Working with Black and Minority Ethnic Communities
A guide for Stop Smoking Service managers
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Introduction

“Reducing smoking prevalence among people in routine and manual groups, some minority ethnic groups and disadvantaged communities will help reduce health inequalities more than any other public health measure.”

National Institute for Health and Clinical Excellence (NICE), February 2008

It is now widely accepted that smoking is the principle avoidable cause of death in this country and the majority of smokers want to quit. But still 87,000 lives are lost every year in England as a direct result of the habit. As well as being individual tragedies, these deaths have a wider impact on the strength and cohesion of our communities. So ten years on from the Smoking Kills white paper and one year on from making the workplace smoke-free, there is still a tremendous challenge (and opportunity) ahead.

The battle needs to be fought on a number of fronts. The National Support Team for Tobacco’s forthcoming document, Excellence in Tobacco Control: 10 High Impact Changes to achieve tobacco control, will highlight these, including tackling contraband tobacco, working with young people and, critically, partnership working. Stop Smoking service play a key role; of all the high impact changes they are the most cost effective.

Like all public services, Stop Smoking Services must be made accessible to a diverse range of people. This document aims to support Stop Smoking Managers who are trying to make their services accessible to people from Black and Minority Ethnic (BME) communities. This is particularly important for three reasons:

Firstly, there are certain BME groups who have very high smoking incidence.
Secondly, some BME groups experience particularly poor health. Thirdly, Government has set a PSA target to reduce prevalence among routine and manual smokers from 31 per cent in 2002 to 26 per cent or less by 2010, recognising the high smoking prevalence amongst this grouping. BME groups tend to be over-represented in the routine and manual occupations.

Here is some of the evidence.

- Bangladeshi men were the most likely group in England to smoke cigarettes (40 per cent in 2004), followed by White Irish (30 per cent) and Pakistani (29 per cent). This compares to 24 per cent in the population as a whole.
- There is anecdotal evidence to indicate that smoking prevalence is higher amongst recent migrants from Eastern Europe and in the Gypsy and Traveller community.

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1 Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE public health guidance 10 (2008)
2 This document will be available shortly on the Department of Health website.
3 As cited in the High Impact Changes document.
• In addition to smoking, chewing tobacco features in a number of Black and Minority Ethnic (BME) communities and the self-reported data itself (as above) is likely to be a dramatic underestimate.

So there is a clear rationale for making sure that Stop Smoking Services cater adequately for BME groups.

Who is this guide for?

It is aimed at managers of NHS Stop Smoking Services. It will also be useful to commissioners of Stop Smoking Services.

How will this guide help?

There is already considerable expertise among many Stop Smoking managers in reaching BME communities. The particular value of this guidance is that it draws together in one place a wide range of best practice tips, case studies, and sources of further information. But it also contains basic information for those new to this subject.

How to use this guide

The guide is split into four sections, based on a model of good practice in public health: mapping, targeting, delivering services, and evaluation. The text is arranged so that you can read all the way through, but you may prefer to dip in and out. Case studies are inserted in the text to illustrate relevant points. A text box at the beginning of each chapter lists the subjects and the case studies contained in the chapter – just click on the headings to go straight to the text you want to read.

A note on evidence

Acquiring formal evidence is certainly a challenge in this area, particularly evidence arising from controlled intervention studies. Hence many of the case studies in this document may not have been rigorously evaluated. It is important that partners recognise this challenge without being discouraged by it. There is evidence for the value of a systematic approach to public health and monitoring ethnicity.5 There is also generic guidance on what works in Stop Smoking practice6 (and no evidence to suggest that it would not work with BME communities). In particular, the new NICE programme guidance on smoking cessation sets out clear evidence based guidelines for future initiatives to follow. Furthermore, where local initiatives are properly evaluated, the information gained makes a vital contribution to our evidence base7.

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5 Ethnic Health Intelligence in London, The story so far – London Health Observatory
6 Ethnicity Monitoring: Benefit and Ethnicity Monitoring: Involvement – Neighbourhood Renewal Unit, 2004
7 Practical Lessons for dealing with Health Inequalities in Health Impact assessments – NICE, 2005
Diversity strands

This guide is focussed on race, but the same principles of mapping, tailoring services and evaluating are applicable to all the traditional equality strands – disability, gender, sexuality, age, religion or belief. Of course, all these diversity strands also exist within BME communities.

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All those who responded to the consultation on this document, including:

- ASH
- Asian Quitline
- South Asian Health Foundation

All those whose case studies have been included in the text
Prompt list

Here is a summary of the main issues raised in the document. If you are looking to improve your service, try considering the following questions.

1. What is the size and profile of the BME population in the local area?

2. What information on tobacco use prevalence and trends do you have for the BME population, including smokeless tobacco and sheeshas (water pipes)?

3. Has a local pattern of health inequalities been identified?

4. Are there local targets and/or appropriate interventions to reduce health inequalities, particularly on tobacco and particular BME groups?

5. Are there already successful culturally specific interventions operating?

6. Are all partners fully engaged? Who else could be involved?

7. Are local communities consulted about the design and delivery of services?

8. Are existing services/interventions evaluated, and is the evaluation being used to drive improvement?

9. How are services adapted for the full range of diversity themes, including; gender; disability; age; sexual orientation; and religion or belief?
Step 1  Mapping

Summary

Themes:
Finding out the profile of the local Black and Minority Ethnic population
Finding out the prevalence of tobacco use within local BME populations – national and local information
The future role of Joint Strategic Needs Assessment
Assessing health inequalities – the Health Equality Audit
Further information checklist

Case studies:

Improving Croft and Cowpen Quay Partnership – Boosting an existing survey in an area with a small BME population

Islington’s Somali population – Using a local survey and proxy indicators to determine the size of the community

Fresh Start Stop Smoking Service/Erewash PCT – Using a Health Equity Audit to assess the profiles of people within the target group.

1. The two most important pieces of mapping you need are the profile of the local Black and Minority Ethnic community, and the prevalence of smoking within that community. It would also be helpful to understand the pattern of health inequalities in the local population, which can be done through a health equity audit.

Finding out the profile of the local Black and Minority Ethnic population

2. Useful sources of information are as follows:

- **The 2001 Census**, which can be used to obtain ethnicity figures at ward level using the Standard Area Statistics. It is important to note that this may not be the full story,

Ethnicity categories:
The standard ethnicity categories are those used by the census – click here – but it may be appropriate to adjust those categories based on local knowledge and migration patterns. For example, the “white other” category in the census captured a wide range of groups.
and not only because the figures are now several years old. The Census categories are not always sufficiently detailed for defining the populations of diverse communities and many different communities may be included within ‘white’ population figures. Furthermore, some groups – such as refugees, asylum seekers, or Gypsy and Traveller communities – may have been underrepresented in the Census figures.

- **The Neighbourhood Statistics website** provides a wide range of population data, (including information on race and ethnicity), at national, regional, local authority, ward, and super output area level.

3. You may be able to get further information from sources including businesses, the voluntary sector, health professionals, faith groups, regeneration projects, or Gypsy and Traveller needs assessments. This is an excellent chance to make contacts and create chances to work together. Sources of more detailed guidance on mapping the local BME population can be found in the bibliography.

4. On top of the above steps, you may still need to supplement by collecting your own information. Here is a case study about an area which did just that.

**Case study: Improving Croft & Cowpen Quay (ICCQ) Partnership**

**How to use a survey to fill in data gaps**

*Black and Minority Ethnic Booster Survey 2004*

**Conducting a survey**

The survey gathered data on the needs and position of BME residents living in a borough where they represented a relatively small proportion of the total population (less than 1 per cent – approximately 800 residents). The need arose because Census data was out of date, and a previous household survey had failed to identify enough BME participants for a meaningful sample.

The ICCQ Partnership therefore worked with local partners to incorporate race equality issues into the biannual borough-wide survey of residents – the Blyth Valley Lifestyle Survey 2004.

The BME group ‘over-sample’ of 100 people, (the minimum needed for meaningful analysis), provided data for analysis between BME and white residents (but not between ethnic groups). It was done by:

- gaining support from local voluntary and community organisations to highlight where BME residents live or take part in various activities
- using ‘snowballing sampling’, where BME residents signpost the survey team to other potential interviewees
- using ‘opportunistic sampling’ to select appropriate residents for interview in busy areas or local businesses
The survey helped the ICCQ Partnership to understand and monitor the needs of BME residents and encourage greater BME involvement in Partnership activities. The evidence convinced key mainstream service providers to undertake ethnic monitoring of their service delivery and change their practices to incorporate the needs of BME residents.

Further information about this case study can be found on renewal.net

Finding out the prevalence of tobacco use within local BME populations

5. The main sources of information include:

- national and local statistics (discussed at paragraphs 12 to 17 below)
- questionnaires (surveys and in-depth interviews – telephone, postal, face to face)
- focus groups
- service user data and feedback
- external evaluations
- statutory surveys
- national and local organisations representing ethnic minority communities
- and citizen juries/panels.

National data

6. Some areas have chosen to use national smoking figures as a guide to priority customers for their services (using ethnicity as a proxy indicator).

7. The General Household Survey and the Health Survey for England (HSE) are both conducted on an annual basis. In addition to the core ground, it focuses on different key themes each year. In 2004, the HSE for 2004 looked specifically at the health of minority ethnic groups and includes a section on the use of tobacco products. The tables which illustrate the headline results can be accessed at Annex 1, page 48. They include some comparisons with the findings of the 1999 survey. (NB these surveys are based on self-reporting and caution should be exercised when interpreting this data.)

Proxy indicator – using a related indicator used to study a situation instead of direct information. This might be because there is no direct information available, or because direct information is slow or expensive to collect.

In other words, if an area houses a lot of Bangladeshi men, and national data shows that Bangladeshi men tend to be heavy smokers, it might be worth local services doing work aimed at Bangladeshi men.
8. The weakness of this approach is that it does not allow for variation in local circumstances. National data may not be sufficiently detailed to capture, for example, ‘white’ ethnicities (such as Turkish) and the ‘Black African’ grouping could mask significant variations between different communities. Mixed race may not be picked up, falling into the group “other”. So it is useful to support national data with local information.

Local information

9. As mentioned, finding local information is not only useful in itself, but is an excellent chance to develop local contacts and open up chances for working together.

10. A wealth of useful and detailed local information is published on the internet, including data on race and ethnicity. The Office for National Statistics website is an obvious source. Data may also be sourced from the neighbourhood statistics website and Nomis, which holds data right down to super output area level. This site gives you access to the most detailed and up-to-date labour market statistics from official sources for local areas throughout the UK, but may also be a ready data source for your needs.

11. **Data held by local partners:** Useful information may be obtained from the operators of existing services, through any ethnicity monitoring they carry out. This might tell you the profile of people using the service, which groups may not be benefiting and why. Other places to look include Race Equality Schemes and current policies. Also see paragraph 16 below on the future role of the Joint Strategic Needs Assessment.

Evaluations

12. You could also investigate whether current interventions have conducted evaluations that assess the accessibility and effectiveness of their approach and whether they break the findings down by equality strand (such as race disability).

Specially commissioned research

13. It can be useful to commission local research to assess needs if you are aware of particularly vulnerable people or communities living locally, e.g. refugees, asylum seekers, recently settled communities, Gypsies and Travellers. If you are aware that the voluntary and community sector are already working with these groups, this may provide a means of engaging with these groups.

14. Citizen juries/panels may be a useful forum for gathering feedback on the perception of local services. Click here for more information.

15. Here is a case study about using local surveys and proxy indicators.
Case study: Islington 2005–6

Using local surveys and proxy indicators

Using a local survey and proxies to determine population size of the Somali population

Islington PCT commissioned Cancer Research UK Health Behaviour Unit at University College London (UCL)

- to explore patterns of tobacco and qat use
- investigate attitudes towards tobacco use, Stop Smoking and a range of other health behaviours (including qat and other substance misuse) among the local adult Somali population,
- identify ways of maximising their engagement with relevant health services.

Qat (or Khat) is a stimulant derived from the leaves of the plant Catha Edulis and is chewed like to tobacco or made into tea.

One of the key challenges for undertaking this research project was determining the size of the Somali community as previous pieces of research had been inconclusive. The 2001 census found that the total population of Somalis living in Islington was 1,226. However, data from the Local Education Authority showed there to be 909 Somali children registered in schools in Islington.

A combination of national, regional and local data sets was used to determine the potential population size, including National Asylum Support Service (NASS) data, previous published literature, local authority figures (such as number of children registered in Islington schools) and contacts with local Somali organisations and housing associations.

The data below details this analysis at London and Local Authority level.

Somali population estimates (data comparisons and time periods)

<table>
<thead>
<tr>
<th>Source</th>
<th>Date</th>
<th>Population estimate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census</td>
<td>2001</td>
<td>33,831</td>
</tr>
<tr>
<td>NASS Somali applicants dispersed to London</td>
<td>2002 + 2003</td>
<td>5,770</td>
</tr>
<tr>
<td>Harris (independent research)</td>
<td>2004</td>
<td>70,000</td>
</tr>
<tr>
<td>Holman &amp; Holman (independent research)</td>
<td>2003</td>
<td>63,000</td>
</tr>
<tr>
<td>Berns McGowan (independent research)</td>
<td>1995</td>
<td>40,000</td>
</tr>
</tbody>
</table>
London Borough of Islington

<table>
<thead>
<tr>
<th>Source</th>
<th>Date</th>
<th>Population estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census</td>
<td>2001</td>
<td>1,226</td>
</tr>
<tr>
<td>School Children (registered in 2005)</td>
<td>2006</td>
<td>909</td>
</tr>
<tr>
<td>NASS cases (including families &amp; single cases)</td>
<td>2005</td>
<td>32</td>
</tr>
<tr>
<td>Islington Somali Community (personal communication)</td>
<td>2005</td>
<td>6,000–7,000</td>
</tr>
<tr>
<td>Somali Welfare Centre (personal communication)</td>
<td>2005</td>
<td>3,000–5,000</td>
</tr>
<tr>
<td>Islington Somali Community survey</td>
<td>1991</td>
<td>1,000–1,500</td>
</tr>
</tbody>
</table>

UCL estimated that, in March 2006, the Somali population in Islington was between 2,500 and 4,000 and a large proportion were less than 39 years of age (as reflected by the 2001 Census).

When undertaking the qualitative research, it was necessary to incorporate the diverse range of social, cultural and political dimensions of the Somali community and to create a sense of ownership, involvement and engagement. The following steps were taken to ensure the PCT delivered a more culturally appropriate Stop smoking Service:

- Scoping exercise to identify Somali community organisations and community leaders by such devices as exploring the Internet, investigating Islington Council’s list and talking to the community itself
- Consultation meetings with community leaders and stakeholders from the Somali community in order to fully involve them with the service design and development, through seeking comments, testing pilot questionnaires and so on
- Development of two questionnaires, in Somali and English, covering such topics as self-reported health behaviours, attitudes towards health issues and tobacco usage habits
- Eight focus group meetings were arranged with community group leaders in order to draw participation from a good cross-section of the community.

Conclusion

- It was found that cultural differences between standard methods of data collection and Somali forms of communication resulted in some difficulties in the administering of the survey. Questionnaires were best administered through the use of Somali research assistants to assist with completion.
- Collaboration with Somali organisations was an effective way to reach the Somali population in Islington, although this was likely to exclude Somalis
The future role of Joint Strategic Needs Assessment (JSNA)

16. In April 2008, a new duty was placed on Local Authorities and PCTs to work together to compile an evidence base and priorities in dealing with health needs in their area. This will be a valuable source of information. The core data set will contain information about ethnicity and smoking prevalence, and the reports will contain views from the local population.

17. JSNA guidance, published December 2007, is available here. For information about how JSNAs fit with new Local Area Agreements, read Delivering Health and Well-being in Partnership – the Crucial Role of the new Local Performance Framework.

Assessing health inequalities – the Health Equity Audit

18. One of the principle aims of improving services for BME groups is to tackle health inequalities, which is where Health Equity Audit comes in. It helps to ensure that any actions taken to improve health reduce inequalities rather than widen them. It will give you a picture of where you are at any particular time, enables you to set clear targets for reducing inequalities and to have an effective means of measuring progress. It has six steps:

1. Agree partners and issues
2. Equity profile: identify the gap
3. Agree high impact local action to narrow the gap
4. Agree priorities for action
5. Secure changes in investment and service delivery
6. Review progress and assess impact

19. The cycle is not complete until something changes that is likely to reduce inequalities markedly. Further sources of information on conducting a HEA are
20. Here is a case study related to the health equity audit.

**Case Study: Fresh Start Stop Smoking Service/Erewash PCT**

**Using a Health Equity Audit**

**Data on service uptake**

During the study period 1,297 people resident in the Erewash PCT area were recorded as having been seen by the Service. Fresh Start’s database holds a great deal of information on all service users including gender, age, ethnicity and postcode of residence (enabling assignment of service users to electoral wards of residence).

**Estimates of smoking prevalence**

Age and gender specific smoking prevalence figures for England as a whole were combined with local demographic data to generate estimated numbers of smokers in each of a number of sub-groups within the Erewash population differing in terms of gender and age. Although such a calculation will not work where there are populations with demographic characteristics which are grossly different from the national population, it is pragmatic and fit-for-purpose, particularly given that the key issue is the relative prevalence in comparison groups – men v women, older v younger, for example.

Smoking prevalence “synthetic estimates” for electoral wards were from a national DH-sponsored project undertaken by the National Centre for Social Research (NatCen). Area-based demographic predictors of smoking status were identified within Health Survey for England data for the period 2000–2002 and used to generate a model which was applied to the known (Census 2001) demographic characteristics of all electoral wards in England. Erewash PCT has a relatively small numbers of residents from minority ethnic groups (approx. 2% of total population). Thus the number of smokers in these groups will be relatively small as will be the number of service users, precluding meaningful analysis of this dimension of equity.

**Generating an Equity Profile**

The audit was particularly useful from the point of view that it generated a great deal of data, which enabled Fresh Start to compare and contrast “use” (service uptake) and “need” (estimated smoking prevalence) in different sub-groups within the Erewash population according to gender, age and residence.

**Equity of Outcome**

In this case study for Erewash PCT the overall recorded quit rate at four weeks was 69.5% (Note: service managers feel that further work is needed before they can say with confidence that outcome recording is complete – 69.5% is the current best estimate).
Equity of Outcome by Gender

Of the 1,297 clients using the service in Erewash, 902 had quit at four weeks. The proportions of male clients and female clients who successfully quit at four weeks was almost identical. An ‘outcome/need’ ratio was generated – the number of successful quitters/the estimated number of smokers. The outcome/need ratio for females (4.4%) was higher than that for males (2.9%).

Equity of Outcome by Age

The quit rate increases with age. Young people aged 16–24 have the lowest quit rate (56.9%) which increases to 82.8% for the 75+ adults. Analysis shows that this trend is irrespective of gender, with the lowest quit rates for both young males and females. The use:need and the outcome:need ratios for males and females in Erewash, by age group, that can be calculated from the data enables an understanding of where need is not being met, and the success of the service in terms of the conversion to four week quitters.

Equity of Outcome by Area of Residence

This data can illustrate the proportion of Erewash clients attending the Fresh Start service who had successfully quit at four weeks by area of residence. Quit rates across the wards in Erewash range from 56.8% in Ockbrook and Borrowash to 84% in Nottingham Road.

Service managers and commissioners agree that the audit provides Fresh Start and Erewash PCT with very useful information on service users and their outcomes. Even though the audit has only recently been completed, it allows them to ensure that when further developing the service they were working towards reducing the inequities highlighted in the report. Some of the issues raised are already being addressed, for example trying to attract more men into the service and expanding the work undertaken with young smokers in schools. It is hoped to be able to use the template on an annual basis to ensure that issues raised in this initial audit continue to be addressed.

Further information checklist:

21. Here is a checklist of further information that may help service planning:

- Local smoking targets as set through local area agreements
- Details of all local Stop Smoking and related services
- The number of local people who smoke, broken down by equality strand (such as gender, race and disability), and geographical area, in addition to ethnicity
- Risk factors and priority groups within BME communities; for example smokers with CVD and diabetes; pregnant women; people with young children
- Local people’s perceptions of existing Stop Smoking Services
- Analysis of protocols, guidelines, pharmacological interventions and guidance (such as NICE and NHS guidance)
- Data and analysis of quit rates
- Service development plans for PCT, specialist Stop Smoking services, and local health-focused community and BME organisations.
## Step 2 Targeting Services

### Summary

**Themes:**

Why target services at BME groups?

Is it best to create specific services for BME communities, or find ways to encourage them to use generic services that already exist?

What can we learn from the evidence on targeted Stop Smoking services?

What good practice examples of targeted services are available?

**Case studies:**

- **Tower Hamlets** – A successful Stop Smoking Service targeted at the Bangladeshi community
- **Burnley, Pendle and Rossendale** – an example of outreach making existing Stop Smoking Services more widely available to BME communities.

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### Why target services at BME groups?

- There are certain BME groups who have very high smoking incidence.
- Some BME groups experience particularly poor health.
- Government has set a PSA target to reduce prevalence among routine and manual smokers. BME groups tend to be over-represented in the routine and manual occupations.
- Some BME groups have well-documented problems in accessing and using services. For example, first generation immigrants, refugees, asylum seekers, and Gypsy and Traveller Communities.

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8 See *Ethnic Health Intelligence in London, The story so far*-London Health Observatory. Page 19 covers services, pages 10 and 18 health inequalities.
Is it best to create specific services for BME communities, or find ways to encourage them to use generic services that already exist?

22. There is no evidence to suggest that mainstream interventions proven to be effective with white smokers should not be successful with BME groups.\textsuperscript{9} The key is to improve accessibility. It seems likely that the simplest way is to make mainstream services more accessible. However, considering local circumstances and community views, it may be appropriate and cost effective to produce specific targeted services.

23. Here are some questions to consider on the accessibility of current services.

- Do current generic smoking services reach the people, including BME groups, who are most at risk from smoking and smoking related disease?
- Are they accessible to everyone in the local BME population? (location, language, illiteracy, transience, disability, gender and age differences, for example)
- What are the views of BME residents on services provided?
- What are the success rates amongst BME groups?
- If local people use chewing tobacco, qat, or other products, do services and local targets address this?
- Are Stop Smoking advisors trained in delivering services to smokeless tobacco users?
- Are there low levels of awareness of the health risks associated with tobacco use amongst BME residents?

What can we learn from the evidence on targeted Stop Smoking Services?

24. An excellent source of existing evidence is Department of Health’s 2003 study of the effectiveness of tobacco prevention initiatives and resources for BME people in England – \textit{Mapping black and minority ethnic tobacco prevention resources}.

25. One important lesson from that study was to make sure that targeting of particular groups was based on careful local needs assessment. Experts were concerned by the apparent focus on South Asian groups at national and local level. The rationale for this emphasis is not supported by the evidence, which suggests:

- smoking rates are only higher in one South Asian group: Bangladeshis

\textsuperscript{9} \textit{op. cit.} page 20
• closer analysis of language and literacy issues indicates only a few demographic sub-groups in South Asian communities will not be reached by English language campaigns
• although rates of CHD are higher in South Asians, it appears that these rates are not explained by smoking but by a broader range of risk factors\textsuperscript{10}.

26. By comparison, some African and Caribbean communities have high incidences of some conditions known to be exacerbated by smoking, such as stroke, diabetes, and hypertension. Furthermore, little consideration is given to the health needs of new communities, refugees, and asylum seekers. Although, as yet, there is no reliable data on these groups, the report notes that there is anecdotal evidence of high smoking rates and significant involvement with the consumption and sale of illegal tobacco\textsuperscript{11}.

27. Clearly the South Asian communities must also be reached. It is important, therefore, to have a good understanding of the profile of the local population and to focus on addressing the health needs of all of the communities who are at risk.

What good practice examples of targeted services are available?

28. \textit{Mapping Black and Minority Ethnic tobacco prevention resources} highlighted four evaluated case studies – in Tower Hamlets (see following case study), Camden, Leicester, and the Day-Mer Turkish and Kurdish Community Centre\textsuperscript{12}. A number of other BME Stop Smoking projects were, or had been, in existence, but these were mostly small-scale, short-term, and involved tailoring existing services to local BME groups. As noted above, the majority concentrated on South Asian groups. Un-evaluated projects should not be regarded as evidence, but they may be valuable in sparking ideas on how to meet identified local needs. As previously stated, services must be built on a good understanding of local circumstances and with monitoring and evaluation built in.

29. Here is one of the evaluated case studies giving an example of a targeted service.

\textsuperscript{11} \textit{Mapping Black and minority ethnic tobacco prevention resources} by Adam Crosier and Dr Ann McNeill, July 2003, page 53
\textsuperscript{12} \textit{Mapping Black and minority ethnic tobacco prevention resources} by Adam Crosier and Dr Ann McNeill, July 2003, page 48
Case study: Tower Hamlets

A successful Stop Smoking Service targeted specifically at the Bangladeshi community

The Bangladeshi Stop Tobacco Project

This was set up following publication of *Smoking Kills* and the completion of primary research indicating the need for a local BME tobacco programme. National surveys have reported that smoking prevalence in Bangladeshi men is around 40% and research in Tower Hamlets has shown that 49% of local Bangladeshi women chew tobacco in paan (a leaf wrapping which can contain spices as well as tobacco). One third of the population of Tower Hamlets is of Bangladeshi origin. Few Bangladeshi men set quit dates with the NHS Stop Smoking Services or successfully stop smoking.

The project aims to tackle barriers to accessing tobacco use by addressing language and cultural sensitivities. It has developed a community-oriented approach to address the needs of the Bangladeshi residents. It actively seeks feedback from the community and uses this to enrich the service delivery model.

The expectation is that clients will be contacted and supported in locations and ways that help them to feel most at ease. This includes:

- being supported by a gender specific project worker
- providing home visits to women and the elderly
- holding regular drop-in sessions
- using language of preference
- offering support, understanding, and Nicotine Replacement Therapy.

The project accepts referrals from GPs, practice nurses and other health professionals. There is a 24 hour client recruitment telephone line, which is advertised through leaflets and a website. It also gains clients and publicity by participating in local community events.

There have been positive results, with the project achieving higher quit rates than the national average (63–66% through 2004–06) in what tends to be regarded as a ‘hard to reach’ group.

30. The second case study concerns a current service which was adapted to be more accessible.
Case study: Burnley, Pendle and Rossendale

Example of outreach making existing Stop Smoking Services more widely available to BME communities.

Smoking Cessation Ramadan Project and Health Promoting Ramadan

This project demonstrates how engaging with a local faith community can help to target existing interventions at BME residents with particularly high rates of smoking and improve access to Stop Smoking Services.

Background and rationale

The Burnley, Pendle and Rossendale district has a significant BME population – 36,000 out of a total population of 240,000 – 15% of which are of Pakistani and Bangladeshi origin.

Nationally, smoking rates for Bangladeshi men are estimated as being much higher than the general population and research has found that smoking is more socially acceptable in Bangladeshi and Pakistani men. Furthermore, research by the HDA in 2000 found some BME groups have lower levels of understanding of the health risks associated with smoking and less success in giving up smoking. Analysis of local Stop Smoking Service data showed that the number of people from BME groups in Burnley, Pendle and Rossendale who have been accessing services was low.

Aims and objectives

These factors led to a campaign to improve access to Stop Smoking Services by members of local minority ethnic groups. Its objectives included:

- raising awareness of the dangers of tobacco smoking and chewing
- achieving strong partnerships with Imams, committees of the Mosques, and other relevant agencies
- getting ethnic minority smokers to sign up to Stop Smoking services
- setting up specialist clinics for members of the community requiring Stop Smoking intervention
- using the month of fasting as an opportunity to help and support the Muslim population to give up smoking.

Carrying out the project

An action plan was developed following consultation with the local Muslim community. This involved:

13 Crosier and McNeill, op. cit.
• producing Ramadan calendars for each Mosque, which included messages on the dangers of tobacco use and contact details for the Stop Smoking Service
• awareness sessions for the Mosques
• a specialist leaflet printed in Bengali and Urdu
• events to launch and evaluate the project
• press releases and broadcasts on Radio Ramadan.

Six out of 18 local Mosques agreed to participate. All of these were visited and the Imams delivered prepared sermons on the dangers of tobacco. Advice and leaflets were given to smokers and some had their carbon monoxide readings taken. Some people agreed to attend drop-in clinics.

Developing the project
In 2005, the project was broadened to a general health remit, and was renamed Health Promoting Ramadan

The work involved:
• training prominent people from the Mosques who could then pass information to their congregations
• summarising this information in a booklet, which was aimed at second generation residents in the hope that they would then relate this to families, friends, and colleagues
• interview slots on Radio Ramadan, which promoted the campaign and information booklets
• outreach to Mosques and GP surgeries.

Learning from the projects
• it does not tend to be beneficial to visit Mosques on a Friday, as this is their busiest time and many people are in a hurry to leave
• female advisors may not be allowed into the Mosques
• consultation on the campaign needs to start several months before Ramadan (at least 6 months)
• literature should not include facial images as these cannot be displayed in Mosques
• the need to provide culturally appropriate smoking Stop Smoking clinics and to explore ways of encouraging more women to access services
• drop-in clinics tend to have the most success
• group work sessions are possible, but are more acceptable with people of the same age and sex
• many smokers from the Bangladeshi and Pakistani communities do not want help to stop smoking.
Step 3 Service Delivery

Summary

Themes:
- How can services engage with BME communities?
- How do we ensure the services are effective?
- How can we make it as easy as possible for people to find out about and attend the service?
- How can we promote services?
- How can this work be linked with local targets?
- Health trainers
- New migrants from European Union states

Case studies:
- **London** – Showing lessons learnt related to community engagement
- **Harrow and Stanmore** – Showing the benefits of providing services in alternative settings
- **Islington** – Engaging the Turkish community, and using alternative settings for treatment
- **Waltham Forest** – Using a media campaign to encourage referrals
- **Newham** – Engaging the local Muslim community
- **Birmingham** – Stop Smoking Film for the Bangladeshi Community – You CAN Do It
- **Westminster City Partnership** – Local Area Agreement – smoking cessation ‘stretch’ targets for BME communities
- **Enfield and Haringey** – Challenges in engaging the Polish community.

31. Successful Stop Smoking Services engage the community that is being served. Regular consultation with BME and faith communities will allow you to develop an understanding of how services might be perceived by users and determine the interventions required for different age groups, genders, cultures, and religion or belief. It will also enable you to engage local advocates of the services.
How can services engage with BME communities?

32. Developing links with communities can take a long time, and you may need to plan this well in advance of the start of a project. The following may provide starting points:

- make use of existing networks – Sure Start, regeneration projects and healthy living centres are already working with communities and can help to identify and build links with appropriate representatives
- local schools can also be useful – they are often the focal point of a community and can be a way to engage parents in health-related projects/events
- community and religious leaders can be useful entry points into some hard to reach groups – however, you should continue to develop contacts to ensure that you reach groups directly as well as using the assistance of community leaders.

33. Further suggestions are included in the case study below. For a comprehensive and evidence based guidance on community engagement, see the NICE community engagement guidance published February 2008. More information is available on the Communities and Local Government website.

Case study: London

Showing lessons learnt related to community engagement.

The Inequalities Collaborative – stop smoking focus

This was a time limited exercise to test the effectiveness of applying the collaborative methodology to reducing health inequalities. A ‘collaborative’ is an effective method of implementing evidence-based practice across multiple sites through the sharing of experience and knowledge of others in a similar setting, over a short period of time. The first topic was Stop Smoking Services and the goal was to increase the number of people who quit smoking by accessing evidence based help. The work therefore draws on lessons from a wide range of experience.

The aims of the project included:

- developing and spreading innovative approaches to stopping smoking based on the best available evidence of what works in the short and longer term
- effectively engaging with and empowering clients by involving smokers and their supporters in the project groups

14 http://qshc.bmj.com/cgi/content/abstract/16/6/409 Barriers and facilitators to the implementation of the collaborative method: reflections from a single site, P J Newton, E J Halcomb, P M Davidson, A R Denniss
addressing inequalities by increasing the number of quitters from hard to reach groups.

It involved nine PCTs from across London, each with a team of 10 from a range of services. Each team agreed a local topic area relating to smoking and inequalities, including projects looking at BME groups.

The collaborative approach

Each team attended a series of four learning workshops in 12 months, to become familiar with the collaborative methodology and to share good practice. (For more general background on the collaborative method, this paper from the Royal Australian College of General Practitioners provides a good survey)

Work by other collaboratives suggests a project site is more effective if:

- it links across a wide range of agencies
- there are community team members involved
- it is supported by a high level steering group within the organisations (with the support of the chief executive).

Learning from the project

A review was carried out to capture the key learning points generated by this programme. This involved interviewing participants about their experiences.

Some of the key points that were identified are:

- for several of the projects, the main impact has been on raising awareness of Stop Smoking Services amongst ‘hard to reach’ groups
- working with ‘hard to reach’ groups is easier when strong community networks are already in place – it can be better to work through existing programmes, rather than to try to develop new ones
- the projects made use of a variety of ways for Stop Smoking Services to engage with local communities and ‘hard to reach’ groups, including working with regeneration and Sure Start programmes, and taking part in school events
- the work of the collaborative reinforced the need for a long term approach to tackling health inequalities. It has also shown that services can achieve results in a shorter timescale by identifying the populations that are not using their services, engaging with a range of organisations, working through community organisations, and listening to ‘hard to reach’ groups
- it is important to engage with the local community at the earliest stages of the project and to continue to encourage their involvement throughout the process – they may need incentives and awareness that their contribution is being valued
• the Smoke Free Homes initiative (being piloted in two areas) can be a useful approach – the focus on protecting children is an easier message to communicate, particularly for community health workers who may feel uncomfortable about tackling people about smoking
• young people may not associate Stop Smoking Services with other tobacco related products – this needs to be considered when services are being developed
• using people from the local community and ‘hard to reach’ groups as advocates and training them as Stop Smoking advisors has helped to develop awareness and knowledge of services, build confidence to use those services, and strengthen local networks
• although the collaborative gained a lot of knowledge, it was noted that more could have been learned if systematic evaluation had been built in right from the start.

Several of the individual projects have been included as case studies in this document. Further learning points can be found in these.

How do we ensure the services are effective?

34. Two key elements are clear targets, and partnership working.

35. From the outset, all partners must work towards clear, measurable, targets. This provides a focus for the project. You also need to make arrangements to regularly gather information and feedback from users. For more information, see chapter 4 on monitoring. Visibility of both national PSA targets, and any agreed tobacco targets in the local area agreements, can be helpful in this respect.

36. Before new services are developed or established services are changed, you should determine:

- a baseline
- what you want to achieve and by when (final target and end date)
- interim targets and milestones
- who you are trying to reach (specific communities and areas)
- how success will be measured, evaluated, and reported
- how/when progress will be monitored and reported
- how data will be collected
- how interventions will be used
- who will be involved (partners and community groups)
- who is responsible for driving delivery
37. Multi-agency partnership working can help you to deliver effective services and projects. *Excellence in Tobacco Control: 10 High Impact Changes to achieve tobacco control* will identify partnership working as the first and most important high impact change for better tobacco control. The London Inequalities Collaborative found that the following factors could be identified in projects where the multi-agency working was deemed ‘successful’:

- there had been a clear and ‘local’ focus to the project and the team
- there had been a focus on areas where community engagement initiatives, links and networks were already in place
- different agencies had a common focus on the same ‘hard to reach’ populations and Stop Smoking was a shared target
- Stop Smoking services had been engaged with and were supportive of the project, without it necessarily being driven by them, and there had been a high level of support from the project director\(^{15}\)

How can we make it as easy as possible for people to find out about and attend the service?

38. Successful Stop Smoking support is time critical. The right time is whenever an individual smoker decides to give up. So the service needs to be easily available at that point.

39. General improvements to services are likely to increase response from BME groups, such as a welcoming atmosphere, and extended opening hours. You could also consider the following specific points:

- providing information and advice in different languages, and/or providing access to translators. Translation is not a universal solution, as some groups may be able to use material in English, but it can be helpful, particular with first generation immigrants.
- considering audio and video communications as well as written
- providing specially tailored sessions – by gender, age group, etc.
- providing mobile services, such as a health bus
- making use of range of settings – health settings like pharmacies and dentists, community settings like community centres or churches, or, after prior agreement, on Gypsy and Traveller sites where accompanied by local members of the Gypsy and Traveller community

40. Here are two case studies about providing services in alternative settings.

\(^{15}\) Review of the London Inequalities Collaborative Stop Smoking Focus Handbook, page 4
**Case study: Harrow and Stanmore**

**Showing the benefits of providing services in alternative settings**

**Outreach clinics in a local mosque**

A local pharmacist carried out an initial visit to the mosque and gave a presentation on the dangers of smoking and the help available. They followed this up with regular visits over a five week period to provide clients with stop smoking advice on a one to one basis.

The local stop smoking advisor explained that “by taking the service to people you reduce the number of hoops people have to jump through in order to stop smoking”. People were found to be very receptive to the service, once they realised that other people cared about their health.

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**Case study: Islington**

**Engaging the Turkish community, and using alternative settings for treatment**

**Turkish stop smoking project**

This project was established in March 2000 to provide community based smoking education and Stop Smoking support to the Turkish speaking communities of Camden and Islington. Its key objectives were:

- to develop culturally appropriate stop smoking resources
- to develop Stop Smoking services to both individuals and groups
- to identify innovative ways of encouraging smokers to quit
- to advertise services to the community

It was launched in the 3 main Turkish Community Organisations within the London borough of Islington: IMECE (Turkish Speaking Women's Group), TEG (Turkish Education Group) and Turkish Cypriot Community Centre. Research into the Turkish communities in Camden & Islington indicated that 57% of the adult population smokes an average of 17 cigarettes a day (Camden and Islington Health 1996). This is higher than the national average of 28% (DOH 1998).

Each organisation employed a part-time Stop Smoking advisor who worked 6 hours per week, making a total of 18 hours per week. The advisors accessed clients in community settings other than primary care and adopted a pro-active approach taking services directly to the clients rather than waiting for clients to approach the service. Due to the Advisors’ knowledge of local communities, the publicity was targeted at key areas within the community, where many Turkish-speaking people congregate (e.g. Turkish cafes, events etc).
Brief opportunistic advice was offered to smokers who the advisers saw on a casual basis. This may have been through a planned health or community event or discussions with individuals at community centres. The advisers also provided one-to-one behavioural support and made recommendations about Stop Smoking aids.

In 2001, the first Stop Smoking clinic for Turkish speakers was launched to provide intensive group support to smokers who wished to stop smoking. A health centre location for the clinic was chosen for the convenience of the community and was in easy travelling distance to where Turkish communities live.

Leaflets, posters, cards and other stop smoking resources were translated into Turkish. Many resources included cartoon designs, which were found to be popular amongst the Turkish community. A Turkish freephone telephone line was also provided, which allowed clients increased access to the service.

Results

The success rates of clients attending one-to-one sessions and group clinics were similar to those of mainstream Stop Smoking Services. One stop smoking group was run every 3 months from February 2001. The overall success rate of 4-week quitters who attended the clinic was 63%.

This outcome is viewed by the organisers as a great achievement when taking into account the perception that Turkish speaking communities will achieve lower success rates.

How can we promote services?

41. Referrals from other agencies can have a significant impact. Try making use of the following:

   • local hospitals and health networks – particularly those specialising in CVD, cancer, and diabetes
   • Sure Start services and regeneration schemes
   • all primary care staff and other health professionals

42. You could also use communications and media campaigns. For example:

   • using local faith communities and employers to promote services
   • local press and locations where people are likely to see promotional material (libraries, community centres, cinemas, shopping centres, etc.)
   • through local radio and satellite television channels, which have regular health promotion messages in local community languages
43. The following case studies illustrate the benefits of using a range of media to reach the targeted audience.

**Case study: Waltham Forest**

**Using a media campaign to encourage referrals**

**Multi media campaign**

This campaign was used to encourage referrals to the Stop Smoking Service. It ran from January to March 2004 – to coincide with New Year & No Smoking Day.

The following approaches were used:

- Full page spread in local newspaper
- Full page advertisement in a local magazine, which is delivered to every house in the area
- Broadcast on GFM radio, advertising the Stop Smoking Service in different African languages
- Leafleting at tube stations
- Bus adverts (both inside and out)
- Billboards at railway stations
- Mailouts to NHS staff, local businesses, voluntary groups, community groups, dentists, opticians, pharmacists etc
- Staff emails

The campaign led to a good recognition of the smoking services logo and hotline number. The service received approximately 2,000 referrals between April 2003 and March 2004, which meant that the PCT reached its 4 week quit target. (Referrals from health professionals, especially in primary care, accounted for more than 85% of the referrals.)

It was noted that the more expensive advertising approaches (e.g. billboards, bus advertisements) did not work.¹⁶

¹⁶ Example taken from Inequalities Collaborative London, stop smoking focus handbook
44. Here is a case study where a variety of approaches, including community based and media, were combined to engage the Muslim Community.

**Case study: Newham**

*Engaging the local Muslim community*

A household panel survey is undertaken in Newham each year. The first wave of this survey (2002–3) indicated that, at 25%, the overall prevalence of smoking in the borough was much less than previous estimates. However, there were marked differences when the figures were broken down by gender and ethnic group; for example, 45% of Bangladeshi men were found to be smokers compared to 1% of Bangladeshi women. Therefore, some thought was given to how this community could be engaged by the local Stop Smoking service. Several approaches have been used.

**Working with Imams and local groups**

They started by getting a local Imam on board. He also works for the local acute trust (Newham University Hospitals NHS Trust) as a Multi-faith Manager. With his help they spoke to local mosques, offering them the opportunity to learn more about smoking and health, and Islam and smoking. They then ran workshops within a few mosques. In these, the PCT Stop Smoking Team talked through the issues in relation to smoking and health and the Imam talked about Islam and smoking.

During the workshops, advisors gave out questionnaires and talked to participants about the current services available in order to determine what was needed. The workshops were also used as the basis of a leaflet for the community, which clearly set out the implications of smoking. They have received very positive feedback on this leaflet from mosques and other PCTs have used the information contained within it to develop their own for their communities.

They also held a meeting to discuss ways of further engaging with the local community. The main leaders from some of the local mosques and relevant voluntary groups were invited. This was used to gain their views and ideas on approaches that could be used. They have remained involved in this work.

**Recruiting and training local people**

In 2005, six advisors were recruited from the Muslim community to further support the work, and they were trained to deliver stop smoking support. They were primarily recruited for the Ramadan campaign and their role was to visit mosques during the busiest periods and offer advice, information and referral to services. During the Ramadan period they had over 180 referrals to the service.

Using male advisors has meant that Muslim men seem much more willing to talk about their smoking. Many have built up good relationships with the advisors, leading to increased use of the service. It has been particularly beneficial that these advisors speak many of the languages spoken in local communities, and this has further broken down some of the barriers that may have initially existed.
Since Ramadan 2005, the advisors have been trained to provide both one-to-one and group support. They have run stop smoking groups specifically for Muslim men and attendance is increasing.

**Cinema and radio advertising campaigns**

Cinema advertising has been used to target Asian communities in the area. The local Bollywood cinema advertised Stop Smoking Services in a slide that appeared before the main feature and during the interval.

The radio broadcasts were carried out during Ramadan on a station that only broadcasts throughout the holy month. The brief advert went out in both English and Urdu. They also did a live phone in show taking questions from callers about smoking.

**Results**

Overall, since 2003, the service has seen an increase in the proportions and overall numbers of men from Bangladeshi, Pakistani and Indian backgrounds accessing the service in 2003.

- The service uptake rate for Bangladeshi men increased 25.1 per 1,000 smokers in 2003/04 to 51.4 per 1,000 in 2004/05.

Here is another excellent case study from Birmingham on a film used to target the Bangladeshi community.

**Case study: Birmingham**

**Stop Smoking Film for the Bangladeshi Community – You CAN Do It**

**1. Background**

Local experience in Birmingham mirrors national findings of high levels of smoking among Bangladeshi men, and tobacco chewing among women. Of the 1,109 smokers who have successfully quit at 4 weeks (January – March 05) through the provision of a drop in service (Boots) in the city centre, only 1 was Bangladeshi. Overall the number (%) of Bangladeshi smokers (2%) who have accessed the PCTs stop smoking services are low compared with the number which might have been expected based on the 2001 census figures (7%).

Language barriers and poor literacy, together with the style and content of general public education, mean that national smoking campaigns have little impact on this group. Many remain unaware of key messages, are not motivated to give up, nor are they aware of what Stop Smoking Services are available.
Despite the Heart of Birmingham PCT establishing specific Stop Smoking Services for BME communities, the number of self referrals from Bangladeshi communities remains relatively low.

2. The process

Dr Jacky Chambers, Director of Public Health, Heart of Birmingham Teaching PCT together with the local Stop Smoking Service and local BME health promotion consultant developed a proposal to increase the number of Bangladeshi smokers who are motivated to quit in the first instance.

A grant proposal submitted to the Pfizer UK Foundation brought set up funding to help produce a smoking cessation film specifically targeted at the Bangladeshi community. Additional PCT funding was used to edit, launch and promote the Bengali film facilitated by Smoke Free Birmingham.

The Bengali drama film, ‘You CAN Do it’ tells the story of a young man who, despite suffering a heart attack, continues to smoke until he is prompted to stop by realising the effect that his actions are having on other people, especially his young family.

Smoke Free Birmingham has experienced strong support from the Bangladeshi business leaders and community organisations, in particular their work with restaurant owners to prepare them for 1 July smoke free legislation.

3. Objectives

1. Consult with Bangladeshi Community organisations to design and create effective “stop smoking” brand:
   - Logo and art work
   - Posters and leaflets

2. To enrol Bangladeshi Community and Religious leaders to create a culture, which acknowledges that smoking is a problem within their communities and does not support a smoking environment.

3. In consultation with local Bangladeshi Community organisations arrange the following:
   - Bangladeshi Press “Stop Smoking” advertisements
   - Radio XL/Unity radio discussion programmes sharing true experiences of members of the community who have quitted
   - Radio XL advertisements
   - Events with Community Organisations e.g. Eid Milan, Park Music and cultural events and festivals
4. To instigate a “Stop Smoking” Art and drama project:
   - Mobile Drama Road Show to go in to health centres, leisure centres, libraries, youth clubs etc.

5. To evaluate the effectiveness of the project:
   - Qualitative evaluation from focus group and individual semi-structured interviews with members of the community, community organisations and Stop Smoking Advisors

4. Film development

The Bengali film was produced using local actors and community members who spoke Bengali and also intermittent English (especially children). English subtitles were included to maximise the message to all age groups.

5. Launch of film

A series of project meetings to implement launch of film to include maximising attendance of target audience:

**Date:** Launched 16 March 2008, in the same week as No Smoking Day. No Smoking Day is a Wednesday, but the community preference was for the film to be shown on a Sunday from late morning onwards when all family members could attend and restaurant workers would be able to attend at either of the scheduled performances.

**Venue:** Liaison with local community members identified several options and most appropriate venue chosen was the Bangladeshi Multi-Purpose Centre, Aston, Birmingham.

The main hall was set up to accommodate over 100 people with a professional sound system.

**Speakers:** PCT Chairman agreed to open the launch

Local Councillors invited and Councillor Islam MBE agreed to give keynote speech

Chairman of Bangladeshi Restaurant Association also agreed to give a speech

**Invitations:** Issued 80 invitations to restaurant owners

Issued over 100 invitations to Bangladeshi organisations listed in Bangladeshi Council profile (2001) publication

Generic invitations distributed by hand by means of community liaison officer
### Promotional material:
- A3 Posters circulated by means of community liaison officer
- Flyers circulated by community liaison officer
- Photographs of the main actors used in promotional posters and leaflets
- Two promotional pull-up banners (reception and stage areas)

### Programme:
Programme agenda included timings of film showing (11 am and 1 pm)

### Resources:
Local Stop Smoking Services attended with two stop smoking advisors – both Bangladeshi

### PR/Media:
- Photographer booked to attend film launch
  - Unity FM – one hour drive time radio session with live phone in
  - 30 second TV advert on Channel S TV week before launch

### Refreshments:
A buffet lunch provided

### Giveaways:
A Smokefree Birmingham drawstring bag that contained a film leaflet together with Stop Smoking Service information was placed on each seat for audience members to take away. Evaluation sheets were also placed on each seat.

The drawstring bag advertising the telephone and text contact numbers of the Stop Smoking Service.

### 6. Evaluation
The audience was invited by the key speaker to complete their evaluation sheets and provide comments on the film. Around 40 evaluation sheets were collected and comments noted.

The 40 evaluation sheets taken from this first public showing of the film were extremely positive, giving a clear signal that this type of approach was appropriate and useful in getting across the key health message of stop smoking. Here are just two examples:

“**A great film, I hope every corner of the country can benefit from this and all the Bengali community.**”

“I found this film very beneficial for our community. This visual showing of the DVD is giving the message that you can stop if you want to, and it is not too late (which is a misconception). However, very good.”
Heart of Birmingham PCT believe they have seen an increase in the number of Bangladeshi men self-referring to the local Stop Smoking Service due to a focus on this particular population group. They anticipate an increase in awareness of the harm of smoking tobacco amongst Bangladeshi families due to the dissemination of the film across the city, together with increased to referral rates to the local Stop Smoking Service in the next 12 months.

For more information, visit [www.smokefree.org.uk](http://www.smokefree.org.uk), or email info@smokefree.org.uk. The film ‘You CAN Do It’ should be available on the website soon.

How can this work be linked with local targets?

46. PCT Local Delivery Plans will have smoking targets.

47. Local Area Agreements (LAAs) may also contain smoking targets. National indicator 123 from the National Indicator Set is the current smoking rate prevalence for the over 16 age group. Many local areas may choose to include smoking in their set of up to 35 national priorities relevant to the local area and agreed with central government. Even if they decide not to, a smoking target could be included as a local priority, and this would receive the same amount of weight in performance management. There would be an opportunity here to include a target related to hard-to-reach groups, including BME groups.

48. For more information about new Local Area Agreements, here is the link.

49. The following case study, although it concerns LAA targets set up under the old system, could be useful in setting local targets under the new LAA system.

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**Case study: Westminster City Partnership**

**Local Area Agreement – smoking ‘stretch’ targets for BME communities**

In 2004/05 the Westminster PCT Stop Smoking Service supported 1,362 individuals to stop smoking, of which 335 were from the local BME community. This was achieved through specialist stop smoking support, community pharmacists, and GPs and practice staff.

To build on this work, the Westminster City Partnership has included stretch targets in the Healthier Communities and Older People block of its Local Area Agreement. This is designed to target services to BME communities (particularly the Bangladeshi community) and building capacity for smoking related services within these communities and local partners. Work includes:

- training Stop Smoking advisers from BME & faith communities

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17 See *The New Performance Framework for Local Authorities and Local Authority Partnerships*. Indicator 123 reads ‘16+ current smoking rate prevalence PSA18’.
• leaflet translation and production
• increased publicity
• community initiatives to raise awareness of the services and the dangers of tobacco
• highlighting the harmful effects of second hand smoke
• funding of NRT products\(^{18}\)
• per quitter payments for community based advisors (in line with the current stop smoking payment structures for GPs and pharmacists)

The following detail sets out the form the stretch target that Westminster used. The target makes it clear that reward grant for the stretch target would not be paid unless the overall target for Stop Smoking Services was met.

**Target 11**
Reduction in the prevalence of smoking within BME communities.

**Indicator by which performance will be measured**
Indicator 4.35: Number of quitters at 4 weeks:
*The number of people reporting to NHS Stop Smoking Services who had set a quit date and who are confirmed as not smoking 4 weeks after their quit date and are from a BME community.*

Indicator 4.36: Number of quitters at 52 weeks:
*The number of people reporting to NHS Stop Smoking Services who had set a quit date and who are confirmed as not smoking 52 weeks after their quit date.*

Source: NHS Stop Smoking Service data

**Current performance (2004/05)**
Indicator 4.35 335
Indicator 4.36 Baseline to be established by 30 September 2006 using 2005/06 full year data from NHS Stop Smoking Services.

**Performance at the end of the period of the Local Area Agreement (2008/09)**
Indicator 4.35 1450
Indicator 4.36 1% increase on established baseline

\(^{18}\) NRT should be prescribed in line with NICE public health guidance 10 on smoking cessation.
Performance expected **without** the Reward Element
Indicator 4.35  1381
Indicator 4.36  No increase from established baseline

**Performance target with** the Reward Element
Indicator 4.35  1450
Indicator 4.36  +1% on established baseline after three years

**Enhancement in performance with** the Reward Element
Indicator 4.35  69
Indicator 4.36  +1% on established baseline

**Allocation of Performance Reward Grant**
Indicator 4.35  50%
Indicator 4.36  50%

**Notes:**
The measurement period for this target is 01/04/2006 to 31/03/2009. To be eligible for PRG, Westminster must ensure that the non-stretch target against indicator 1 of 1,950 for the population as a whole as specified in the local delivery plan is reached. *No PRG will be payable in respect of four week quitters if the performance for Westminster as a whole is less than 1950 in 2008/09.*

The baseline for indicator 2 must be established by 30 September 2006 and relate to 2005/06 full year data. The baseline will represent those 4 week quitters responding positively to a follow up survey at 52 weeks as a proportion of the total number of 4 week quitters (and not as a proportion of respondents to the survey).

The data for NHS Stop Smoking will be collated on a quarterly basis, one quarter in arrears throughout the period April 2006 to March 2009. The claim for the PRG can therefore only be made after this date.

Westminster Primary Care Trust interpretation of BME groups is any group other than White British (Census categories). This target will however focus on the most deprived BME groups such as the Bangladeshi community. The identification of a BME participant will be by a process of self-selection of a category by the participant.

The number of smoking quitters for the reward enhancement for both targets is expressed as a cumulative total.
Health trainers

50. Health Trainers is a service well suited to support those from BME communities to stop smoking. Introduced in 2005, the Health Trainer service provides one-to-one advice, motivation and practical support to individuals in their local communities to help them change their behaviour.

51. There are currently more than 115 Health Trainer services across the country with more than 1,200 qualified Health Trainers employed in NHS, voluntary sector or private sector organisations. They are based in a wide range of community settings often at the heart of many BME communities, including schools, faith centres, supermarkets, community facilities. Where appropriate Health Trainers are recruited from local communities as their knowledge, language skills and visibility can help in working with traditionally hard-to-reach groups.

52. Health Trainers can work directly with clients on smoking, refer them to Stop Smoking Services, or deal with related issues like low self esteem and confidence.

53. If you do not know whether there is health trainer scheme in your area, you can contact the PCT. Examples of Health Trainer services which recruit from and support BME Communities include Rotherham Health Trainer Service website and Bradford District Health Trainer Service.

New migrants from European Union states

54. There is anecdotal evidence that migrants from European Union accession states have high rates of smoking, but limited information or best practice available as yet on working with these groups. One important point is that in monitoring and assessing the population it is important to use more detailed categories than just ‘white other’, to work out exactly what communities are present.

55. Here as an example of working with these groups is a case-study from Islington of a programme which achieved its principle aims, but has less than expected engagement from the Polish community.
Case study: Enfield and Haringey

Challenges in engaging the Polish community.

Enfield and Haringey PCT commissioned a piece of work to get greater uptake of Stop Smoking Services in a particular part of Haringey. As the area is home to a large Polish community, it was noted that providing this service may also improve engagement with the Polish community. Although the project was successful in attracting more clients, the service did not significantly increase use of the service by the Polish community.

Enfield and Haringey PCT commissioned Innovision Healthcare to manage the stop smoking work carried out by advisers in local GP Practices and as part of this work. Innovision took it upon themselves to use the premises of a Haringey GP Practice to offer a new stop smoking clinic available to all but particularly catering to the needs of the local Polish community by providing a Polish speaking adviser.

The clinic runs from 9 to 12 on a Saturday morning. Previously, clinics had only been available on week days. The service was advertised in a local Polish Newspaper and on the GP practice premises and was promoted during calls to the Enfield and Haringey Stop Smoking Service.

The Saturday morning service achieved a significant increase in uptake and continues to do so. However, the interest from the Polish community was minimal.

Possible lessons learnt:

- Extended opening hours is a useful tool
- Setting up a service in a specific area is not sufficient to increase uptake by a particular target group. A more strategic, directed approach would be needed to achieve this.
- A variety of channels are needed to advertise the service to a particular community
Step 4 Monitoring and Evaluation

Summary

Themes:
Checklist of the stages of evaluation

56. **Evaluating projects and services is an integral part of delivery.** It can help to improve performance and build capacity, and makes it possible to demonstrate the success of the project. It needs to be considered at the planning stage of any project, as part of setting the objectives. Another key benefit of evaluation is that it results in verified best practice that can be shared with others.

57. Stop Smoking Services generally have a high level of monitoring and evaluation. Stop Smoking managers will be aware of Department of Health’s Gold Standard Monitoring form, which invites recording of ethnicity. The categories are not broad enough to pick up a range of white ethnicities.

Checklist of stages of evaluation

58. The following paragraphs set out the basic elements of the evaluation process as a reference, and highlights points relevant to BME groups.

*Step 1: establishing the purpose of the evaluation, and who is accountable for it*

59. This work needs to be at the planning stage of a project. The evaluation can have many purposes. A key purpose of the evaluation will obviously be to measure progress against objectives, according to the success measures which have been set. But other purposes could include opportunities to improve management processes or share information with stakeholders. Key questions to consider include:

- What are you evaluating, why and for whom?
- When will the evaluation be done?
- How much will it cost?

Monitoring means – gathering regular factual information which allows you to make day to day improvements to service performance.

Evaluation means – using monitoring and other information to assess the longer term value of the activity.
• Who will carry out the evaluation?
• Who will be responsible for making sure evaluation happens?

60. Success measures will need to be determined to measure performance. In doing this, it would be sensible to consider both the quantitative and qualitative aspect of the service. Examples of each would be related to BME groups might be:

Quantitative:
• Are more people from the targeted BME groups accessing services?
• Do you have registers of all forms of tobacco use in all targeted groups?

Qualitative:
• Is there an improved awareness of the dangers of tobacco?
• What do users from all diversity strands think of services?

Step 2: write up a monitoring and evaluation plan

61. This plan should set out:
• Aims and objectives – be clear about what you want to know
• Conceptual framework
• Action plans – with a detailed plan for the next 12 months and an outline of what you want to achieve over the longer term, setting out how you will monitor and collect information.
• How you will report on and disseminate your findings

Step 3: implement the plan

62. Though the evaluation may take place later, the monitoring systems will need to be in place from the beginning of the project.

63. Your clients and your partners are an essential element of the evaluation process, so it is important to ensure that the information gathering process is open and transparent. Keeping the client group informed of what’s going on will give them a sense of contributing to the success of the scheme, will foster a positive attitude and stop the feeling that they are being observed.

64. You can find excellent advice on how to undertake evaluation at renewal.net. In particular, there are two documents on How to plan and manage an evaluation and How to evaluate a project.

65. For more ideas on methodology, you could look at an Evaluation of pilot project on smoking cessation services in prison – November 2002, available on the Department of Health website at the following link, under the title ‘Public Health’.
Conclusion

66. The document has aimed to demonstrate how organisations across the country have done a wide range of innovative work to deliver Stop Smoking Services to BME communities. Hopefully this work will inspire others working in the same field.

67. A particularly important message to take away is the powerful impact that organisations can have when they work together. A Stop Smoking service working in partnership, with an overall framework of wider tobacco control, can make a real difference to health inequalities in this country.

68. If you want further information on this document, or have any feedback, please send an email to contactus@communities.gov.uk or call 020 7944 4400.
Bibliography and useful references

Key documents

On tobacco control:


On Stop Smoking Services:

*Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities*. NICE public health guidance 10 (2008)

On partnership working:

*Delivering Health and Well-being in Partnership – the Crucial Role of the new Local Performance Framework* (Communities and Local Government and Department of Health, 2007)

Step 1: Mapping

For an overall picture of ethnicity data in the UK, try:

www.statistics.gov.uk/focuson/ethnicity/

Smoking levels in BME groups:

*Health Survey for England 2004* (The Information Centre, 2006)

*Health Survey for England 1999* (Department of Health, 1999)

For levels of smoking attributable mortality:


For general guidance on ethnicity monitoring see:

*Ethnicity Monitoring: Benefit and Ethnicity Monitoring: Involvement* (Neighbourhood Renewal Unit, 2004)

For a health and social care oriented version:

*Practical Guide to Ethnicity Monitoring in the NHS and Social Care*, Department of Health, 2005
Two guides on data are available from ORRION:

**Online Race Resource for Improving Outcomes in Neighbourhoods** include Accessing and using data and A guide to ethnic monitoring data sources (for health): monitoring floor and local targets.

New Deal for Community surveys – each NDC will have information derived from a national MORI survey (see www.mori.com)

London Health Observatory Tobacco Page

**Step 2: Targeting**


“evidence can form part of all decision-making processes (and) … once an agenda for tackling inequalities is agreed, evidence for specific and effective interventions can be sought and built upon. However, using evidence as a starting point will narrow the agenda, leave existing patterns of core services unchanged, vested interests unchallenged and counter local processes for democratic decision-making”.

**Tackling health Inequalities for Minority Ethnic Groups – Challenges and Opportunities** (Gurch Randhawa for the Race Equality Foundation, July 2007)

Renewal.net has a large number of smoking related materials that might be helpful, including a ‘solving the problem’ document entitled *Smoking Cessation*. This points to a series of evidence based Stop Smoking guidelines that have been produced, many of which are on the ASH website.

**CIEH ASH briefing paper on Local Area Agreements and smoking prevalence**

**Step 3: Service delivery**

Inequalities Collaborative – stop smoking focus

**Handbook: and Review**

Translations – Here is the link to the booklet Stop Smoking, Start Living in a wide range of languages:

http://gosmokefree.nhs.uk/quit-tools/downloads/

Further case studies on working with Race and Faith from the Asian Quitline can be found at this link:

Step 4: Evaluation

Renewal.net contains a range of sources of information and guidance that might be helpful, including:

How to plan and manage an evaluation

www.renewal.net/Documents/RNET/Toolkit/Howplanmanage.doc

How to evaluate a project

www.renewal.net/Documents/RNET/Overview/How%20To/Howevaluateproject.doc

*Evaluation of pilot project on smoking cessation services in prison – November 2002* (Susan MacAskill and Douglas Eadie) available on the Department of Health website at the following link, under the title ‘Public Health’.
Annex 1: National data on tobacco use broken down by gender and ethnic group, from Health Survey for England 2004

These are available at: www.ic.nhs.uk/pubs/hlthsvyeng2004ethnic/HSE2004Headlinerresults.pdf/file

Self-reported cigarette smoking status, by minority ethnic group and sex

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<td>17</td>
<td>8</td>
<td>9</td>
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<tr>
<td>General population</td>
<td>24</td>
<td>27</td>
<td>23</td>
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Number of cigarettes smoked by current smokers, by minority ethnic group and sex (2004)

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<th>Men</th>
<th>Women</th>
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<tr>
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<td>Chinese</td>
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<td>41</td>
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<tr>
<td>General population</td>
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<td>39</td>
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x – results not known due to small base sizes
Prevalence of chewing tobacco, by age within South Asian minority ethnic groups and sex

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