

PUBLIC HEALTH GUIDANCE

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) 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).

- c) 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).
- d) This guidance will provide recommendations for good practice based on the best available evidence of effectiveness and cost effectiveness. It is aimed at providers of evidence-based smoking and tobacco cessation services, health and social care practitioners and all those 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. Examples include GPs, dentists, nurses, dental nurses, health trainers, community and religious leaders, community champions and peer educators. In addition, the guidance will be of relevance to: local authority elected members, retailers and suppliers of smokeless tobacco products, people who want to stop using smokeless tobacco and other members of the public.
- e) 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 product containing tobacco that is placed in the mouth or nose and not burned¹. 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

¹ Note: nicotine replacement therapy (NRT) and other 'nicotine-containing products' (NCPs) are not included within the scope of this guidance because they do not contain tobacco.

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 or Shupari (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 health problems including:

- nicotine addiction
- mouth and oral cancer
- periodontal disease
- heart attack 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).

(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 in the UK since 1989 (Cancer Research UK 2010). Exactly how smokeless tobacco is linked to this increase is unknown. However, the incidence of oral and pharyngeal cancer is significantly greater among South Asian women (some of the main users of these products in the UK) compared with other women. This is the case, even after controlling for the effect of socioeconomic deprivation

(Moles et al. 2008). In Moles' 2008 study, South Asian women were 3.67 times more likely to have oral cancer and 2.06 times more likely to have pharyngeal cancer. 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 likely to use 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) The heterogeneity of the various subpopulations using smokeless tobacco presents a challenge when developing interventions to prevent or help people to stop using it. Other potential barriers to helping South Asian people quit include:
- Lack of services and materials in appropriate languages.
 - 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' 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 origin², 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.
- 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:

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

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.

- b) Brief interventions (including brief advice) by health and social care professionals, including dental practitioners and GPs. This may involve a referral for more intensive support or the use of pharmacotherapies.
- c) Brief interventions (including brief advice) by community members or peers.
- d) Local community-based initiatives to raise awareness of the harm caused by smokeless tobacco and to encourage the uptake of cessation services by people who use smokeless tobacco.
- e) Interventions to raise awareness and knowledge among health and social care professionals about smokeless tobacco use.

4.2.2 Interventions that will not be covered

- a) Interventions aimed only at prevention (that is, they do not address cessation).
- 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, religion, 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? Do these factors also determine the particular varieties used?

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 health and social care professionals' awareness of the prevalence and dangers of smokeless tobacco use, and the different varieties of product.
- A rise in the number of South Asian smokeless tobacco users who set a quit date and quit in the short term (4 weeks) or the long term (12 months).

4.4 Status of this document

This is the final scope, incorporating comments from a 4-week consultation which included a stakeholder meeting on 7 April 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)

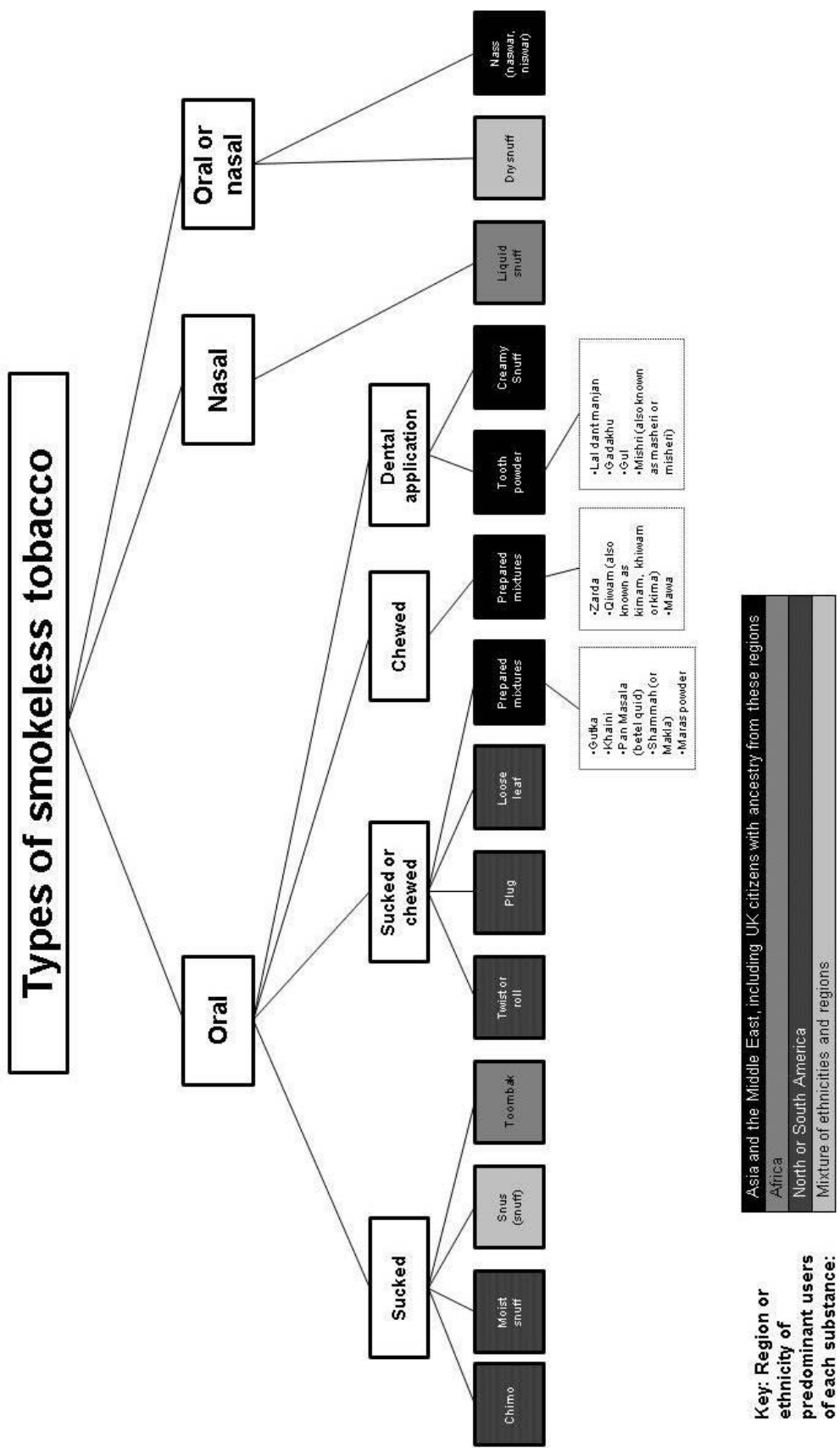
Smoking cessation in secondary care. NICE public health guidance (publication expected September 2013)

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



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, cultural, religious or wider contextual 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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