NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH GUIDANCE

DRAFT SCOPE

1 Guidance title

Tobacco: helping people of South Asian origin to stop using smokeless tobacco

1.1 Short title

Smokeless tobacco: South Asians

2 Background

a) The National Institute for Health and Clinical Excellence (NICE) has been asked by the Department of Health (DH) to develop public health guidance on cessation services for users of smokeless tobacco.

b) NICE public health guidance supports the preventive aspects of relevant national service frameworks (NSFs), where they exist. If it is published after an NSF has been issued, the guidance effectively updates it. Specifically, in this case, the guidance will support the NSF on coronary heart disease (DH 2000).

c) This guidance will support a number of related policy documents including:

- 'Cancer reform strategy' (DH 2007).
- 'Healthy lives, healthy people: a tobacco control plan for England' (DH 2011a).
- 'Healthy lives, healthy people: our strategy for public health in England' (DH 2010a).

- ‘Securing good health for the whole population’ (Wanless 2004).
- ‘The NHS outcomes framework 2011/12’ (DH 2010b).
- ‘The operating framework for the NHS in England 2011/12’ (DH 2011b).

d) This guidance will support a range of UK international agreements including: the ‘EU directive on tobacco products’ (European Union 2001); the World Health Assembly resolution on the prevention of oral cancers (Petersen 2008); and the World Health Organization framework convention on tobacco control (World Health Organization 2003).

e) This guidance will provide recommendations for good practice based on the best available evidence of effectiveness and cost effectiveness. It is aimed at all providers of evidence-based smoking cessation services. It is also aimed at practitioners such as doctors, dentists, nurses and dental nurses, as well as commissioners, managers and other professionals with public health as part of their remit. They may be working within the NHS, local authorities or the wider public, private, voluntary and community sectors. In addition, it will be of interest to leaders and peer educators in the communities most affected by smokeless tobacco use, people who want to stop using smokeless tobacco and other members of the public.

f) The guidance will complement NICE guidance on how to help people stop smoking. For further details, see section 6.

This guidance will be developed using the NICE public health intervention process.

3 The need for guidance

a) Smokeless tobacco is defined here as any tobacco product that is placed in the mouth or nose and not burned[1]. The types of smokeless tobacco products most used in the UK often contain a mix of ingredients including slaked lime, areca nut and spices, flavourings and sweeteners. (Appendix B gives a more detailed breakdown of the different types). Terminology varies between different countries and ethnic groups but the main products used in the UK are:

- Gutka, Khaini, Pan Masala (betel quid), Shammah and Maras powder (these are sucked or chewed)
- Zarda, Qiwam, or Mawa (chewed)
- Lal dantmanjan, Gadakhu, Gul, Mishri, or Creamy Snuff (dental products which are used as toothpaste or rubbed on gums)
- Nass (can be used either nasally or sucked or chewed).

These products are associated with a number of medical conditions including:

- nicotine addiction
- mouth and oral cancer
- periodontal disease
- myocardial infarction and stroke
- problems in pregnancy and following childbirth (including foetal anaemia, abnormal placental pathology, stillbirth, younger gestational age at birth and lower birthweight)
- late diagnosis of dental problems (caused because the smokeless tobacco product helps mask the pain).

[1] Note: Although nicotine replacement therapy (NRT) and other 'nicotine-containing products' (NCPs) are both smokeless products derived from tobacco, they are not included within the scope of this guidance.

(Boffetta and Straif 2009; England et al. 2010; Gupta and Subramoney 2004; Pau et al. 2003; Quandt et al. 2005; West et al. 2004.)

b) There has been a steady increase in oral cancer rates since 1989 (Cancer Research UK 2010). Exactly how smokeless tobacco is linked to the rise is unknown. However, the incidence of oral and pharyngeal cancer is signficiantly greater among South Asian women (some of the main users of these products in the UK) compared with white women, after controlling for the effect of socioeconomic deprivation. (It was 3.67 times the rate of non-South Asian people and 2.06 times respectively [Moles et al. 2008]). Areca nut, which is often mixed in with South Asian varieties of smokeless tobacco, is also likely to be linked to the prevalence of oral cancer among this group. Areca is a mildly euphoric stimulant. It is addictive and carcinogenic in its own right – and is widely used among South Asian groups (Auluck et al. 2009; Warnakulasuriya 2002).

c) Survey results suggest that, in addition to South Asian women, certain other subgroups from South Asian communities are more at risk from the effects of smokeless tobacco:

- people of Bangladeshi origin (as opposed to other South Asian groups)
- those in older age groups
- those from lower socioeconomic groups.

(Moles et al. 2008; Prabhu et al. 2001; The NHS Information Centre 2006).

d) Smokeless tobacco products are readily available in shops in South Asian neighbourhoods in England. Around 85% of the different product types are sold without any regulatory health

warning. Generally, they are cheap compared to cigarettes (Longman et al. 2010). Estimates vary on how much they are used by South Asian communities. The NHS Information Centre (2006) confirmed that Bangladeshis were the biggest users among this community in 2004, with 9% of men and 16% of women saying that they used these products. However, these figures may be an underestimate. For example, another study, based on saliva analysis and questionnaires, reported that 49% of adult Bangladeshi women in Tower Hamlets used these products (Croucher et al. 2002).

e) One report suggests that smokeless tobacco use fell among the Bangladeshi community between 1999 and 2004 (The NHS Information Centre 2006). However, other sources appear to indicate a rise in use. First, the number of outlets selling such products appears to be growing (Croucher et al. 2009). Second, over the last 11 years there has been a rise in legal imports of smokeless tobacco, even when the calculation is derived from the balance of imports over exports (HM Revenue & Customs 2011). Third, a recent rise in illegal imports has also been reported (HM Revenue & Customs and UK Border Agency 2008). In addition, a high percentage of young South Asians in at least some parts of the UK are using these products (Prabhu et al. 2001; Williams et al. 2002). There are also claims that the packaging of these products appears to be targeted at younger people (Panesar et al. 2008).

f) There are a number of potential barriers to helping South Asian people quit smokeless tobacco. These include:

- Low level of awareness among health professionals.
- A belief among some users that these products are healthy and therapeutic (some use them to ease indigestion or oral pain).

- A lack of awareness among some users of the tobacco content of these products.
- Social acceptability and religious belief (including a belief in the divine nature of the Areca nut).
- Cultural tradition – smokeless tobacco is part of some users's cultural identity and the upheaval of migration can create a particularly strong attachment to it.
- People who have migrated to the UK may feel uncertain about certain aspects of western medical practice, including the idea that an apparently healthy person should be screened for health risks.

(Auluck et al. 2009; Health Development Agency 2000; Longman et al. 2010; Panesar et al. 2008; Roth et al. 2009.)

4 The guidance

Public health guidance will be developed according to NICE processes and methods. For details see section 5.

This document defines exactly what this guidance will (and will not) examine, and what the guidance developers will consider. The scope is based on a referral from the DH (see appendix A).

4.1 Who is the focus?

4.1.1 Groups that will be covered

People of South Asian origin[2], of all ages, who use smokeless tobacco.

4.1.2 Groups that will not be covered

- People who smoke but who do not use smokeless tobacco products.

[2] Someone of South Asian origin is defined here as a UK citizen or resident with ancestry, parentage or extraction from India, Pakistan, Bangladesh or Sri Lanka.

- People who chew Areca nut without added tobacco.

4.2 Interventions

4.2.1 Interventions that will be covered

The guidance will cover the following interventions, as well as local initiatives to increase the uptake of these interventions, to help people stop using smokeless tobacco.

a) Behavioural support or counselling for individuals or groups offered by evidence-based stop smoking services. This may involve the use of pharmacotherapies.

b) Brief interventions by dental practitioners, GPs and other health professionals. This may involve a referral or the use of pharmacotherapies.

4.2.2 Interventions that will not be covered

a) Interventions solely aimed at preventing the uptake of smokeless tobacco use.

b) Interventions focused only on helping people to stop smoking tobacco.

c) Wider tobacco control measures (for example, legislation, taxation, advertising regulation and the use of health warnings on products).

4.3 Key questions

Below are the overarching questions that will be addressed along with some of the outcomes that would be considered as evidence of effectiveness. (Also see appendix C.)

Question 1: Which interventions, or combination of interventions, are effective and cost effective in helping South Asian people to stop using smokeless tobacco in England?

Question 2: How should interventions be targeted and tailored for the different subcategories of users within the South Asian community (grouped, for example, by gender, age, socioeconomic status or by country of origin)?

Question 3: What opinions, attitudes or cultural practices encourage (or predispose) South Asian people in England to use smokeless tobacco?

Question 4: Are health professionals aware of the widespread use of smokeless tobacco among South Asian communities and its dangers? Does lack of awareness mean that people are not being referred for, or receiving, support to stop using these products, or that support services are not being commissioned?

Expected outcomes

Several key outcomes are listed below:

- A reduction in self-reported use of all types of tobacco, both frequency of use by individuals and in terms of the overall number of people using it.
- Changes in knowledge and attitudes among the South Asian community in relation to smokeless tobacco use.
- A reduction in morbidity and mortality caused by smokeless tobacco use.
- A rise in clinician awareness of the prevalences of smokeless tobacco use.

4.4 Status of this document

This is the draft scope, released for consultation on 21 March 2011 until 18 April 2011, to be discussed at a public meeting on 7 April 2011. Following consultation, the final version of the scope will be available at the NICE website in June 2011.

5 Further information

The public health guidance development process and methods are described in 'The NICE public health guidance development process: An overview for

stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' available at www.nice.org.uk/phprocess and 'Methods for development of NICE public health guidance (second edition, 2009)' available at www.nice.org.uk/phmethods

6 Related NICE guidance

Published

Quitting smoking in pregnancy and following childbirth. NICE public health guidance 26 (2010). Available from www.nice.org.uk/guidance/PH26

Prevention of cardiovascular disease. NICE public health guidance 25 (2010). Available from www.nice.org.uk/guidance/PH25

School-based interventions to prevent smoking. NICE public health guidance 23 (2010). Available from www.nice.org.uk/guidance/PH23

Preventing the uptake of smoking by children and young people. NICE public health guidance 14 (2008). Available from www.nice.org.uk/guidance/PH14

Smoking cessation services. NICE public health guidance 10 (2008). Available from www.nice.org.uk/guidance/PH10

Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007). Available from www.nice.org.uk/guidance/PH5

Smoking cessation – varenicline. NICE technology appraisal 123 (2007). Available from www.nice.org.uk/guidance/TA123

Brief interventions and referral for smoking cessation. NICE public health guidance 1 (2006). Available from www.nice.org.uk/guidance/PH1

Head and neck. NICE cancer service guidance (2004). Available from www.nice.org.uk/CSGHN

Under development

Smoking harm reduction. NICE public health guidance (publication expected May 2013)

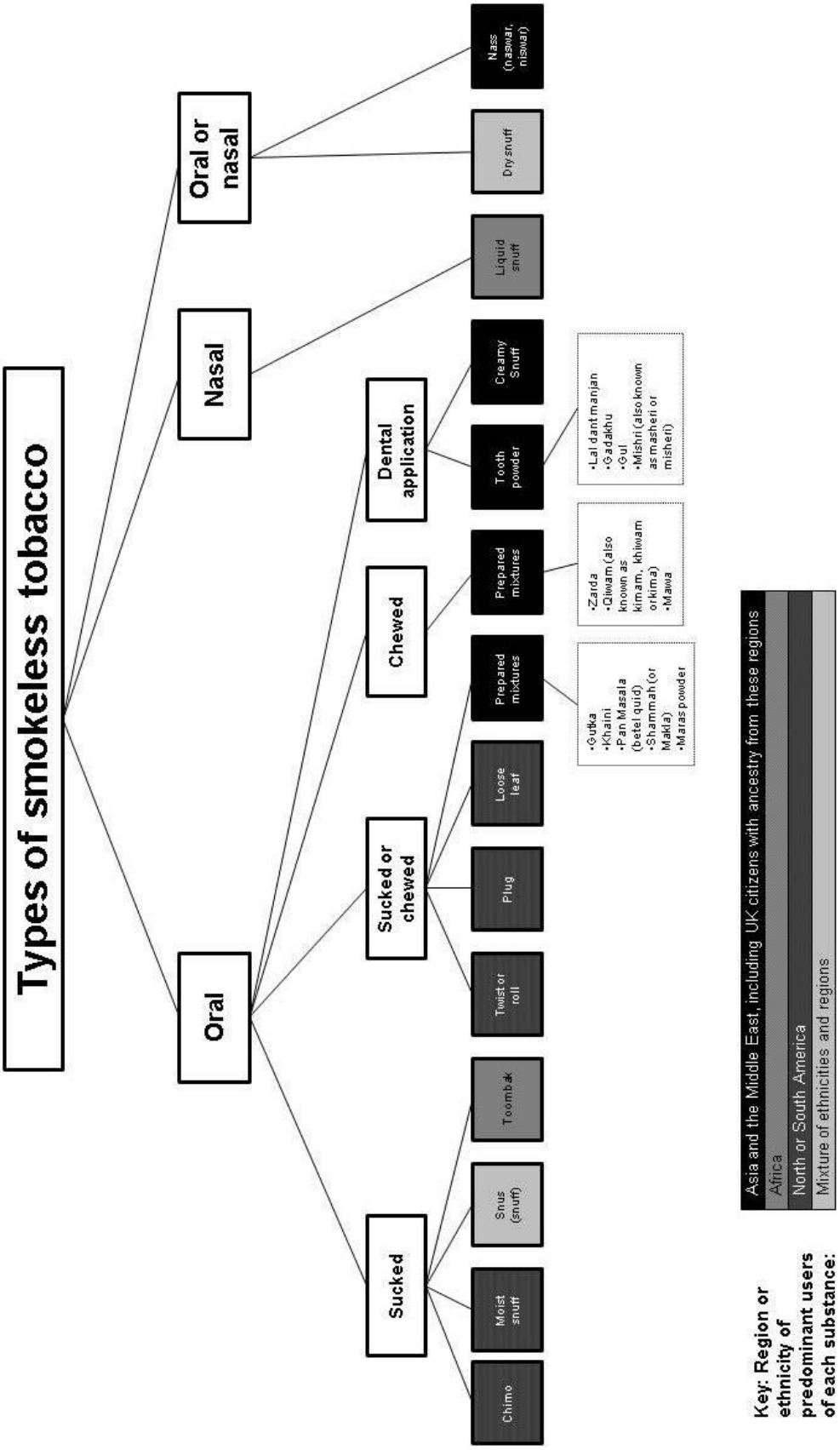
Smoking cessation in secondary care. NICE public health guidance (publication expected September 2013)

Appendix A Referral from the Department of Health

The Department of Health asked NICE:

‘To produce public health guidance for commissioners and providers on delivering cessation services for users of smokeless tobacco.’

Appendix B


Types of smokeless tobacco
Oral
Oral or nasal
Nasal
Sucked
Sucked or chewed
Chewed
Dental application
Chimo
Moist snuff
Snus (snuff)
Toombak
Twist or roll
Plug
Loose leaf
Prepared mixtures
Prepared mixtures
Tooth powder
Creamy Snuff
Liquid snuff
Dry snuff
Nass (naswar, niswar)
•Gutka
•Khaini
•Pan Masala (betel quid)
•Shammah (or Makla)
•Maras powder
•Zarda
•Qiwam (also known as kimam, khiwam or kima)
•Mawa
•Lal dant manjan
•Gadakhu
•Gul
•Mishri (also known as masheri or misheri)
Key: Region or ethnicity of predominant users of each substance:
Asia and the Middle East, including UK citizens with ancestry from these regions
Africa
North or South America
Mixture of ethnicities and regions

Appendix C Potential considerations

It is anticipated that the Public Health Interventions Advisory Committee (PHIAC) will consider the following issues for each intervention:

- Whether it is based on an underlying theory or conceptual model.
- Whether it targets specific individuals or populations.
- Whether it is effective and cost effective.
- Critical elements. For example, whether effectiveness and cost effectiveness varies according to:
    - the diversity of the population (for example, in terms of age, gender or ethnicity)
    - the status of the person delivering it and the way it is delivered (one-to-one or group-based)
    - the content and intensity of the intervention
    - its frequency, length and duration
    - where the intervention is delivered and whether it is transferable to other settings.
- Any trade-offs between equity and efficiency.
- Any social or cultural factors that prevent – or support – effective implementation.
- Any adverse or unintended effects. For example, is there a danger that people could start (or resume) smoking tobacco instead? Or could interventions not specifically tailored for South Asians have a negative impact on the community's attitude towards the NHS – or towards tobacco cessation initiatives?
- Current practice.
- Availability and accessibility for different groups.

Appendix D References

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