Evidence into practice: Supporting Black and Minority Ethnic (BME) populations

Introduction

This briefing is intended to act as a guide for local authorities, NHS organisations and others working with smokers to support them to consider the needs of BME smokers. It provides an overview of current differences in smoking rates between different populations, barriers to accessing quit support or engaging with quit messaging and insights into use of different tobacco products by different populations. It provides case studies to support practice and areas to consider as organisations are developing local approaches.

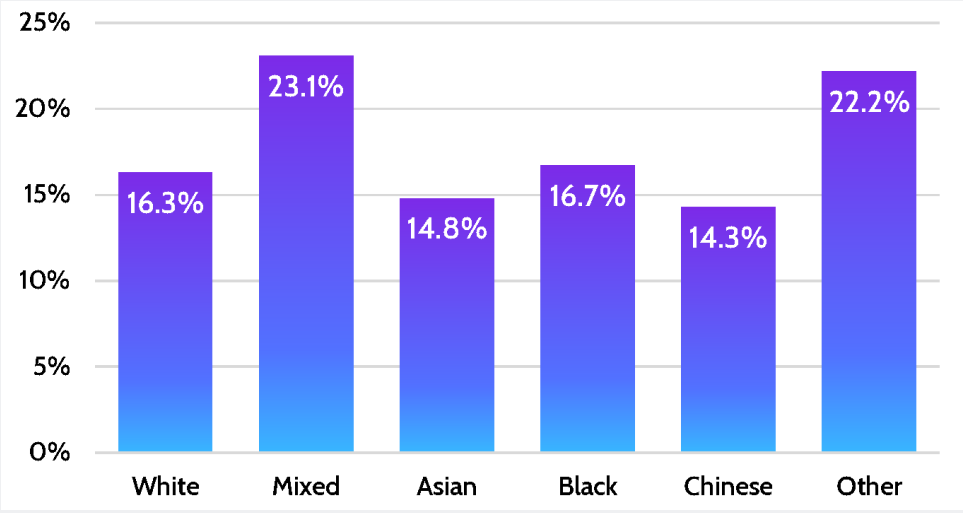
BME populations are heterogeneous and this briefing is not advocating a single approach but rather a set of considerations in assessing the needs of your local population and structuring your tobacco control activities to maximise opportunity to reduce rates in high prevalence populations.

Existing evidence base

Rates of smoking in the BME population

Smoking rates in most BME populations are lower than that of the white British population but there is wide variation in rates and big differences by gender.[1]

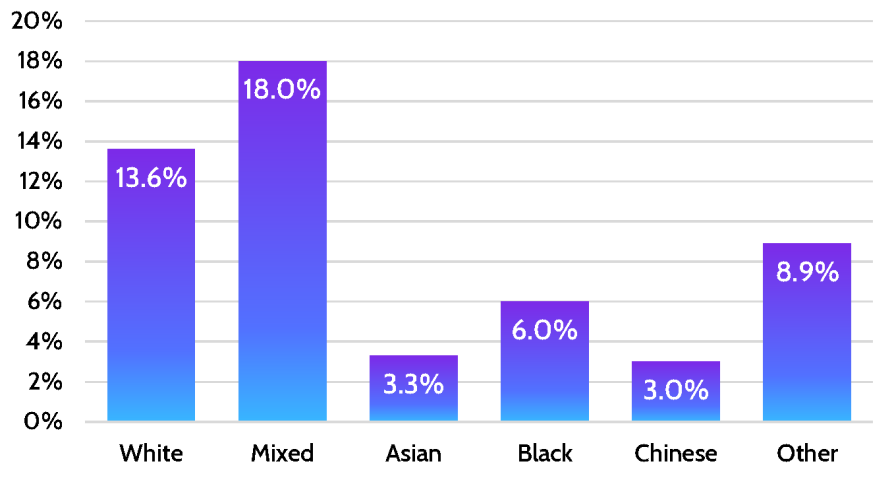
Fig 1: Smoking rates among men (APS 2018)



Sample Sizes

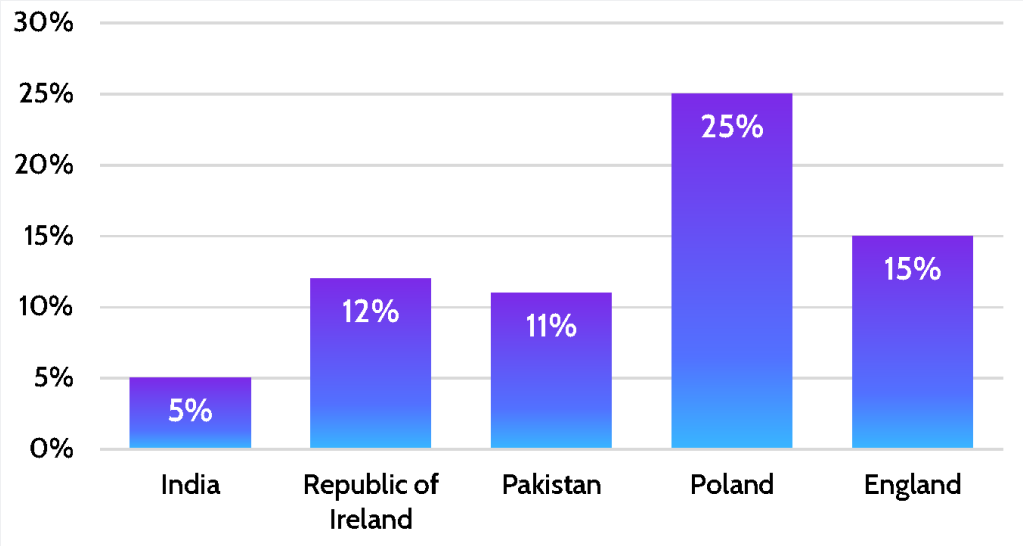
White - 64,127; Mixed - 604; Asian - 4,521; Black - 1,799; Chinese - 290; Other - 1,054.

Fig 2: Smoking rates among women (APS 2018)



Some populations are likely to have higher rates than national ethnicity figures would indicate, particularly people who are recent migrants from countries with higher rates of smoking than the UK. People from Eastern European countries are much more likely to come from communities where smoking is common and may, therefore, be more likely to be smokers themselves. Smoking rates between men and women in many Eastern European countries are both higher than among the white British population.[2 3]

Fig 3: Smoking rates by country of birth (APS 2018)



Current service provision

The reach of existing stop smoking services would appear to be broadly reaching an equitable proportion of people from BME populations who smoke. For example an analysis of the Stop Smoking Service returns (236,175 quit attempts)[4] finds that in 2018/19 7.4% of quit attempts by men in stop smoking services were among Asian men, which is a similar proportion of the English population who are Asian. The self-reported quit success rates were similar across ethnic groups with Asian men having the highest self-reported quit rates at 57% (compared to 52% for all people accessing services).[4]

A survey by ASH of local authorities found that of the local authorities that responded to the survey 62% were doing some form of outreach or targeted support for BME populations. This activity included:

- Engaging local BME groups/networks to promote local service (32%)
- Targeted communications or campaigns, sometimes in multiple languages (24%)
- Conducting insights work to understand the need of different BME smokers (5%)
- Delivering support/locating advisors/training other frontline workers in organisations to support BME communities (27%)

Among those local authorities that had no targeted approach a number of reasons were provided:

- Limited resources to target support was identified alongside the idea that universal services are open to all
- Small local BME population
- Unaware of the evidence based for tailoring support
- A lack of knowledge about the local BME population
- A diverse local BME population was identified as a barrier to targeting support as it lead to uncertainty around who to target and how

Ethnicity of people accessing services is a required field for reporting to NHS Digital for local stop smoking services and is therefore captured as a matter of routine. Our survey found that additionally, a majority of services also capturing nationality which is not a required field.

As the data on nationality is not a mandatory field and not collated nationally it's not possible to determine if there is equitable access to stop smoking services for some important populations. In particular, populations from Eastern Europe where immigration to England is high and rates of smoking in home countries is also high.[2] [3]

Use of aids to quit

Nicotine Replacement Therapy is the most commonly prescribed aid to quitting in England.[4] While uptake of stop smoking services would appear to reflect the proportion of BME smokers in the population there is evidence from the US that the use of NRT as a quitting aid is lower in some BME populations.[5]

E-cigarettes are now the most popular aid to quitting in this country.[6] There is growing evidence that they are as effective or more effective than traditional aids such as NRT and they have contributed to reductions in smoking prevalence.[7] New research suggests that their use among smokers in some BME populations might be lower than in the white British population.[8]

The differences in use of nicotine as a quitting aid could be cause for concern if it leads to a disparity in the rate at which smokers in BME groups successfully quit.

Recent migrants

Around 14% of people in the UK were born overseas.[9] Recent migrants of BME status are likely to pose different challenges to reducing tobacco related harm from those in established BME communities.

First, and most obviously, there is much more likely to be language and communication barriers to healthcare access but there are a range of other issues which could inhibit recent migrant engagement with quitting services and activity. Migrants who have come to the UK from countries with high rates of smoking may have different cultural norms around smoking and/or less exposure to information about the harms from smoking.

They will have experience of different healthcare systems many of which may differ substantially from our primary care model. As such they may not be familiar with professionals other than doctors providing healthcare interventions.[10]

Most recent migrants are likely to be younger and healthier than the general population and may therefore be less likely to engage in quitting behaviour or attend a stop smoking service.

Recent migrants may also return regularly to countries with much lower tobacco prices than in the UK.[11] As such they have greater opportunity to bring cheaper tobacco back into the UK.

Smoking in pregnancy

Women in most BME communities are less likely to smoke than their white British counterparts but they may be at greater risk of exposure to secondhand smoke as rates of smoking are significantly higher among men in many BME groups. Approaches to addressing smoking in pregnancy need to take this into account.[12]

Women from Eastern European countries often have higher rates of smoking than the England average.[2] Targeted approaches may be necessary for this population given they are more likely to have language barriers and less likely to be exposed over time to information about the harms of smoking in pregnancy.

Different tobacco products

Some BME populations have a higher prevalence of other tobacco products beyond cigarettes.

Smokeless tobacco products are varied and use of specific products is often highly culturally specific. Products vary in their delivery of nicotine and levels of harm. Use is particularly high among South Asian populations, but people of Black/African/Caribbean and Other/Mixed ethnicities also use smokeless tobacco at notably higher rates than white populations. For more information see our briefing on smokeless tobacco.[13]

Smokeless tobacco use by ethnicity	White	South Asian	Black/African/ Caribbean	Other/mixed
Ever tried	12%	23%	19%	20%
Regular use (at least monthly)	1%	7%	5%	3%
Never tried	86%	64%	75%	75%

Shisha smoking is a practice most common in Middle Eastern populations. However, it is also highly correlated with cigarette smoking. For most users smoking cigarettes will be a more frequent activity than Shisha use. See our fact sheet on ethnic minorities for more information.[14]

Shisha use	Never smoker	Ex-smoker	Smoker
Ever tried	8%	12%	22%
Once a year or more	1%	2%	5%
Less often	7%	10%	17%
Never tried	78%	77%	63%

Lessons for practice

1. Monitoring smoking populations

Those services providing complete stop smoking returns are collecting and reporting basic data on ethnicity. However, as noted elsewhere in this brief it is likely that some groups are not well captured by these labels. Additional questions relating to nationality could be useful to include, particularly where an authority has a concentration of recent migrants within the community.

The reach of the stop smoking service across different ethnicities should be regularly audited against local ethnicity data to ensure that all populations have equitable access to the service and highlighting any areas where action might be needed.

2. Targeted approaches

Many BME populations have lower smoking rates than the white English population and as such may not need any specific targeting. But there are specific groups where rates of smoking are higher and where there are specific barriers to reducing rates of smoking.

Services for Polish smokers in London

Stop smoking provider Kick It has a history of different outreach programmes some located in community specific settings, such as a clinic for Polish smokers located with the Polish Social and Cultural Association in Hammersmith and regular stop smoking events that were run in association with a Polish church in Bermondsey. Both models had success at reaching the target group but relied on being able to treat people from across London boroughs at a central community location in order to be effective. This is no longer possible as 'residents only' funding formulas have been imposed.

LESSON: Where there are disparate populations of people with specific needs (e.g. language or culturally sensitive care) localities may find economies of scale in collaborating across council boundaries.

3. Inclusive services and communications

Most local authorities will find it difficult to fund targeted services in the current environment but there are things mainstream services can do to ensure they are inclusive and meet the needs of different BME communities. Addressing language barriers within service delivery and in outreach materials is important but the nature of communications is also important.

Including recent migrants

PHE have produced a migrant health guide which is a free online resource for primary care practitioners to support them when they see migrants in their practice but can also be used by other health professionals in community settings. The guide includes:

- a checklist to help assess new migrant patients;
- country pages that highlight needs that may be particular to migrants from specific countries (over 100 in the list);
- a page about culture, spirituality and religion; and
- a page about access to translation and interpretation services.

Some national resources are also available in translation such as The Smoking in Pregnancy Challenge Group 'Test your Breathe' cards.

LESSON: National resources can be used to support local delivery.

Addressing the language barrier

The main barrier many recent migrants experience in accessing support is not speaking the same language as the service provider. Stop Smoking provider Kick It try to embed support within mainstream services to improve accessibility:

- Kick It employs an External Engagements Officer who maintains a register of pharmacists who are able to speak different languages – so that clients can be directed to support in the language that they need
- Kick It have also hired stop smoking advisors who speak Polish in order to build good links with the local community

LESSON: Mainstream services have existing assets that can help to meet the needs of BME smokers without significant additional cost.

Outreach materials and service delivery need to resonate with all communities. For example, localities ensuring that visual imagery is inclusive and that smokers from different communities can recognise themselves in outreach materials.

4. Community partnerships

Some BME communities have strong local networks which can provide a powerful route for engagement. Community organisations may have a more established relationship, be a trusted provider of information and know how to engage with their population in the most effective way. Public health teams may wish to co-locate clinics with community organisations,provide training around brief advice, utilise events or newsletters or simply use community organisations to test the content and relevance of materials.

Servicing Bangladeshi smokers in Sunderland

The Sunderland Public Health team engaged their Bangladeshi community (which has high smoking and smokeless tobacco use prevalence) via a local Muslim organisation led by imams. They built good links with the Islamic Scholars Union, a micro-NGO, which was interested in helping the community to quit smoking.

The Public Health team arranged for level 2 smoking cessation training to be provided to the group and set them up to deliver a stop smoking service on a payment by results contract based on successful quits. The service delivered a small, but steady, stream of quitters – between 10 and 12 each month.

Unfortunately, new procurement rules disrupted the relationship with the Islamic Scholars Union, due to their size – meaning this service has come to an end. Further efforts to reach the same community via a broader, general support contract for the BME community is not proving as successful.

The Public Health team have worked with procurement colleagues to find a way to engage micro-organisations with strong community links through their framework and this is ongoing.

LESSON: Engaging with community groups may require a more flexible approach than traditional contracts will accommodate and innovative approaches will be needed.

Reaching Eastern European smokers in Berkshire

In Berkshire the service has been targeting smokers in the Polish, Romanians and Lithuanian communities since 2012. Over this time they have worked with 5,300 'white other' Europeans. This engagement has been built on:

- Knowing the communities: where they live, local industries they're working in, local social clubs, specific churches, shops, schools, particular shopping centres, GP surgeries and pharmacies.
- Recruiting staff from these communities who are not only able to talk to clients in their first language but who also know the local communities well.
- Targeted communications: including translated leaflets, engaging on Facebook posts and community specific websites.
- Attending events in Polish schools sports day, churches, community events.
- Engaging with community organisations and businesses such as Polish shops, Polish centres, e.g. the Polish Association in Slough.

LESSON: Active engagement with communities can promote quitting, raise awareness of the dangers of smoking and attract people to services. Activity doesn't need to be confined to quit support wider community engagement can have value.

5. Beyond cigarettes

BME populations are more likely to access support for smoking while also using another tobacco product such as shisha or a smokeless product. For more information see our briefing on Smokeless Tobacco[13] and recent PHE CLeaR deep dive on niche tobacco products.[15]

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