Research Article
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The use of smokeless tobacco among UK South Asian communities

Abstract

Background: More than two million people in the UK consume chewing tobacco products, of which the majority are from South Asian communities. The use of chewing tobacco products needs to be investigated due to the association with adverse health effects amongst its users.

Aim: The purpose of this research was to investigate the opinions and attitudes towards the use of smokeless tobacco amongst South Asian people in England.

Method: Twelve semi-structured interviews were conducted and transcribed verbatim. Data were analysed using a deductive thematic analysis using the layers of influence model as a framework: Individual characteristics, Lifestyle factors, Social and Community networks, and Environmental and Cultural conditions. Results: The themes identified confirmed the layers of determinants can be used to understand an individual's use of chewing tobacco products.

Conclusion: This research provides a starting point for the development of interventions for the cessation of smokeless tobacco, which is currently lacking within the UK. It has been identified through this research, that a multifaceted approach is needed in order to address the use of chewing tobacco and the resulting health disparities. This includes education and training for health professionals to understand the cultural context of chewing tobacco; campaigns to raise awareness of the dangers and harm related to chewing tobacco at a community level and a reconsideration of national control policies.

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Janice Constance,[1] Joanne M Lusher,[2] Esther Murray[3]
[1]London Metropolitan University, London
[2]University of the West of Scotland, London
[3]Queen Mary University of London, London

Correspondence: Joanne M Lusher, University of the West of Scotland, 235 Southwark Bridge Road, London,
Email joannelusher@uws.ac.uk

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Introduction

The term smokeless tobacco refers to products that are consumed without the use of combustion.[1] One form of smokeless tobacco, commonly found in areas of the UK is chewing tobacco[2] that is made up of betel quid (paan with tobacco); which normally consists of slaked lime and sliced Areca nut that are wrapped together in a betel leaf.[3,4] Chewing tobacco products are most commonly used by South Asian communities, with some reports estimating up to 600 million users globally and more than two million people in the UK alone.[5] Prabhu, Warnakulasuriya, Gelbier and Robison [6] named these products the fourth most abused substances after caffeine, tobacco and alcohol. The NHS Information Centre[5] identified that on average 9% of Bangladeshi men and 16% of Bangladeshi women use a form of smokeless tobacco. However, Croucher, Shanbhag, Dahiya, Kassim, and McNeill[7] reported that around 48.5% of adult Bangladeshi women had reported using smokeless tobacco. In some areas of the UK, especially where there are large South Asian communities, smokeless tobacco products are readily available in shops and are generally much cheaper in comparison to cigarettes and as much as 85% of products are sold to the general public without a regulatory health warning.[1]

The use of smokeless tobacco products in the UK is worthy of investigation because it is a significant contributor to a number of adverse health effects amongst its users.[8] Studies [8,9] suggest a continuous increase in the rates of oral cancer in the UK since 1989 and one of the most recognised risk factors for oral cancer is the consumption of tobacco, with over 90% of oral cancer patients reporting using some form of tobacco.[10] Furthermore, tobacco and the Areca nut have been proven to be carcinogenic[11,12] as the risk of mouth cancer, heart disease and gum disease is increased among people who use these products.[11] Given the number of health risks associated with smokeless tobacco use, there is currently limited evidence of effective cessation programs.[13] Due to the multitude of factors surrounding smokeless tobacco use, it is clear that a multifaceted approach is necessary to address the impact it has on individuals' health by raising public awareness, linking in with the local community and developing targeted and culturally sensitive cessation services.

Such a multifaceted approach can be better understood in the wider context by considering factors such as individual, social and environmental determinants that may impact on health. Dahlgren and Whitehead[14] suggested that these determinants are centred on core idiosyncratic characteristics consisting of unmodifiable factors such as age, sex and genetic factors. Surrounding layers of determinants of health include modifiable factors such as social and community networks, the individuals living and working conditions, environmental and cultural factors. NICE[13] have reported that interventions might be effective with smokeless tobacco users, in some cases, although the evidence of effectiveness is currently weak. Therefore there is first a need for research that uncovers the use of smokeless tobacco products amongst the South Asian population in determining reasons behind the use of these products. This study therefore aimed to:

a. Investigate the opinions and attitudes that encourage or predispose South Asian people in the UK to use smokeless tobacco products.
b. Investigate the reasons for smokeless tobacco use against the main determinants of health as proposed in the layers of influence model.[14]

The objective of this investigation was to adopt a method in which to ask about the use of smokeless tobacco in a sensitive and culturally aware manner. This included challenging any perceived benefits of smokeless tobacco use to provide a good basis and a starting point for the development of a smokeless tobacco cessation programme.

Method

This study utilised a deductive thematic analysis informed by Braun and Clarke.[15] Deductive thematic analysis was chosen as this approach complemented the research aims by facilitating an investigation of the interview from a theoretical perspective, i.e. the use of smokeless tobacco in the wider context of individual, social and environmental determinants of health as proposed by Dahlgren and Whitehead[14] in the layers of influence model.

Participants

Participants for this research consisted of people of South Asian origin, i.e. Indian, Bangladeshi, Pakistani or Sri Lankan origin, both male and female living in London, with an age range of between 18 to 65 years old who reported the use of any smokeless tobacco products within the last 12 months. These criteria ensured that the qualitative data reflected a practical knowledge of the cultural context in smokeless tobacco use. To maintain anonymity, any details that would lead to the identification of the participants were omitted or changed. In total, twelve participants were recruited opportunistically through promotional events held by local council's smoking cessation team.

Materials

An interview schedule consisting of eleven questions was developed based on current literature regarding the use of smokeless tobacco products. The questions were formed as open and non-leading to discourage one word answers and to encourage participants to express their views. Some examples, of the questions that were asked, were; *"Can you tell me about some of the smokeless tobacco products you may have heard of?", "Can you tell me about your religion's perspective on smokeless tobacco?"* Prompts and probes were developed for each question to assist the interviewer in eliciting information from participants. Once drafted, the questions were reviewed by a second researcher. A pilot interview was conducted to determine any limitations within the interview design and responses demonstrated that the questions within the interview were appropriate and understood. Semi-structured interviews allowed for the voice of the participants to be heard and a balance between exploring pre-theorised questions and the possibility that new data can emerge from the spontaneous responses.[16]

Procedure

Ethical approval was gained from the University's Research Ethics Committee. Approval was also gained from the local stop smoking service where all interviews were conducted. It was ensured that the information sheet explained the nature of the research. Participants were given a consent form to read and sign before taking part and informed that they had the right to withdraw at any point and up to three weeks after the interview before the process for analysis began. At the end of the interview, participants were debriefed and provided with contact details. All data including the audio records were kept confidential throughout the research. Participants were informed that their data would be anonymised and their names would be replaced with pseudonyms. All raw data were kept in a locked cabinet, and accessed only by those within the research team.

Analysis

Stage 1: Transcription

Interviews were recorded with a digital audio recorder and were transcribed verbatim by the researcher. The transcription was carried out following interviews, as hearing the taped conversation when the interview is still fresh in mind, allows for ease in the transcription process. Several detailed hearings of the audio data allowed familiarisation with the accounts.

Stage 2: Familiarisation with the data

Transcripts were read a number of times, and sets of data identified. These sets of data were then transferred onto a document where any phrases or concepts that the researcher considered interesting or significant were placed within the right margin and any initial thoughts regarding the data were noted in the left margin.

Stage 3: Coding

A template was developed, based on the research questions and the theoretical framework developed by Dahlgren and Whitehead[14] on the layers of influence, by designing a coding table that contained three columns. The first column contained five broad categories that were identified in accordance with the proposed theoretical framework. The second column included a brief definition of these five categories. The final column contained instructions on when to categorise the data within these five categories.

Stage 4: Identifying themes

Notes made in reference to the theoretical framework were transformed into specific themes. This was achieved by writing down each quote on an index card along with references. Quotes were then sorted under appropriate themes, or discarded if they were vague. At this stage, a second independent reviewer was involved in discussing the findings until an agreement was reached, to ensure validity and appropriateness of each of the themes identified. Data were re-read, and themes refined into specific clusters. A final analysis of the selected extracts was related back to the research question and appropriate literature.

Results

Individual, physical, social and environmental factors have been shown to determine the health of an individual.[14] The present data support the model's five categories of individual characteristics; lifestyle factors; social and community networks; living and working conditions; and environmental and cultural conditions in which the emerged themes are situated.

a. Individual characteristics

Age and gender were identified as two main themes within this layer, as having an impact on an individuals' reasons for smokeless tobacco use.

Older generation versus younger generation

Participants described how there was a difference in relation to age groups using smokeless tobacco: *"they are more typical to do that, but the paan masala, the more senior citizens as I said would use it than the youngster." (Rubina: L73).* Participants also made reference to what they perceived as the reasons for age differences in using these products. The younger generation thought of smokeless tobacco products as old-fashioned and that using cigarettes is thought to be more modern in comparison.

Ladies being ladylike

Smokeless tobacco was mostly used by women as it was not seen

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as culturally acceptable for women to be smoking a cigarette. In South Asia, especially in India, traditional values are not in favour of the young and women smoking. Tobacco use is seen as an unattractive trait for a female as it is perceived to be more of a masculine behaviour:

"I don't know I think it's that whole societal pressures of ladies being ladylike… oh, no one will marry you if you look like… if you're acting like a man kind of thing, you know… but you get a reputation if you're a girl as a bad girl but if a boy walks around with a cigarette or this Munikchand then its fine which is not fair, but that's the reality yeah." (Ankita: L77-80).

Lifestyle factors

The next layer of the model refers to the habits, attitudes, beliefs or moral standards that together constitute the mode of living of an individual. The focus here is on areas where it is recognised that individuals have a certain degree of choice using smokeless tobacco products. Four main themes were identified within this layer; these are *Medicinal purpose, Lack of awareness, Addiction and Enjoyment.*

Medicinal purpose

Participants here described diverse opinions about the medicinal properties smokeless tobacco has on their health. Some expressed that the snuff has homoeopathic properties and can be used to cure common ailments such as a cold. Participants described health benefits of chewing tobacco in association with traditional beliefs, more likely endorsed by the older generation. There was also reference made to other types of smokeless tobacco products used with the belief to aid other common ailments such as headaches and digestion.

"This is flavoursome and as like a digestion… helps aid digestion. So some people eat it for that reason I think. It's like fennel seeds you eat that after a meal and you know people enjoy eating it and it also aids digestion." (Sanam: L59-61).

Lack of awareness

Despite the growing evidence with regard to the harmful effects these products have on health, there remains a lack of awareness among users. As found through the data, most participants did not know the ingredients: *"Something strong I think erm… a variety of things actually… yeah, but I have no idea what exactly they're putting in by name." (Deepak: L8-9).*

With products such as paan masala that contain the Areca nut, it became apparent that there was a shared belief that these were harmless. The following quote illustrates the view that paan masala is harmless: *"…they give it out at weddings just as a mouth freshener at the end to sweeten your mouth, but that's not always with a leaf it can be just the filling and in a bag and you kind of put a bit in a spoon and kind of spoon it into your mouth but that's just to refresh your mouth it hasn't got anything in it like tobacco." (Ankita: L80-83).*

Addiction

Participants described addiction to smokeless tobacco to be so strong that even when experiencing negative health effects the use of these products continued:

"My cousin he dies of it and… cause he couldn't smoke any, he started this and his been addicted to it for many… I don't know how many years maybe 10… 10, 15 years and as a result of which he had throat cancer, and he passed away so." (Neerav: L97-100).

Enjoyment

This theme refers to the extent to which individuals subjectively experience positive moods such as satisfaction, pleasure and euphoria when using smokeless tobacco products. When asked by the interviewer the reasons why these products are used, Hameed described it as a source of gratification for people who chew tobacco *'just to give them satisfaction I think… make them more relaxed.' (Hameed: L9-10).* Whereas some thought the motivation behind habitual use was associated feelings of euphoria *I've heard people say that the high is like weed so you just get that kind of high and then when the high just stops you just spit it out or just take it out." (Rubina: L39-40); "Just to get a high yeah." (Deepak: L38).*

b. Social and community networks

This layer is primarily concerned with how the interactions between groups of people and organisations impact on the use of smokeless tobacco. *Acceptability* and *Family and Peer Influence* are the two main themes that were identified within this layer.

Acceptability

Participants described that some of the smokeless tobacco products were used for several symbolic functions, such as to celebrate wedding rituals. From the extracts, the social aspect of chewing tobacco could be seen as having been passed down from generations before, therefore cementing the acceptability of these products. The extracts described paan masala as having sociocultural characteristics in common with food *'so it's more of a desert kind of thing that people tend to have after they like have dinner'.* It is apparent that the use of these products is an action that is socially acceptable in the community. It is repeatedly described as being shared amongst the participant's social network, suggesting that the participants within this study believed that the use and the sharing of the paan masala is a way to affirm social ties within their social network and has become a norm within this community and integrated as part of their daily lives.

Living and working conditions

Educational status was considered an important determinant of tobacco use:

"Here it's not so much a norm people don't have Tulsi and Munikchand in my age group its more cigarettes but not many, cause we have been educated a lot I think… my generation we have been educated a lot especially if you went to school in this country. Tobacco is bad for you, lung disease, cancer but I don't think they are educated like that in other countries so maybe that doesn't help." (Ankita: L116-120).

More of a working class thing

There are a number of ways in which work can affect health and the data gathered here suggest that occupation plays a role in the use of smokeless tobacco. As shown in this extract, it was mainly people in a working class category who are likely to use smokeless tobacco:

"So it is more of a working class thing than, it is with any of the professional things. I haven't really seen any of the professionals eat it much, but I have seen shopkeepers being addicted to it. A lot of the Asian shopkeepers from the Indian origin are addicted to it and although you tell them… and they are not uneducated some of them are educated, and you tell them this is an addictive product; this has got tobacco and cancer-causing they take no note." (Maya: L72-77).

c. Environmental and cultural conditions

The final layer refers to how variables that may exist in an individual's physical environment can impact on decisions to use smokeless tobacco. Four themes emerged within this layer: Cultural beliefs, Migration, Availability and Geographical Origins.

Cultural beliefs

Here, Maya describes a scenario that explains how paan use has been integrated into everyday life: *'so after a meal people used to go to the paan seller and just have 3 or 4 paans made up to take with them.'* Neerav felt that the reasons to use smokeless tobacco was because it had been used culturally by the older generation within his community: *"I think yeah, it's racial it's been used by many you know old age people, so it's got to be like you are using it so." (Neerav: L23-24).* As Maya suggests this could have an impact on the reasons to use smokeless tobacco. Maya also felt that the use of these products usually starts at an early age, a tradition that has been carried forward through the years by each new generation *'It's been brought down from generations…'* and '*a small amount would be torn off and be given to a child.'*

Easily available

Paan products are readily available in Asian grocery shops, *'comes with a small sachet, which you can buy from any convenience store' (Amit: L8-9).* These products are the takeaway type of paan mixtures which are very popular among men and use of some are illegal:

"No, no, no but this one like munikchand this one is getting illegal, but people still have it… they do… many shops are not supposed to sell it, but they do sell it which is not right." (Bindu: L67-68).

The new Asians

Health risk factors and legal status of migrants are often linked together, which determines an individual's level of access to health and social services. Participants here made clear associations with migration and smokeless tobacco use.

Geographical origins

Finally, there are some parts of India were the use of smokeless tobacco is more common than smoking such as the states of Bihar and Maharashtra.[8] Participants within this research stated specific areas of India that are more prone:

"There is one particular Asian community which are from Diu and Dhaman which are the two islands off the coast of Gujarat… it is mainly the Gujurati community who are prolific user of chewing tobacco, but those who are from Diu and Dhaman are hardened people…" (Maya: L91-94).

Discussion

The qualitative approach adopted in this research aimed to explore the use of smokeless tobacco amongst people of South Asian origins in relation to the main determinants of health and to the best of our knowledge; this is the first UK study to do this. Themes identified here confirm that layers of determinants can be used to understand an individual's use of smokeless tobacco. It can be interpreted from the data that the reasons for using smokeless tobacco products are not solely affected by an individual's characteristics, but rather a combination between determinants of health within the layers of influence model.

Individuals believe there to be medicinal benefit to using smokeless tobacco products. Having a lack of awareness to the associated health risks and belief in the perceived benefits to a range of health issues such as dental problems and stress, encouraged the use of smokeless tobacco amongst participants. This suggests that a majority of participants may be exposing themselves to the carcinogens found in these products, but are unaware of the risk. It is essential that health professionals understand the cultural significance and the adverse health effects of using chewing tobacco products, in order to empower users to understand the associated health effects.

Smokeless tobacco use was also associated with feelings of euphoria and satisfaction. Similar results have been echoed in a number of studies where participants reported that their chewing habit was motivated by a desire to relieve boredom, feeling confident and happy.[17–19] However, it is important to explore the role of affect management surrounding the use of these products, in order to inform interventions that focus on preventing relapse. There have been questions raised about the perception of consumers regarding the safety of smokeless tobacco due to the recent growth in their promotion and consumption, specifically in vulnerable and high-risk populations. Results from this study make similar connections to that made by Messina et al.[20] in that contextual factors like stress, traditional messages, health beliefs and the lack of awareness of the health risks are potential factors that could influence the use of chewing tobacco. There is a need for further research on the use of smokeless tobacco in regards to risk perceptions to aid in the development of appropriate intervention.

The present findings highlight that social support can act both as a facilitator to continued use of chewing tobacco and act as a barrier to successful cessation. The association with family tradition and socialising with friends are found to be compelling factors that perpetuate the use of these products between generations.[21] There is overarching evidence that social support and constructive social relations are important contributors to positive health outcomes.[22] Social support can provide the emotional and practical resources individuals' need in order to maintain their health. Belonging to a social network of mutual obligation provides individuals with a sense of being cared for, loved, esteemed and valued, which can have a powerful effect on health behaviours. It is important that that these factors are considered when planning and designing smokeless tobacco cessation programmes.

A way forward for smokeless tobacco cessation is to integrate complementary strategies that can facilitate long-term abstinence. There is a need for a multifaceted cessation programme which can be split in to four areas; integrating appropriate intervention programmes of smokeless tobacco cessation; education and training for health professionals to understand the users perspective and the cultural context of chewing tobacco; campaigns to raise awareness of the dangers and harm related to chewing tobacco and a reconsideration of national control policies. This research emphasises that consideration should be given to integrating interventions in order to achieve long-term cessation. Therefore, questions need to be asked about what kind of further interventions or support can be followed up. The answers can be found in the narratives of users.

This research offers an alternative approach to understanding the use of smokeless tobacco. Having a deep understanding of users' views and perspectives is essential in designing cessation interventions for the use of smokeless tobacco.[23] The use of smokeless tobacco products is a pressing public health concern globally. Despite the demonstrable

health risks associated with it, little is understood about predictors and reasons for its use amongst the South Asian population. The present research draws attention to the involvement of multiple factors that impact on reasons for using smokeless tobacco. Socio-demographics, social interactions and cultural motivations all play a role for initiation and continued use. This research provides a starting point for the development of interventions for the cessation of smokeless tobacco. It is clear that a multifaceted approach is necessary to tackle this concern. Implementing various measures such as regulations, ban on the advertisements, promotion and sale of smokeless tobacco products are required alongside targeted cessation interventions in order to successfully reduce the smokeless tobacco disparities amongst South Asian communities in the UK.

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Conflicts of interest

Author declares no conflicts of interest**.**

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