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Slowing the Epidemic of Tobacco Use Among Asian Americans and Pacific Islanders

Data on tobacco use among the Asian American/Pacific Islander (AAPI) population remain limited, although existing studies indicate that tobacco use prevalence among males from specific AAPI groups is significantly higher than in the general US male population.

This high prevalence of tobacco use and the disparities in use result from social norms, targeted marketing by the tobacco industry, lack of culturally and linguistically tailored prevention and control programs, and limited impact of mainstream tobacco control programs for AAPIs.

We review the available literature on tobacco use among AAPI men and women, highlight a national agenda that promotes tobacco prevention and control for AAPI communities, and acknowledge recent trends including the increase of tobacco use among AAPI women and girls. (*Am J Public Health.* 2003;93:764–768)

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THIS MILLENNIUM HAS BEGUN with an increase in discussions on health disparities as a public health priority. Certainly, one cannot discuss health disparities without addressing the tremendous impact of tobacco use on communities of color and other populations. And yet, despite the tobacco settlement and recent funding opportunities for these populations, tobacco use among Asian Americans and Pacific Islanders (AAPIs) continues to be a growing public health challenge. Particularly among certain ethnic groups of AAPI men, significantly high tobacco use prevalence rates are resulting in increased rates of lung cancer and other tobacco-related diseases.[1]

AAPIs represent the fastest growing racial group in the United States, numbering 11.9 million (alone or in combination with one or more other races) and constituting 4% of the population in 2000,[2] and Pacific islanders numbering 874 000, or 0.3% of the population.[3] AAPIs, however, are a heterogeneous group composed of more than 50 diverse ethnic and language subgroups. Geographically, AAPIs reside in all 50 US states as well as 6 Pacific island jurisdictions spanning more than 12 time zones. This diversity is also seen in terms of disparate poverty rates, educational levels, and other socioeconomic characteristics.[4] For instance, whereas an average of about 14% of Asians lived in poverty, the rates were much higher for Hmong (64%), Cambodians (43%), and Laotians (35%).[5] The aggregation of data across these diverse AAPI populations has led to the "model minority myth"—the assumption that AAPIs are healthier than other racial/ethnic populations.[1] Unfortunately, there is still very limited published information on tobacco use among AAPIs, particularly in terms of data disaggregated according to specific AAPI subgroups.

DOCUMENTING TOBACCO USE AMONG AAPIS

In the United States, documentation of national smoking prevalence rates among AAPIs has been hampered by the lack of adequate sample sizes both in surveys conducted via the Behavioral Risk Factor Surveillance System and in the National Health Interview Survey.[6] In addition, these surveys have been conducted in English, producing AAPI samples that are more highly acculturated than actual AAPI populations. Moreover, though selected surveys (e.g., the National Household Survey on Drug Abuse[7]) have started to identify some of the major AAPI subgroups, disaggregation of national tobacco use data by AAPI ethnic groups still is not routinely performed.[8]

Lack of good data has been a major barrier in documenting and addressing tobacco use among AAPIs. Results of local studies as well as observational findings have shown that tobacco is a significant problem in many of our AAPI populations. Yet, only limited published data are available to support or explain the problem.[9]

During the past decade, however, researchers have slowly begun to address this major gap in data on AAPI tobacco use, prevention, and control. In 1990, a Medline (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi) search of the keywords "Asian Americans" and "tobacco" revealed only 10 citations. In July 2002, a Medline search produced 47 citations involving the keywords "Asian Americans and tobacco" and 13 citations for "Pacific Islanders and tobacco."

In addition, the number of tobacco use prevalence studies focusing on specific AAPI subgroups and involving the use of appropriate languages has increased, most involving Vietnamese Americans. Few studies, however, published or unpublished, have focused on tobacco use among South Asian or Pacific Islander groups.

Table 1 displays published ethnicity- and sex-specific data on smoking among AAPIs derived from studies conducted in the appropriate language or languages. The results reveal high rates of smoking among male members of specific AAPI subgroups. Interestingly, although these data have been produced by different local and statewide studies, there are close parallels in terms of

TABLE 1—Percentages of Current Adult Smokers, by Sex: Selected Asian American/Pacific Islander Populations

	Men, %	Women, %	Location
Cambodian Americans			
1985[10]	70.7	12.9	San Diego County, California
1989[11]	32.8	. . .	Washington State
1995[12]	38.8	21.5	Franklin County, Ohio
Chinese Americans			
1989–1990[13]	28.1	1.2	Oakland Chinatown
2000[6]	33.6	2.1	Chicago Chinatown
Chinese-Vietnamese:			
1985[10]	54.5	1.7	San Diego County, California
Hmong Americans:			
1985[10]	26.0	1.7	San Diego County, California
Korean Americans:			
1989[14]	38.5	. . .	Los Angeles, California
1994–1995[15]	38.7	6.0	Alameda County, California
1998[16]	31.0	6.9	Chicago, Illinois
Laotian Americans			
1987[17]	72.0	. . .	
1989[11]	51.2	. . .	Washington State
1995[12]	48.2	10.8	Franklin County, Ohio
South Asians:			
2001[a]	26.0	. . .	New York City
Vietnamese Americans			
1985[10]	64.7	0.0	San Diego County, California
1987[18]	56.0	9.0	Oakland, San Francisco
1989[19]	39.1	2.3	San Francisco Bay Area, Los Angeles
1989[11]	41.7	. . .	Washington State
1991[20]	34.7	0.4	California
1994[21]	43.2	. . .	Massachusetts
1995[12]	43.3	9.3	Franklin County, Ohio
Native Hawaiians:			
1990[22]	42.0	34.0	Hawaii
American Samoans:			
1989[23]	50.0	14.0	American Samoa
Chuukese:			
1985[23]	53.0	11.0	Weno, Chuuk
Palauan:			
1995[b24]	58.3	67.2	Palau

[a]From unpublished data, but represents only known data on South Asians.
[b]Only reported use of tobacco with betel nut.

prevalence rates within specific groups (e.g., Korean American men and women).

Although smoking continues to be a behavior more commonly found among AAPI men, several caveats to this sex difference should be discussed. Among Asian Americans, for example, available data show marked sex differences in smoking rates, but these differences are generally observed among foreign-born adults. In addition, Wewers and colleagues conducted cotinine verification tests among their respondents and found frequent underreporting of smoking behavior, particularly in the case of AAPI women.[25] While smoking prevalence rates may be significantly lower among AAPI women than men, studies have shown that this is not true for certain groups, such as Native Hawaiians[22] and Cambodian Americans in Ohio.[25] Moreover, Palauan women's use of other forms of tobacco, specifically chewing tobacco mixed with betel nut, has actually been reported to be higher than that of Palauan men.[24]

Tobacco use data for other adult Pacific Islanders have been limited with the exception of a few Pacific Island jurisdictions.[23] Researchers have collected smoking data among Native Hawaiians (in the state of Hawaii),[26] Pacific Islanders (in Guam),[27] and Asian American ethnic groups (in Pennsylvania and New Jersey),[28] but their reports do not provide ethnicity- or sex-specific information. In addition, although there have been attempts at collecting national data for some AAPI groups (National Asian Women's Health Organization, unpublished data, 1998), their scope has been limited, and data have not been collected on tobacco use prevalence rates for other ethnic groups such as Laotians, Cambodians, and Pacific Islanders.[9]

There is a growing awareness of the problem of tobacco use among AAPI girls and women. A national study conducted by Appleyard and colleagues[29] provides revealing data on the dramatic increases in smoking observed among Asian American girls (as well as boys) from the 7th through 12th grades. Other studies have documented high rates of smoking among Hawaiian and Pacific Islander girls.[27,30] While it is commonly believed that second-generation AAPI girls do not experience the same social norms that constrain AAPI immigrant women from smoking, work conducted by Spigner and Gran-O'Donnell showed that AAPI girls still hold a "bad girl" image of female smokers.[31] The degree to which this image promotes or inhibits smoking initiation among AAPI girls has not been investigated.

The challenge of promoting tobacco control among AAPIs in the United States is also compounded by a more global problem, that of tobacco use in Asia and the Pacific Islands. According to estimates of Jha and colleagues,[32] the highest percentages of smokers 15 years and older reside in East Asia and the Pacific. There, the smoking prevalence is 34%, with 62% of men and only 5% of women estimated to be smokers. Because 67% of the AAPI population is foreign born, tobacco use overseas may have a major impact on use among AAPI groups in the United States.

Finally, there is only a limited amount of published research on the predictors of tobacco use among AAPI subgroups. Many more studies are needed if we are to gain a better understanding of the continuing problem of tobacco use in our AAPI communities.

CAPACITY BUILDING, INCLUSIVENESS, AND OTHER CHALLENGES

In addition to the dearth of data on tobacco use among AAPIs, other challenges create barriers to addressing tobacco prevention and control. Robinson

and colleagues described the low capacity of AAPIs and other communities of color to respond to tobacco use issues, particularly in terms of resources, infrastructure development, and focused leadership on tobacco control.[33] Part of this challenge may stem from the many priorities that must be addressed by these communities, including other health issues, economic development, discrimination, civil rights, and sovereignty issues.

Limitations in regard to community resources and leadership also relate to the degree to which AAPIs and other populations have not been part of the tobacco control movement. Historically, the tobacco control and public health movements have not adequately embraced or addressed tobacco issues among communities of color and other priority populations. Although disparities in tobacco use are slowly beginning to be addressed, many such disparities and inequities are built into our system. Whether the issue is related to allocating adequate tobacco control resources and funding to all communities or whether it involves the way in which representatives from key affected communities are included (or not included) in the decisionmaking process, the end result is the same: the inability of the tobacco control and public health movements to address elimination of tobacco use disparities.

While there have been some successful local and regional efforts to mobilize and educate AAPI communities in regard to tobacco issues, we do not know the impact, if any, of statewide programs on reducing tobacco use among AAPIs. According to Kershaw,[30] the statewide Florida Tobacco Pilot Program, the first tobacco prevention program funded by a tobacco settlement, seems to have had little impact in terms of changes in the smoking status of Florida's AAPI youth population. In fact, AAPIs were the only group in Florida not to show a significant decline in youth smoking rates.

The California Tobacco Control Program, the largest in the world, has made some strides in addressing tobacco issues among AAPIs, most notably through funding of statewide ethnic networks, competitive grants, and a statewide media campaign. However, the success of these efforts may not be transferable to other statewide tobacco control programs, particularly if there is limited infrastructure and resource support for local community projects.

Finally, a major challenge has been the heavy targeting of AAPI communities by the tobacco industry both in the United States and overseas.[34–36] The presence of such targeting has been supported by tobacco industry documents, obtained as a result of the Minnesota lawsuit, revealing a tailored marketing strategy by the industry to reach the growing AAPI community with its harmful tobacco products.[37]

A COMPREHENSIVE TOBACCO CONTROL AGENDA FOR THE AAPI COMMUNITY

There are many barriers to tobacco control efforts among the AAPI population, and for more than a decade AAPI community leaders have been grappling with how to successfully address these challenges. If they are to be effective, efforts aimed at addressing tobacco disparities in diverse AAPI populations require a comprehensive, 4-pronged approach designed to (1) increase tobacco prevention and control efforts within the AAPI community, where tobacco issues have not been assigned a high priority; (2) increase efforts within tobacco control organizations, for which AAPIs have not historically been a high priority; (3) increase the involvement of policymakers, among whom neither tobacco control nor the AAPI community has been a high priority; and (4) increase efforts against the tobacco industry, for which AAPIs are, in fact, a high priority.

Given these challenges, Asian Pacific Partners for Empowerment and Leadership (APPEAL), a national AAPI social justice network with a focus on tobacco, has established capacity building, advocacy, and leadership development as priorities in its tobacco control efforts. APPEAL has developed 2 models focusing on community leadership and readiness to confront the multipronged challenges involved in addressing tobacco disparities in AAPI populations. The APPEAL Leadership Model,[38] which has been implemented in the AAPI community and adapted for the Latino community, has helped to identify and train community leaders to implement tobacco prevention and control activities at the local level through intensive training and a yearlong program.

The APPEAL Stages of Readiness Model[39] is a planning and evaluation tool that can be used in identifying a community's level of readiness to engage in tobacco control efforts. This model recognizes the need to provide communities that are implementing tobacco control programs with technical assistance, along with an appropriate level of training, in the areas of research and data collection, infrastructure development, and policy.

FUTURE PRIORITIES: MOVING TOWARD PARITY

APPEAL has also recently published a policy framework for preventing and reducing tobacco use in the AAPI community.[40] One section of this policy manual documents the history of tobacco prevention and control efforts in AAPI populations across the United States. There have been many significant local and national accomplishments in the area of tobacco control among AAPIs in the past 5 years, even though overall funding for community-tailored programs is lacking.

The APPEAL policy framework includes recommendations regarding 8 primary areas of tobacco prevention and control. The recommendations are relatively extensive and comprehensive, but 5 key points can be summarized.

1. Community capacity building needs to be supported, particularly in the case of AAPI populations at early stages of readiness, and resources need to be provided for local and national efforts.
2. Focused efforts need to be targeted toward addressing systemic changes in the tobacco control movement and health care system that can move us toward achieving parity for AAPIs and other priority populations.
3. Tobacco industry tactics need to be closely monitored, and efforts to counter industry targeting require support and re-

sources, including policy support for tobacco industry regulation and a strong international tobacco control treaty.
4. Data collection and research on tobacco use among specific AAPI groups need to be expanded.
5. Changing trends and demographics need to be closely monitored to respond to tobacco issues proactively and effectively, including a focus on transnational tobacco issues and the increasing tobacco use among AAPI women.

Whatever the specific recommendation, a shared responsibility is critical in addressing tobacco use among AAPIs and other communities. We need a commitment from tobacco control organizations, health departments, and health agencies to provide resources and support to communities in recognition of the current and tremendous potential impact of tobacco on AAPIs and other diverse communities. The AAPI community needs to support these tobacco prevention and control activities and lead the fight to change social norms regarding tobacco use. In addition, policymakers and decisionmakers need to develop policies and allocate adequate resources to support comprehensive tobacco control efforts and systemic change.

We must continue to address the increased rates of tobacco use among AAPI men as well as the growing problem among AAPI girls and women. We also need to view the tobacco epidemic as a global issue and consider the growing tobacco industry influence in Asia, the Pacific, and developing countries of the world. Finally, we need to gain knowledge on AAPI groups for which tobacco use data are lacking, including Pacific Islanders who have immigrated to the continental United States, South Asians, and newer populations that can be considered to be part of the AAPI population, such as Afghani refugees.

If we do not invest in a comprehensive approach involving evidence-based tobacco prevention and control efforts among the diverse AAPI community, we will continue to face a growing epidemic that will have tremendous health, economic, and social consequences for entire populations of AAPIs and for the overall public health of the United States. We need to move toward parity in health and toward a tobacco-free country. ■

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Contributors

R. Lew conceptualized, wrote, and edited the first draft. S.P. Tanjasiri assisted in the conceptualization and contributed to both the writing and editing of the final draft.

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