

# Asian American and Pacific Islander Adolescent Cigarette Smoking: A Review

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**INTRODUCTION** Tobacco use is the leading cause of preventable death and illness in the United States. Despite declines in the smoking rates among adults over the past few decades, smoking rates have begun to increase again in the 1990s among adolescents of all racial and ethnic groups. Of the more than 1 million Americans who become new smokers each year, or nearly 3,000 who start smoking each day, the majority are recruited from the ranks of children and adolescents (Pierce *et al.*, 1989; CDC, 1998). As stated by U.S. Surgeon General, Dr. David Satcher, “If tobacco use continues to increase among minority adolescents, we can expect severe health consequences to begin to be felt in the early part of the next century” (U.S. DHHS, 1998).

Patterns of tobacco use and exposure among and within Asian American and Pacific Islander (AAPI) communities are of particular concern. Because of the diversity found among the various ethnic subgroups of AAPIs—including differences in lifestyles, cultural beliefs and practices, and environmental exposures—no single factor can be considered the determinant of tobacco use or exposure. For this reason, rigorous surveillance and prevention research must be conducted in order to unveil the many specific factors that influence tobacco use and exposure among AAPIs, particularly the influences resulting from differences between ethnic subgroups and from the effects of acculturation to “Western lifestyles.”

**DEMOGRAPHICS** AAPIs are the fastest growing racial/ethnic group nationwide. On July 1, 1998, AAPIs represented approximately 3.8 percent of the U.S. population and its associated Pacific Island Jurisdictions compared to only 0.4 percent of the nation’s population in 1960. From 1980 to 1990, the U.S. AAPI population increased by over 95 percent. In the same time period, the Hispanic population increased 51.5 percent, the Native American population 27.7 percent, the African American population 13.2 percent, and the non-Hispanic White population 4.2 percent. Between July 1, 1990 and July 1, 1998, AAPIs again had a higher rate of population growth than any other race in the nation—37 percent. The Census Bureau projects that size of the AAPI population will reach 34.4 million by the year 2050, representing almost 10 percent of all Americans. Immigration to the United States and resettlement of refugees from Southeast Asia in the mid-1970s have accounted for much of the population growth (86 percent). However, several Asian groups, such as the Chinese and Japanese, have been in the United States for generations; relatively few Pacific Islanders are foreign-born, and Native Hawaiians are the indigenous people of the state of Hawaii, having settled there more than 2,000 years ago (U.S. Bureau of the Census, 1995).

According to the 1990 U.S. Census, the single racial category referred to as “Asian American and Pacific Islander” is comprised of almost 30 percent youths and children (0-17 years old) and just over 6 percent elderly (65 years and over). Of the 13 AAPI ethnic subgroups reported in the 1990 Census, recent immigrant populations, such as the Hmong, had the highest percentage of children and youths—60 percent. By comparison, youths within the same age band represented less than 20 percent of the Japanese-American population.

The AAPI population is extremely heterogeneous and has a high proportion of immigrants and refugees. The AAPI single racial classification consists of approximately 30 Asian and 25 Pacific Island nationalities, all with distinct languages, cultures, immigration histories, and community norms, many of which have impacts on community members’ health and well being. Some of the ethnic subgroups included in the category “Pacific Islander” are the Chamorro (Guam/Commonwealth of Northern Mariana Islands), Chuukese, Fijian, Hawaiian, Kosraean (Federated States of Micronesia), Melanesian, Palauan (Republic of Palau), Pohnpeian, Samoan (American and Western Samoa), Tongan, and Yapese. Ethnic subgroups in the category “Asian” include Afghani, Asian Indian, Bangladeshi, Burmese, Cambodian, Chinese, Filipino, Hmong, Indonesian, Iwo-Jiman, Japanese, Korean, Laotian, Malaysian, Mien, Nepali, Okinawin, Pakistani, Sikkim, Sri Lankan, Thai, and Vietnamese. The six largest AAPI subgroups are from China, the Philippines, India, Japan, Korea, and Vietnam (Gardner, 1994).

Nearly 40 percent of the nation’s AAPI population live in California. Other states with large AAPI communities include New York (9.3 percent), Hawaii (8.3 percent), Texas (4.7 percent), New Jersey (3.9 percent), Illinois (3.8 percent), and Washington (3.0 percent) (National Center for Health Statistics, 1995). According to the March 1994 Current Population Survey, AAPIs were more likely than non-Hispanic Whites to reside in metropolitan areas (95 percent versus 75 percent). Although over 50 percent of all AAPIs live in the western part of the United States, the AAPI population has increased significantly in other regions: by 139 percent in both the South and Northeast, and by 97 percent in the Midwest (Takeuchi and Young 1998).

Another example of a variable distribution within the AAPI population is evident through examination of English proficiency. The 1990 U.S. Census shows that almost 60 percent of the U.S. Hmong population live in households in which no persons over 14 years of age speak English “very well.” Yet only 1 percent of the Hawaiian population lives in similar conditions. Based on the 1990 Census, approximately 95 percent of AAPIs living in the United States were employed; yet, a sizable proportion of the AAPI population was uninsured—28 percent, compared to 20 percent of non-Hispanic Whites (National Center for Health Statistics, 1995).

The many distinct AAPI ethnic subgroups reflect not only cultural and linguistic differences, but also socioeconomic, educational, and generational differences, all of which influence the decision-making skills and social support networks necessary for prevention of adolescent tobacco use and exposure in the AAPI community.

**AAPI TOBACCO  
RESEARCH:  
EPIDEMIOLOGY  
& BEHAVIORAL**

It is difficult to produce an accurate, nationwide profile of the current tobacco use prevalence among youths of AAPI descent due to the absence of published research conducted with this racial/ethnic group. Because national data are aggregated, the data that do exist often mask health disparities between different ethnic AAPI sub-populations. Moreover, the generalizability of results is limited by the lack of adequate sample sizes for AAPIs within national data systems (e.g., National Health Interview Survey) and in epidemiological and behavioral research studies. Of particular concern is the fact that AAPIs are historically and persistently under-represented in federal and state government, academic, and foundation research studies. More often than not, an entire segment of the AAPI immigrant population is overlooked because research studies limit their design solely to English-speaking populations.

National survey data reveal that adult smoking prevalence was lower among AAPIs (15.3 percent) than among Hispanics (18.9 percent), Whites (25.9 percent), African Americans (26.5 percent), and American Indians and Alaskan Natives (39.2 percent) (U.S. DHHS, 1998). However, significant variations in smoking prevalence emerge when AAPI data are disaggregated. In particular, higher smoking rates are seen among Asian men, ranging from Korean males (30 percent; Han *et al.*, 1989) to Laotian males (70 percent; Levin, 1985), Kampuchean males (71 percent; Rumbaut, 1989), and Chinese-Vietnamese males (71 percent; Rumbaut, 1989).

Reviewed literature shows considerable variation in AAPI sample size, and the majority of studies have been conducted with adults only. The following are highlights of some of the tobacco-related AAPI studies that have been completed:

*AAPI Adults Only*

- A study conducted in Boston during 1994 and 1995 showed that 32 percent of the study population—99 recent Vietnamese immigrants—were smokers. Smoking prevalence was substantially different between Vietnamese men and Vietnamese women (54 percent versus 9 percent respectively; Nelson *et al.*, 1997).
- A 1994 Korean American Community Health Survey found that 39 percent of men and 6 percent of women were current smokers. Level of English proficiency impacted the awareness of smoking as a health hazard. Eighty-seven percent of the study population who were English proficient knew that smoking is related to heart disease, while only 76 percent of those who spoke little or no English understood that fact (Wisner *et al.*, 1997).
- AAPI immigrants who are limited in their English proficiency are more likely to be smokers than their American-born counterparts. A study in Oakland's Chinatown found that 40 percent of Chinese men did not know that smoking could cause heart disease (Chen, 1992).

*AAPI Youth Only*

- Approximately 21 percent of Asian American high school boys smoke compared to 14 percent of Asian American high school girls (U.S. DHHS, 1998).
- Asian youths' susceptibility to smoking has increased by 30-50 percent, and their smoking rates have also increased dramatically—by more than 50 percent in California from 1993 to 1996 (CDHS, 1997).
- A 1993 study in San Diego, California found that the highest average number of tobacco displays was found in Asian-American stores (6.4), compared to Hispanic (4.6) and African-American (3.7) stores (Elder *et al.*, 1993).
- Data from the 1990-1996 California Youth Tobacco Survey can be examined for patterns of smoking behavior among subgroups of Asian-American youths in California (grades 7-12). As illustrated in Table 6-1, different ethnic subgroups of Asian-Americans vary widely in their smoking behaviors. In addition, higher levels of acculturation are associated with higher smoking prevalence rates and earlier age of smoking onset. Breakdowns of this type are important because few studies exist that directly examine Asian and Pacific Islander immigrant versus AAPI American-born youth populations with respect to levels of acculturation and associated smoking prevalence rates.

Clearly, these studies suggest that, in order to support the refinement of tobacco control programs, we need to more clearly investigate factors like age, gender, language barriers, and cultural differences, both between AAPI ethnic subgroups (*e.g.*, Korean versus Chinese youth) and within the AAPI subgroups themselves (*e.g.*, Vietnamese immigrant versus Vietnamese American-born youth). The challenge in building a successful tobacco control program for such a diverse population will be to clearly understand the factors affecting AAPI youth smoking. In addition to understanding the differences between and among AAPI ethnic subgroups, it will be necessary to establish a level of "trust" with the AAPI youth and to build within them a sense of both self and community. With that foundation, it will be possible to design effective tobacco control prevention and intervention strategies that are culturally and linguistically accessible and appropriate for AAPI youth.

Table 16-1

**Disaggregated AAPI Subgroup-Specific Analyses Revealed Significant Lifetime Smoking Prevalence Differences among AAPIs in California: 1990-1996 California Youth Tobacco Survey**

	<b>Lifetime Smoking Prevalence</b>	<b>30-Day Smoking Rate</b>
Aggregated	16.1% for Asians 26.1% for non-Asians	
Filipinos	18.9%	8.6%
Japanese	17.3%	7.4%
Koreans	16.3%	8.3%
Chinese	11.0%	2.8%
Asian Americans	13.7%	7.2%

**FACTORS AFFECTING AAPI YOUTH SMOKING** Factors that influence the initiation of tobacco use among AAPI youth are both complex and interrelated. Such factors include experimentation and peer pressure, cultural norms and family smoking, and the environment.

**Experimentation and Peer Pressure** A California tobacco survey was conducted with 454 Filipino-American youths in Southern California in 1999 (Youth UNITE, 1999). Of the youths surveyed, 45.5 percent were born outside of the United States (the majority of those were born in the Philippines) and the remaining 54 percent were born within the United States. Of those who smoked, 86.7 percent had smoked for more than 1 year, and more than half of the smokers smoked at least one pack a day. According to the youths who identified themselves as smokers, the two biggest factors influencing their decision to become smokers were experimentation (48.3 percent) and peer pressure (22.8 percent). An overwhelming majority of Filipino youths preferred Marlboro as their brand of choice (63 percent). Of the smokers who preferred Marlboro, most did so because they liked the taste and the advertisements. It is noteworthy that, even though the distribution of single cigarettes is illegal in California, the youths surveyed reported single cigarettes from liquor stores to be their major source of tobacco.

In recent tobacco control work conducted by the Asian and Pacific Islander American Health Forum in California, focus group findings of Chinese (Mandarin and Cantonese), Vietnamese, and Korean youths revealed that immigrant Asian youths are highly influenced by their friends (U.S. DHHS, 1999). Consistently, these Asian youths commented that they understood both the financial burden of cigarettes and the negative impact of smoking (health hazards, social problems related to smoking around nonsmokers, environmental tobacco smoke issues, etc.).

Overall, few of the smokers or nonsmokers knew that cessation clinics and free cessation hotlines were available. The majority of youths interviewed were never advised by a health professional to quit smoking. Some of the smokers believed that they would be able to quit with no assistance from family or peer support groups and also believed they could quit without using nicotine replacement therapy (e.g., nicotine gum, patches, etc.).

Similar to previous research conducted with adolescents, the findings revealed that teens tend to view life as black or white, rely on their immediate experience, often have an attitude of invincibility, and do not necessarily believe in preventative health measures. It is clear from the focus group results that influencing these teens to deter or stop their smoking requires multi-dimensional strategies in support of tobacco-use cessation (*e.g.*, integration of culturally and linguistically acceptable tobacco control messages from peers, family, and the environment).

**Cultural Norms and Family Smoking** Socioeconomic and cultural factors play important roles in self-identification and behavioral risk towards tobacco use or acceptance among AAPI youths; cultural factors include language, cultural beliefs, and immigration status. Because a majority of AAPIs are immigrants and refugees, it is essential to understand the cultural context of tobacco and how that context influences acceptance, or lack thereof, among AAPI youths. In Asia, cigarette smoking is common in men, ranging from 30 to 70 percent. For Asian women, smoking prevalence is much lower, approximately 3-10 percent (U.S. DHHS, 2001).

For some developing countries (*e.g.*, Vietnam and China), tobacco use is culturally accepted and is often considered an attribute of wealth. For other Asian and Pacific Rim countries (*e.g.*, Cambodia), tobacco is used as a gift and is provided, much like alcohol, to guests in one's home. In some Asian traditions, cigarettes are distributed at social gatherings and are used in healing practices.

As noted earlier, AAPI adult smoking patterns vary across ethnic subgroups. One study showed that, among Southeast Asian men, those who had higher English language proficiency and had lived in the United States longer were less likely to be smokers (Chen *et al.*, 1993; McPhee *et al.*, 1993). Using questionnaire items from the Youth Risk Behavior Survey translated into Vietnamese for a school-based sample of Vietnamese adolescents in Worcester, Massachusetts, Weicha (1996) found that the prevalence of cigarette smoking among Vietnamese boys (27.9%) was similar to that for White boys (28.3%) and was higher than that for Hispanic boys (19.7%) or African American boys (18.9%). Vietnamese girls smoked rarely (3.7%). They were also significantly less likely than others to have smoked their first cigarette at age 12 years or younger. Among Vietnamese adolescents over age 16, increasing length of time in the United States was associated with decreasing smoking prevalence. To uncover the factors that influence smoking initiation among AAPI youths, more research is needed that not only disaggregates national AAPI data in order to more closely monitor different ethnic subgroups, but also dissects acculturation influences such as age of arrival in the United States, English language proficiency, educational experiences, and cultural norm changes. Little tobacco control research has been conducted to compare and contrast newly arrived AAPI immigrants, acculturated AAPI immigrants (with 5 years or more of residency), and AAPI American-born youths.

Studies have shown that a majority of adolescent smokers have parents who smoke. Consistent with other research focusing on adolescents is the finding that teenagers are three times more likely to smoke if their parents and at least one older sibling smoke (Moss *et al.*, 1992). In a tobacco survey conducted among Filipino youths in Southern California, a significant number of youth smokers had family members who were also smokers (59.7 percent). Of those surveyed, 22.7 percent had more than four other family members who smoked.

Members of traditional Asian cultures place great value on social order and control of emotions and feelings (Hirayama and Hirayama, 1986). Like youths of other minority groups for whom respect of elders is an important cultural norm and practice, AAPI youths value parental acceptance and are loath to take actions that could be seen as bringing shame to their family. This makes tobacco use by other family members an especially strong obstacle to overcome, particularly when it is the parents or other elders who smoke. Although surveyed youths may have knowledge that smoking is harmful to both their health and that of others, respect for their elders and the acceptance of tobacco within their family do not provide an environment within which behavior modification could be easily accomplished.

**Environment** Successful strategies to prevent the use of tobacco, alcohol, and other drugs have incorporated the following approaches in modifying behavior among adolescents (Perry, 1987):

- Transfer knowledge of why people of their age smoke cigarettes or use other drugs;
- Provide information to youths on how the tobacco industry has manipulated the public in associating positive characteristics with smoking through film, advertising, older role models, and peers;
- Educate youths on how to resist the influences urging them to smoke or use other drugs; and
- Provide opportunities for using life skills and competencies to counterbalance the functions served by cigarette smoking and other drug use.

Recent research has shown improved effectiveness of health education and other prevention measures when the age level of adolescents is considered. For example, general communication-based prevention is more likely to succeed with younger teens before they become addicted and socially entwined in peer reinforcements (Worden *et al.*, 1988). In order to effectively understand the influences on AAPI youths and tobacco uptake, research must consider the age segment of the youth population, immigration and the number of years in the United States, culture, language, and the environment of the AAPI community itself (geographic, socioeconomic, etc.).

To further support the rationale for community participation models, it has been documented within the literature that adults are more likely to pursue community change when they believe that change is worthwhile and achievable and that they have the skills to achieve the desired change

(Zimmerman, 1995). Similarly, teens who have a strong sense of self-determination and of being in control can benefit from community participation and youth empowerment models that build their skills and competencies.

For example, the Asian Pacific Islander Tobacco Education Network convened a conference to bring together Pacific Islander youths to increase their awareness of how tobacco issues impact their community and to provide a forum for these youths to begin building life skills within a Pacific Islander community context. When queried about new information learned at the Gathering of Pacific Islanders forum, Pacific Islander youths stated that they learned that “Pacific Islanders do care about youth learning to improve their lives and the lives of others.”

Although Pacific Islander Americans as a whole tend to be fluent in English and to share a strong belief in the importance of both the family unit and traditional values, different ethnic groups tend to have experienced different degrees of marginalization due to various social, political, and economic histories in the United States (*e.g.*, Hawaiians, Samoans, Tongans, Chamorros, etc.). Forums like the Gathering of Pacific Islanders are beneficial in allowing youths from diverse cultures to have a sense of community with others of their own racial/ethnic background.

In 1995, a community-needs assessment study was conducted in selected AAPI communities to identify the extent and scope of alcohol, tobacco, and other substance abuse (Bueno and Lau, 1996). The select AAPI ethnic subgroups included Chinese, Filipino, Japanese, Korean, and Vietnamese communities in Los Angeles County. A survey instrument that was culturally acceptable and accessible was designed. In addition, researchers collected data through three methods: a) door-to-door survey; b) survey of participants in community events/sites; and c) surveys that were supported by the elementary school authorities who facilitated the process of getting the students to bring home the surveys for their parents to complete.

From every aspect of the research project, designated community participants were integrated into the various levels of decision-making. These levels included the variables to be surveyed, the methods to be used in data collection, the times for conducting the surveys, the flyers to be used in promoting the survey in the target areas, and the feasibility of the areas to be surveyed (*e.g.*, venue selection such as cultural events).

When asked the question, “Why do people abuse alcohol, tobacco, and other drugs (ATOD)?” respondents among all AAPI target areas identified the following factors that they felt contributed to ATOD abuse:

- Emotional problems
- Moral weakness/easy access
- Peer pressure
- Adjustment to problems of immigration
- Family smokes/drinks

Another important finding of this community-needs assessment was that all respondents from the five AAPI target communities stated that they would hesitate to seek out services designed to assist those attempting to overcome alcohol, tobacco, or other drug abuse. The basis for low utilization of social services may be due to lack of confidence in existing services that may not be culturally appropriate or to the lack of awareness on the value of these services (Bueno and Lau, 1996).

**DOMESTIC AND  
INTERNATIONAL  
ADVERTISING  
AND PROMOTION**

AAPI youths, like other minority youths, are susceptible to tobacco advertising and promotion. The lure for minority youths is marketing “American” themes such as sophistication, stardom, sexual prowess, “being cool,” and “fitting in.” As the U.S. tobacco market declines due to restrictions on advertising and promotions, the tobacco industry is unveiling new strategies for promoting its products, including a large amount of indirect advertising. Indirect advertising includes sponsorship of sporting events and teams, ethnic culture events, discos, and the arts. In addition to sponsorship, the tobacco industry has pushed “brand stretching,” which markets its logos on products such as clothing lines, racing boats, back packs, coffee, and umbrellas (Economic Research Services, 1997). To further gain market share with girls and women, both domestically and internationally, Philip Morris launched a \$40 million advertising campaign for Virginia Slims targeting African American, Hispanic, and Asian American women. The theme of the ad campaign is “Find Your Voice” and centers on magazines that will display the 4- to 6-page insert. Participating magazines include *Glamour*, *Ladies’ Home Journal*, *People*, *Essence*, *Vibe*, and *Latina* (Virginia Slims Has Come A Long Way, Bebe, 1999). Such indirect advertising requires new strategies to combat its influence. In California, for example, the Asian Pacific Islander Tobacco Education Network has worked closely with cultural event organizers to persuade them to adopt policies refusing tobacco sponsorship.

Given the current global trends, more than 10 million people will die worldwide from tobacco-related disease by the year 2025. As three out of the five countries in the world that have the largest cigarette markets are Asian countries (China sold 1.7 trillion cigarettes in 1996), it is projected that a majority of these deaths will originate from Asia and the Pacific Rim (Hammond, 1998). Given these projections, the AAPI youth population—both those who have recently immigrated and those who are continuously exposed to overseas print, videos, and film from their countries of origin—are at risk from unregulated tobacco advertising and promotions overseas. As tobacco control expert Judith Mackay notes, “If multinational tobacco companies could capture the China market, it wouldn’t make a difference if every American stopped smoking tomorrow” (Lin, 1997). The global aspects of tobacco use prevalence are far reaching and impact the AAPI youth directly because mediums of communication across borders cannot be controlled (*e.g.*, cigarette promotional items, no bans on selling cigarettes to minors in many Asian countries, and no health warnings required by law on cigarette packs overseas).

**CONCLUSIONS** Research investigating tobacco use and exposure among AAPI youths has been extremely limited. Understanding the differences among and between AAPI ethnic subgroups is essential in designing relevant qualitative tobacco control research nationwide—for both youths and adults. In order to conduct community-based research in the AAPI community, researchers will need to consider many factors, including socioeconomic status; cultural characteristics; acculturation factors; stresses; advertising targets, both domestic and international; prices of tobacco products; and capacities of communities to mobilize against tobacco influences (*e.g.*, the roles of community, schools, and family and social networks).

As the nation moves into the 21st century, it is clear that the AAPI population will continue to contribute to the multicultural fabric of this society. As tobacco control advocates and researchers, it is necessary that we take responsibility within and across the borders of the United States to protect the health of all our children from tobacco health hazards.

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