

Tobacco use, ethnicity and health

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Key points:

- 4% of Scotland's population is from a minority ethnic group
- minority ethnic groups often have poorer health than the general population, although in Scotland this is not the case for all-cancers and common cancers
- ethnic inequalities in health tend to be neglected in policy discussions and omissions in routine data collection may compound this
- smoking is one of the major contributors to health inequalities
- there are many interlinked factors involved in ethnic health inequalities but lower socio-economic status (which is itself an influence on tobacco use) may be the most important.

This specialist briefing is aimed at professionals and policy makers. It provides a short overview of the evidence surrounding tobacco use, ethnicity and health.

Scotland's minority ethnic population is low (4%¹). Minority ethnic populations are generally characterised as being disproportionately affected by death and disease², although the Scottish Health and Ethnicity Linkage Cohort Study³ suggests that for all-cancers and the common cancers this is not so. What is certain is that ethnic inequalities in health tend to be neglected in policy discussions⁴.

Smoking is the main preventable lifestyle factor, particularly for cancer, respiratory and cardiovascular diseases⁵, and the National Institute for Health and Clinical Excellence⁶ has suggested that reducing tobacco consumption among minority groups would reduce health inequalities more than any other measure. The Medical Research Council at the University of Glasgow has noted that ethnic minorities are often under-represented in research⁷, although successful engagement can be achieved

using culturally appropriate strategies⁸. Similarly there are deficits in data collection⁹ although The Scottish Health and Ethnicity Linkage Study¹⁰ has demonstrated that national cancer statistics can be obtained by ethnic group and called for its methods to be applied wherever a population census or database records ethnic group.

Ethnic group demographics

Population estimates by ethnic group from Scotland's 2011 Census¹¹:

- the size of the minority ethnic population in 2011 was just over 200,000 or 4% of the total population of Scotland
- the Asian population was the largest minority ethnic group (3% of the total population or 141,000 people)
- just over 1% (1.2% or 61,000) of the population recorded their ethnic group as White: Polish. The cities of Edinburgh and Aberdeen had the highest proportions at 3% of their total population
- in Glasgow City, 12% of the population were from a minority ethnic group, in City of Edinburgh and Aberdeen City it was 8% and Dundee City it was 6%¹².

2011	% of total population	% of minority ethnic population(rounded estimate)	base
African	0.6	14	30,000
Asian/Asian Scottish/Asian British	2.7	67	141,000
Caribbean or Black	0.1	3	7,000
Mixed/Multiple ethnic groups	0.4	9	20,000
Other ethnic group	0.3	7	14,000
White	96.0	n/a	5,084,000
<i>All Minority Ethnic Population</i>	4.0	100	211,000
All Population	100	n/a	5,295,000

Migrants

According to the Migration Observatory at the University of Oxford¹³, in 2004 the number of non-UK born residents was estimated to be 204,000 and the number of non-British nationals was 127,000. Both of these numbers have increased continuously over time. In 2012 there were 375,000 non-UK born people resident in Scotland (7.2%) and 285,000 non-British nationals. This total represents an increase of 84% in the non-UK born population and an increase of 124% in the non-British population since 2004. An estimated 5.5% of Scotland residents in 2012 were non-British nationals which also represents an increase from the 2004 value (2.5%). The share of Scotland's population which is non-UK born is smaller than that of the UK as a whole (12% in 2012). Likewise, the share of Scotland's population with non-British nationality is smaller than that of the UK (7.8%).

Gypsy travellers

The term 'Gypsy/Traveller' refers to distinct groups - such as Romany Gypsies, Scottish and Irish Travellers - who regard the travelling lifestyle as being part of their ethnic identity. Scottish Government figures from July 2008¹⁴ recorded an estimated 744 households living on sites and encampments in Scotland. This is estimated to represent a population of around 2,455 people. Research based on the English and Welsh population¹⁵ suggests that rates of smoking are very high in the Gypsy or Irish Traveller group, 49% and 46% for males and females respectively.

Smoking prevalence

Although the Race Relations (Amendment) Act 2000 and NHS policy require health services to show that they are promoting racial equality and reducing ethnic inequalities, routine data sources in Scotland do not include the information needed to (a) measure health inequalities, (b) assess service use, and (c) demonstrate compliance with policy and legislation¹⁶.

According to the Scottish Health Survey¹⁷, in 2012 one in four adults (aged 16 and above) in Scotland was a current cigarette smoker. No difference was found between men and women (25% and 24% respectively), although smoking did vary by age, with the highest rate among adults aged 25 to 44 (29%). A report using four years (2008-2011) of the Scottish Health Survey¹⁸ reported on prevalence by ethnic group. However, even combining four

years of survey data, the number of respondents in these ethnic groups is still too small to estimate smoking prevalence reliably. The report does note though that respondents from 'Pakistani' and 'Asian, Other' ethnicities were less likely to smoke than the national average (13% and 9% respectively, compared to the average of 25%). Older survey work¹⁹ conducted in England noted that there are also large gender differences in smoking within some ethnic groups (eg smoking in Pakistani and Indian women was very low at around 5%, while the rate among men was more similar to the general population) - some of these differences also may be true for Scotland. A study of minority ethnic tobacco use in Glasgow confirmed higher rates of smoking, especially among Pakistani respondents, young people and women²⁰.

A 2007 study²¹ of the smoking behaviours of UK resident Bangladeshi men showed that smoking initiation and use is linked to gender, age, religion and tradition, and that three cheaper alternative tobacco types were also used: illicit, roll-ups and traditional chewing tobacco in paan (chewing tobacco mixed with areca (betel) nut rolled in a betel leaf). Smoking behaviour was also linked to a reported isolation and exclusion from current tobacco control initiatives.

Ethnicity and health inequalities

Mortality data have identified the following kinds of differences in health across ethnic groups²²:

- generally poorer health among non-White minorities, with Bangladeshi people having the poorest health, followed by Pakistani, Black Caribbean, Indian and Chinese people
- high, but variable, rates of diabetes across all non-White groups
- high rates of heart disease among South Asian people, but particularly among Bangladeshi and Pakistani people.

The risk of cardiovascular disease varies across ethnic groups within the UK with the lowest rates in the Chinese-born and the highest in the South Asian-born groups²³. It has been apparent since the 1980s that UK South Asians have a higher risk of developing cardiovascular disease and diabetes and that African-origin populations have a higher risk of developing cerebrovascular diseases (causing strokes) and diabetes²⁴. Scotland is noted for its internationally high cardiovascular disease rates, and Pakistanis in Scotland have the highest incidence of acute myocardial

infarction²⁵, suggesting a need for a clinical care and policy focus on reducing incidence through more aggressive prevention.

A study²⁶ which used cross-sectional data from the 2007 Citizenship Survey linked to the 2001 UK census notes that '[t]here is strong evidence that the economically poorer areas in which ethnic minority people on average live, negatively impact on health over and above individual socio-economic markers.' There are many interlinked factors involved in ethnic health inequalities but lower socio-economic status (which is itself an influence on tobacco use) may be the most important²⁷.

Other tobacco products

The World Health Organization has predicted that tobacco use will kill one billion people in the 21st century²⁸, and although most will be killed by cigarettes it is nevertheless important to recognise that tobacco can be consumed in many other forms, all of them harmful. Chewed tobacco products are associated with an increased risk of mouth and throat cancers among users²⁹. People in the Indian, Pakistani and Bangladeshi communities are the most likely to use chewed tobacco products and the tobacco is usually mixed with betel nut which is itself a mood-altering stimulant, possibly carcinogenic and potentially dependence forming³⁰. The UK is the number one importing country for paan outside of Asia, with imports having doubled since the early 80's³¹. In some parts of the Asian community young children start using sweetened betel nut products but begin to add tobacco later in their adolescence³². A 2010 study³³ on the accessibility of chewing tobacco products in England found that less than half (48%) of chewing tobacco purchased had any form of health warning, while only 15% of products complied with the current legislation of health warnings for smokeless tobacco products, suggesting a need to challenge retailers selling smokeless tobacco to ensure they comply with the current UK and EU labelling and health warning regulations. There is a lack of knowledge and understanding about the health risks of chewing tobacco in South Asian communities³⁴ but the links between smoking and lung cancer are recognised.

The 2009 Global Tobacco Youth Survey³⁵ (which examined time trends [1999–2008] of tobacco use of over half a million youth aged 13–15 years) reported that whereas cigarette smoking is showing either stable or declining trends globally in this age group, other forms of tobacco use are showing a rising trend, mainly as a result of waterpipe smoking. In a 2012

survey of approximately 1,000 people aged 18 or over in Scotland, around 7% reported ever having used a shisha pipe. Most were infrequent users, with less than 1% reporting use once or twice a month or more frequently¹.

Smoking cessation interventions

A December 2013 systematic review³⁶ of smoking cessation interventions adapted for ethnic minority groups concluded that whilst there was no clear evidence of the effectiveness of adapted interventions in promoting smoking cessation in ethnic minority groups, there was evidence of greater acceptability. In Leicester, an NHS smoking cessation service called STOP! increased uptake among minority ethnic groups from 14% in 2007 – 08 to 21% in 2010 by actively engaging with the community and developing partnerships with key advocates such as local GPs, community colleges, Imams and the Federation of Muslim Organisations and Confederation of Indian Organisations³⁷. STOP! also actively promoted the month of Ramadan as a good time to quit smoking. Similarly, the Bangladeshi Tobacco Cessation Project in the London Borough of Tower Hamlets provided a tailored programme which was culturally sensitive and worked with the East London Mosque, and reported four week quit rates ranging from 63 – 68% between 2003 to 2006³⁸. Adaptations might include using images with which ethnic minority groups can identify, targeting relevant venues, and developing materials which reflect cultural values.

As smoking behaviour is significantly different in some of Scotland's new population groups³⁹, notably East European migrants, stop smoking services may have to adapt to the particular patterns of smoking behaviour and language skills within different communities of descent.

Further information

- ASH Scotland Tobacco and Inequalities Project – tobacco and minority ethnic communities: www.ashscotland.org.uk/what-we-do/tackle-inequalities/minority-ethnic-communities.aspx
- ASH Scotland inequalities information: www.ashscotland.org.uk/what-we-do/supply-information-about-tobacco-and-health/key-topics/inequalities.aspx

¹ Figures are from YouGov Plc. Total sample size was 1055 adults. Fieldwork was undertaken between 27th February and 13th March 2012. The survey was carried out online. The figures have been weighted and are representative of all Scottish adults (aged 18+).

- ASH Scotland information about shisha:
www.ashscotland.org.uk/what-we-do/supply-information-about-tobacco-and-health/briefings/shisha.aspx
- ASH Scotland information about other types of tobacco used by some minority ethnic communities:
www.ashscotland.org.uk/media/62897/types%20of%20tobacco%20used%20in%20some%20minority%20ethnic%20groups.pdf

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- ⁷ Medical Research Council/Chief Scientist Office, Social and Public Health Sciences Unit. University of Glasgow Annual Report 2013. www.sphsu.mrc.ac.uk/publications/annual-reports.html
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- ¹² Scotland’s Census 2011, Release 2A. www.scotlandscensus.gov.uk/census-results

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