ash fact sheet
action on smoking and health

Tobacco and ethnic minorities

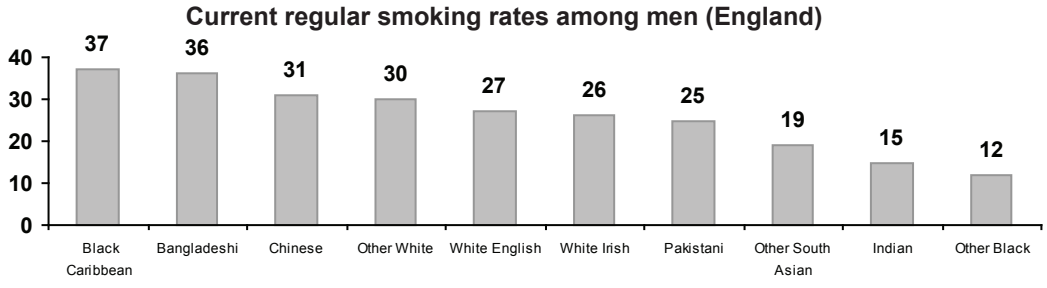
Population profile

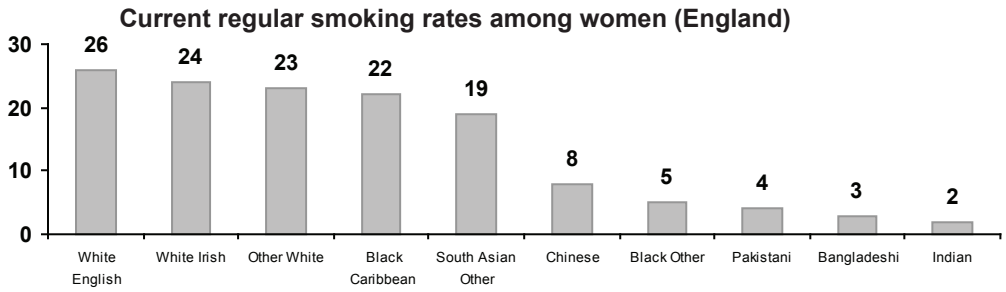
According to the 2001 census, the size of the ethnic minority population in the United Kingdom was 4.6 million, representing 7.9 per cent of the total population. Indians were the largest minority group, followed by Pakistanis, those of mixed ethnic background, Black Caribbeans, Black Africans, and Bangladeshis.[1] Since the 1990's there has been a shift in migration and settlement patterns of people born outside the UK, which includes economic migration from Central and Eastern European Countries. Nearly half (48 per cent) of the total minority ethnic population lived in the London region, where they comprised 29 per cent of all residents.[2]

Smoking prevalence and consumption by sex and ethnic group

Smoking rates vary considerably between ethnic groups. In men, compared to the general population, rates are particularly high in the Black Caribbean (37%) and Bangladeshi (36%) populations but these differences are explained by socioeconomic differences between the groups. Among women, smoking rates are low (at 8% or below) with the exception of Black Caribbean (22%) and Irish (24%) compared with the general population.[3] Overall, smoking rates among ethnic minority groups are lower than the UK population as a whole.

Current regular smoking rates by ethnic group[3]





Smokeless tobacco

Smokeless tobacco is used by some ethnic minority groups, particularly those from South Asia. Chewing tobacco is most commonly used by the Bangladeshi community with 9% of men and 19% of women reporting that they use chewing tobacco.[4]

However these figures may reflect a degree of under-reporting by some respondents. For example, self-reported use of all tobacco products was 44% and 17% among Bangladeshi men and women respectively. Including respondents with a saliva cotinine level indicative of personal tobacco use, the estimates rise to 60% of men and 35% of women.[4] A separate study which explored under reporting among Bangladeshi women found that 15% of women under-reported their personal tobacco use.[5]

Types of smokeless tobacco products

Betel quid or paan is commonly chewed in many Asian communities. Paan can be prepared in a variety of ways but usually contains sliced areca nut, slaked lime and catechu, wrapped in betel leaf. The resulting quid is then placed in the mouth and sucked or chewed. Paan itself is not a tobacco product but smokeless tobacco is often mixed with the other ingredients. Gutkha refers to the product with tobacco and pan masala is the same product but without tobacco. Other smokeless tobacco products include khaini (dried tobacco and slaked lime) and zarda (a mixture of tobacco, lime, spices, areca nut and flavourings).[3]

Chewing tobacco is associated with a range of diseases including an increased risk of cardiovascular disease and oral cancer. However there are many misconceptions regarding the health benefits of chewing tobacco which are promoted by misleading claims from manufacturers, such as betel quid having curative effects for dental pain.

Regulation on smokeless tobacco

Smokeless tobacco products are required to have health warnings under the terms of the 2001 EU Tobacco Products Directive 2001/37/EC. However many fail to comply. A study on the accessibility of chewing tobacco products in England found that less than half of chewing tobacco purchased had any form of health warnings with only 15% of products complying with the current legislation of health warnings for tobacco products.[6]

Waterpipes

Waterpipes, also known as hookah, shisha or hubble bubble pipes, have traditionally been used to smoke tobacco in the Middle East. However there has been a recent global resurgence of waterpipe smoking and in recent years shisha bars have become particularly popular among young people from ethnic minority groups in the United Kingdom who use them as an alternative to visiting pubs and nightclubs.

The health dangers of smoking shisha are well established and there is a growing body of evidence demonstrating that the harm from using waterpipes is similar to, if not greater than smoking cigarettes. One study found that compared to a single cigarette, 45 minutes of waterpipe smoking doubles carbon monoxide and triples nicotine exposure.[7]

For further information see the ASH Factsheet on Waterpipes.

Health impact of tobacco use among ethnic minorities

Circulatory diseases

Among some minority groups, the risk of heart disease is particularly high due to the combination of smoking and the presence of other risk factors. Bangladeshi and Pakistani communities tend to eat fewer fruit and vegetables than other minority groups and also take less physical exercise. Ethnic variations in the levels of HDL cholesterol (the 'good' cholesterol) are considerable. Nearly half (45%) of Bangladeshi men have an HDL-cholesterol level of less than1.0 mmol/l compared to one in six (17%) of men in the general population. By contrast, Black Caribbean men and women have a relatively low prevalence of low HDL-cholesterol.[8]

Although Black Caribbean people have a lower risk of coronary heart disease they have a higher risk of stroke. The 2004 Health Survey for England found that among respondents aged 55 and over Black Caribbean men had the highest prevalence (11.5%) of stroke while among women aged 55 and over the highest prevalence was among Bangladeshi (11.9%) and Pakistani (10.1%) respondents.[3]

Diabetes

The prevalence of diabetes is much higher among some ethnic minority communities than in the general population. In Black Caribbean and Indian men, the prevalence of diagnosed Type 2 diabetes is more than twice that found in the general population.[8] The prevalence for Black Caribbean and Pakistani women is two and a half times that of the general population. However, diabetes among Black African and Irish women is substantially lower than for the general population.[8]

There is a growing body of evidence to suggest that smoking is an independent risk factor for diabetes as smoking has been identified as a risk factor for insulin resistance, a precursor for diabetes.[9]

Compared to non-smokers with diabetes, people with diabetes who smoke have twice the risk of premature death. Furthermore, the risk of complications associated with tobacco use and diabetes in combination is nearly 14 times higher than the risk of either smoking or diabetes alone.[10]

For further information about smoking and diabetes see the ASH Factsheet on smoking and diabetes.

Cancer

Almost 90% of oral cancers are associated with tobacco use.[11] According to the International Agency for Research on Cancer (IARC) areca nut and betel quid are both carcinogenic and place users at an increased risk of developing oral cancer. A separate study found that areca nut, betel quid, cigarettes and oral snuff all independently increase the risk of oesophageal cancer. The authors also found that cigarette smoking alongside chewing betel quid increased the risk further.[12]

The poor levels of ethnicity recording in cancer registry data mean that there is no reliable routine data on ethnic differences in cancer incidence in the UK. In South Asia the primary cause of the high incidence of oral cancer is the widespread habit of chewing betel quid (paan). Studies in India found that men who chewed betel quid with tobacco had relative risks of oral cancer varying between 1.8 and 5.8, and risks for oesophageal cancer of 2.1–3.2.[13] Furthermore, pregnant women in India who used smokeless tobacco had a threefold risk of still birth and a two- to threefold increased risk of having a low birth weight child.[13]

The risk of all tobacco-related diseases decreases after the cessation of tobacco use. The excess risk of oral cancer from tobacco use almost disappears with 10 years of cessation. The risk of developing a second tumour is also reduced if patients cease to use tobacco.[11]

Health inequalities

There is a strong link between tobacco use and socio-economic status. Smoking accounts for over half the difference in risk of premature death between the highest and lowest social classes in the UK.[14] A report by the Equality and Human Rights Commission found that poverty through low income is higher among minority ethic groups. The highest rates were among Bangladeshi and Pakistani communities, with almost two thirds living in low-income households.[15] The 2004 Health Survey for England also showed that minority ethnic groups were more likely to report ill health than the general population.[4]

Guidance by the National Institute for Health and Clinical Excellence noted that reducing smoking prevalence among some minority groups would reduce health inequalities more than any other measure.[16]

Attitudes and beliefs

Ethnic minorities have been shown to possess relatively poor knowledge about cigarette smoking and disease and to be less likely to cite smoking as a health risk than the UK population as a whole.[17] The proportion of African-Caribbean men (27%) who say their smoking has 'no effect' on their current health is above the rate for the UK (12%) as is that among Bangladeshi men (22%) and Pakistani men (20%).

Religion may have an influence on some ethnic minorities' attitudes towards tobacco use. For example chewing tobacco is embedded in many aspects of South Asian culture with symbolic implications at religious and cultural ceremonies. Some religious leaders also believe that smoking and the sale of tobacco is prohibited by Islam.[18]

Tobacco use may also be influenced by the level of community involvement. Studies have shown that for men and women of all ethnic groups, community activity is positively associated with lower cigarette smoking although this is not replicated for chewing tobacco use.[19]

Stopping smoking

Smokers from minority ethnic groups are as ready to quit smoking as their counterparts in the UK population as a whole. Since 1998 overall smoking prevalence in Great Britain has declined by 7 percentage points. However prevalence among minority ethnic groups has failed to show a similar pattern.

Research suggests that Bangladeshi and Pakistani smokers may be particularly receptive to advice from a doctor to stop smoking.[20]

Specialist helplines offering counselling services in different ethnic minority languages have proved to be popular. The national charity QUIT hosts services in seven ethnic minority languages.[21]

NHS Choices provide resources and materials on South Asian health issues. This includes information on the health risks of smokeless tobacco and leaflets and helpline telephone numbers in alternative languages to help tobacco users quit.[22] See also the ASH website for more information on smoking cessation help lines.[23]

The National Institute for Health and Care Excellence (NICE) is currently developing guidance on helping people to stop using smokeless tobacco.[24]

References

1 The UK population: by ethnic group. Office for National Statistics, 2001.
2 White A. Social focus in brief: Ethnicity, 2002. Office for National Statistics, 2002.
3 Millward D & Karlsen S. Tobacco use among minority ethnic populations and cessation interventions. A Race Equality Foundation Briefing Paper, May 2011.
4 Sproston K and Mindell J. (eds) Health Survey for England 2004. The health of minority ethnic groups. Leeds, The Information Centre, 2004.
5 Roth MA, Aitsi-Selmi A, Wardle H & Mindell J. Under-reporting of tobacco use among Bangladeshi women in England. Journal of Public Health, 2009; 31: 326–34.
6 Longman JM, Pritchard C, McNeill A, Csikar J & Croucher RE. Accessibility of chewing tobacco products in England. Journal of Public Health, 2010; 1–7.
7 Eissenberg T & Shihadeh A. Waterpipe tobacco and cigarette smoking. Direct comparison of toxicant exposure. American Journal of Preventive Medicine, 2009; 37 (6): 518–23.
8 Joint Health Survey Unit. Health Survey for England 2004. Leeds, The Information Centre, 2005.
9 Ko G & Cockram C. Cause as well as effect: smoking and diabetes. Diabetes Voice: smoking and diabetes special issue, 2005; 50:19-22.
10 Haire-Joshu D & Thomas J. Gambling with addiction: Dangerous beliefs about smoking and diabetes. Diabetes Voice: smoking and diabetes special issue, 2005; 50:15-18.
11 Cancer Stats: Oral Cancer Prevention. Cancer Research UK, 2007.
12 Saeed A, Sheikh A, Qureshi H. Chewing areca nut, betel quid, oral snuff, cigarette smoking and the risk of oesophageal squamous-cell carcinoma in South Asians: A multicentre case–control study. European Journal of Cancer 2011.
13 Gupta P & Ray C. Smokeless tobacco and health in India and South Asia. Respirology, 2003; 8: 419–43
14 Acheson D. Independent Inquiry into Inequalities in Health. London, TSO,1998.
15 Equality and Human Rights Commission. How Fair is Britain? Equality, human rights and good relations in 2010. The first triennial review, 2010.
16 National Institute for Health and Clinical Excellence (NICE). Smoking Cessation Services in Primary Care, Pharmacies, Local Authorities and Workplaces, Particularly for Manual Working Groups, Pregnant Women and Hard to Reach Communities. NICE Public Health Guidance 10, 2008.
17 Tobacco and England's Ethnic Minorities. London, Health Development Agency, 2000.
18 Khayat MH (Ed). Islamic ruling on smoking. World Health Organization Regional Office for the Eastern Mediterranean, Alexandria, 2000.
19 Ethnic inequalities in health and smoking behaviour. London, Health Development Agency, 2000.
20 Black and Minority Ethnic Groups and tobacco use in England. Health Education Authority, 1999.
21 See: http://www.quit.org.uk
22 See: http://www.nhs.uk/Livewell/SouthAsianhealth/Pages/Smokingandpaan.aspx
23 See: http://www.ash.org.uk/stopping-smoking/quitting-smoking/helplines
24 See: http://guidance.nice.org.uk/PHG/Wave23/20