TOBACCO AND ETHNICITY:
A LITERATURE REVIEW

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1. INTRODUCTION: What the literature review is

This document is an update of the 2004 Tobacco and Inequalities Literature Review, originally written during the third phase of ASH Scotland’s Tobacco and Inequalities project. More detail on the Tobacco and Inequalities Project is available on the following section of the ASH Scotland Website - www.ashscotland.org.uk/ash/5371.html

An update to the 2004 document was felt to be necessary in light of the completion of the project cycle for the ASH Scotland Tobacco and Inequalities Initiative Small Grants Funded Projects and further developments in the published research literature around tobacco use and Black and Minority Ethnic (BME) groups.

Since 2004 there have also been national and local policy developments, publications, resources and research dealing with the issues surrounding tobacco and ethnicity. The aim of this document, as with the original, is to provide a summary of relevant research (focussing on journal published, but also relevant unpublished work), policy drivers, and raw prevalence/demographic data around the topic of tobacco and ethnicity. No prior knowledge of the subject is assumed.

For ease of reference, the body of this document (sections 3 to 5) cover the core subject matter, including:

- an overview of tobacco and health in Scotland
- what is known about tobacco use and ethnicity, including prevalence, type of product used, knowledge and attitudes
- approaches and attitudes to tobacco cessation among BME groups.

While the background and context section (section 3) deals with issues such as population demographics, for the reader that wishes to investigate in more detail, a larger appendix of BME population data from the 2001 census has been collated and is presented in section 6, covering the following areas:

- defining ethnicity and measuring the BME population
- a discussion of the size of the BME population in Scotland and regional variations
- a discussion of the other variables in minority ethnic population in Scotland, such as housing, employment, age and gender.

Any suggestions of omissions, questions, or comments on this review are invited, and should be directed to: enquiries@ashscotland.org.uk

For more information about the work of ASH Scotland, the Tobacco and Inequalities project or Partnership Action on Tobacco and Health (PATH), please visit the ASH Scotland website or get in touch with us by phone or email at the address given on the cover of this document.
2. METHODOLOGY: Conducting the literature review update

The methodology for the original 2004 review is presented below:

- details of relevant literature and contacts were noted as they came to light (over a 12-month period beginning in May 2003 and ending in June 2004)
- searching the relevant section of the ASH Scotland library
- PubMed database keyword searches (using terms such as ‘ethnicity’, ‘BME’, ‘tobacco’ and smoking’)
- keyword public domain internet searches using a search engine to find web-based information outside of published journals
- focused searches on selected websites: ASH Scotland, NHS Health Scotland, the Scottish Government and the Health Development Agency (the Health Development Agency’s functions were transferred to the National Institute for Health and Clinical Excellence in 2005)
- searching for relevant information posted on Globalink, an online tobacco control community and listserv.

During this update, a repeat of the above methodology was conducted, with database literature searches set up to search for research published between the start of the 2004 calendar year to the start of the 2010 calendar year (i.e. documents published since the review was originally conducted). For published research the ASH Scotland Information Service's weekly research digest was used to identify literature published in the desired timeframe. (A catalogue of published minority ethnic and tobacco research from 2007 to present is available on the ASH Scotland website at: www.ashscotland.org.uk/ash/7766.html).

Due to time and resource constraints detailed scrutiny and critique of the methodology of each study was not carried out as would be the case in a systematic review or meta-analysis. Hence this literature review does not make any judgements on the rigour of the research that is referred to. However, when deemed appropriate, information is presented about the sample and methodology used to give context to the research that is cited, particularly when conclusions are drawn from observation or case report only, to allow the reader to make their own judgements regarding the conclusions of the research.
3. TOBACCO AND ETHNICITY: Background and context

3.1 Tobacco, health, and tobacco policy in Scotland

The use of tobacco remains the single largest preventable cause of ill-health and premature death in Scotland, also being a significant indicator, and cause, of health inequalities. Scotland has more than a million adult smokers, making up approximately one-quarter of the adult population.

Each year, an estimated 13,500 people die from tobacco-related diseases: lung cancer, other cancers, cardiovascular diseases, and respiratory disorders. In addition to the risks posed by active smoking there is also a body of evidence highlighting the health risks associated with exposure to second-hand smoke.

There is a strong correlation between smoking and deprivation. People on low income are more likely to smoke cigarettes and are more likely to smoke more cigarettes per day on average. In 2008 45% of Scottish adults smoked in the most deprived tenth of areas, contrasting with just 11% of adults who live in the least deprived tenth.

A Scottish study published in 2009 examining the health outcomes of a cohort of approximately 15,000 Scots recruited in 1972-76 in Renfrew and Paisley demonstrated powerfully that both male and female smokers in all social positions had poorer survival than never smokers in even the lowest social classes. In other words, smoking itself was a larger source of health inequality than social position.

The scale of harm caused by tobacco smoking in Scotland has been subject to a great deal of research, and corresponding action in public health policy over the last decade.

For the reader interested in studying the general background of tobacco control, and public health in Scotland, the following documents are recommended (most recently published first):

- **Scotland’s future is smoke-free: a smoking prevention action plan, 2008**
  www.scotland.gov.uk/Publications/2008/05/19144342/0/
  Scotland’s future is smoke-free sets out the Government’s priorities and actions for youth smoking prevention.

- **Better health, better care, 2007**
  www.scotland.gov.uk/Publications/2007/12/11103453/0
  This Action Plan sets out the Government’s programme to deliver a healthier Scotland by helping people to sustain and improve their health (particularly in disadvantaged communities) ensuring better, local and faster access to health care. It also details targets for smoking cessation services in Scotland.
• Towards a future without tobacco, 2006
  www.scotland.gov.uk/Publications/2006/11/21155256/0
  A report of the smoking prevention working group, it makes a series of recommendations on measures to prevent young people from becoming smokers.

• A breath of fresh air for Scotland, 2004
  www.scotland.gov.uk/Publications/2004/01/18736/31541
  This document takes forward a commitment to review national tobacco control policy and to set out a new tobacco control action plan. The report describes actions that give most help to disadvantaged communities, where the highest rates of smoking are found.

• Reducing smoking and tobacco-related harm – a key to transforming Scotland’s health, 2003
  This document, produced by ASH Scotland and NHS Health Scotland, makes recommendations of further action that can be taken in Scotland to reduce ill-health caused by tobacco.

• Towards a Healthier Scotland, 1999
  www.scotland.gov.uk/library/documents-w7/tahs-00.htm
  This Scottish Public Health White Paper stresses a commitment to reducing smoking and states initial targets for smoking reduction in three target areas - young people, pregnant women, and adult smokers.

• Smoking Kills, 1998
  www.archive.official-documents.co.uk/document/cm41/4177/contents.htm
  The 1998 UK White Paper on tobacco, Smoking Kills, emphasises the major health risks of smoking and sets targets to reduce smoking rates among young people and pregnant women, and to provide more support for adult smokers who want to quit.

As a result of recommendations given in these documents, campaigning action, and public support, Scotland has taken its place in a vanguard of nations who are tackling the adverse health outcomes of smoking through far-reaching policy actions.

These actions include: comprehensive bans on tobacco advertising; large-scale investment in a national network of stop smoking services through the NHS; a ban on smoking in enclosed public places; text and picture warnings on cigarette packs; and, most recently, the prohibition of self-service cigarette vending machines and a ban on the display of cigarettes at the point of sale due to come into force between 2011-2013.
3.2 Ethnicity, inequalities and health

Despite the passage of time between the original publication of this literature review and the current update, Scotland-specific data on BME health issues, including smoking, remains limited. However, the limitations of current data sources have been acknowledged in a report by the Scottish Government ministerial task force on health inequalities, *Equally Well*, which includes a recommendation that the Government should 'commission a review of health data needs that covers ... ethnicity. The review should be published and include a plan of action with milestones to fill information gaps identified.' This gives some hope that the gaps in information in ethnic health are at least acknowledged, and research will be commissioned to fill the gap in the future. Work is underway to investigate the feasibility of estimating the population of Scotland by ethnic group in a similar manner to that used by the Office of National Statistics in England, however there are several limitations, including relatively low base population.

Due to lack of Scotland-specific information on BME groups and health, information from wider UK sources (particularly the UK Department of Health’s *Health Survey for England*) will be used to provide data on the health issues and tobacco use of BME groups when Scottish data is not readily available.

The main source of data on ethnicity in Scotland is still the 2001 national population census, which contained a question on self-reported ethnicity. The census is carried out every ten years, with the next due in 2011. The 2001 census used a five-category classification (White, Mixed, Asian, Black, Other) with sub-categories (e.g. Scottish, Indian, Caribbean) under each heading. Approximately 2% of Scotland’s population are from, what were called at the time, ‘minority ethnic’ backgrounds, representing an increase from 1.3% in the previous 1991 census. Overall, the largest single ethnic group are people from Asian descent, particularly from Pakistan. There is some regional variation in the size and composition of the minority ethnic population throughout Scotland, with minority ethnic populations concentrated in the major cities and towns. Nonetheless, people from minority ethnic backgrounds live in all of Scotland’s Health Board Areas.

Many minority ethnic groups are not likely to be adequately represented within the 2001 census data, including Refugees and Asylum Seekers, people from Turkey, the Middle East and Central or Eastern Europe and Gypsy Travellers. Nonetheless, members of these populations can see themselves as distinct ethnic groups and may face discrimination and disadvantage. In light of these concerns, the ethnicity classification recommended for use in the census was revised in 2008 to address some of these issues. Further information on defining and measuring ethnicity, problems with the census data, and the revisions to future ethnicity classification are discussed in section 6.

While there have been attempts to adapt health and other public services to take account of Scotland’s multicultural and multi-faith society, inequalities in health status and use of services persist between different ethnic groups. People from minority ethnic backgrounds may face obstacles of overt discrimination, racism and stereotyping (hopefully relatively rare occurrences within the NHS), or the more everyday (but no less
important) issues of language barriers and cultural differences in the understanding and provision of services.

The pressure for racial equality in all forms of public service provision comes from many sources, from Government policy to the work of voluntary sector organisations. The following documents provide further reading and background to ethnicity, health and equality in Scotland:

- **NHS Health Scotland: Health in our multi-ethnic Scotland - future research priorities, 2009**
  A report by the Scottish Ethnicity and Health Research Strategy Working group acknowledging the current gaps in knowledge around BME health in Scotland, and proposing future research direction.

- **Chex/Scottish Community Development Centre - policy context, 1997 – 2009**
  A summary of the policy context in health inequalities summarised by a Scottish agency that provides a resource to support community development approaches to reducing health inequality.

- **Equally Well: Report of the ministerial task force on health inequalities, 2008**
  [http://www.scotland.gov.uk/Publications/2008/06/25104032/0](http://www.scotland.gov.uk/Publications/2008/06/25104032/0)
  A report examining all aspects of service provision related to health inequality, providing recommendations to the Scottish Government on future action.

- **Better health, better care, 2007**
  A component of this plan for improving Scotland's healthcare service includes making sure that services are equitable and that the quality of care provided does not vary because of personal characteristics such as ethnicity or socio-economic status.

- **Delivering for Health, 2005**
  A Government document describing a programme of action for the NHS that intends to reduce the reliance on acute care and move towards a system that places more effort on improving health and well-being through preventative measures.

  Report that recommends all organisations in Scotland adopt a mainstreaming approach to tackling racism and promoting race equality. It highlights the importance of race equality training, better information and research, and consultation with minority ethnic communities to get minority ethnic health into the
mainstream of planning, policy design and service delivery.

- **Fair for all: Improving the health of ethnic minority groups and the wider community in Scotland, 2000**
  A Scottish Executive report describing NHS Scotland’s approach to service provision for diverse ethnic groups, outlining best practice in working towards culturally competent services.

- **Equality strategy: Working together for equality, 2000**
  Scottish Executive report demonstrating executive’s drive for equal opportunities and promotion of equality.

- **Our National Health: A plan for action, a plan for change, 2000**
  Describes the Scottish Executive’s commitment to ensuring that NHS staff are professionally and culturally equipped to meet the distinctive needs of people from minority ethnic communities.

- **The Race Relations (Amendment Act) 2000**
  An act which extended the Race Relations Act 1976, placing positive duty on public bodies to promote racial equality, to recognise institutional racism and to work to eradicate it.

### 3.3 Developing appropriate services for BME groups

The policy, legal and guidance documents presented above are not intended to be an exhaustive list, but rather an introductory overview of the key legislative and policy frameworks relevant for professionals working to provide services (including health promotion and stop smoking services) for minority ethnic communities.

Professionals wishing to provide smoking cessation and tobacco education initiatives should be encouraged to create detailed profiles of the population living in their area in order to inform appropriate and culturally sensitive approaches to tobacco education and smoking cessation. Factors such as age, gender, social class, occupation, income, education, family and social networks, ethnicity, religion, housing and place of residence can impact on an individual’s way of life, tobacco use, health status and access to services. This should not be seen as action taken just to comply with legislation or organisational requirement, but rather to maximise the chances of a successful healthcare intervention, as later sections of this review will describe.

While it is important to be aware of the influence that ethnicity may have on a person’s background and lifestyle, it is equally important not to stereotype or make assumptions about people based on their apparent or reported ethnicity. There is great diversity both within and between different ethnic groups, between men and women, between
generations, between people born in the UK and other countries, and between people with different levels of education and language abilities. People from black and minority ethnic communities are not a homogeneous group and their interests, needs and wishes vary as widely as those of the general population.
4. TOBACCO USE AND ETHNICITY

The ethnic composition of the Scottish population is significant for professionals involved in providing information and advice on tobacco use. Culture and tradition shape how people think, feel and represent notions of health and illness. A person’s cultural background may also influence their use of tobacco, attitudes towards tobacco and stopping smoking, and thoughts about health-related information. Types of tobacco used can also vary amongst BME groups. In contrast to the general population, where manufactured cigarettes are by far the dominant form of tobacco use, some non-smoked forms of tobacco have particularly high rates of use among ethnic groups, which has clear implications for service delivery.

This section will profile patterns of tobacco use among the minority ethnic groups in Scotland, focusing on the following topics:

- patterns of smoking, and smoking-related diseases among minority ethnic groups
- the use of non-smoked tobacco products (e.g. paan, gutkha and mishri) and other forms of smoked tobacco (e.g. hookah pipes)
- variations in tobacco use between different sectors of minority ethnic communities (e.g. men and women, different age groups, different ethnic backgrounds)
- experiences of cessation amongst BME groups, current access to services, and challenges and successes.

4.1 Patterns of smoking among minority ethnic groups

Challenges in gathering information

Before describing patterns of tobacco use among minority ethnic groups it is worth discussing the validity of tobacco use surveys in minority ethnic populations. Most research relies on self-reported data, which can be problematic. One issue is under-reporting, particularly when the topic being researched is considered taboo or shameful. Appropriate assurance of anonymity can assist with this. Language difficulties might also be an issue among recent and older immigrants and refugees, who may not have full competency in English. A further challenge for data collection is that some languages have different written and spoken forms (such as Arabic and Cantonese), while other languages may not have a written form at all (like the Sylheti variant of Bengali). Even when professional translations are used, things may be translated literally, rather than using culturally appropriate meanings. 12

A study 13 found that the quality of data obtained from surveys in the UK using languages other than English may be compromised because of inadequacies in the translation procedures, failure to compare questionnaire content across languages, failure to consider the cultural appropriateness of items, and lack of standardisation in terminology, sampling and the grouping of samples. This can lead to inconsistency in prevalence data, as seen in different major UK national studies. The project team for this study developed guidelines on achieving cross-cultural competency and suggest that new questionnaires should be formulated for cross cultural tobacco research.
It is vital that methods used to measure health behaviours such as tobacco use are appropriate, valid and reliable for the group concerned. Researchers working with ethnic minorities should be aware of the customs, values and beliefs of the target group(s) before designing any project. They should take into account the cultural relevance and the subtle connotations of words and phrases to encourage collection of quality data. A 2004 report from the Public Health Sciences Unit at the University of Edinburgh describes the process involved in creating a cross-culturally valid questionnaire that can be used in multi-ethnic surveys to collect high quality data on tobacco use.

**Smoking prevalence amongst ‘visible’ minority ethnic groups**

As discussed, there is currently limited evidence on tobacco use within minority ethnic groups in Scotland; the most recent nationally representative data is from 2004, finding that smoking prevalence was 18% amongst minority ethnic groups compared to 27% amongst white ethnic groups. This data is based on relatively small numbers of survey respondents however, and should be treated with caution.

More comprehensive exists for England, and although the composition of the Scottish versus English BME populations differ, it may nevertheless provide some utility in the absence of more detailed Scottish data. Figure 1 gives the smoking prevalence in England from the 2004 Health Survey.

**Figure 1: Smoking prevalence in England, 1999 and 2004 by ethnicity**

Cigarette smoking prevalence clearly varies across the ethnic groups defined in the survey as well as by gender, and as time passes.

The 2004 data shows the whole population average smoking prevalence in England to be
around 24% in 2004, a statically significant decrease from the level found in 1999. This compares with the following prevalence figures for minority ethnic groups:

- **Black Caribbean**: 2004 rates of cigarette smoking among Black Caribbean women (24%) and men (25%) were around the same as those found in the general population.

- **Indian**: Smoking prevalence in 2004 amongst Indians appears to be slightly lower than the general population for Indian men (20%) and significantly lower for women (5%).

- **Pakistani**: Male Pakistani smoking prevalence in 2004 was slightly higher than the general population (29%), with female Pakistani prevalence being significantly lower (5%).

- **Bangladeshi**: Smoking prevalence was very high amongst Bangladeshi men (40% - the highest prevalence for any subgroup in the survey), and very low for Bangladeshi women (2% - the lowest prevalence for any subgroup in the survey).

- **Chinese**: Male Chinese smoking rates were lower than the general population (21%) with female rates much lower (8%).

- **Irish**: Irish smoking prevalence was higher than in the general population among both men (30%) and women (26%).

Within the general population, adult smoking prevalence tends to decreases with age (that is, those aged 16-34 have the highest prevalence), which was mirrored for Irish and Chinese men. However, for South Asian and Black Caribbean men, smoking was most prevalent amongst 34-55 year olds, bucking this trend.

Comparing cigarette smoking in these populations in 2004 with the data from 1999 shows that most groups in both genders reported lower prevalence in 2004. For men, with the sample size of the survey, only the decreases amongst Black Caribbean, Irish, and men in the general population were statistically significant. For women, only the decrease in prevalence within the general population and the Irish sub-sample were statistically significant, though some other minority ethnic groups also reported a non-significant decrease.

While there have been no equivalent national surveys on minority ethnic tobacco use in Scotland, an exploratory study carried out to examine the perceptions and experiences of tobacco use among Black and minority ethnic adults living in Glasgow in the late 1990s remains useful as a starting point, though it needs to be followed up with work of a broader scope.

This study was predominantly qualitative in approach and most data was collected through one-to-one in-depth interviews with 85 representatives from the four main minority ethnic groups in Glasgow - Pakistani, Indian, Chinese and Black (in this case March 2010).
collectively referring to those describing themselves as Black-Caribbean, Black-African, or Black-other). Nearly 60% of respondents were of Pakistani background. The majority of the respondents were under-35, with a fairly even distribution of male and female respondents. Twenty representatives from organisations working in the field of health and minority ethnic services were also interviewed.

Although the sample is too small to draw meaningful population-level conclusions, the findings of the research suggested that the prevalence of tobacco use amongst the population subgroups studied may be higher than recognised at the time. This was particularly true with the Pakistani respondents, who were the heaviest smokers in the study. There were also indications in the study that smoking was escalating (or perceived to be escalating) among South Asian girls, particularly in Pakistani women. These initial conclusions warrant further investigation.

**Smoking prevalence amongst migrant groups**

Recently there has been interest in research around the smoking prevalence of immigrants to Scotland, particularly from Eastern European members of the expanded EU in 2004 and 2007 who are granted free movement throughout the Union. Smoking prevalence in Eastern European entrants into the Union (such as Poland and the Czech Republic) is typically higher than the UK and it has been hypothesised that the additional pressures and stress of integration to a working life in UK may act as a driver to increased tobacco consumption. Although this review did not find published evidence in Scotland of this, a recent analysis of smoking behaviours among Polish immigrants in Dublin, Ireland, found that prevalence rates were significantly higher amongst Polish immigrants than the general Irish population (47.6% versus 27.8%). In addition, being employed, having only primary-level education, and having a longer stay in Ireland were significant predictors of current smoking amongst Poles dwelling in Ireland. This would appear to lend support to the 'stress of integration' hypothesis.

**Smoking prevalence amongst Gypsy Travellers**

It can be difficult to find information on tobacco use amongst less visible minority ethnic populations, such as Gypsy Travellers, refugees or asylum seekers in the UK. However, it has been documented that these groups often have poor health and face inequalities in accessing services. A recent published study of Gypsies and Travellers resident in England validated these concerns, finding that Gypsies and Travellers were significantly more likely to be current smokers than the general population (58% versus 25%), with correspondingly poorer health outcomes versus comparison groups of African Caribbean and Pakistani Muslim populations, who in turn have poorer health outcomes than white residents of England. It is reasonable to assume that similar issues affect Gypsy Traveller populations north of the border.

There were no published studies found examining smoking behaviour amongst refugees or asylum seekers in Scotland. As is the case with populations who arrive in the UK through other immigration processes, it seems reasonable to hypothesise that variance in
the smoking prevalence and the cultural acceptability of smoking in asylum seekers and refugees' home nations will result in smoking prevalence that differs from the Scottish population average. Studies in other nations have investigated smoking patterns within asylum seekers specifically. An American study of resettled Bosnian refugees examined the connections between smoking status, nicotine dependence and post-traumatic stress disorder (PTSD), finding that severity of PTSD experienced was significantly positively associated with nicotine dependence. A study of Somali immigrants living in Minnesota (Somalis also comprise one of the largest asylum seeking populations in the UK) found high (50%) perceived prevalence of tobacco use, and stressed the importance of social and cultural factors in influencing uptake. Likewise, a Canadian study of tobacco use among immigrants and refugee youth emphasised the importance of social and family influences on smoking, finding that immigrant and refugee youths were more likely to be non-smokers if they did not have a father who smokes and had fewer close friends who smoke. Anti-smoking and tobacco information resources for this population should take account of these influences.

4.2 Smoking-related diseases

The major health problems experienced by minority ethnic groups living in Scotland are similar to those of the majority population: coronary heart disease, stroke and cancer. The fact that smoking is the single greatest cause of preventable illness and premature death in the UK, the prime cause of cancer and coronary heart disease (CHD), and the cause of many other fatal conditions and chronic illnesses (including strokes) is true for everyone, regardless of their ethnicity. Exposure to second-hand smoke (SHS), though virtually eliminated in public settings since the Smoking, Health and Social Care (Scotland) Act came into force in Scotland in 2006, is also an issue for all sectors of society, increasing the risk of lung cancer and coronary heart disease.

Nonetheless, there are considerable differences within and between ethnic groups in patterns of smoking related diseases. It has been suggested that minority ethnic groups in general appear to be at greater risk of developing coronary heart disease and some cancers than Caucasians.

Data from the 2004 English health survey confirms that mortality from coronary heart disease is particularly high among Irish and South Asian groups (particularly Pakistanis and Bangladeshis).

Recent studies examining difference in mortality from circulatory disease in England and Wales (using country of birth as a proxy measure for ethnicity) found that all-cause mortality for people aged 20 and older were significantly higher for people born in Ireland, Scotland, East Africa and West Africa than the population average, and significantly lower for people born in China or Hong Kong. Standardised mortality ratios for circulatory disease were highest among individuals born in Bangladesh (who have the highest male smoking prevalence of any minority ethnic group in the UK) and lowest among those born in China and Hong Kong.
A similar study conducted with Scottish data found that Scottish residents born in Scotland, Northern Ireland, Ireland, India and Hong Kong had high all-cause, coronary heart disease and stroke mortality when compared to England and Wales. While comparisons within the Scottish population do not show the same degree of excess mortality by country of birth as the England and Wales study above, when England and Wales are used as a comparison group a substantial excess coronary heart disease risk amongst South Asians in Scotland also becomes apparent.

The same authors found that the incidence of acute myocardial infarction (AMI - heart attacks) was 60-70% higher among South Asians versus non-South Asians, concluding in a university report that the control of coronary heart disease in South Asian, Scottish-born, and Irish-born populations should be made a key priority.

As mentioned above, less visible minority ethnic populations, such as Gypsy Travellers, refugees or asylum seekers, often have poor health and face inequalities in accessing services. For example, Gypsy Travellers’ life expectancy is up to 10 years less than that of the settled population.

While smoking-related disease is high within the general population of Scotland, making it difficult to disaggregate the impact of tobacco use within particular sub-groups, it is clear that some populations (particularly South Asians) are at increased risk of disease in any instance and hence are highly likely to benefit from culturally appropriate prevention and cessation efforts.

4.3 Smoking initiation among minority ethnic groups

With regards to the reasons why individuals from minority ethnic groups start and continue to smoke, studies found these to be comparable to the reasons commonly cited by the general population. These included ‘friends smoking’ or ‘peer pressure’ and family influence (having a sibling or parent who smoked), and also relaxation, socialising and management of stress and social pressure. The Smoking Prevention Working Group’s report Towards a future without tobacco describes in more detail factors at the individual, personal environment and social and cultural environment that influence smoking uptake.

Other research with minority ethnic young adults has found that for young adults there were similarities with white people regarding the cultural contexts for smoking. Some participants saw smoking as more prevalent in young Bangladeshi and Pakistani women due to western influences, and cited ‘rebellion’ or expressing independence from family members as motivation for young people starting to smoke. While consideration should be made to cultural issues surrounding smoking (particularly gender and religion), many of the reasons for smoking uptake identified in the literature are the same for minority ethnic young people as for the general population.
4.4 Non-smoked tobacco products

As the manufactured cigarette is by far the dominant form of tobacco use amongst the general population in Scotland, the large variety of non-smoked tobacco products, most commonly used within minority ethnic groups has only recently been the focus of study in Scotland.

Tobacco can be consumed orally, as well as smoked. Tobacco can be chewed on its own, or in paan masala when it is mixed with betel nut, areca nut, slaked lime and sometimes flavouring agents. A quid is placed in the mouth, between the gum and cheek and gently sucked or chewed. This can be particularly problematic for health outcomes, as betel-quid and areca nut use is carcinogenic even when no tobacco is used in preparation. 36

Another popular form of chewing tobacco is gutkha, which is a commercially manufactured, flavoured and sweetened tobacco product, often sold in small brightly coloured packets. Other types of chewing tobacco include powder applied to teeth and gums (mishri) and creamy snuff (tobacco toothpaste).

Unlike smoking, chewing tobacco is more socially acceptable among many South Asian communities, including amongst women (where smoking itself can be somewhat taboo). Chewing tobacco is often used to deodorise the mouth after eating and tobacco is sometimes used as an indigestion reliever. Tobacco pastes and powders are marketed in many South Asian countries as dentifrice and hence there is a general misconception that such products are good for the teeth.

There are many distinct types of non-smoked tobacco product, each with their own profile of harm, and often studies attempting to examine the health effects of oral tobacco use are confounded by the carcinogenic properties of ingredients that the tobacco is consumed with (e.g. the areca nut). The consensus of the evidence however, is that chewed tobacco products are associated with an increased risk of mouth and throat cancers among users in India. 37 Epidemiological data from the USA and Asia also shows a raised risk of oral cancer. 38 There are also association between smokeless tobacco and coronary heart disease 39, 40

In a Glasgow-based study 41 on tobacco use in minority ethnic groups, most respondents used tobacco in the form of cigarettes, although a small number of South Asians also used paan. The service providers who took part in the study expressed concern at the easy availability of paan in Asian shops and the lack of warning information on paan packages. Some brands of gutkha also do not mention on the packet that they contain tobacco.

Research in England in 2000 42 found that chewing tobacco products was most prevalent among some South Asian groups, particularly Bangladeshis, with consumption rates higher in older generations. Amongst Bangladeshis, 32% of people surveyed reported chewing tobacco within the last 4 weeks. Rates were particularly high among women aged over 30, with 78% of women aged 30-49 reported recent usage, and 92% of women aged 50-74. Chewing tobacco was less common among Bangladeshi men, but was still
reported by over a third. Chewing tobacco use was more limited in Indian and Pakistani people in England, with only 1-3% of people from these groups reporting recent chewing of tobacco.

The more recent 2004 English survey produced differing figures for the use of oral tobacco (in this survey, if they reported using paan with tobacco, paan with masala, or chewing tobacco). Among Indian and Pakistani groups, use of oral tobacco was low, varying between 1% of Pakistani women to 4% of Indian men. Amongst Bangladeshi respondents, use of oral tobacco was more prevalent (though not to as great a degree as the 2000 survey suggests), with 9% of men and 16% of women reporting use.

Interestingly a study examining under-reporting of tobacco use among Bangladeshi women in the above survey found that around 15% of Bangladeshi women aged 16 years and older under-reported their tobacco use. Under-reporters tended to be older and less educated than cotinine validated non-users of tobacco, and were much more likely to report chewing paan without tobacco.

The following additional resources are available to help inform health practitioners, those working with minority ethnic communities, and others interested in oral tobacco products:

- **Trans-cultural tobacco information sheet and DVD**
  The Minority Ethnic Health Inclusion Project (MEHIP) and ASH Scotland have released a new resource addressing ‘trans-cultural’ tobacco. For more information on the DVD contact MEHIP, Springwell House, Ardmillan Terrace, Edinburgh, EH11 2JL. 0131 537 7565. E-mail: nancy.tonner@nhslothian.scot.nhs.uk

- **Smokeless tobacco fact sheets**
  Compendium of fact sheets on smokeless tobacco products. Includes information about the brand and common names of the products, their geographic location of use, their ingredients, how the products are used, who primarily uses them, and the processes of their manufacture. [http://dccps.nci.nih.gov/TCRB/stfact_sheet_combined10-23-02.pdf](http://dccps.nci.nih.gov/TCRB/stfact_sheet_combined10-23-02.pdf)

- **Smokeless Tobacco and Some Tobacco-specific N-Nitrosamines**

4.5 Other tobacco products

There has been some anecdotal evidence to suggest that *hookah* pipes - used to smoke tobacco filtered through water (also known as *argila, hubbly bubbly, shisha pipe or narghile*) – are increasingly popular in some areas of Britain, both in homes, and in the bar/cafè scene (though the ban on smoking in public places means that the use of these products are no longer permitted indoors).
A study on tobacco use among minority ethnic groups in Glasgow confirmed that a small number of South East Asian respondents – mostly males – were smoking tobacco using hookah pipes. Service providers expressed concern about the general belief among hookah users that tobacco filtered through water is less harmful than cigarette smoking.

A World Health Organisation study group report on waterpipe smoking reviewed what was known at the time about the likely health effects of waterpipe use, concluding that using a waterpipe to smoke tobacco poses a serious potential health hazard to smokers and others exposed to the smoke emitted. However recent analysis shows that, despite recommendations for further research by the WHO report and other sources, what is known about waterpipe smoke and health is fragmented and often contradictory.

Bidis (beedis) are another type of smoked tobacco popular in South Asia. Bidis are thin unfiltered cigarettes that are wrapped in green or brown leaves and tied with a short length of thread. They come in different flavours, such as vanilla, strawberry and chocolate. Although bidi use is generally not documented as a significant issue in the UK, some evidence indicates they have become increasingly popular among young people in the USA and are marketed on the internet. Given the global market in tobacco and the fact that other imported tobacco products (e.g. paan and gutkha) are sometimes sold in Asian food stores, it is worth considering that bidis may become a cause for concern in the UK at a later date.

Even though it is not actually a tobacco product, khat (quat/qat) is a stimulant that is chewed like tobacco or is made into tea or a paste. A study of adult male Yemeni residents in Sheffield and Birmingham found that khat chewing creates dependency and correlates with tobacco smoking and nicotine dependence. Khat has long been consumed by people in some parts of Africa and the Arabian peninsula and has recently turned up in the UK among immigrants from countries such as Somalia, Ethiopia and the Yemen. The effects of Khat are similar to amphetamines and although the plant itself is not controlled under the Misuse of Drugs Act (though it is illegal in most EU countries, the US and Canada), ingredients in the produce (cathinone and cathine) are class C drugs.

Khat’s status is currently being monitored by the Government, but for now it remains a legal, and contentious, product.

4.6 Knowledge of health effects

In the Glasgow-based study on tobacco use within minority ethnic communities, almost all interviewees were aware of the adverse effects of smoking. However, many felt that the perceived beneficial effects – relaxation, socialising and managing stress – outweighed the disadvantages. Survey data from England echoed these findings; in a Health Development Agency report South Asians were found to place greater emphasis on smoking to relieve stress and indigestion, and were less likely to acknowledge the habitual and addictive nature of smoking.

The vast majority of current regular smokers in the first English minority ethnic health and lifestyles study believed that smoking had an effect on their health. Many also identified...
possible future health problems they might encounter due to smoking. When asked to describe what effect their smoking had on their health the most commonly identified factors were breathlessness, coughing, being prone to chest infections and a sense of being less fit - similar effects to those described by respondents in the general population.

The second English health and lifestyles survey looked in more detail at knowledge of specific diseases associated with smoking. The disease most likely to be linked to cigarette smoking by each ethnic group was lung cancer. Knowledge about the links between smoking and other respiratory diseases, heart disease and throat/mouth cancer were poor. Around a quarter of each population linked smoking to heart disease; approximately 50% with lung cancer; between 10-15% with other respiratory disease; and less than 1% of each ethnic group identified throat and mouth cancer as associated with tobacco use. Unfortunately the most recent survey from 2004 did not investigate similar issues so more recent data on awareness of health problems linked to smoking is not readily available.

4.7 Attitudes towards tobacco

Research across the UK has looked at attitudes towards tobacco use within minority ethnic groups. As is the case in any population; tradition, culture and the family play an important part in creating values and norms around smoking.

Interviews with people from Asian backgrounds in Glasgow discovered that tobacco use was perceived to be widespread within their communities, although many respondents believed that smoking was treated with disdain; in particular, smoking by women was often met with disapproval. These attitudes might have an impact on covert smoking practices, which may not be detected by surveys or by health professionals.

Similar findings emerged from a qualitative study on smoking involving interviews with 141 Bangladeshi and Pakistani adults in Newcastle. Four dominant, inter-related themes - gender, age, religion and tradition - appeared to have an important influence on smoking attitudes and behaviours. Smoking was widely accepted and deeply ingrained in Bangladeshi male culture - connected with socialising, sharing and male identity. Among women it was associated with stigma and shame, hence female smoking was often hidden from family members, offering some insight to the particularly low smoking prevalence among Bangladeshi women described previously.

The Newcastle study also found that age influenced the cultural acceptability of smoking. Smoking by young people was regarded as ‘disrespectful’, especially in front of elders, who have a respected status in South Asian society. Therefore, it was more acceptable for older men, and to a lesser extent, older women, to smoke openly, with younger people tending to hide smoking from their elders. There were varied and conflicting interpretations of how acceptable smoking is within Islam and other religions.
4.8 Quit attempts

Some UK-based surveys asked respondents about experiences of giving up smoking. In general, stopping smoking appears to be a more recent phenomenon in the minority groups than in the wider population, at least in the English context, with African-Caribbean and South Asian groups reporting they were less likely to give up smoking than the wider population.58

The table below shows the proportion of people who were ex-regular smokers, among people who had ever smoked, at the time of the second English minority ethnic health and lifestyle survey and the Chinese health and lifestyle survey, 2000. This shows that a higher proportion of the general English population were former smokers than among the minority ethnic groups. Ex-smokers within the minority ethnic groups tended to report having quit recently.

**Figure 2: Proportion of ex-regular smokers, amongst people who had ever smoked**

<table>
<thead>
<tr>
<th></th>
<th>All of England</th>
<th>Bangladeshi</th>
<th>African Caribbean</th>
<th>Pakistani</th>
<th>Chinese</th>
<th>Indian</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>46</td>
<td>17</td>
<td>28</td>
<td>26</td>
<td>10</td>
<td>35</td>
</tr>
</tbody>
</table>

**Source:** Black and Minority Ethnic Groups in England: The Second Health and Lifestyle Survey59 and HEA Health and Lifestyles of the Chinese Population in England60

In Scotland, which has a smaller proportion of BME population than England, official statistics from stop-smoking services can only tell us that around 1% of the clients who set a quit date with the service in the most recent year (2008) of recording were from an ethnic group other than ‘White-British’ or ‘White other’.61 A previous analysis of Scottish cessation service data from 200762 found that the highest four-week cessation rates were observed in Black, White-Other and White-British groups (40-42%) and the lowest in mixed ethnic groups (33%), though the small number of records for clients from these groups mean that the results are unlikely to be statistically reliable. If there is a difference in quit success based on ethnic group in Scotland it is likely to be a relatively small effect.

In North-East England, smokers from BME groups were reportedly less likely to access cessation services, though did not seem to be less likely to be successful in quitting.63 National data from stop-smoking services across England as a whole found that, in the most recent years (08/09) individuals from minority ethnic groups accounted for 7% of those who set a quit date, representing an increase from 6% in 07/08 and 3% in 01/02.64 Contrasting with the general population, where women are more likely to set a quit date with the services than men, for minority ethnic groups the situation was reversed with nearly twice as many men than women setting a quit date. Examining quit success, individuals from minority ethnic groups were likely to be similarly successful with quit rates for the Asian (48% quit at four weeks), Black (45%), and Chinese or other groups (47%) being comparable with the population average (50%).
No studies in Scotland were found examining the likelihood of receiving advice to quit from GPs or other physicians based on ethnicity, though an American study based on survey data demonstrated differences in the likelihood in some subgroups, in some survey years, emphasising the importance of guidance to primary care physicians stressing that all individuals should be asked about tobacco use and encouraged to stop, regardless of ethnic group.

Qualitative research in England uncovered more detail about reasons why people from minority ethnic backgrounds stop smoking. A number of factors were cited as influencing the desire to stop smoking, although many of these were hypothetical and related to possible reasons for giving up in the future. Religious factors were cited across all ethnic groups and Ramadan was cited as an influence to give up by some Muslims. The majority of participants expressed little desire to give up smoking because they enjoyed it, felt it contributed to their quality of life or because it was a coping mechanism in stressful situations.

A recent report commissioned by NHS Health Scotland describes a systematic review of health promotion interventions involving Pakistani, Chinese and Indian communities in relation to cardiovascular disease and cancer prevention. The report describes the lack of evidence in this area and provides pointers and recommendations for those who plan services and research. Conference papers and presentations on follow-up work to this report by a team of researchers in Edinburgh who have established a project to explore the modification of health promotion interventions with ethnic minorities are also available. Part of this follow-up work explores the provision of smoking cessation interventions and is of interest to those who plan and provide these interventions.

Current clinical guidance for specialist stop-smoking services from the National Institute for Health and Clinical Excellence recommends that NHS stop-smoking services target minority ethnic groups at least in proportion to their representation in the local population of tobacco users. Forthcoming guidance for Scotland due to be published in May 2010 will support this recommendation for service managers, planners and commissioners in Scotland.

### 4.9 Approaches to stopping smoking

A mapping exercise was carried out in England to find out about black and minority ethnic tobacco prevention resources. The mapping report notes examples of initiatives geared at tackling tobacco use, including non-English language quitlines, a Department of Health Asian media campaign, the transcultural tobacco website and various projects and services in operation throughout the country. The information on tobacco cessation and information services presents suggestions for approaches that could be adopted elsewhere and can be used to inform good practice.

ASH Scotland undertook a similar mapping exercise in 2004/5 through literature review, mapping of services and resources, interviews with service providers, and focus groups with community members. Conclusions and proposed actions were that: people from the target groups do not always receive appropriate advice or support to address...
their tobacco use; services should be better integrated to meet client needs; and evaluated pilot projects should be established to test new and innovative approaches when working with particular inequality groups. As one output of the mapping exercise, a resource directory was created, which includes a section on resources, projects and services, training, and contacts for organisations working with minority ethnic communities. The resource is available from:
(Note that it may not reflect the most recently created resources and services.)

A Glasgow-based study \(^{73}\) found that smokers were more likely to attempt to give up unaided and to seek advice on smoking cessation within their own social circles rather than through professional agencies. There was generally a low level of awareness regarding anti-tobacco agencies, pharmacological aids (e.g. Nicotine Replacement Therapy [NRT] and Bupropion [Zyban]) and prevention materials. Anti-tobacco material was criticised for lacking visual representation of people from minority ethnic backgrounds and it was commented that it was often not suitable for older members of the community. The majority of participants in the research thought that smoking cessation services would not be able to provide the necessary information and support, in an appropriate manner. Respondents generally felt that inclusive strategies within mainstream services and proactive approaches by agencies in the field would be the most effective way to address smoking with minority ethnic communities.

Since the 2000 Glasgow study, pilot projects and research over the last ten years have also looked in detail at the methods used by people from minority ethnic backgrounds in their attempts to stop smoking and at their attitudes towards information on the health risks of tobacco. Projects managed by ASH Scotland and PATH with full reports available on the ASH Scotland website \(^{74}\) include:

- **REACH Community Health project:** Action research to investigate the reasons why young people from BME communities in Glasgow smoke, that informed the development of an audiovisual education DVD.

- **Save the Children (Scotland):** Developed a tobacco awareness programme aimed at young Gypsy and Travellers.

- **Minority Ethnic Health Inclusion project:** Used their funding to raise awareness of smokeless tobacco products amongst the South Asian community in Edinburgh. A multimedia DVD was produced as a result of the work.

- **Edinburgh Dental Institute:** In partnership with MEHIP (above) tackled the issue of chewed tobacco and its impact on oral health through production of a multilingual patient information leaflet.

- **Voluntary Action Lochaber (Fort William):** Worked to develop a culturally sensitive, partnership approach to deliver stop-smoking support to gypsy and travellers.
University of Edinburgh: Conduced research to develop cross-culturally valid methods for measuring prevalence of smoking and tobacco use in Punjabi, Urdu, Sylheti and Cantonese.

Some of these findings from pilot or community research in Scotland are similar to larger scale survey data from England. The first minority ethnic health and lifestyles survey asked current smokers who have tried to give up about their use of cessation aids. Figure 3 below shows the proportion of people from different ethnic groups who used different methods to help them stop smoking.

Figure 3: Use of aids to give up smoking amongst minority ethnic groups

<table>
<thead>
<tr>
<th></th>
<th>UK population</th>
<th>Bangladeshi</th>
<th>African Caribbean</th>
<th>Pakistani</th>
<th>Indian</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Help &amp; support from family</td>
<td>22</td>
<td>17</td>
<td>15</td>
<td>21</td>
<td>32</td>
</tr>
<tr>
<td>% Help &amp; support from friends</td>
<td>15</td>
<td>11</td>
<td>8</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>% Help &amp; support at work</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>% Advice from doctor</td>
<td>10</td>
<td>23</td>
<td>9</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>% Prescription from doctor</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>% Aid bought from chemist</td>
<td>21</td>
<td>6</td>
<td>7</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>% Special clinic/group</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>% Advice booklets</td>
<td>14</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>% Counselling</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>&lt;0.5</td>
</tr>
<tr>
<td>% Alternative treatment</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>&lt;0.5</td>
<td>&lt;0.5</td>
</tr>
<tr>
<td>% None of these</td>
<td>46</td>
<td>52</td>
<td>65</td>
<td>48</td>
<td>37</td>
</tr>
</tbody>
</table>

Base: Current smokers who have tried to give up
Source: Health and Lifestyles: Black and Minority Ethnic Groups in England. 76

Social support was most frequently mentioned amongst the South Asian groups, with medical advice also playing a significant role. Other aids, such as Nicotine Replacement Therapy (NRT) or advice leaflets were less frequently mentioned. Across all groups, people who tried to give up smoking were most likely not to use any aids in their quit attempt. Indian smokers tend to rely on support from their family, while Bangladeshis are more likely to follow advice from their doctor. However this data is aging rapidly now, and national statistics from the English stop-smoking services indicate that mainstream NHS stop-smoking services are being accessed by minority ethnic groups though not to the same degree as the general population. No data of this nature is available for Scotland.

In addition to smoking cessation, some projects have worked on oral tobacco cessation with South Asian groups. Smokeless tobacco cessation guidelines have been issued in England. 77 The guidelines recommend offering advice to stop, combined with behavioural support and counselling, but state that there is insufficient evidence at
present to recommend the use of Nicotine Replacement Therapy (NRT) or Bupropion (Zyban) to aid smokeless tobacco cessation. These guidelines also recommend that health professionals, especially doctors and dentists, should routinely assess and record smokeless tobacco use in patients belonging to relatively high prevalence groups, and that they should educate smokeless tobacco users to the potential health risks and offer advice to stop.

Emphasising the importance of culturally-appropriate interventions, mentioned elsewhere in this review, a study from the USA aimed at measuring the effectiveness of the REACH initiative (Racial and Ethnic Approaches to Community Health) found the decreases in smoking prevalence in Asian communities served by the project were greater than those without, suggesting the approach may show some promise.

Looking at culturally-specific materials in particular, an American pilot study examining the efficacy of a culturally specific booklet amongst an African American population found that, while culturally specific materials were more effective at capturing attention and gaining interest than generic materials among the target population, they did not result in a difference in quit outcomes.

An oral tobacco cessation pilot in Tower Hamlets, London, working with 130 Bangladeshi women, found that NRT was helpful, in combination with encouragement, but that oral pain was reported as a barrier to successful cessation. However, a more recent systematic review of interventions to help people stop using smokeless tobacco found that pharmacotherapy such as NRT did not increase quit success, though behavioural interventions and counselling (including after an oral examination by a dentist or hygienist) may help patients to stop. All studies examined in this review were conducted in the United States however, where the nature of and types of smokeless tobacco use can differ from that as used by minority ethnic groups in the UK.
5. CONCLUSIONS

Literature summarised in this review suggests that the prevalence of tobacco use is high amongst certain minority ethnic groups in England; it is likely that the same patterns are prevalent amongst the same ethnic groups who reside in Scotland. There is a growing body of evidence on how to tackle use of tobacco in minority ethnic groups (including smokeless tobacco), with several resources and tools available developed in Scotland to meet the needs of particular population or professional groups.

Evidence on access to, and outcomes of, cessation services for BME groups is limited in Scotland due to small sample sizes. However more extensive data from England demonstrate that, although minority ethnic groups seem to access services less than the general population, they have quit outcomes that are broadly comparable. Given that, there is still a need to adapt and test culturally appropriate smoking cessation interventions for minority ethnic groups, as should be the case for any significant subgroup of the population who have different service needs.

Health professionals and service planners who provide services for minority ethnic groups should familiarise themselves with the available evidence on the population characteristics of the groups they intend to serve. They should be aware of the size of ethnic groups, their distribution within their locality, and be sensitive to cultural, linguistic and religious influences. The context of deprivation, social exclusion and labour market disadvantage (including low pay and unemployment) should also be considered as key factors in tobacco use. It is important not to make assumptions about the needs of individuals from minority ethnic backgrounds or adopt a ‘one size fits all’ approach; individuals from ethnic minorities are individuals as well as members of their respective ethnic groups.

Underpinning all of these actions is the need for good information on the composition of ethnic groups within Scotland, and their health behaviours, attitudes and beliefs. It is disappointing that, in nearly six years since this literature review was originally published, there has been little progress in understanding the particular population composition and health behaviours of BME groups in Scotland at the national level through national statistics or reporting – the reason this review relies heavily on information from England.

Although there have been a range of encouraging and enlightening research papers, pilot projects and local initiatives carried out and published since 2004, there has been less progress than would be desirable at the national level in better understanding these issues (though for understandable reasons, such as the relatively small – when compared to England – proportion of Scotland’s populations who identify as being from a minority ethnic group). Although the next census in 2011 will provide a much-needed update of our central source of information on BME groups in Scotland, it is hoped that those awaiting the next important update of our knowledge in this area will not have to wait a further decade for new information.
6. APPENDIX - Ethnicity in Scotland

This appendix contains information that may be of interest to people who would like to read more about the concept of ethnicity and the ethnic composition of Scotland’s population.

6.1 Defining ethnicity

There is a great deal of debate surrounding the term ‘ethnicity’; both race and ethnicity are socially constructed and imposed labels of identity that categorise people according to one or more of the following characteristics: physical appearance such as skin colour, facial features or hair type, or geographic or ancestral origins.

Ethnic labels are designations assigned to people by someone else, based on a set of criteria that distinguishes them from others in the eyes of whoever controls the categorisation. Concepts and definitions of ethnic minorities vary widely from one country to another and may include:

- **visible minorities**: those who are vulnerable to discrimination, largely because of physical characteristics, but also because of other features such as name
- **assimilated minorities**: usually white citizens originally from another country
- **recent arrivals**: refugees, asylum seekers and illegal immigrants (including those from Central and Eastern Europe and ‘visible minorities’ from Africa, Asia or the Middle East)
- **minorities regarded as nomadic**: includes Gypsy Travellers and Roma (who may actually be settled)
- **Jewish communities**

As ethnic classifications are based on a limited set of criteria, such as skin colour, religion, nationality or ancestry, they may not do justice to how an individual perceives themselves. Ethnic terminology should therefore be used with an awareness that the peoples to whom they are applied may neither identify their ethnicity as such, nor share a common culture. Indeed, a person’s sense of ethnicity may change depending on the situation, time and place they are in.

In the Scottish context of this report, the majority ethnic population are those classified as White, while the ‘minority ethnic’ or ‘BME’ population refers to all other ethnic groups. In its broadest sense the term ‘minority ethnic’ captures the diversity that exists in Scotland. It includes all ‘visible’ minority ethnic communities - those born in the Asian and African continents and their descendants - who are most easily distinguished as ‘different’ by physical traits such as skin colour, facial appearance or hair type, and who are particularly susceptible to racial discrimination and disadvantage. It also includes less visible groups such as Gypsy Travellers, asylum seekers and refugees (who may or may not classify themselves as ‘White’), as well as religious or faith communities.
6.2 Measuring ethnicity

The current preference when gathering data on ethnicity is for self-assessment, although alternative methods such as assigning ethnicity based on skin colour, name, nationality, birthplace and ancestry also exist.

The main source of data on ethnicity in Scotland comes from the national population census, relied on extensively in the main section of this review, the last of which was in 2001. The 2001 census gave the following options for ethnicity:

A) White  
B) Mixed  
C) Asian (including Asian Scottish or Asian British)  
D) Black, (including Black Scottish or Black British)  
E) Other ethnic background

Although self-assessment of ethnicity provides basic information on the ethnic composition of a population, this approach can be problematic. Ethnicity classifications in the census are based on a mix of skin colour, nationality, and country of descent, which may not do justice to a person’s self-image or identity. As a person’s ethnicity can change according to the context they are in, and may alter over time, making longitudinal comparisons can be difficult.

A number of issues can affect the reliability of ethnicity data from the census. One issue is that within the ethnic groups there may be heterogeneous groups with different languages, customs and religions. For example, the term ‘White’ is very broad and can lead to the invisibility of some ethnic groups (e.g. Gypsy Travellers, migrants from Eastern Europe, Turkey or the Middle East, or Irish minorities); likewise the term ‘Indian’ encompasses a range of diverse ethnic identities and religions.

In response to these, and other issues, in 2008 the Scottish Government and the General Register Office for Scotland, following extensive consultation, revised the classification.85 The new classifications are overleaf in Figure 4:
Figure 4: Ethnicity questions in the 2001 Scottish Census

A. White

- Scottish
- English
- Welsh
- Northern Irish
- British
- Irish
- Gypsy/Traveller
- Polish
- Any other white ethnic group, please specify

B. Mixed or multiple ethnic groups

- Any mixed or multiple ethnic groups, please specify

C. Asian, Asian Scottish or Asian British

- Pakistani, Pakistani Scottish or Pakistani British
- Indian, Indian Scottish or Indian British
- Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Chinese, Chinese Scottish or Chinese British
- Other, please specify

D. African, Caribbean or Black

- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British
- Black, Black Scottish or Black British
- Other, please specify

E. Other ethnic group

- Arab
- Other, please specify

- Not Disclosed

The report accompanying the change summarised the decision-making process and rationale behind the changes in further detail.

6.3 The ethnic composition of Scotland’s population

The total population of Scotland recorded at the 2001 census was just over 5 million (5062011). Data on the ethnic composition of the Scottish population is presented in the following table:

Figure 5: Ethnic composition of Scotland at 2001 Census

<table>
<thead>
<tr>
<th></th>
<th>All People</th>
<th>White</th>
<th>Pakistani/Other S. Asian</th>
<th>Chinese</th>
<th>Indian</th>
<th>Mixed</th>
<th>‘Other’</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>5062011</td>
<td>4960334</td>
<td>39970</td>
<td>16310</td>
<td>15037</td>
<td>12764</td>
<td>9571</td>
<td>8025</td>
</tr>
<tr>
<td>Percentage of total</td>
<td>100.0</td>
<td>98.0</td>
<td>0.8</td>
<td>0.3</td>
<td>0.3</td>
<td>0.25</td>
<td>0.19</td>
<td>0.16</td>
</tr>
</tbody>
</table>

Source: Data from 2001 Census, (tables S201 and UV10) General Register Office for Scotland
The largest ethnic group in Scotland is people who identified themselves as White, representing 98% of the population. The remaining 2% are from minority ethnic backgrounds, including Asian, Black, Mixed and Other ethnicity. This is a rise since the last census in 1991, when 1.3% of the population classified themselves as belonging to one of the non-White backgrounds.

Asian groups (Asian, Asian Scottish or Asian British) together represent 1.4% of the population. The largest of these groups is Pakistani/Other South Asian (including Bangladeshi), which comprises 0.8% of the population in Scotland, followed by Chinese and Indian, which each represent 0.3% of the population. Together all other ethnic groups (including Black, Mixed and Other ethnic background) represent 0.6% of the population in Scotland. The Black population (Black, Black Scottish or Black British) in Scotland is the smallest individual minority group, with 0.16% of the total.

The ethnic composition varies across the UK with Scotland and Wales typically having less ethnic diversity than England (particularly major English population centres like London). The 2001 Census showed that the percentage of the total UK population identifying themselves as White was 92.1%, with 7.9% from minority ethnic backgrounds. In the whole of the UK, people identifying themselves as Black make up 2.0% of the total population (this includes Black British, Black Caribbean, Black African and Black Other), followed by Indians at 1.8% and Pakistanis at 1.3% of the total population.

6.4 The ethnic composition of different regions

The 2001 Census data can be broken down into different geographic areas: Scottish Parliamentary Constituency; Scottish Parliamentary Region; Local Council Area; Health Board Area; Census Area Sector and Census Area Ward. Breaking the Census data down into regions gives information about the ethnic composition of different parts of the country.

The Census data was analysed for each of the fifteen NHS Scotland Health Board Areas. (On 1st April 2006, NHS Argyll and Clyde was merged with two other health boards: NHS Highland and NHS Greater Glasgow – this amalgamation becoming NHS Greater Glasgow and Clyde. Unfortunately, no more recent national census data is available at time of writing that reflects this change). These delineations are used for the purposes of health service provision and funding. Furthermore, smoking cessation services and other community based health initiatives often operate at Health Board level.
Figure 5: Population by Health Board Area, as of the 2001 census

![Bar chart showing population by Health Board Area](chart.png)

Health Board Area

Source: Data from 2001 Census, (table S201) General Register Office for Scotland

Figure 5, above, shows the overall population in each of the Health Board Areas. The most populous areas are Greater Glasgow and Lothian Health Boards, which serve the populations of Scotland’s two largest cities – Glasgow and Edinburgh. Both have populations of over 700,000 people.

The next most populous areas are Lanarkshire and Grampian, with around 520,000 and 550,000 residents. Grampian is home to Scotland’s third largest city, Aberdeen, while Lanarkshire encompasses many central belt towns and parts of the Greater Glasgow conurbation. The next five Health Board Areas (Argyll and Clyde, Tayside, Ayrshire and Arran, Fife and Forth Valley) have between 420,000 and 270,000 residents. Again these are all areas in South Central Scotland with many large and small towns.

The following three Health Board Areas (Highland, Dumfries and Galloway and Borders) have between 210,000 and 100,000 people, representing more sparsely populated towns and rural areas in the north and south of mainland Scotland. The remaining areas – the island Health Boards - (Western Isles, Shetland and Orkney) have less than 27,000 inhabitants.

Figure 6, over, shows the ethnic composition of the different Health Board Areas, from the area with the biggest minority ethnic population, down to the smallest. The aggregate number of all minority ethnic groups (e.g. Asian, Black, Mixed and Other) is presented to...
facilitate analysis, as the number of individuals from the different ethnic classifications can be small at Health Board level.

Figure 6: Minority ethnic population by Health Board Area at 2001 Census

<table>
<thead>
<tr>
<th>Area (Health Board)</th>
<th>Total population</th>
<th>Absolute minority ethnic population (total)</th>
<th>Relative minority ethnic population (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>5062011</td>
<td>101677</td>
<td>2.0</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>867150</td>
<td>39318</td>
<td>4.5</td>
</tr>
<tr>
<td>Lothian</td>
<td>778367</td>
<td>21783</td>
<td>2.8</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>552819</td>
<td>6559</td>
<td>1.2</td>
</tr>
<tr>
<td>Grampian</td>
<td>525936</td>
<td>8544</td>
<td>1.6</td>
</tr>
<tr>
<td>Argyll and Clyde</td>
<td>420491</td>
<td>4144</td>
<td>1.0</td>
</tr>
<tr>
<td>Tayside</td>
<td>389012</td>
<td>7495</td>
<td>1.9</td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>368149</td>
<td>2509</td>
<td>0.7</td>
</tr>
<tr>
<td>Fife</td>
<td>349429</td>
<td>4426</td>
<td>1.3</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>279480</td>
<td>3180</td>
<td>1.1</td>
</tr>
<tr>
<td>Highland</td>
<td>208914</td>
<td>1671</td>
<td>0.8</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>147765</td>
<td>969</td>
<td>0.7</td>
</tr>
<tr>
<td>Borders</td>
<td>106764</td>
<td>589</td>
<td>0.6</td>
</tr>
<tr>
<td>Western Isles</td>
<td>26502</td>
<td>172</td>
<td>0.6</td>
</tr>
<tr>
<td>Shetland</td>
<td>21988</td>
<td>232</td>
<td>1.1</td>
</tr>
<tr>
<td>Orkney</td>
<td>19245</td>
<td>86</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Source: Data from 2001 Census, (table S201) General Register Office for Scotland

Unsurprisingly, the areas with the larger total populations have higher minority ethnic populations - in both absolute and relative terms. The largest minority ethnic populations are in and around Scotland’s two largest cities - Glasgow and Edinburgh. The percentage of individuals from minority ethnic groups in both areas is above the Scottish average of 2.0%. The figure is particularly high for Greater Glasgow Health Board Area where 4.5% of the population identified themselves as from minority ethnic backgrounds. Other areas with sizeable minority ethnic populations are those with Scotland’s other main cities (Aberdeen and Dundee), larger towns and urban sprawls in the central belt. Smaller numbers of minority ethnic groups are found in the more rural regions of Scotland, around the Borders and the Highlands and Islands.
It is worth mentioning here that a commitment to providing culturally sensitive services is important in all areas of Scotland, even those with smaller minority ethnic populations. A report on rural racism in Scotland entitled ‘Needs not numbers’ noted that minority ethnic groups in rural areas experience racism, discrimination and isolation, and do not have sufficient access to the services they need. Uptake of services was often low, due to a lack of information about what was available, language barriers and the inappropriateness of services for the needs of minority ethnic groups. This report challenged the presumption that race equality issues are relevant only to areas with substantial numbers of minority ethnic groups.

By breaking down the total minority ethnic population into discrete categories, the ethnic composition of different areas can be compared. In all Health Boards either Pakistani/Other South Asian or Other ethnicities (e.g. Black, Mixed and Other combined) were the largest minority ethnic groups. The pie charts and tables below illustrate that there is some variation in the ethnic composition of different regions.

Comparing the charts for the two main areas of minority ethnic settlement – Greater Glasgow and Lothian – shows differences between the ethnic compositions of these cities. More than half of Greater Glasgow’s ethnic minorities are from Pakistani/Other South Asian backgrounds, with Chinese representing the smallest group.

**Figure 7**

![Cultural backgrounds of Greater Glasgow Health Board’s Minority Ethnic Population](chart)

**Source:** Data from 2001 Census, (table S201) General Register Office for Scotland

In Lothian, on the other hand, there are roughly equal numbers of Pakistani/Other South Asian people and individuals from ‘Other’ ethnic backgrounds (Black, Mixed and Other), followed by Chinese.
A further example illustrating local variance is from Ayrshire and Arran, where Chinese is the largest single minority ethnic group (after ‘Other’ combined), and Pakistani is marginally the smallest.

Minority ethnic populations are concentrated in Scotland’s main towns and cities, but people from different ethnic backgrounds live in every Health Board. Overall, the largest single ethnic group are those from Asian descent, especially from Pakistan, followed by people of Chinese descent and then from India. Many others identified themselves as being of Mixed or Other ethnicities. The Black population of Scotland is the smallest overall ethnic group. The picture is subject to some regional variation, with different ethnic compositions in different areas. Given the differences that exist, local areas should be encouraged to create their own ethnic profiles.
6.5 Invisible minorities

‘Invisible’ minority ethnic populations in Scotland may not be adequately represented within the 2001 Census data though are likely to be better represented in the 2011 and subsequent years following the change in classifications described above. Hidden populations include people from the Middle East and Central or Eastern Europe who might identify themselves as ‘White’ but could arguably be defined as distinct ethnic groups facing discrimination and disadvantage. The same applies to traditionally nomadic groups such as Gypsy Travellers (who may actually be living in fixed accommodation) and ‘newcomers’ such as refugees, asylum seekers and illegal immigrants.

The Scottish Executive recognises Gypsy Travellers as a distinct ethnic group and identifies them as a specific community of interest in their work. In relation to health and social care, organisations are recommended to develop and implement strategies to improve their liaison with Gypsy Traveller communities and include them in consultations, and to train staff on Gypsy Traveller cultural values.

It is similarly difficult to estimate the numbers of asylum seekers and refugees currently residing in Scotland. This population is reported to be extremely diverse, including those from Afghanistan, Sri Lanka, Iraq, Iran, Bosnia, Kosovo, Sudan, Somalia, Russia, Estonia and Chile 88 (Macaskill and Petrie, 2000). These communities may also face inequalities, isolation, ill-health and cultural or linguistic barriers to communication. Particular action plans for health and social care in relation to asylum seekers and refugees have been identified, with organisations encouraged to provide culturally sensitive services.

6.6 Demographic and socio-economic profiles

In addition to questions on ethnicity, the 2001 Scottish Census included questions on occupation, unemployment, housing, age, gender, and religion, which are useful for building up a more detailed picture of the minority ethnic population in Scotland. Such demographic and socio-economic factors are important considerations as they influence a person’s lifestyle and behaviours, which may in turn impact on their tobacco usage, health status and uptake of services.

A common inference is that ethnic health differences are a consequence of genetic factors or cultural differences. While culture, religion and beliefs are certainly significant influences on lifestyle and behaviour, other explanations, such as deprivation, employment and housing are also important.

The following section documents some findings from the 2001 Census relating to minority ethnic groups which may have an impact on health, lifestyles and tobacco usage, or which may be important considerations for those trying to provide culturally sensitive services. The findings are supplemented by information from other studies when appropriate.
Employment status

Occupation classifications are used as proxy measurements for socio-economic status, to assess levels of relative deprivation within a given population. A person’s employment status can have a bearing on their social and material environment, lifestyle and health behaviours. For example, stressors associated with financial hardship and isolation can contribute to greater cigarette smoking as a coping mechanism. Deprivation is strongly associated with health inequalities and higher levels of tobacco use.

Figure 10 shows socio-economic classifications for the main ethnic groups in Scotland, as a percentage of each groups’ working age population.

Figure 10: Socio-economic classifications for different ethnic groups. (As a proportion of each ethnic group’s workforce)

<table>
<thead>
<tr>
<th>Classification</th>
<th>White</th>
<th>Indian</th>
<th>Pakistani/Other S. Asian</th>
<th>Chinese</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Higher managerial &amp; professional occupations</td>
<td>6.8</td>
<td>18.8</td>
<td>6.0</td>
<td>8.1</td>
<td>10.9</td>
</tr>
<tr>
<td>2. Lower managerial &amp; professional occupations</td>
<td>17.5</td>
<td>11.9</td>
<td>8.6</td>
<td>7.7</td>
<td>14.8</td>
</tr>
<tr>
<td>3. Intermediate occupations</td>
<td>9.5</td>
<td>5.7</td>
<td>5.2</td>
<td>3.7</td>
<td>6.7</td>
</tr>
<tr>
<td>4. Small employers and own account workers</td>
<td>5.6</td>
<td>11.8</td>
<td>14.3</td>
<td>13.1</td>
<td>4.3</td>
</tr>
<tr>
<td>5. Lower supervisory and technical occupations</td>
<td>7.5</td>
<td>2.6</td>
<td>3.0</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>6. Semi-routine occupations</td>
<td>12.6</td>
<td>8.8</td>
<td>11.9</td>
<td>14.7</td>
<td>9.2</td>
</tr>
<tr>
<td>7. Routine occupations</td>
<td>10.5</td>
<td>4.0</td>
<td>4.0</td>
<td>4.5</td>
<td>6.2</td>
</tr>
<tr>
<td>8. Never worked and long-term unemployed</td>
<td>4.0</td>
<td>10.3</td>
<td>21.5</td>
<td>7.6</td>
<td>9.8</td>
</tr>
</tbody>
</table>

Source: Data from 2001 Census, (table S213) General Register Office for Scotland - For long term unemployed the last year worked was before 1999

The most common classifications for White people in Scotland were lower managerial and professional occupations, semi-routine and routine occupations. This pattern is quite different among minority ethnic groups. The proportionate number of workers in higher managerial and professional occupations is significantly higher amongst those from Indian backgrounds (18.8%) than it is for Whites (6.8%). It is also greater among those from ‘Other ethnic’ backgrounds (10.9%) and among those of Chinese origin (8.1%). Nonetheless, there are lower proportions of people from all minority ethnic backgrounds
(between 8.6% among those of Pakistani/Other South Asian origin and 14.8% among ‘Other ethnicities’) in lower managerial and professional backgrounds than among White people (17.5%).

Minority groups of Asian origin (both those from the Indian subcontinent and China) are more likely to be self-employed or work for small employers. Only 5.6% of the White workforce is included in this category, compared to 14% of Pakistanis/Other South Asians, 13.1% of Chinese and 11.8% of Indians. This is reflected in the high numbers of Asians who work in the retail trade and in restaurants. At the 2001 Census 5049 people whose ethnic background is in the Indian sub-continent (e.g. India, Pakistan, Bangladesh) stated that they worked in wholesale and retail trades. Many Asians in Scotland also work in the hospitality industry, with 3283 people of Chinese origin working in restaurants and hotels, and 2416 South Asians.

On balance, minority ethnic groups appear to be disadvantaged in the labour market in comparison to White people. Figure 10, above, shows that the percentages of people who have never worked or are long term unemployed are greater for all minority ethnic groups than they are for Whites. This is particularly true for those from Pakistani or Other South Asian backgrounds, who are more likely than any other ethnic group to have never worked or be long term unemployed (figures are five times greater for Pakistanis/Other South Asians than Whites). As aforementioned, smoking prevalence is associated with financial hardship and isolation, and is particularly high amongst the unemployed.

Rates of economic activity are also lower among women from minority ethnic backgrounds than for White women. Figure 11, below shows the percentage of women over the age of 25 whose primary occupation is looking after the home and/or family.

**Figure 11**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistani and other South Asian</td>
<td>40.0</td>
</tr>
<tr>
<td>Indian</td>
<td>35.0</td>
</tr>
<tr>
<td>Chinese</td>
<td>25.0</td>
</tr>
<tr>
<td>Other</td>
<td>15.0</td>
</tr>
<tr>
<td>White</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Around twice as many women from Indian, Chinese and ‘Other’ ethnic backgrounds are primarily homemakers than White women. The figure is over three times higher for Pakistani/Other South Asian women. This may be significant in relation to tobacco use in women from minority ethnic backgrounds. In the general population smoking has been identified as a coping mechanism in situations where people feel isolated or excluded from wider society.

**Housing and households**

Housing tenure is another indicator of socio-economic status. As with employment, the social and material environment in which a person lives may have a bearing on their lifestyle, behaviours and health status. Occupancy of council or other socially rented accommodation and/or overcrowding can be used as proxy measures for deprivation. Figure 12 shows the housing tenure of households from different ethnic backgrounds in Scotland.

**Figure 12: Housing tenure of Scottish households, by ethnic group**

<table>
<thead>
<tr>
<th></th>
<th>All Households</th>
<th>White</th>
<th>Indian</th>
<th>Pakistani/Other S Asian</th>
<th>Chinese</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Households</strong></td>
<td>2192246</td>
<td>2161597</td>
<td>4935</td>
<td>10600</td>
<td>5400</td>
<td>9714</td>
</tr>
<tr>
<td><strong>Owned</strong></td>
<td>1372103</td>
<td>1354636</td>
<td>3231</td>
<td>6668</td>
<td>3506</td>
<td>4062</td>
</tr>
<tr>
<td><strong>Rented from council</strong></td>
<td>472894</td>
<td>469266</td>
<td>291</td>
<td>1074</td>
<td>472</td>
<td>1791</td>
</tr>
<tr>
<td><strong>Other social rented</strong></td>
<td>122249</td>
<td>120489</td>
<td>179</td>
<td>616</td>
<td>227</td>
<td>738</td>
</tr>
<tr>
<td><strong>Private rented or living rent free</strong></td>
<td>225000</td>
<td>217206</td>
<td>1234</td>
<td>2242</td>
<td>1195</td>
<td>3123</td>
</tr>
</tbody>
</table>

The proportion of households from each ethnic group owning their homes is roughly similar (between 60-65%), although it is slightly lower for ‘Other’ ethnicities (i.e. not White or Asian). Minority ethnic groups are less likely to rent from the council than White people, except for ‘Other’ ethnicities who are as likely as White people to be council tenants. There is little difference in the proportions of different ethnic groups in other social rented accommodation. Minority ethnic groups are two to three times more likely to rent privately than White people. The results suggest a mixture of relative advantage and disadvantage in the housing market.
Age and gender

Age and gender are other factors which impact on health, lifestyles and tobacco use, and which should be taken into consideration by those wishing to offer culturally sensitive smoking cessation and health promotion services. Different approaches might be appropriate for different age groups or sexes, as well as for people from different ethnic backgrounds.

Figure 13 below shows the proportion of people from different age groups in Scotland, divided approximately into 20-year intervals. Percentages are shown for the total population and for different ethnic groups.

Figure 13: Proportions of the Population in Different Age Groups

<table>
<thead>
<tr>
<th>Age Group</th>
<th>All People</th>
<th>White</th>
<th>Pakistani/Other S. Asian</th>
<th>Chinese</th>
<th>Indian</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>24.2</td>
<td>23.9</td>
<td>39.9</td>
<td>30.2</td>
<td>29.7</td>
<td>38.6</td>
</tr>
<tr>
<td>20-39</td>
<td>28.0</td>
<td>27.8</td>
<td>36.3</td>
<td>40.6</td>
<td>41.1</td>
<td>39.0</td>
</tr>
<tr>
<td>40-59</td>
<td>26.8</td>
<td>26.9</td>
<td>17.6</td>
<td>22.0</td>
<td>21.0</td>
<td>17.2</td>
</tr>
<tr>
<td>60-80</td>
<td>17.3</td>
<td>17.5</td>
<td>5.8</td>
<td>6.5</td>
<td>7.6</td>
<td>4.4</td>
</tr>
<tr>
<td>Over 80</td>
<td>3.8</td>
<td>3.9</td>
<td>0.4</td>
<td>0.7</td>
<td>0.7</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: Data from 2001 Census, (table S201) General Register Office for Scotland

All four ethnic groups are, on average, younger than White people. The proportion of people in the 0-19 and 20-39 age groups are greater for all the minority ethnic groups than they are for Whites. Correspondingly, there are less people from minority ethnic backgrounds in the older age groups (over 40) than in the ethnic majority. Notably the percentage of people aged over 60 from minority ethnic backgrounds is significantly lower than it is for White people. These trends are most evident with Pakistani/Other South Asians. Nearly 40% of this ethnic group are under the age of 20, with 76% under the age of 40 and only 6% aged over 60.

Such a population structure may impact on the future ethnic make-up of Scotland. As younger people from minority backgrounds grow older and have children, there may be a rise in numbers of people identifying themselves as belonging to one of the minority ethnic groups (although of course, this depends on how people view their own ethnicity, which may differ from their parents or may change over time). Similarly, as people grow older there may be an increase numbers of older people from minority ethnic groups.

Between the 1991 and 2001 Censuses the proportion of ethnic minorities rose from 1.3% to 2.0% and this trend looks set to continue. As Scotland seeks to reverse its population decline by encouraging immigration, it is likely that the country will become more ethnically diverse in the coming years. This will have implications for the provision of services appropriate for minority ethnic groups in forthcoming years.
Country of birth, religion and language

Country of birth, religion and language are other pertinent considerations for professionals wishing to address smoking and provide appropriate services. As aforementioned, those born outside the UK might be influenced by behaviours and beliefs adopted from their country of origin. (Indeed, it is worth mentioning that a large proportion of the world’s smokers are in developing countries and tobacco companies are increasingly targeting Asian markets. When people emigrate to another nation they are likely to bring with them tobacco habits acquired in their home country). It is also useful to know about country of origin as some people from non-English speaking countries may lack the skills to communicate effectively in written or spoken English. Religion can also be an important factor in people’s lifestyle and behaviours, and service providers might wish to take this into account.

The Scottish 2001 Census included data on country of birth, revealing that 3.8% of those living in Scotland at the time of the Census were born outside of the UK. It is possible to break this data down into specific countries – for example 12645 people were born in Pakistan, 10523 were born in India and 1181 were born in Bangladesh.

Finally, religion may be an important consideration for those wishing to promote healthy lifestyles and targeting tobacco usage. Intoxicants and addictions are disapproved of in many religions and might be influential factors in some people’s attempts to stop smoking. Places of worship and community or religious leaders may be appropriate avenues for promoting healthy lifestyles and/or advertising services.

Figure 14, below, shows figures for religion of upbringing and current religion for some of the main minority religious groups in Scotland. (The majority religious background was Christian, with 65.1% stated they belonged to a Christian denomination, 27.6% stated no religion, all other responses constituted 5.6% of the population).

Figure 14

Source: Data from 2001 Census, (tables UV16, UV17) General Register Office for Scotland
In particular Scotland has a sizeable Muslim population, at around 42,000 people. The other main South Asian religions (Sikh, Hindu and Buddhist) have smaller populations, at between 5000 and 6000 each. People from these religious backgrounds are located throughout Scotland, in every Health Board. Unsurprisingly the highest numbers are found around the main cities (Glasgow, Edinburgh, Aberdeen and Dundee) and around the central belt. Figure 15 shows the five health boards areas with the highest numbers of people from these minority religious backgrounds.

Figure 15: Minority Religious Groups in Five Health Board Areas

<table>
<thead>
<tr>
<th></th>
<th>Muslim</th>
<th>Buddhist</th>
<th>Sikh</th>
<th>Hindu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow</td>
<td>20902</td>
<td>1454</td>
<td>3731</td>
<td>2016</td>
</tr>
<tr>
<td>Lothian</td>
<td>8206</td>
<td>1471</td>
<td>875</td>
<td>1373</td>
</tr>
<tr>
<td>Tayside</td>
<td>3377</td>
<td>484</td>
<td>248</td>
<td>489</td>
</tr>
<tr>
<td>Grampian</td>
<td>2190</td>
<td>875</td>
<td>165</td>
<td>579</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>2647</td>
<td>365</td>
<td>318</td>
<td>358</td>
</tr>
</tbody>
</table>

Source: Data from 2001 Census, (tables UV16, UV17) General Register Office for Scotland

Around half (just under 21,000) of Scotland’s Muslims live in the Greater Glasgow area. The majority of Scotland’s Sikhs also live in this area (around 3700), and there are sizeable Buddhist and Hindu communities. Edinburgh has the next largest concentration of these religions, followed by other central belt areas.

The data on religion corresponds with the size of the populations from different South Asian backgrounds. For example, the 2001 Census in England and Wales showed that Pakistanis and Bangladeshis are predominantly Muslim, while Indians are more religiously diverse, split between Hindu, Sikh and Muslim.

Summary

The above demographic and socio-economic profiles highlight some of the differences between minority ethnic groups and the White majority population in Scotland. The factors discussed could be significant in terms of a person’s propensity to use tobacco and/or access services.

An understanding of ethnic composition of a local population, their concentration (or dispersal), socio-economic status and wider cultural issues is useful information for those involved in planning, developing and providing services. Professionals wishing to provide appropriate smoking cessation and tobacco education initiatives should be encouraged to create detailed profiles of the ethnic communities in their area in order to inform appropriate approaches to tobacco education and smoking cessation.
However, it is worth stressing that there is great diversity both within and between different ethnic groups. Differences exist between men and women, between generations, between people born in the UK and other countries, and between those with different levels of education and language abilities. While it’s important to be aware of the influence that ethnicity may have on a person’s background and lifestyle, it is equally important not to stereotype or make assumptions about people based on their apparent ethnicity.

It is worth reiterating that while official sources such as the Census and other local surveys provide useful information about the demographic, social and lifestyle characteristics of the minority ethnic groups in local areas, they do have limitations. Consulting practitioners working with ethnic minorities is also recommended to provide a deeper understanding of the composition of local populations and of local issues which may influence their health or behaviours.
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