Smoking Cessation Needs Assessment Report

of BME Population Living in South East Community Health & Care Partnership
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Acknowledgements

The authors of this report would like to acknowledge everyone who contributed to this needs assessment including staff from NHS Greater Glasgow & Clyde, staff from South East Glasgow CHCP, representatives of the local South Asian and Eastern European community, case study participants and local community organisations.

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Welcome

This report details the key findings from the Smoking Cessation Needs Assessment of the BME communities within South East Glasgow CHCP.

Tobacco use remains the number one cause of preventable ill health and death within Scotland, and over 31% of adults in this area smoke. South East CHCP has a very diverse population, including the highest BME population in Scotland.

Evidence shows that although a high percentage of the BME communities smoke, or use tobacco products, very few access local cessation services.

This needs assessment was commissioned to examine whether services are culturally sensitive, whether they meet the needs of our diverse population, and to inform future service delivery.

We look forward to working in partnership with a range of local organisations and agencies in taking forward an agreed local action plan.

Bailie James Scanlon
Chair, South East Glasgow Community Health & Care Partnership
Executive Summary

Background
Population figures for the South East of Glasgow reveal a significant black and minority ethnic (BME) community in the area, predominantly of South Asian and Indian descent but with an increasing number of Eastern Europeans (Slovakian in particular).

Although smoking has reduced amongst Scottish adults to around 25% of the population, the number of smokers in deprived areas and amongst BME communities remains higher. UK Census information and anecdotal evidence from the Department of Communities, Local Government and studies by ASH, suggest that smoking is particularly high amongst Eastern European immigrants and Asian communities (around 29% - 40%).

In common with other areas in Glasgow, South East Glasgow CHCP (SE CHCP) offers a range of smoking cessation support including groups, one-to-one support and pharmacotherapy available in hospitals, GPs and community pharmacies. A service for pregnant smokers is also available. However, local data suggests that only 1.4% of clients using the community smoking cessation services in South East Glasgow are from the BME population.

Methodology
Given the large BME population in the area, SE CHCP wished to ensure that their Stop Smoking services were culturally sensitive and met the needs of local ethnic smokers. They also wished to establish what factors would be important to encourage local BME smokers to use the service.

A combination of literature review, case study development and stakeholder engagement, using one-to-one depth interviews and focus groups, was adopted and the research was conducted in five waves as follows:

- A literature review to identify smoking prevalence amongst BME communities and to highlight examples of best practice in culturally sensitive Stop Smoking services elsewhere in the UK
- Development of case studies of 6 examples of best practice
- Interviews with 17 key partners of the current Stop Smoking Service in the SE CHCP area
- Interviews with 15 key informants from the local BME community
- 9 focus groups with representatives of Pakistani, Indian and Eastern European tobacco users from the local community.

Learning from others
The literature review combined searches in a range of journals and databases and reviews of national statistical sources and specialist organisations’ websites. The search was looking for Stop Smoking services specifically aimed at local BME populations in areas with similar demographic, socio-economic and deprivation profiles as the South East of Glasgow. It identified 9 Stop Smoking projects across the UK, from which 6 were selected and profiled as case studies.

Whilst each service was designed specifically to meet the needs of local BME communities, there were a number of common themes in their approach to delivering a culturally sensitive service, particularly in terms of:

- Contact and engagement:
  - The services were marketed specifically at the BME community using local community links.
• Service delivery:
  • Cessation services linked with other health issues appeared more successful in encouraging engagement with, and attendance from, the local BME community.
  • Confidentiality of service provision was critical to encourage attendance (particularly amongst female South Asian smokers).
  • Services were delivered at times which suited the BME community. This often meant that services were provided in evenings or at weekends.

• Service infrastructure:
  • Services were delivered in locations which the BME community was familiar with and comfortable in.

• Workforce planning and development:
  • Engagement and attendance was most successful when the services were delivered by members from the BME communities targeted, overcoming potential issues with cultural sensitivity and language.
  • All staff providing the service had received specific training in both the service pathway and smoking cessation.

These themes were explored in more detail with key partners, key informants and smokers from the South Asian and Eastern European communities in South East Glasgow to establish to what extent they impacted upon the local Stop Smoking service.

Attitudes to current service provision in South East Glasgow

Feedback from the key partners, key informants and representatives of the local BME community suggested that there were two key factors preventing members of the BME community using the current Stop Smoking services - cultural influence and lack of awareness of the local service. The research indicated that both issues impacted on the Stop Smoking service's ability to:

• Contact and engage with the BME community;
• Deliver effective stop smoking support to the BME community;
• Provide an effective infrastructure to support service delivery.

Contact and engagement

Whilst many of the barriers to effective contact and engagement are specific to each culture, two issues were common to both communities, namely:

• Lack of awareness of the service;
• Language barrier and literacy issues, particularly amongst older South Asians and the Slovakian community.

In addition to lack of awareness, South Asian tobacco users were concerned about anonymity and confidentiality. Keeping their habit hidden is of paramount importance to female smokers who go to considerable lengths to hide their smoking. Even male smokers suggested that they preferred not to smoke at home and did not smoke in their parents' house.

They suggested that, as a result, they would be unlikely to seek advice about stopping smoking from their community leaders and some female smokers would be reluctant to raise the matter with anyone, even their GP.

The Eastern European population, Polish and Slovakian, are fairly transient preventing
regular contact with services and also creating more pressing problems with housing and employment, reducing their concern about, and interest in, stopping smoking. Smoking is also an accepted pastime amongst Eastern Europeans, with whole families smoking in the community.

Service delivery
In both communities, key informants and smokers were aware that smoking was bad for people’s health. However other health problems were considered to be of more importance than smoking, particularly diabetes, stroke and stress and smokers were more likely to attend these services than stop smoking services.

In addition, the South Asian community’s desire to keep their smoking confidential and to retain anonymity meant that these smokers were highly unlikely to attend any service which was recognisable as a purely Stop Smoking Service.

Service infrastructure
The length of commitment required to attend Stop Smoking services was a potential deterrent for both communities. Long working hours and more pressing family commitments were found to prevent participation in local activities. Local groups supporting the BME community suggested that any service needed:

- Regular contact with participants;
- Personal contact with the individual attending rather than relying on messages being left with other family contacts;
- A reminder system to contact participants on the day of the event;
- Flexibility in service hours to accommodate evenings and weekends;
- The ability to drop in and out of the service to accommodate other family commitments.

Smoking is a highly sensitive topic in the South Asian community. Key informants providing group support in other equally sensitive health areas such as mental health and domestic violence emphasised the need for the service infrastructure to support:

- Long lead-in times to encourage people to engage with the service;
- Single sex groups;
- Participants to be from the same community to allow them to share meaningful experiences;
- Advice to be reflective of the community and their cultural experiences;
- Advice to be repeated over a period of time before smokers will act on it.

Eastern Europeans find it difficult to understand a system which requires attendance at a specific time. Their transient lifestyle also means that they cannot attend services regularly.

They also tend to reside in large family groups and attend services with the entire family. As a result, the key partners and key informants have developed support services which adopt a drop in approach, allowing more flexibility in attendance and which can address multiple health issues and deal with multiple patients at any one time.

Workforce planning and development
Credibility of the service provider and their understanding of the cultural implications of smoking are of vital importance to the BME smokers, particularly the South Asians. It is important to them that they are being asked to
give up smoking for genuine health reasons and not for religious or cultural reasons and that the advice given is achievable within their own cultural and religious requirements.

However, the need for cultural awareness requires to be balanced with the need for confidentiality in the South Asian community. Many of the smokers expressed concern that using local members of their community to deliver the services would result in their families and friends finding out about their smoking. These smokers would prefer an adviser who understood their culture without necessarily living in their local community.

Many of the BME smokers suggested they would approach their GP for stop smoking advice in the first instance. Discussions with practice staff indicated differences in attitudes to raising smoking issues amongst health professionals, and also suggested varying degrees of cultural awareness. The interviews highlighted some misconceptions about smoking in the BME community, the most common being that it is banned in Muslim and Sikh religions and that South Asian women do not smoke.

The interviews with the primary care staff also suggested varying degrees of awareness of the current service pathway and a reluctance to refer BME smokers to the Stop Smoking service.

Conclusions and Recommendations

Conclusions

Feedback from the key partners, key informants and from representatives of the local South Asian and Eastern Europeans suggested that smoking was very prevalent in both communities. However, service usage data indicates that only a small proportion of the BME smokers appear to engage with the current Stop Smoking Service.

Key informants and BME smokers suggested that low uptake might be a result of:
- A lack of awareness of the existence of a local Stop Smoking Service in both communities;
- A greater focus on health issues other than smoking;
- A concern that the service would not take account of cultural influences in its delivery, particularly in terms of:
  - Confidentiality
  - Anonymity
  - Methods of contact - impacting on confidentiality and anonymity
  - Family commitments and the need to prioritise these over other appointments
  - Providing advice which fits into their lifestyles.

Recommendations

It has been highlighted from the key partners, key informants and a sample of BME smokers in South East Glasgow, that the four factors identified from the case studies are indeed vital to providing culturally sensitive Stop Smoking services, namely:

- Contact and engagement
- Service delivery
- Service infrastructure
- Workforce planning and development.

It has been suggested that some changes to the current Stop Smoking service would be beneficial and would provide a more culturally sensitive service for BME tobacco users.
Contact and engagement

Lack of awareness was a key barrier to contacting and engaging with BME smokers. This could be addressed through:

- Enhancing the links between the Stop Smoking service and local community groups with service representatives attending local group meetings as key speakers.
- Raising key informant awareness of the service pathway. Service representatives could deliver sessions directly to the management and staff in local organisations which support the BME community to improve their understanding of the service and what it can offer.
- Promoting the service in locations which are well used by the BME community and are not associated with a Stop Smoking service such as ethnic foodstores, workplaces and religious centres.
- Promoting the service in local health centres, clinics and GPs, given that many BME smokers regard their GP as their first port of call in seeking stopping smoking support.

Understanding English was also raised as a potential barrier to some older Asian smokers and Slovakian smokers engaging with the service. Both groups felt that their command of English was not sufficient for them to participate fully in, and benefit from, the Stop Smoking discussions. A potential solution to this issue is addressed further below in Workforce Development and Planning.

Service delivery

Both communities have wider health issues, many of which are exacerbated by tobacco use. This, together with the South Asian desire for confidentiality and anonymity, would suggest that the service should be linked to other health services or projects to provide a wider, more holistic approach to stopping smoking, building on the model used in the local Health Shop and in some Community Pharmacies.

This integrated service delivery model could also incorporate:

- A flexible service composition combining the current delivery methods of one-to-one consultations, telephone support and group support. If group support were to be provided it would be vital to offer the option of same sex/same culture groups in addition to the current mixed support groups.
- Flexible attendance. BME smokers need a service which allows them the opportunity to dip in and out of the service (preferably without an appointment) without feeling that they are either missing out or inconveniencing the service.

Service infrastructure

Key factors for consideration are:

- Location: The need for confidentiality suggests that the service should be offered from premises which are recognised locally as having another function (ie not specific to Stop Smoking).

Similarly, smokers’ desire for the support to cover other health issues as well as smoking cessation might allow the opportunity to offer services from recognised health service sites currently used by the BME community such as clinics and GP practices, as well as the Health Shop which currently offers a range of advise, including stop smoking services.
• Administration: The need for confidentiality means that consideration requires to be given to how contact is made and maintained with smokers. Written communication to the home or telephone contact to the home telephone number would create considerable anxiety amongst female smokers. Other, more direct means of contact with the service user, should be considered such as mobile phones or emails.

• Flexible hours: Long working hours and family commitments suggest that providing a service where access times were more flexible might encourage uptake.

• Personal contact methods: Neither culture responds well to the appointment system. A reminder system on the day of the appointment was considered useful. The service needs to provide a reminder system which maintains regular contact with the service user (particularly important for people dropping in and out of the service over time and also for transient populations). Experience from the key informants suggests that this reminder needs to be on the day of the service delivery to secure attendance.

Workforce planning and development

Information from the key informants and BME smokers suggest that service planners need to consider the following:

• Credibility: The majority of smokers would only access a service if they felt that the people delivering it were specialist in the subject. For many of the smokers, this meant that the service should either be delivered by advisers from the indigenous Scottish population, as they are perceived as having more credibility, or from highly trained health professionals from the BME community.

• Language: All participants felt that it would be beneficial if advisers were bilingual. Supporting material should also be translated for Eastern European smokers. Many South Asian smokers, whilst speaking Punjabi or Urdu, have difficulty in understanding it in written text, and therefore were not as concerned with translated material.

• Cultural awareness: The feedback from the BME smokers indicates that some key partners may not fully appreciate BME culture and that they do not understand the context in which they are giving them advice. Also, misconceptions regarding BME smokers willingness to receive support may also be preventing primary care staff from referring smokers to the service. There may, therefore, be benefit in developing awareness raising or training sessions on cultural awareness for key frontline community staff.

• Awareness of the service pathway: The feedback from key partners suggests a lack of awareness of the Stop Smoking Service pathway. There may be benefit in scoping out the pathway for the culturally sensitive Stop Smoking Service. Providing a clear demonstration of the service pathway should allow those referring to the service, as well as those delivering the service, to provide clients with their optimal service journey, thereby enhancing their service experience. The pathway should include:

  • Entry points
  • Current service providers
  • New/alternative service provision
  • Potential client journeys through the range of services offered
  • Referral options
• Awareness raising sessions: Once the pathway has been scoped it may also be beneficial to develop awareness raising sessions for individuals involved in referring to the service or in providing the service itself. These sessions would:
  • Improve staff understanding of the services offered, the entry points and referral options;
  • Ensure a consistent understanding of the service pathway and optimum client journey;
  • Allow key partners, particularly in primary care, to provide effective information on Stop Smoking services and to appropriately refer smokers for support, if approached.
Section 1: Introduction

South East Glasgow

South East Glasgow has a population of around 101,020. The area is rich in cultural diversity with 11% of its residents from BME communities (five times the Scottish average), predominantly South Asian and Indian but with an increasing number of Eastern Europeans (Slovakian in particular).

In common with other areas in Glasgow, South East Glasgow CHCP (SE CHCP) offers a range of smoking cessation support including groups, one-to-one support and pharmacotherapy available in hospitals, GPs and community pharmacies. A service for pregnant smokers is also available. However, local data suggests that only 1.4% of clients using the smoking cessation services in South East Glasgow are from the BME population.

1.2 Tobacco use

Tobacco use remains one of the principal causes of preventable ill health and premature death in Scotland. Cessation targets were set for each NHS Board in Scotland in 2004 and further revised in 2008 requiring Boards to support 8% of their smoking population towards quitting by 2011.

Although smoking has reduced amongst Scottish adults to around 25% of the population, the number of smokers in deprived areas and amongst minority ethnic (BME) communities remains higher.

UK Census information and anecdotal evidence from the Department of Communities, Local Government, and studies by ASH, suggest that smoking is particularly high amongst South Asian and Eastern European communities (29% - 40%).

A combination of smoking, poor diet and limited exercise in some BME communities, is also increasing the risk of heart disease. Pakistani communities, in particular, tend to eat fewer fruit and vegetables than other BME groups and also tend to take less physical exercise. They also have a high prevalence of strokes.

Diabetes is also of higher prevalence among some BME communities than in the general population. In Indian men and Pakistani women the prevalence of diagnosed diabetes is more than twice that found in the general population.

Limited recording of ethnicity in cancer registry data means that there is no reliable routine data on ethnic differences in cancer incidence in the UK. However in South Asia, oral cancer is highly prevalent with the primary cause being the widespread habit of chewing betel quid (paan) and over 90% of oral cancer patients use tobacco either by smoking or chewing it.

1 Glasgow Centre for Population Health: Community Health & Wellbeing Profile 2008
3 ASH Scotland: Tobacco use and minority ethnic groups, 2008
4 ASH Scotland: Tobacco & Ethnic Minorities Factsheet No 26
1.3 Tobacco prevalence in minority ethnic communities

Available information on tobacco use and smoking prevalence amongst BME communities is extremely limited particularly for Scotland and is mostly confined to household surveys conducted by the Office of National Statistics (ONS), the Tobacco Control Database operated by the World Health Organisation (Europe) and ad-hoc surveys conducted by ASH.

Whilst very little information exists regarding smoking prevalence among BME communities in Scotland, data from WHO\(^5\) suggests that although smoking rates in BME communities were broadly the same or slightly lower than in the general population, rates were high within certain ethnic sub-groups, particularly Pakistani males (29%) and Eastern Europeans (40% of males and 25% of females).

Smoking prevalence was considered to be lower amongst Indian and Pakistani females (5% each)\(^4\), however a study of BME tobacco use in Glasgow confirmed higher rates of smoking, especially among Pakistani respondents, young people and women\(^6\), suggesting that there may be under-reporting of prevalence amongst these groups.

In addition to cigarettes, smokeless tobacco is used by some BME groups, particularly those from South Asia\(^4\). Tobacco is often consumed in combination with other products. For example, Betel pepper leaf is used to wrap the fillings to form a quid. The leaf has a mint flavour and is generally considered by the community to be a mouth freshener. Although the leaf (paan) itself is relatively harmless, the health risks arise from the tobacco and other ingredients contained in the paan.

1.4 Implications of prevalence data in South East Glasgow

Activity rates for the SE CHCP Stop Smoking community services\(^7\) suggest a total of 332 clients between January and December 2008, of whom less than 1% were from South Asian, Indian or Eastern European ethnic background. Figures from the NHS Greater Glasgow and Clyde Public Health Pharmacy service suggest a slightly higher number of BME smokers use Community Pharmacies (averaging 2.4% from 2003 to 2008)\(^8\).

Local population data\(^1\) suggests that there are around 8,500 South Asians resident in South East Glasgow, together with around 2,000 Eastern Europeans. The prevalence of smoking in Pakistani and Eastern European communities suggests that there should be around 2465 Pakistani and Indian tobacco users and 800 Eastern European smokers in the South East area of Glasgow. These figures, together with the client breakdown, clearly indicate that BME tobacco users in South East Glasgow are not using the Stop Smoking service.

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4 ASH Scotland: Tobacco & Ethnic Minorities Factsheet No 26
5 World Health Organisation: Tobacco Control Database, WHO Regional Office for Europe
Section 2: Methodology

2.1 Research objectives
South East Glasgow CHCP wished to commission a needs assessment to establish how to make their stop smoking support more culturally sensitive to all communities, including South Asian, Indian and Eastern European users and what factors would be important to encourage local BME smokers to use the service. Six specific objectives were set for this needs assessment, namely:

- Explore the knowledge base around smoking behaviours in the BME population;
- Explore the knowledge and understanding around the impacts of smoking on health;
- Explore the knowledge of current cessation services and the barriers to accessing these services;
- Identify the type of cessation service this population would utilise;
- Explore the views of health professionals on what appropriate services need to be developed and how this could be achieved;
- Make recommendations on the way forward for smoking cessation services for the BME community.

2.2 Methods used
A combination of literature review, case study development and stakeholder engagement using one-to-one in-depth interviews and focus groups was adopted. The literature review sought to establish the prevalence of smoking amongst the BME community, the availability of culturally sensitive stop smoking services in other areas of the UK and how these services had addressed any cultural barriers to service engagement. The in-depth interviews and focus groups provided a rich insight into the suitability of the current service model for the BME community, together with key motivators required to encourage engagement and service uptake.

The research was conducted in five waves as follows:

- A literature review to identify smoking prevalence amongst BME communities and to highlight examples of best practice in culturally sensitive Stop Smoking services elsewhere in the UK;
- Development of case studies of 6 examples of best practice;
- Interviews with 17 key partners of the current Stop Smoking Service in the SE CHCP area;
- Interviews with 15 key informants from the local BME community;
- 9 focus groups with representatives of Pakistani, Indian and Eastern European tobacco users from the local community.

The research took place between April and November 2009 and the research participants were sourced as follows:
Section 2: Methodology

Smoking Cessation Needs Assessment Report

- Key partners – from GP practices across SE CHCP who were regular, infrequent and non-referrers to the local stop smoking service together with service planners and co-ordinators from the SE CHCP and NHS Greater Glasgow and Clyde. Participants included GPs, practice nurses, health visitors and midwives.

- Key informants – interviews were conducted with a variety of individuals and organisations that were considered to be well known and influential within the local community including development workers, local support projects and representatives of the local BME community, including representatives from local Sikh temples. The sample of local religious leaders from the Muslim community declined to participate.

- South Asian, Indian and Eastern European tobacco users – from Axiom Consultancy’s panel of local BME residents and from local support groups (Slovakian community).

A complete sample breakdown can be found in Appendix 1.

The findings and recommendations from this needs assessment are detailed in Sections 3 - 5 of this report. Copies of the discussion guides used in the interviews and focus groups can be found in Appendix 2.
Section 3: Culturally sensitive cessation services – learning from others

SE CHCP were interested to learn how other smoking cessation services delivered stop smoking support to their BME communities, in particular how any cultural barriers preventing the local BME community from engaging with the service had been overcome.

A literature review was conducted, combining searches in a range of journals and databases and specialist organisations’ websites. Sources included NHS Scotland e-library, the British Medical Journal, Information Services Division, ASH, UK Centre for Tobacco Control Studies and Smoke Free websites.

The search was looking for Stop Smoking services specifically aimed at local BME populations in areas with similar demographic, socio-economic and deprivation profiles as the South East of Glasgow. The search identified 9 Stop Smoking projects across the UK, from which the following 6 were selected and profiled as case studies.

- **REACH Community Health Project in Govanhill** providing a 12 week stop smoking course for South Asians.
- **East Berkshire Primary Care Trust** providing a stop smoking service for Eastern European communities (particularly Polish and Roma) using a stop smoking adviser from the local Polish community.
- **Lambeth Primary Care Trust** providing drop-in stop smoking support for BME communities, using a range of targeted marketing and communication channels to engage directly with BME smokers.
- **Newcastle and North Tyneside** providing stop smoking services as part of an overall health improvement service for BME communities.
- **NHS Bristol** providing a stop smoking service using health trainers from local BME communities.
- **Tower Hamlets** providing a stop smoking service for their Bangladeshi community using local influencers, community groups and sponsorship to market the service and communicate directly with local BME smokers.

The purpose of this review was to learn from these service providers any key factors which were considered to be essential to delivering culturally sensitive stop smoking support. Interviews were conducted with representatives from each of these services to:

- Explore the cessation services provided;
- Establish their understanding of the key cultural factors which can prevent members of the BME community engaging with the cessation services;
- How the Stop Smoking Service had tailored their service offering to meet
cultural needs;

• What resources were required to deliver the service;

• Establish the methods service providers were using to contact and engage with potential service users.

Each of the 6 services was profiled and copies of these profiles can be found in Appendix 3.

The feedback from the interviews conducted with each of the service providers suggested that, whilst each service was designed specifically to meet the needs of local BME communities, there were four key themes that were common to all 6 service models and which were fundamental to their approach to delivering a culturally sensitive service. These themes were:

**Contact and engagement**

• The services needed to be marketed specifically at the BME community, using local community links.

**Service delivery**

• The cessation services which linked with other health issues appeared more successful in encouraging engagement with and attendance from the local BME community.

• Confidentiality of service provision was critical to encourage attendance (particularly amongst female South Asian smokers).

• Services needed to be delivered at times which suited the BME community. This often meant that services were provided in evenings or at weekends.

**Service infrastructure**

• Services needed to be delivered in locations which the BME community was familiar with and comfortable in.

**Workforce planning and development**

• Engagement and attendance was most successful when the services were delivered by members from the BME communities targeted, overcoming potential issues with cultural sensitivity and language.

• All staff providing the service had received specific training in both the service pathway and in smoking cessation.

Given the importance of these four themes in each of the 6 case studies, it was decided to explore these in depth with service planners and providers and BME smokers in South East Glasgow to determine to what extent they should influence future service delivery.
Section 4: Attitudes to tobacco use and the current Stop Smoking services in South East Glasgow

4.1 Attitudes to tobacco use

Participants in the focus groups were asked about their attitudes to tobacco use. The majority of participants were regular tobacco users, mostly of cigarettes and all felt that smoking was quite prevalent in their communities.

“A lot of people smoke – young and old. For men, particularly, it’s not that unusual” (South Asian male, aged 35)

Those participants who moved to the area (both South Asian and Eastern European) suggested that, whilst they had used tobacco at home, their smoking consumption was heavier here than at home. They suggested that this was primarily due to stress and working long hours. Stress was also suggested by the key informants as one of the main drivers for people within the BME community to continue smoking.

All smokers from both the South Asian and Eastern European communities were aware of the health risks from smoking, citing lung cancer, strokes and heart disease. However, few were aware of the range of chemicals that cigarettes were manufactured from and seemed generally disturbed by this.

“I’m not sure anyone would smoke if they knew arsenic was in their cigarettes.” (South Asian female, aged 29)

Both communities were more concerned about health issues other than smoking, such as diabetes and strokes, and did not link these health issues with smoking. One older South Asian said:

“Pakistanis have poor health anyway. I live in Glasgow where life expectancy is lower anyway. I’ve got to 65 – I’m doing OK so why bother giving up now?” (South Asian male, aged 65)

This view was also shared by the Slovakian residents, one of whom pointed out:

“We’ve got more problems than smoking when we come here – we need houses and jobs. Who cares about smoking?” (Slovakian male, aged 38)

The key informants in both communities also suggested that many regarded smoking as a social activity, particularly older South Asians and younger Eastern Europeans. This perception was confirmed by the smokers in the focus groups:

“I meet up with my friends every week at the Centre, they all smoke – it’s what we do” (South Asian male aged 65+)
“All my friends smoke - at home we meet in local cafes for coffee and cigarettes. Everyone does it” (Polish female aged 21)

Indeed, socialisation appeared to be the main reason for the majority of focus group participants not wishing to give up smoking, particularly amongst older and younger smokers in both communities.

South Asian community attitudes to tobacco use

Some Pakistani participants had used chewing tobacco but this was generally when they had returned to Pakistan for family events such as weddings. All of the South Asian focus group participants smoked cigarettes.

Smoking, whilst not banned by South Asian religious beliefs, is not encouraged within South Asian culture (particularly amongst females) and, as a result, people are often reluctant to admit that they smoke and often do not smoke openly. Very few of the smokers (male or female) suggested that their families were aware that they smoked. Whilst the male smokers did not smoke at home because they felt that it would be disrespectful to their parents, females stated that they (and probably their families) would be ostracised by their community if their smoking was discovered. With the exception of one smoker, the females went to considerable lengths to ensure that no-one discovered they smoked (including their South Asian friends). Female smokers will not admit publicly that they smoke and many of the key informants and service providers thought that South Asian women, in fact, did not smoke.

Despite cultural disapproval, key informants from the South Asian community and South Asian smokers all
felt that smoking was increasing amongst younger South Asians (including young females) with many picking the habit up at school. All expressed concern at the numbers of younger smokers. Those who grew up in the area indicated that they started smoking at school. Feedback from younger South Asian smokers (aged 18 – 21) suggested that smoking was used as a way for them to fit into the local community and be accepted by their peer group. One young South Asian female stated:

“I started smoking because all my school friends were. They are all white and they all smoke. If I didn’t smoke I’d have been standing myself at school breaks with no-one to talk to.”

**Eastern European community attitudes to tobacco use**

Smoking was very common amongst the Eastern European community to the extent that the focus group participants felt it was almost unusual if someone did not smoke. Smoking also begins early in this community. Both Polish and Slovakian smokers in the focus groups suggested that they had started smoking from the age of 10 and that virtually everyone in their family and amongst their friends had smoked.

In addition to their laissez-faire attitude to smoking, none of the smokers were particularly put off by the cost of cigarettes. The Eastern European smokers, for example, returned to Poland and Slovakia on a regular basis (every three months or so) and were able to access cheap cigarettes there which they brought back with them.

**4.2 Attitudes to the current Stop Smoking service in South East Glasgow**

Key partners, local key informants from the South Asian and Eastern European communities and smokers from both these communities were asked about the perceptions of the Stop Smoking services in South East Glasgow, particularly their opinions on the four critical elements identified from the case study reviews, namely:

- Contact and engagement;
- Service delivery;
- Service infrastructure;
- Workforce planning and development.

Feedback from the interviews with the key partners and key informants, together with the focus groups participants, suggested that there were two key factors preventing members of both communities using the current Stop Smoking services - cultural influence and lack of awareness of the local service. They suggested that both of these factors were having a considerable impact on the Stop Smoking service’s ability to:

- Contact and engage with the BME community
- Deliver effective stop smoking
support to the BME community

• Provide an effective infrastructure to support service delivery

Each of these issues is considered in more detail below. Issues which are common to both South Asian and Eastern European communities are outlined initially, in each section, with issues specific to either community discussed thereafter.

4.2.1 Contact and engagement

Whilst many of the barriers to effective contact and engagement are specific to each culture, two issues were common to both communities, namely:

• Lack of awareness of the service;
• Language barrier.

Common issues with both communities

Very few interviewees, South Asian or Eastern European, were aware that Stop Smoking support was available locally. Most of the small number of smokers who had attempted to quit had done so on their own (generally unsuccessfully). A few had approached their GP looking for advice and had been given prescriptions (mostly Champix) or NRT. One (Polish client) had seen an advert for Pharmacy support when attending their local Pharmacy for other health issues. Interestingly, none of the smokers realised that the GPs were linked into the Stop Smoking service and none had been referred to any other part of the service by their GP.

Many GPs and Practice Nurses interviewed tended to provide prescriptions for their BME tobacco users rather than referring them to the Stop Smoking service. Some GPs appeared unsure of the range of stop smoking services on offer (particularly South Asian GPs) and also were not as clear on the services offered by the Pollokshields Health Shop and how they could link in to these. The Pollokshields Health Shop is a community resource aimed at making health and social care services more accessible and available to all communities within Pollokshields. The Shop provides a range of health improvement activities such as diabetic management sessions, Triple P parenting programmes, health MOT’s and weigh in and walking programmes. In addition to these activities, staff can signpost clients to other local support agencies and community groups.

Lack of awareness of the range of Stop Smoking services available locally may be preventing GPs referring BME tobacco users to the service. Many of the key informants interviewed were also unaware of the local Stop Smoking support.

Whilst some sections of the BME community have a good command of English (generally younger South Asians and Polish residents), older South Asians and the Slovakian residents have little or no understanding of English. Indeed, younger members in South Asian families often attend parents’ appointments at their GP to act as interpreters. Interviewees described embarrassment about their lack of understanding of
Smoking Cessation Needs Assessment Report

Section 4: Attitudes to tobacco use and the current Stop Smoking Service

English and suggested that this often prevented people from their community attending services, particularly anything in a group format unless it was aimed specifically at their own community.

“I would worry that my English would not be good enough to understand everything that was being said in a group - especially if people were all talking at once or talking very quickly. I’d only go if it was in Punjabi” (South Asian male, aged 62)

The local GPs interviewed confirmed this concern, stating that they found similar issues when organising other services for the BME community such as stress groups.

The material produced for stop smoking participants was generally well received, particularly the information on the content of cigarettes which seemed to strike a chord with the South Asian community. However older South Asians and Slovakian smokers had some difficulty in understanding the written material. Issues with literacy were highlighted as a factor which may be preventing BME tobacco users from accessing the service. Interviewees suggested that older South Asians (particularly females) are often uneducated and are not able to read or write (even in their native language) and Slovakian command of English is generally poor, hindering understanding.

South Asian community issues

Whilst lack of awareness was the main reason South Asian tobacco users were not using the local service, concerns surrounding anonymity and confidentiality would prevent many engaging with it. Smoking appears to be a hidden habit and one which, although not banned religiously, is not encouraged and as a result, few smokers would approach their religious leaders for advice on stopping smoking.

Smoking, in general, does not appear to be discussed openly, even amongst males in the community. Keeping their habit hidden is of paramount importance to female smokers who went to considerable lengths to hide their smoking, even from their own friends who smoked.

“My parents don’t know I smoke and would be devastated if they found out. I mostly smoke away from the house but if I do smoke at home I lock myself in my bathroom and hang out of the window”. (Female, aged 22)
“I phone my friend regularly. I can hear her drawing on the cigarette and blowing out the smoke when we talk but if I ask her if she smokes she says absolutely not ... but I know she does”. (Female, aged 39)

Even male smokers suggested that they prefer not to smoke at home and do not smoke in their parents’ house.

“It’s disrespectful. My parents don’t smoke so I don’t when I am there. I don’t think they would like their friends to know I smoke either so I do it elsewhere”. (Male, aged 35)

Keeping their smoking hidden from families and neighbours is also important. They suggested that, as a result, they would be unlikely to seek advice about stopping smoking from their community leaders in case others in their community found out. Concerns over confidentiality also meant that some female smokers would be reluctant to raise the matter with anyone, even their GP.

**Eastern European community issues**

The Eastern European population is fairly transient and returns to their native country regularly throughout the year and, in the case of the Slovakian community, this can be for up to three months at a time. The mobility of this population is a key issue for the service in terms of service contact and engagement because:

- Contact details change very regularly as residents change address following their return from Poland or Slovakia;
- Other factors, such as obtaining housing and employment, are of greater importance to the community than stopping smoking;
- Many of the residents are not registered with GPs in the South East of Glasgow but have retained their Polish or Slovakian doctor, limiting a traditional source of information on stop smoking services (the GP practice);
The residents have regular access to cheaper tobacco from home negating cost factors as a key quit message.

In addition to this, Slovaks in particular, tend not to integrate to any great extent with the local community in South East Glasgow when they return. They seem to prefer to live (and work) close by and tend to socialise amongst themselves, possibly because of language difficulties. This reduces the extent to which Eastern Europeans, Slovaks in particular, can access information on Stop Smoking Services.

Also, unlike the South Asian community, smoking is an accepted pastime amongst Eastern Europeans. Nearly everyone smokes and they begin at a young age.

“Everyone smokes – it’s more unusual if you don’t”. (Polish female, aged 25)

This, together with the fact that the community (particularly the Slovakian residents) has other issues which they regard as more pressing, means they appear less open to the stop smoking message.

“I need a job and a house for my family – smoking is not important just now”. (Slovakian male, aged 39)

4.2.2 Service delivery

Common issues with both communities

In both communities, key informants and smokers were aware that smoking was bad for people’s health. However other health problems were considered to be of more importance than smoking, particularly diabetes, strokes and stress. The smokers in both communities indicated that they would be more likely to seek help for these issues than to give up smoking. Neither community appeared to make the link between these health issues and smoking. This was confirmed by feedback from the GPs and Practice Nurses who highlighted that those BME smokers who had received prescriptions to support them stopping smoking had all attended the GP practice for other health issues and that their smoking had been raised as part of the discussion.

South Asian community issues

The South Asian community had more concerns with the current service delivery approach than the Eastern Europeans. The desire to keep their smoking confidential and to retain anonymity was very important to these smokers and their major concern with the current delivery model. They stipulated that they were highly unlikely to attend any service which was billed as a Stop Smoking Service.

“I wouldn’t want people to know I was getting help to stop smoking – they don’t know I smoke and I want to...
They suggested that they were, at present, more likely to attend their GP because they thought that, because it was an individual consultation, it was more private, more confidential and not specifically a stop smoking service, allowing them to mask their attendance for reasons other than smoking.

The male smokers also preferred to attend something which was more than just about stopping smoking. Improving their health generally was more important to them than stopping smoking alone.

“I’d be more likely to go if it was about other things not just smoking. If it was about getting fitter – I’d go to that”. (Male, aged 27)

The wider health focus was also important to older South Asian males. They thought they should be able to stop smoking if they wanted to themselves and therefore the service needed to provide them with other information about their wider health.

“I should be able to give up myself so I’d need to feel it was about keeping myself well – healthy eating and the like”. (Male, aged 58)

The belief that people should be able to give up smoking themselves was fairly widely held amongst older South Asian male smokers and tended to make them skeptical about group support and counselling which they tended to see as:

“... airy fairy. All you’re doing is talking ... I can’t see how that helps anyone”. (Male, aged 60)

Younger smokers were more open to support and many felt that they could benefit from the support provided by counselling and groups.

4.2.3 Service infrastructure

Common issues with both communities

The length of commitment required to attend stop smoking services was raised as a potential deterrent for both communities by GPs, Practice Nurses and key informants. Many key informants ran groups locally for members of the BME community and all cited problems in securing regular attendance. Long working hours and more pressing family commitments were found to prevent participation in local activities. The key informants suggested that these issues required:
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- Regular contact with participants to build up user confidence and trust
- Personal contact with the individual attending rather than relying on messages being left with other family contacts
- A reminder system to contact participants on the day of the event
- Flexibility in service hours to accommodate evenings and weekends
- The ability to drop in and out of the service to accommodate other family commitments.

Family is also highly important in both communities and key informants also suggested that any service provided had to accept that last minute requests from families would be given precedence over any appointments to attend their service.

South Asian community issues

Smoking is a highly sensitive topic in the South Asian community. Key informants providing group support in other equally sensitive health areas such as mental health and domestic violence emphasised the need for the service infrastructure to support:

- Long lead-in times to encourage people to engage with the service
- Single sex groups
- Participants to be from the same community to allow them to share meaningful experiences
- Advice to be reflective of the community and their cultural experiences
- Advice to be repeated over a period of time before smokers will act on it.

Sensitivities over confidentiality and anonymity also mean that the smokers, particularly females, are highly unlikely to attend services which are held in premises which are widely known as Stop Smoking clinics.

“I’d prefer to come along to a building that had many other services in it – not just stop smoking support. That way I could be coming to anything”. (Female, aged 28)

The smokers were also concerned that if they engaged with the service they would receive information from the service either by post or by telephone to their homes and that this would result in their families and friends finding out about their smoking.

Eastern European community issues

A key constraint within the Eastern European community is their attitude to the local health service infrastructure. They are used to health services which do not require an appointment and find it difficult to understand a system which requires attendance at a specific time.

“Why can’t we go when we want to? That’s what we do at home and it works OK”. (Slovakian female, aged 32)
Their transient lifestyle also means that services such as Stop Smoking which are delivered over a period of time, or which require consecutive attendance, suffer during the periods when the residents return to Eastern Europe. Returning home is a regular occurrence and can be for significant periods at a time (e.g., three months or so).

In addition to this, the Slovaks, in particular, tend to reside in large family groups and attend services with the entire family when they return to Glasgow. Their reluctance to integrate and their transient lifestyle make them heavily dependent on each other and they find it inconceivable that other members of their family are not involved in everything that they do. As a result, the key partners and key informants have developed support services which adopt a drop-in approach. For example, the local Health Centre has introduced a drop-in health clinic which has no appointment system but allows Eastern European families to attend the clinic during opening hours. Health issues for the whole family are also addressed at this clinic as well as the needs of individual patients. This drop-in approach allows the residents more flexibility in when they attend and also allows them to attend with other family members if they want to. The services are designed to address multiple health issues and deal with multiple patients at any one time.

4.2.4 Workforce planning and development

Common issues with both communities

All of the issues raised regarding workforce planning and development equally related to both communities, South Asian and Eastern European.

Feedback from the key partners, key informants and members of the BME community suggested that the people providing the Stop Smoking service are equally as important in ensuring its cultural sensitivity as its content and format.

Credibility of the service provider and their understanding of the cultural implications of smoking are of vital importance to the BME smokers, particularly South Asians. It is important to them that they are being asked to give up smoking for genuine health reasons and not for religious or
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cultural reasons (South Asians in particular) and that the advice that they are given is achievable within their own cultural and religious requirements. One South Asian smoker explained:

“I go to another group for help with something else. I tell them that I feel under pressure from my in-laws and that I don’t feel I have any time for myself. They tell me to tell my mother and sister in law that I need my own space. This is just not possible ... elders in our community are the boss and I can’t tell them to go away”. (Female aged 41)

However, the need for cultural awareness also requires to be balanced with the needs for confidentiality in the South Asian community. Many of the smokers expressed concern that using local members of their community would result in their families and friends finding out about their smoking. These smokers would prefer an adviser who understood their culture without necessarily living in their local community.

Many of the BME smokers suggested they would approach their GP for stop smoking advice in the first instance. Discussions with practice staff indicated differences in attitudes to raising smoking issues amongst health professionals. Those with smoking cessation as a larger part of their role appeared more willing to raise the issue and to probe deeper with the patient. In addition, the feedback also suggested varying degrees of cultural awareness amongst primary care staff, ranging from limited understanding (South Asian culture) to no understanding whatsoever (Slovakian). The interviews highlighted some misconceptions about smoking in the BME community, the most common being that it is banned in Muslim and Sikh religion and that South Asian women do not smoke. The interviews with the primary care staff also suggested varying degrees of awareness of the current service pathway and a reluctance to refer BME smokers to the Stop Smoking service. Several staff interviewed believed that BME smokers attended their practice because they preferred a prescription for NRT or pharmacology solutions to help them stop smoking rather than attending the Stop Smoking service. Feedback from BME smokers suggested that they attended the practice primarily because they were unsure where else to go and were unaware of any other support option aside from NRT or pharmacology.
Section 5: Conclusions and recommendations

Conclusions

Feedback from the key partners, key informants and from representatives of the local South Asian and Eastern Europeans suggested that smoking was very prevalent in both communities. However, service usage data indicates that only a small proportion of the BME smokers appear to engage with the current Stop Smoking Service.

Feedback from representatives of local community organisations and from South Asian and Eastern European smokers themselves in the South East of Glasgow suggests that this is essentially the result of:

- A lack of awareness of the existence of a local Stop Smoking Service;
- A greater focus on health issues other than smoking;

A concern that the service would not take account of cultural influences in its delivery, particularly in supporting their need for confidentiality and also in providing advice which fits into their lifestyles.

Awareness of the service appeared limited, in both communities, even amongst key informants and some key partners from the South Asian community (GPs in particular). Many interviewees and focus group participants thought that their GP was the only support available in the area.

Both communities have a wide range of health (and social) issues, many of which are of greater concern to the population than their smoking and were given greater prominence than giving up cigarettes.

Confidentiality was of great concern amongst the South Asian smokers. South Asian smokers appeared unlikely to engage with the service if there is any opportunity for others in their community discovering their involvement with it. Smoking is a private matter in this community and the smokers were especially concerned with preventing their families from uncovering their habit.

South Asian smokers also expressed concern regarding the Service’s current methods of contact, such as letters or phone calls to smokers’ homes. These are considered unsuitable as they offer the opportunity for others to find out about the individual’s smoking, increasing the community’s concerns surrounding
anonymity and confidentiality. In addition to this, family commitments are also of paramount importance in South Asian and Eastern European communities and often means that appointments can be forgotten about, or ignored, if family situations arise.

5.2 Recommendations

Feedback from the key partners, key informants and a sample of BME smokers in South East Glasgow confirm that the four service factors highlighted from the case studies are indeed vital to providing culturally sensitive Stop Smoking services, namely:

- Contact and engagement;
- Service delivery;
- Service infrastructure;
- Workforce planning and development.

The feedback suggests that some changes to the current Stop Smoking service would be beneficial and would provide a more culturally sensitive service for BME tobacco users. The implications of the feedback from the key partners, key informants and smokers from the local South Asian and Eastern European communities for the Stop Smoking service in South East Glasgow are considered below.

5.2.1 Contact and engagement

Lack of awareness was a key barrier to contacting and engaging with BME smokers. This could be addressed through:

- Enhancing the links between the Stop Smoking service and local community groups. Concerns over confidentiality and credibility mean that direct approaches from key members of the BME community would make smokers uncomfortable and may be counter-productive. However, key informants were very keen to help the service raise awareness locally and suggested that service representatives could attend their local group meetings as key speakers and present directly to the BME community. Their presentations could focus on the service, the options for support and the main entry points.

- Raising key informant awareness of the service pathway. Service representatives could deliver sessions directly to the management and staff in local organisations which support the BME community (eg The Well, Hidden Gardens, Pollokshields Development Agency, Crossroads, Daisy Street Drop in (Slovakian) etc). The purpose of the sessions would be to improve their understanding of the service and what it can offer in order that they can pass this information on to their local community if asked. At present they do not understand the service and could not offer any advice, even a signposting service, to anyone who wanted to quit.

- Promoting the service in locations which are well used by the BME community and are not associated with a Stop Smoking service such as ethnic foodstores, workplaces and religious centres. Several key
informants, including the Sikh temples, indicated that they would be keen to make information leaflets on stopping smoking available for any member of the community to pick up.

- Promoting the service in local health centres, clinics and GPs. Given that many BME smokers regard their GP as their first port of call in seeking stopping smoking support, it will be important to raise the profile of the local service in these locations either as a means of encouraging people to access the service or as a catalyst for discussing stopping smoking with a health professional.

Understanding English was also raised as a potential barrier to some older Asian smokers and Slovakian smokers engaging with the service. Both groups felt that there command of English was not sufficient for them to participate fully in, and benefit from, the Stop Smoking discussions. A potential solution to this issue is addressed below in sub-section 5.2.4 Workforce Development and Planning.
5.2.2 Service delivery

Both communities have wider health issues, many of which are exacerbated by tobacco use. This, together with the South Asian desire for confidentiality and anonymity, would suggest that the service should be linked to other health services or projects to provide a wider, more holistic approach to stopping smoking (e.g., healthy eating, increased physical activity, stress reduction, mental health and wellbeing etc.). The model for this approach already exists in the local Health Shop and in some Community Pharmacies and could perhaps be expanded further in the South East. All of the needs assessment participants felt that this approach would encourage people to use the Stop Smoking service and would encourage males to discuss smoking and other health issues as well.

It would also be of benefit if this integrated service delivery model could also incorporate:

- **Flexible service composition:** This could combine the current delivery methods of one-to-one consultations, telephone support and group support as many of the smokers recognised the need for counselling within the Stop Smoking provision. If group support were to be provided it would be vital to offer the option of same sex/same culture groups in addition to the current mixed support groups.

- **Flexible attendance:** Family and work life pressures made it difficult for some BME smokers to attend anything regularly over a period of time. BME smokers need a service which allows them the opportunity to dip in and out of the service (preferably without an appointment) without feeling that they are either missing out or inconveniencing the service.
5.2.3 Service infrastructure

Cultural sensitivities mean that the main change needed to the service delivery model is, in fact to the infrastructure surrounding the service. Key factors for consideration are:

- **Location**: The need for confidentiality suggests that the service should be offered from premises which are recognised locally as having another function (i.e., not specific to Stop Smoking). The support offered by many of the local organisations already engaging with sections of the BME community, such as Hidden Gardens, The Well, Dixon Hall and Govanhill Neighbourhood Centre, Slovak Association of Glasgow etc., could provide an opportunity to offer the service from these locations, none of which are currently associated with Stop Smoking.

  Similarly, smokers’ desire for the support to cover other health issues as well as smoking cessation might allow the opportunity to offer services from recognised health service sites currently used by the BME community such as clinics and GP practices, as well as the Health Shop which currently offers a range of advice, including stop smoking services.

- **Administration**: The need for confidentiality, particularly amongst female South Asians wishing to engage with the Stop Smoking service means that consideration requires to be given to how contact is made and maintained with smokers. Written communication to the home or telephone contact to the home telephone number would create considerable anxiety amongst female smokers. Other, more direct means of contact with the service user should be considered such as mobile phones or emails.

- **Flexible hours**: Long working hours and family commitments suggest that providing a service where access times were more flexible might encourage uptake. Smokers themselves suggested the inclusion of evening and weekend provision would be highly beneficial.

- **Personal contact**: A reminder system on the day of the appointment was considered useful. Key informants often find that even regular service users need to be reminded of the date and time for their attendance. The service needs to provide a reminder system which maintains regular contact with the service user (particularly important for people dropping in and out of the service over time and also for transient populations). Experience from the key informants suggests that this reminder needs to be on the day of the service delivery to secure attendance.
5.2.4 Workforce planning and development

Feedback from the key informants and BME smokers suggest that service planners need to consider the following issues when determining who will be delivering the service to the BME community, namely:

- **Credibility:** The majority of smokers would only access a service if they felt that the people delivering it were specialist in the subject. For many of the smokers, this meant that the service should either be delivered by advisers from the indigenous Scottish population, as they are perceived as having more credibility, or from highly trained health professionals from the BME community.

- **Language:** All participants felt that it would be beneficial if advisers were bi-lingual to overcome any language barriers (particularly Slovaksians and older South Asians). Supporting material should also be translated for Eastern European smokers. Many South Asian smokers, whilst speaking Punjabi or Urdu, have difficulty in understanding it in written text, and therefore were not as concerned with translated material.

- **Cultural awareness:** The feedback from the BME smokers indicates that some key partners may not fully appreciate BME culture and that they do not understand the context in which they are giving them advice (i.e. what is and is not achievable). Also, misconceptions regarding BME smokers willingness to receive support may also be preventing primary care staff from referring smokers to the service. There may, therefore, be benefit in developing awareness raising or training sessions on cultural awareness for key frontline community staff.

- **Scoping out the service pathway:** The feedback from key partners suggests a lack of awareness of the Stop Smoking Service pathway. There may be benefit in scoping out the pathway for the culturally sensitive Stop Smoking Service. Providing a clear demonstration of the service pathway should allow those referring to the service, as well as those delivering the service, to provide clients with their optimal service journey, thereby enhancing their service experience. The pathway should include:
  - Entry points;
  - Current service providers;
  - New/alternative service provision;
  - Potential client journeys through the range of services offered;
  - Referral options.

- **Awareness sessions:** Once the pathway has been scoped it may also be beneficial to develop awareness raising sessions for individuals involved in referring to the service or in providing the service itself. These sessions would:
• Improve staff understanding of the services offered, the entry points and referral options;
• Ensure a consistent understanding of the service pathway and optimum client journey;
• Allow key partners, particularly in primary care, to provide effective information on Stop Smoking services and to appropriately refer smokers for support, if approached.

5.3 Summing up
South East CHCP will now take forward the recommendations from this needs assessment, and develop an action plan which will include short, medium and long term outcomes.

For further information about this report, or about the work which will be undertaken, please contact Heather Bath, Health Improvement Senior, Tobacco Control on 0800 028 5208 or heather.bath@ggc.scot.nhs.uk.
Appendices

Appendix 1 Breakdown of sample

Key Partner In-depth Interviews

<table>
<thead>
<tr>
<th>Role</th>
<th>Number of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners</td>
<td>5</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>5</td>
</tr>
<tr>
<td>Health Visitors</td>
<td>3</td>
</tr>
<tr>
<td>Community Pharmacist</td>
<td>1</td>
</tr>
<tr>
<td>Midwife (Tobacco)</td>
<td>1</td>
</tr>
<tr>
<td>Smoking Cessation Co-ordinator</td>
<td>1</td>
</tr>
<tr>
<td>Principal Health Promotion Officer, Tobacco</td>
<td>1</td>
</tr>
</tbody>
</table>

Key Informant In-depth Interviews

- AMINA – Muslim Women’s Resource Centre (Network House)
- Community Development Team
- Community leader representing South Asian women in East Pollokshields
- Lead Public Health Pharmacists, NHS Greater Glasgow & Clyde
- Dixon Hall Carers
- Glasgow Association for Mental Health
- Glasgow Community Development Trust
- Hidden Gardens
- Pollokshields Development Agency
- Roma Development Workers
- Shimla Pinks
- Strawberry Gardens
- St Andrews Drive Temple
- The Well Project
- Youth Counselling Support Agency

BME Smokers Focus Groups

<table>
<thead>
<tr>
<th>Population Sub Group</th>
<th>Participant Profile</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polish/Slovakian</td>
<td>8 smokers - 4 Polish &amp; 4 Slovakian (mix of male and female)</td>
<td>16 - 44 years</td>
</tr>
<tr>
<td>Polish/Slovakian</td>
<td>8 smokers - 4 Polish &amp; 4 Slovakian (mix of male and female)</td>
<td>45 and above</td>
</tr>
<tr>
<td>Pakistani</td>
<td>8 female smokers</td>
<td>16 - 44 years</td>
</tr>
<tr>
<td>Pakistani</td>
<td>8 female smokers</td>
<td>45 years and above</td>
</tr>
<tr>
<td>Pakistani</td>
<td>8 male smokers</td>
<td>16 - 44 years</td>
</tr>
<tr>
<td>Pakistani</td>
<td>8 male smokers</td>
<td>45 years and above</td>
</tr>
<tr>
<td>Pakistani</td>
<td>8 male smokers</td>
<td>65 years &amp; above</td>
</tr>
<tr>
<td>Indian</td>
<td>8 male smokers</td>
<td>16 - 44 years</td>
</tr>
<tr>
<td>Indian</td>
<td>8 male smokers</td>
<td>45 years and above</td>
</tr>
</tbody>
</table>
Appendix 2 Discussion Guides

Job No 04/09/02
Client South East CHCP
Project Smoking Cessation Needs Assessment of BME Population living in South East CHCP

Key Partner Depth Interview Discussion Guide

1. Introduction (5 minutes)

- Interviewer Introduction
- Purpose of Interview
- Explain background to needs assessment
- Explain Axiom’s role in needs assessment and outline research programme
- All comments made are strictly confidential and will not be attributed to participating individuals
- Interview will last up to 1 hour

2. Discussion topics (50 minutes)

Interviewee Role

- Discuss for each interviewee:
  - Role and objectives of the organisation they represent
  - Own role and responsibilities
  - Involvement in smoking cessation services

Current Service Provision

- Explore current service delivery, including:
  - What smoking cessation services are available
  - How services are accessed currently
  - Who the services are targeted at
  - Extent of demand for the service generally
  - The resources required to deliver these services

BME Smokers

- Discuss the profile of BME smokers in area
- Explore the extent of current demand for the service from BME smokers;
- Probe for extent to which practitioners currently refer BME smokers to the service and reasons
  - Explore the extent to which the current services meet the needs of BME smokers;
  - Probe for which elements of the current service practitioners refer BME smokers to and reasons
  - Probe for which elements of the current service practitioners do not refer BME smokers to and reasons
  - Review any perceived barriers to BME smokers using the current services:
    - Probe for current gaps in smoking cessation services for BME smokers and rank according to importance of gap
  - Explore any areas of pressure within the current service provision
  - Review key strengths of current service delivery approach and rank according to importance

Background to service (Heather Bath & Agnes McGowan only)

- Explore the reasons for choice of current service delivery model
- Review the cost of providing these resources
- Compare approach taken in referring BME smokers in SE CHCP to other CHCPs across Glasgow (if known)

Future Service Model

- Discuss perceptions of levels of future demand for smoking cessation services amongst BME community in area
- Explore implications for current service model
  - Probe for the key factors which would make the service culturally sensitive and rank according to importance
  - Visioning exercise to explore future services needed to meet demand including:
    - Suggestions for additional services
    - Improvements to services
    - Replacements for current services
    - Matrix ranking to prioritise future needs
  - Key challenges and how these might be overcome
- Explore awareness of other culturally sensitive smoking cessation service delivery models including suggestions for case studies
Job No 04/09/02
Client South East CHCP
Project Smoking Cessation Needs Assessment of BME Population living in South East CHCP

Key Informant Depth Interview Discussion Guide
1. Introduction (5 minutes)
   • Interviewer Introduction
   • Purpose of Interview
   • Explain background to needs assessment
   • Explain Axiom's role in needs assessment and outline research programme
   • All comments made are strictly confidential and will not be attributed to participating individuals
   • Interview will last up to 40 minutes

2. Discussion topics (35 minutes)

   Interviewee Role
   • Discuss for each interviewee:
     • Role and objectives of the organisation they represent
     • Own role and responsibilities
     • Involvement in smoking cessation services

   Smoking cessation
   • Explore understanding of the impact of smoking and tobacco products on people's health
   • Explore awareness of smoking cessation services in the area
     • Probe for types of service, location, hours of operation
     • Discuss source(s) of information for BME tobacco users in area and extent of influence
     • If aware, probe for their perception of how the service is accessed
   • Discuss perception of extent of tobacco use among BME community locally (ie males/females, age group etc)
   • Explore the extent to which the current services meet the needs of BME tobacco users locally (if unaware of service then describe service available);
   • Probe for reasons for satisfaction or dissatisfaction with elements of the current service
   • Explore perceived reasons for any non use of the current service
   • Probe for any perceived barriers to BME tobacco users using the current services:
     • Explore how barriers could be overcome

Future Service Model
   • Explore what factors they perceive would be important in encouraging BME tobacco users to access smoking cessation services locally
   • Explore what role they think they could play in encouraging BME tobacco users to quit
   • Use a visioning exercise to explore future services needed to meet demand including:
     • Suggestions for additional services
     • Improvements to services
     • Replacements for current services
     • Matrix ranking to prioritise future needs
     • Key challenges and how these might be overcome
   • Discuss how they believe these future services should be made available
   • Explore if they are aware of other culturally sensitive tobacco cessation services in other areas and examine what makes them different
Case Study Interview Discussion Guide

1. Introduction

- Interviewer Introduction
- Purpose of Interview
- Explain background to needs assessment
- Explain Axiom’s role in needs assessment and outline research programme
- All comments made are strictly confidential and will not be attributed to participating individuals

2. Discussion topics

Interviewee Role

- Discuss for each interviewee:
  - Role and objectives of the organisation they represent
  - Involvement in smoking cessation service provision in their area
  - Own role and responsibilities

Background to service delivery model

- Discuss the extent of current demand for smoking cessation services
  - Probe for prevalence in local population
  - Probe for profile of smokers, numbers engaging with the service, quit rates etc
  - Explore profile of local BME smokers

Cessation services for BME tobacco users

- Explore current service delivery model, including:
  - What cessation support is available:
    - Probe for extent to which this includes wider use of tobacco products
  - Who the support is targeted at
  - How the support is marketed including:
    - Materials used

- Key messages
- Extent to which it varies by cultural group
- Use of local influencers – probe for type and how used
- Use of local success stories/case studies etc
- Methods used to encourage uptake (ie discount/reward scheme):
  - Probe reasons for choice
  - Perceived effectiveness
- How support is delivered:
  - Probe for whether it is provided as specialist service or as an element of a holistic service;
  - If holistic – probe for what this includes
  - Method(s) of entry to service and reasons for choice
  - Method(s) of delivery and reasons for choice
  - Methods used to obtain and maintain contact with users
  - Location(s) of service and reasons for choice
  - Links with other agencies/organizations and reasons for choice
- Who provides the support, including:
  - Roles and responsibilities
  - Hours worked (ie full/part time)
  - Reason for choice
  - Previous experience
  - Training/support provided
- Barriers encountered and methods used to overcome, including:
  - Language
  - Terminology
  - Accessibility (including access to medication)
  - Contact methods
- Explore extent to which any changes have been made to the services and reasons for change

Resource requirement

- Explore the resources required to deliver the services including:
  - Level of funding required
  - Sources of funding
  - Staffing levels
  - Type of staff and skill requirements
  - Extent of involvement required from range of
agencies (statutory and voluntary) and linkages among agencies (ie health, housing, social work, criminal justice etc)

Effectiveness
- Explore what the service for BME tobacco users was expected to achieve (outcomes set etc)
- Explore to what extent expectations have been met
  - Probe for level of satisfaction with the approach taken
  - If service was changed - explore what effect the changes have had
  - Review key strengths of approach including matrix ranking of strengths
- Explore critical success factors for planning and implementing the services (including matrix ranking of success factors)
- Explore the key challenges and how they would address these if undertaking the exercise again

Sustainability of Approach
- Discuss perceptions of levels of future demand for the service from BME smokers
- Explore the implications for the approach including any planned changes/enhancements and the reasons for this
Appendix 3 Case Studies

REACH Community Health Project, Govanhill

Organisation providing service:
Reach (national charity)

Interviewee:
Stop Smoking Service Co-ordinator.
Responsible for management of service and staff.

Smoking prevalence:
Over 80% of males in Asian community in Govanhill.
One new service user each week.
Service in operation for 2 years (100 users to date).
60% quit rate.

Support available:
Drop in service.
1:1 with Community Pharmacist.

Marketing of support:
Very limited use of flyers.
Most marketing done by visit of community education worker to organisations and individual in local BME community.
Leaflets left with local organisations.
Also receives referrals from YCSA.

Encouragement:
No incentives used.

Delivery of support:
Concentrates only on smoking cessation.
Discussion with Community Pharmacist.

Access to services:
Referrals from local organisations (eg YCSA).
Drop in clinic runs for 3 hours one evening per week.

Method of contact:
Face to face – believes personal contact essential to build up trust.

Staff involved:
1 co-ordinator (part time, qualified doctor).
1 community pharmacist (3 hours per week).
1 community education worker, part time.
1 admin (part time).

Staff training:
Smoking cessation.
Cultural awareness – engaging with BME community. Reach provides training for other organisations on cultural sensitivity.

Barriers:
Language – apart from community pharmacist, all staff from local BME community. They believe this to be vital to building up understanding and trust.
Groups less successful – BME population don’t want to commit to regular attendance.
Deadlines don’t work – takes time to build up trust and confidence. BME community will not self refer to services and need to be cajoled into taking part.
Women very reluctant to admit smoking, culturally unacceptable for them to smoke. Needs to be part of wider service to main confidentiality.

Resource requirement:
Not given – part funded by NHS GG&C.

Effectiveness:
Suggests 2 in 3 service users quit over time.
Around a third drop out.
Reluctant to discuss targets.
Believes BME staff are more effective in engaging with BME smokers – relatively high quit rate for BME smokers.
Personal contact with staff on individual seen as more effective - groups impinge on confidentiality.
East Berkshire Primary Care Trust - Slough

**Organisation providing service:**
East Berkshire PCT

**Interviewee:**
Slough Locality Lead
Responsible for delivery of local smoking cessation service

**Smoking prevalence (general population):**
34% of population
Just under 2500 smokers used service in 2008
43% quit rate generally

**BME Stop Smoking data:**
53% quit rate for Asian smokers
70 out of 115 Polish smokers quit using service

**Model used:**
Maudsley

**Support available:**
NRT
Counselling
Telephone follow up
1:1
Don’t use GPs – many Polish people not registered, use services in Poland

**Marketing of support:**
Press releases advertising local clinics
Library service has link on their website (links into Polish book service)
Posters in community centres, mother & toddler groups
Provide material translated into Polish – use How to Stop Smoking and Stay Stopped from NHS Health Scotland (polish translation available)
Key messages: Free service, Polish tend to think they have to pay for the services
Financial cost of smoking

**Encouragement:**
No incentives used - many word of mouth referrals

**Delivery of support:**
Concentrates on smoking cessation but can signpost to other services as need arises
Provides support for the family as well as the individual - whole families come into drop in clinic (particularly Roma community)

**Access to services:**
Run as drop in clinics
Slough library - Saturday all day & Tuesday evening
Times organised to suit community - weekdays not convenient as most of community work

**Method of contact:**
Face to face – key to encouraging commitment
Telephone follow up

**Staff involved:**
1 Polish smoking cessation adviser

**Staff training:**
2 day smoking cessation training (training delivered in house)
Quarterly refresher training

**Barriers:**
Availability of community - work long hours during week. Need to be flexible in delivery
Language - need to have people who can speak the language fluently

**Resource requirement:**
Provide service for 7 hours per week. Pay adviser bank staff rate of £15 hour. No venue costs incurred.

**Effectiveness:**
Quit rate in excess of other communities
Use of Polish adviser from local community seen as being key to success
Lambeth Primary Care Trust

Organisation providing service:
Lambeth Primary Care Trust

Interviewee:
Smoking Cessation Co-ordinator
Responsible for management of local smoking cessation service

Smoking prevalence (general population):
35% of population
Just under 4000 smokers used service in 2008
42% quit rate generally

BME Stop smoking data:
50% quit rate for Asian smokers

Model used:
Maudsley

Support available:
1:1 (very popular with BME community)
Alternative therapies (links with local services)
NRT
Counselling
Telephone follow up
Groups
Also pharmacy service and GPs

Marketing of support:
General leaflets
Website (uses success stories from members of the local BME communities)
Links with local community groups (including residents meetings)
Stall at local weekly markets
Links with key influencers (eg club DJs, MPs etc)
Less emphasis on printed material – believe personal contact more important in influencing smokers

Encouragement:
£5 voucher which can be spent in number of local shops – linked to 4 week quit

Delivery of support:
Mostly concentrates on smoking cessation but BME adviser is also health trainer
Runs as drop in - individual discussion including assessing level of addiction. Once quit agreed then individual can access up to 12 weeks free NRT therapy

Access to services:
Referrals from national helpline
GPs
Local pharmacies
Drop ins (market stalls etc)
Limited day time delivery - people not available
Advisers work evenings and weekends

Method of contact:
Face to face – key to encouraging commitment
Text messages for appointments and ongoing contact
Telephone follow up

Staff involved:
4 advisers (1 from BME community)
Geographical coverage

Staff training:
2 day & 3 day smoking cessation training (Levels 2 & 3)
Adviser from BME has health trainer courses (Brief Interventions, Counselling, Behavioural Change etc)
Quarterly refresher training

Barriers:
Availability of community - work long hours during week. Need to be flexible in delivery

Resource requirement:
£421,000 per year
7 staff (4 advisers, 1 co-ordinator, 1 admin, 1 manager)
**Effectiveness:**
Targeting 1,707 BME quitters over 3 years (since 2007)
Achieved 1,405 to date
BME adviser nearly twice as successful as other advisers
Newcastle & North Tyneside

Organisation providing service: Newcastle Primary Care Trust

Interviewee: Specialist Smoking Adviser – Communities & Workplace

Smoking prevalence (general population): 25% of population
Just under 4000 smokers used service in 2008
47% quit rate generally

BME Stop Smoking data: 33% quit rate for Asian smokers

Model used: Maudsley

Support available:
Gum for chewing tobacco
NRT
Counselling
Groups (mostly women attend)
Telephone - translators available
1:1
GP appointments (mostly men)

Marketing of support:
Attendance at health fairs
Posters in health centres and mosques
Visits to mosques
Leaflets on smoking cessations (translated)
Leaflet on giving up chewing tobacco
Local influencers - Imams

Encouragement:
No incentives used

Delivery of support:
Standalone and as part of free health check
Includes dental care, blood pressure, diabetes, healthy eating
Health check seen as less threatening than purely smoking cessation - can link discussion to improving wider health

Access to services:
GPs
Dentists
Pharmacists
Mosques
Health centres
Home visits - popular with Asians

Method of contact:
Face to face and telephone
Reducing emphasis on telephone – difficult to manage with translators

Staff involved:
5 Health trainers - remit to educate on healthy living
• 3 employed by PCT
• 2 privately funded by charity
• Full time

Staff training:
Healthy living
Smoking cessation
Media

Barriers:
Language - use multilingual trainers and translation service
Child care an issue - services offered mid morning to mid afternoon around school timetable
Need for confidentiality - conflict with religious beliefs
**Resource requirement:**
Funded by PCT
Cost of service linked to staff salaries
5 trainers
2 specialist advisers (not BME specific)
1 manager (not BME specific)

**Effectiveness:**
No clear objectives set other than to increase BME quit rates
Attendance at group activities still low from BME community
NHS Bristol

Organisation providing service:
NHS Bristol

Interviewee:
Stop Smoking Service Manager
Responsible for management of service and staff

Smoking prevalence (general population):
35% of population
Just under 2700 smokers used service in 2008
47% quit rate generally

BME Stop Smoking data:
53% quit rate for Asian smokers

Model used:
Maudsley

Support available:
Groups
1:1
NRT
Counselling
GP appointments
Nothing specific for wider tobacco products

Marketing of support:
Targeting long terms smokers with low health attendance – until this year had focused on smokers who were health aware
Leaflets
Posters in GP practices, dentists and opticians
Flyers and posters in pubs, supermarkets and community centres
No specific BME materials - general available from Dept of Health and Smoke Free website

Delivery of support:
Standalone and part of wider health check
Includes blood pressure, healthy eating, cholesterol (area has large number of residents with chronic health conditions linked to multiple deprivation and smoking)
Part of general smoking cessation service

Access to services:
GPs (most referrals from GPs)
Dentists
Opticians
Pharmacists
Pubs
Supermarkets
Community centres
PCT contracts with GPs locally to refer to Stop Smoking Service

Method of contact:
Face to face – reducing emphasis on telephone
Texting to remind people of appointments
Texting health messages

Staff involved:
Health trainers - 3 are from local BME communities
Remit to educate on healthy living
Contract with GP practices to provide health training service and stop smoking service
Full time

Staff training:
Brief Advice
Behavioural Change
Brief Intervention
Smoking cessation
Smoke Free Homes
Updated quarterly

Encouragement:
No incentives use
**Barriers:**
Language – use BME health trainers
No translators – found they slowed down the interaction with the individual
Groups less successful – BME population don’t want to commit to regular attendance

**Resource requirement:**
£1.287 million invested by PCT in Stop Smoking service – not broken down by target populations
10 staff in total (includes 1 manager and 1 admin)

**Effectiveness:**
Overall targets set of increasing number of 4 week quitters from 2416 to 2456 in 2009/10. Presently 19% of target.
No specific targets set for BME population
Health trainers seen as most effective
Believes BME health trainers more effective in engaging with BME smokers – relatively high quit rate for BME smokers.
Groups less successful with BMEs – problems with consistency of attendance. Personal contact with health advisers on individual (or family basis) seen as more effective.
Tower Hamlets, London

Organisation providing service:
NHS Tower Hamlets

Interviewee:
Tobacco Programme Lead
Responsible for purchasing the local smoking cessation service (service contracted out)

Smoking prevalence:
Around 60% of Bangladeshi population smoke
Chewing tobacco more prevalent amongst women (75%)
Just over 3,000 users of smoking cessation service (420 of whom were Bangladeshi)
50% quit rate for general population
65% quit rate for Bangladeshi tobacco users

Model used:
Variety of approaches

Support available:
1:1
NRT (not used by BME community)
Counselling
Groups
Homes visits (popular with BME women)
Drop in service
Also pharmacy service and GPs

Marketing of support:
Very little use of printed material (literacy issues amongst older BME population)
Very little use of translated material (material in English equally as successful as translated)
Greater reliance on word of mouth and personal contact – use coffee mornings for attracting BME women
Some use of posters and leaflets in restaurants, bars, mini cabs etc
Limited use of the website but plan to increase its use in future. Have used case studies in the past of BME smokers in the local community who have given up successfully.

Strong links with local community groups
Sponsor a number of local groups including football teams etc
Stall at local weekly markets
Links with key influencers – have trained local Imams to highlight service in their local mosque and to reinforce health message. Also use local counsellors from BME community
Regular items in local media – newspapers, local radio and local TV
Less emphasis on printed material – believe personal contact more important in influencing smokers
Need to emphasise service is free
Information covers all tobacco products

Encouragement:
No incentives used

Delivery of support:
Specialist smoking cessation advisers – referrals made to local health trainers where required
Services delivered in local community venues – those frequented by BME population. Also drop in and home visits available
Delivery methods altered to suit age of population ie younger smokers and middle aged men happy with groups and 1:1, women smokers prefer home visits

Access to services:
Community groups, market stall and local influencers are main sources of referral. Word of mouth from within the BME community also important
Some referrals from GPs
Service also available in pharmacies
Limited day time delivery – people not available
Advisers work evenings and weekends

Method of contact:
Face to face – key to encouraging commitment
Advisers visit homes and liaise with family members

Staff involved:
4 advisers – 2 males, 2 females
All from BME community
Geographical coverage

**Staff training:**
2 day & 3 day smoking cessation training (Levels 2 & 3)
All speak Bangladeshi dialects

**Barriers:**
Availability of community - work long hours during week. Need to be flexible in delivery
Literacy - older BME population often can't read or write
Strong family ties - older people and women heavily influenced by family opinion (particularly extended family) - need to deal with whole family when addressing smoking cessation
Social culture requires a slow build up to raising the issue of smoking cessation. Advisers from local culture critical to overcoming cultural barriers

**Resource requirement:**
£400,000 per year
6 staff (4 advisers, 1 admin, 1 manager)

**Effectiveness:**
Have increased quit rate by 30% amongst BME smokers
Advisers from BME community seen as essential to ensure engagement
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