

**Tobacco Disparities, Asian Americans and Pacific Islanders,  
and the Need for Social Justice  
Interagency Committee on Smoking and Health  
March 9, 2004**

**Rod Lew, M.P.H.**

**(Slide 1)**

Good morning.

I would like to express my deep appreciation to the Interagency Committee on Smoking and Health and the Surgeon General for the opportunity to share my presentation on the impact of tobacco and tobacco-related disparities on the Asian American, Native Hawaiian and Pacific Islander community here today. For the purposes of this presentation, I will be using the term AAPI to represent this very diverse community.

**1. Background- challenging conventional wisdom**

**(slide 2)** I would like to start by illustrating the impact of tobacco within one specific AAPI community and one family. This is the story of a Cambodian American family living in southern California- it's one of many stories I collected this past year while filming a documentary video on the impact of tobacco on communities of color. The Heng family is typical of families that came to the U.S. as refugees from war-torn Southeast Asia in the 1970's. Mr. Heng, the head of the household, was a farmer in his home country of Cambodia, but when he came to the U.S. he was not able to find a job. Whether partially through a habit formed while in Cambodia and partially through stress from the challenges of an immigrants' life, Mr. Heng became a two-pack a day smoker. Until, in March, 2003, he began to cough up blood. But he didn't want to burden his family with his problems (already he was unemployed), so he tried to hide this from his family for several weeks. And despite challenges with accessing the medical care system, he eventually went to a doctor and they were able to tell him that it was some type of lung disease (but not malignant). Still tobacco has changed his life and that of his family. And that it wasn't just a tobacco issue, but one of health access, economics, cultural challenges and community competence. Unfortunately, as community advocates will attest, this is story is becoming more common in the AAPI community.

Like other families impacted by tobacco, there's a pervasive silence that runs through the Heng family because of hardship in this new country and that combined with tobacco almost resulted in permanent silence.

This millennium has begun with increasing discussions on health disparities as a public health priority. Certainly, one cannot talk about health disparities without addressing the tremendous impact that tobacco has had on communities of color and other priority populations. And yet, despite the tobacco settlement and recent funding opportunities for priority populations, tobacco use among AAPIs continues to be a growing public health challenge.

But first, I think it would be helpful to describe who AAPIs are?

**(Slide 3)**

Asian Americans, Native Hawaiians and Other Pacific Islanders (or AAPIs) have been one of the fastest growing racial groups in this country over the past two decades, numbering 12.7 million and representing 4% of the population. AAPIs are a very heterogeneous group comprised of more than 50 distinct ethnic and language groups, some languages included in this slide. **(Slide 4)** Geographically, AAPIs are located in the 50 states and six Pacific Island jurisdictions spanning over 12 time zones. Although there has traditionally been large populations of AAPIs in states like California and Hawaii, there is also tremendous growth in states that have not traditionally had AAPIs like Nevada and Arizona. This diversity is also seen in terms of varying educational levels and disparate socioeconomic status with high poverty rates for example among some Southeast Asian and Pacific Islander groups seen in previous presentations. High rates of those without health insurance also exist for some AAPI ethnic subgroups, for example among Korean Americans. This diverse picture of AAPI subgroups has been described as a bipolar distribution with some AAPI ethnic subgroups having higher income levels and other groups in poverty status.

Unfortunately, this picture of a diverse group, gets lost with the public perception that AAPIs are the model minority, a myth that media has helped to perpetuate. This model minority myth extends to the perception that AAPIs also don't have health problems and in this case, don't have problems with tobacco.

Policymakers who can impact tobacco are left with the impression of a model community perhaps to ignore in times of tight or diminishing resources.

## **2. Documenting Tobacco Use among AAPIs**

So what evidence do we have about tobacco's toll on AAPIs? Unfortunately much of the national data on tobacco use among AAPIs feeds into the conventional misperception about AAPIs. **(Slide 5)** As Dr. Caraballo has shared, the documentation of national smoking prevalence for AAPIs has been hampered by lumping together or aggregating tobacco use data for all AAPIs. In addition, these national surveys have been conducted in English. Since two-thirds of AAPIs are immigrants, this may produce samples of AAPIs that are probably more highly acculturated than actual AAPI communities. As a result, we have national data that we feel may actually misrepresent the problem of tobacco in specific AAPI groups.

We have therefore, looked to local studies which have revealed significantly high rates of smoking for males from specific AAPI ethnic groups. For example, Cambodian American males have high rates of smoking as shown by the range of 32-71% smoking prevalence and 48-72% for Laotian American males. **(Slide 6)** For Asian American women, the picture is somewhat the opposite with smoking use low particularly among immigrant women. However, recent trends have shown increase among more acculturated Asian American women and girls, something that we believe relates to tobacco industry targeting.

**(Slide 7)** For Pacific Islanders, recent data shows that Guam (a U.S. territory with primarily PIs) has the second highest smoking prevalence among all U.S. states and territories, a fact that would be lost in aggregating all AAPI data together. Smoking continues to be high for both Native Hawaiian men and women. And it must be recognized that tobacco use not only includes smoking but chewing tobacco with betelnut.

**(Slide 8)** Tobacco-related diseases like lung cancer also are a strong indicator of tobacco disparities. One example for AAPIs would be that lung cancer rates are 18% higher among Southeast Asian Americans than among white Americans.

**(Slide 9)** Smoking is also a growing problem among AAPI youth. The 2001 National Youth tobacco Study showed an alarming increase of smoking among both Asian American boys and girls from 7<sup>th</sup> to 12<sup>th</sup> grades, the greatest increase among all ethnic groups. There was also a surprising trend of high use of menthol cigarettes, previously tied to targeted marketing to particular ethnic groups. And Hawaiian and Pacific Islander girls had the highest smoking prevalence among all middle school groups.

The challenge of tobacco control among AAPIs in the U.S. is also compounded by the global problem of tobacco use in Asia and the Pacific Islands. According to some studies, the highest proportion of smokers (age 15 years and older) is estimated to be found in East Asia and the Pacific. And as I mentioned earlier, since nearly two-thirds of the AAPI population are foreign born, tobacco use overseas may have a major impact on AAPI communities here in the U.S.

**(Slide 10)** But we cannot discuss tobacco use among AAPI and other communities of color without highlighting the heavy and deliberate targeting of our communities by the tobacco industry in the U.S. and overseas. A recent article in Tobacco Control Journal revealed the contents of the secret tobacco industry documents and the industry's tailored marketing strategy to reach the growing AAPI community with its harmful tobacco products. **(Slide 11)** This study showed that as early as the late 1980's, tobacco industry recognized the growth of the AAPI population which translated into high consumer purchasing power and the high percentage of retail business owners who were Asian American. As a result, some companies and their advertising firm recommended specific strategies, for example, Philip Morris developed a strategy known as PUSH, PULL and CORPORATE GOODWILL.

**(Slide 12)** These are some examples of each of the three-prong strategy. The PUSH strategy involved developing a relationship with AAPI retail business owners **(slide 13)** and using what they called "cultural sensitivity" like these lucky red envelopes given out at the time of the Lunar New Year celebrations as a way to promote their products. **(Slide 14)** While billboards are no longer allowed under the tobacco settlement, this billboard in New York's Chinatown is an example of the PULL strategy to reach new potential AAPI smokers during the 1990's. **(Slide 15)** And the CORPORATE GOODWILL was a strategy to sponsor community events, publications (like this

directory) and leadership as a way to increase their legitimacy in the AAPI community.

**(Slide 16)** It is important to understand the history of tobacco industry targeting to understand the challenges facing the AAPI communities, other communities of color and the LGBT community. And when combined with a historic inattention by the tobacco control movement, we can better understand the depth of these tobacco-related inequities. In fact, as the authors wrote “the tobacco industry probably knew how to reach the AAPI community (through culture and diversity) better than the mainstream tobacco control movement.”

**(Slide 17)** Another quote from the Documents article articulates the future potential that the industry saw in the AAPI community. Quote “Investigate the possibility of utilizing men and women and targeting youth in advertising strategies... the literature suggests that Asian American women are smoking more as they believe they should enjoy the same freedom as men.”

**(Slide 18)** And in fact, the industry’s campaigns as depicted in the \$40 million Virginia Slims campaign actually targets AAPI women and also other ethnic women of color. Ironically this campaign was called Find Your Voice. **(Slide 19)** After the Documents article was published, the editor of the Journal was quoted in a news release saying that the targeting of Asian Americans and Pacific Islanders in the U.S. has helped the industry learn how to better design their marketing programs for Asia and the Pacific region worldwide. And here you can see how tobacco industries globally have stepped up their efforts such as the use of the Virgin Mary to sell tobacco in the Philippines.

### **Capacity Building, Inclusivity and Tobacco Industry Targeting Challenges**

**(Slide 20)** As Dr. Robinson described, AAPIs and other communities of color have a low capacity and infrastructure to respond to tobacco particularly in terms of resources, infrastructure development and focused leadership. Part of this challenge may stem from the many priorities that our communities of color must address including other health issues, economic development, discrimination, civil rights and sovereignty issues.

Although addressing tobacco disparities is slowly beginning, low capacity through limited resources and leadership also relate to the historic lack of inclusivity of AAPIs and other priority populations in the tobacco control movement.

One example is the limited impact of some statewide programs on reducing tobacco use among AAPIs. For example, the statewide Florida Tobacco Pilot Program, the first tobacco prevention program funded by a tobacco settlement, seems to have had little impact on changing the smoking status of Florida’s AAPI youth. In fact, Asian Americans were the only group in Florida not to show a significant decline in youth smoking.

So disparities can present not only in terms of prevalence, lung cancer and tobacco-related diseases, but also in terms of health access, language access, community competence and overriding social disparities. The goal becomes to move toward parity

and social justice.

**(Slide 21)** And this is why tobacco can be described as a social justice issue especially for AAPIs and other communities of color. When tobacco is the only product that when used as intended is harmful, and when tobacco is the only community issue that has health, economic, social, political and environmental ramifications with a multi-billion dollar industry targeting their product to our communities, it's an issue of social justice.

**(Slide 22)** Because the challenge for effectively addressing tobacco disparities in diverse AAPI communities requires a comprehensive array of strategies and initiatives, a four-pronged advocacy approach is needed. First, increased advocacy is needed within the AAPI community where tobacco is not the highest priority. Second, increased advocacy is needed within tobacco control organizations where AAPIs and communities of color have not been historically a high priority. Third, advocacy is needed among key policymakers and decision-makers where neither AAPI nor tobacco control has been a high priority. Finally, advocacy is needed against the tobacco industry where AAPIs *are* a high priority.

### **3. A Decade of Activism on Tobacco Control in AAPI Communities**

**(Slide 23)** It's not just an issue of what we don't have. We, like other communities, have shown tremendous resiliency to combat major battles facing our people. And this is the lesson that I think is important over the past five to 10 years for AAPIs. What we can do. While there have been many challenges and continue to be many challenges, the AAPI community has shown endurance and the ability to develop leadership and creative programs to understand and respond to the tobacco problem.

And to face these challenges, we created the Asian Pacific Partners for Empowerment and Leadership (APPEAL), a national AAPI social justice network. For the past 10 years APPEAL has focused on capacity building, advocacy and leadership development in its tobacco control efforts. APPEAL now consists of over 400 community organizations and partners fighting for the elimination of tobacco disparities and the move toward parity in tobacco control.

**(Slide 24)** In the past two decades, we in public health have talked about the new paradigm of policy change- the ability to impact many people at one time as opposed to individual behavior change. But more and more is the realization that we need to include a new paradigm (or rather, a renewed paradigm) of community change. Why? It is clear when we talk about health and tobacco disparities that effective change has not happened or happened fast enough. In this new paradigm, are what I call the 4R's: readiness, relevance, resources, and responsibility: 1) readiness (understanding what level each community is at and recognizing the capacity and infrastructure building, which is where we are at, takes time); 2) relevance (developing culturally tailored and community appropriate approaches); 3) resources (that we can't sustain tobacco control without adequate resources); and 4) responsibility (that it's a shared responsibility between individuals, communities and especially tobacco control organizations, the public health community and policymakers).

While there isn't time to describe the successful and unsuccessful tobacco control strategies for AAPIs, APPEAL has developed two models on community readiness and leadership which I think helps to illustrate successful response to the multi-pronged challenges in addressing tobacco disparities for AAPI communities. **(slide 25)** The APPEAL Stages of Readiness Model is a planning and evaluation tool for identifying a community's level of readiness to do tobacco control. This model recognizes the need to provide technical assistance and training at an appropriate level to communities that are doing tobacco control in the four areas you see in this slide: research and data collection, infrastructure development, programs and policy.

**(Slide 26)** The APPEAL Leadership Model was launched in 1997 and has resulted in the training of over 300 community leaders and tobacco control advocates across the country. Why leadership? We've already talked about the need to advocate on the four levels including countering the co-optation of our leadership by the tobacco industry, but I think an APPEAL fellow says it best, "the small local impact that I am making in the tobacco control field is beginning to extend to the rest of the state and hopefully, nationwide.

**(slide 27)** Other outcomes include the following capacity and infrastructure building on the local community level. Implementation of smoke-free restaurants and the passing of Guam's clean indoor air law. While we initially designed the leadership program for AAPIs, we have been fortunate to have collaborated with other communities in adapting the APPEAL model, for example with Latinos and with diverse communities, including the LGBT community, in Washington State. And finally, we designed a leadership programs specifically for the future of our communities, AAPI youth.

**(Slide 28)** We believe the power of our stages of readiness and leadership model is the ability to bring people together and begin to launch a national movement on tobacco control that is community led and community competent.

#### **4. Future Priorities of AAPI Tobacco Control: Moving Toward Parity**

**(Slide 29)** Many significant accomplishments have been made locally and nationally on AAPI tobacco control in the past 5-10 years although funding for local community-tailored programs on tobacco prevention and control for AAPIs overall is lacking. In 2000, APPEAL published a policy framework for preventing and reducing tobacco use and tobacco disparities in the AAPI community.

In this framework for addressing tobacco disparities through social justice and comprehensive tobacco control, recommendations are listed for eight primary areas of tobacco prevention and control for AAPIs. Given the limited time, I will highlight only a few of the recommendations:

1. Adopt and implement a comprehensive research and data plan for understanding tobacco's impact on AAPIs, one that highlights disaggregated data and participatory action research.
2. Continue to support capacity and infrastructure building particularly for AAPI

- communities at early stages of readiness and include leadership development.
3. Fund development of community interventions including community competent cessation programs for AAPI ethnic groups with high tobacco use.
  4. Fund initiatives to address tobacco as a social justice issue including countering tobacco industry marketing and programs which address those AAPI populations that are disenfranchised.
  5. Changing trends and demographics need to be closely monitored to respond to tobacco issues proactively and effectively. These include a focus on the increasing tobacco use among AAPI women, AAPI LGBTs and transnational tobacco issues.

Whatever the specific recommendation is, a shared responsibility is critical to addressing tobacco use among AAPIs and other communities- one that involves an honest and committed partnership between communities, tobacco control organizations, health departments and agencies, policymakers and decisionmakers moving together toward parity in tobacco control.

**(Slide 30)** In conclusion, we must heed the evidence provided by local community studies and tobacco document research. We must refocus our energies and resources on the paradigm of community change and the four R's. We must build the capacity, infrastructure and leadership to address the critical needs of specific ethnic communities. In particular, we need to recognize that capacity building takes time and there needs to be a sustained commitment to capacity building, programs and policy for AAPIs, communities of color and other priority populations. It would not be fair to start a process and then pull resources. If that happens, this could be painfully detrimental to the AAPI's ability to respond to tobacco and eliminate tobacco disparities in the future. We must combine this vision with action.

**(Slide 31)** If we do not invest in a comprehensive approach of evidence-based tobacco prevention and control efforts for the diverse AAPI community, we will continue to face a growing epidemic that will have tremendous health, economic and social consequences not only on AAPI men, like Mr. Heng, but on entire communities of AAPIs and the public health of the U.S. We, instead, should be moving toward being a tobacco-free AAPI community and parity in health. Thank you for your attention and allowing me to share this critical information on tobacco disparities with you.