Imams, the Federation of Muslim Organisations and Confederation of Indian Organisations. STOP! also carries out campaigns during the month of Ramadan, which include active media coverage through local radio stations. A recent lifestyle survey highlighted that STOP! received 80% brand recognition ([NHS East Midlands Equality & Diversity Strategy, 2010](#)).

A study that looked at tobacco use among Bangladeshi and Pakistani adults found that smoking among men was seen not only as socially acceptable, but as deeply socially ingrained among Bangladeshi men, contributing to group cohesion and identity. The study concluded that more investment is needed in providing and evaluating culturally sensitive smoking cessation services for South Asian people ([Bush *et al.*, 2003](#)).

The Bangladeshi Tobacco Cessation Project in the London Borough of Tower Hamlets demonstrates the success of a tailored cessation programme. The Bangladeshi community has the highest rates of smoking

and chewing tobacco in the borough, with 60% of Bangladeshi men smoking cigarettes and 50% of women chewing tobacco in paan (CLG, 2008). The Bangladeshi Tobacco Cessation Project provides a tailored programme that is culturally sensitive and works with the East London Mosque to provide a Stop Tobacco Service for visitors. The project reported four-week quit rates, which were above the national average, ranging from 63% to 68% for three years 2003–04 to 2005–06 (CLG, 2008).

Waltham Forest, a London borough with high levels of deprivation, ran a campaign using a range of media to reach a target audience that included local minority ethnic groups (APHO, 2008; CLG, 2008). The media campaign was used to encourage referrals to the stop smoking service from January to March 2004. The range of media used included advertisements in local newspapers, local magazines and local radio broadcasts in different African languages. Information was also sent to NHS staff, local businesses, voluntary groups and pharmacists, and leaflets were handed out at train stations. The campaign led to a good recognition of the stop smoking service logo and hotline number. The service received 2000 referrals between April 2003 and March 2004 and met the four-week quit target (CLG, 2008).

A pilot study of oral tobacco cessation among Bangladeshi women found that nicotine replacement therapy helped in the cessation of chewing tobacco. Of those who successfully stopped, 22% had received NRT and 17% brief advice and encouragement alone. The researchers concluded that traditional cessation methods that have been identified as helping cigarette smokers to quit can be adapted for tobacco chewers (Croucher *et al.*, 2003).

These studies and other successful local campaigns demonstrate the importance of local mapping to understand the profile and prevalence of smoking and tobacco use among minority ethnic groups within local communities. When planning the delivery of stop smoking services, local authorities and primary care trusts (PCTs) with large minority ethnic communities should carry out joint needs assessments and local mapping to provide a tailored approach to cessation services. Stop smoking services will be able to identify the best methods and practices to engage and support smokers in their attempt to stop smoking to ensure that their service is accessible and appropriate to the needs of the minority ethnic community.

Examples of good practice and innovative projects

Crewe

Forty-eight per cent of Polish migrants smoke compared with 25% of the local population in Crewe. The local stop smoking service has provided a dedicated Polish-speaking stop smoking service, and between October 2009 and February 2010 the service successfully helped twenty people to quit at four weeks, with fifty smokers setting a quit date (Cheshire East Council and Central and Eastern Cheshire NHS Primary Care Trust, 2010).

The Wirral

NHS Wirral's Quit and Win campaign in 2009 successfully worked with local black and minority ethnic organisations to increase uptake of the stop smoking services among minority ethnic groups. The campaign was delivered by working with local black and minority ethnic organisations and two community ambassadors who used their local knowledge and networking skills to engage with residents from black and minority ethnic communities. The success of the scheme has led to the model being replicated for the NHS Wirral, including the Your Reason, Your Way campaign (NHS Wirral, 2010a,b).

Smokefree South East

A smoking cessation project targeted at Gypsy and Traveller communities is under development. The project aims to support community leaders to become stop smoking champions to enable them to help their own community members to stop smoking (Community Health Buckinghamshire, 2010).

Mapping black and minority ethnic tobacco prevention resources

A mapping exercise was commissioned by the Department of Health to identify and map black and minority ethnic-related tobacco prevention initiatives and resources across England. The evaluation indicated that smoking cessation services are not as accessible to minority ethnic groups as they are to

the general population. It recommends that models of good practice do exist and need to be shared among PCTs, that more data on ethnic groups and quitting need to be collected by PCTs and that coordinators should endeavour to ensure that smoking cessation services are accessible to all ethnic groups. It also recommended that strategic level work should be done with PCTs to emphasise the importance of targeting black and minority ethnic groups to reduce their tobacco use ([Crosier and McNeill, 2003](#)).

Conclusion

In the last decade, overall smoking prevalence has declined among the general population. However, the pattern is more complex among minority ethnic groups. Although health inequalities among minority ethnic groups are influenced by a number of factors, smoking remains one of the biggest causes of inequalities in health. Improving access to, and uptake of, local stop smoking services by identifying existing barriers and recognising the social, cultural and economic needs of minority ethnic groups will reduce health inequalities, reduce tobacco use and improve the health of minority ethnic communities.

Resources

ASH

www.ash.org.uk

ASH is a campaigning public health charity that works to eliminate the harm caused by tobacco. Information and links to other resources are available on the ASH website.

Cancer Research UK

www.cancerresearchuk.org

Cancer Research UK provides information on the dangers of smoking and smokeless tobacco use, as well as offering information leaflets in a variety of languages, including Bengali and Urdu, and promoting the NHS Smoking Helpline, the NHS Asian Tobacco Helpline and Asian Quitline.

Cardio Wellness Charity

www.cardio-wellness.com

The Cardio Wellness Charity provides advice, support, counselling and education to the multi-ethnic community on cardiovascular health. Advice is provided in a number of multi-ethnic languages, including Hindi, Urdu, Punjabi, Gujarati, Polish and Swahili, and there is smoking cessation information in several languages on their website.

NHS Asian Tobacco Helpline

<http://smokefree.nhs.uk/advice-and-information/south-asian-tobacco-use/index.php>

Smokefree England provides a dedicated NHS Asian tobacco helpline which offers one-to-one support and advice in Urdu, Punjabi, Hindi, Gujarati or Bengali on Tuesdays between 1 pm and 9 pm:

- Urdu: 0800 169 0 881
- Punjabi: 0800 169 0 882
- Hindi: 0800 169 0 883
- Gujarati: 0800 169 0 884
- Bengali: 0800 169 0 885

Quit smoking toolkits, which include South Asian leaflets and alternative language guides, are available on the Smokefree website:

<http://smokefree.nhs.uk/quit-tools/downloads/index.php>

Tower Hamlets

The Bangladeshi Stop Tobacco Project has trained Bengali-speaking male and female advisers. They can be contacted from Monday to Friday between 9 am and 6 pm:

- female adviser: 020 7782 8669
- male adviser: 020 7882 8660

QUIT

www.quit.org.uk

QUIT is an independent charity whose aim is to save lives by helping smokers to stop. It offers advice and has helplines available in Arabic, Bengali, Gujarati, Hindi, Kurdish and Turkish, Punjabi and Urdu.

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