SSM – Population Health 3 (2017) 305–317

Contents lists available at ScienceDirect

SSM – Population Health

journal homepage: www.elsevier.com/locate/ssmph

Article

Intergenerational differences in smoking among West Indian, Haitian, Latin American, and African blacks in the United States

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ARTICLE INFO

Keywords:
USA
Black immigrants
Smoking
Intergenerational disparities
Race

ABSTRACT

Due in large part to increased migration from Africa and the Caribbean, black immigrants and their descendants are drastically changing the contours of health disparities among blacks in the United States. While prior studies have examined health variation among black immigrants by region of birth, few have explored the degree of variation in health behaviors, particularly smoking patterns, among first- and second- generation black immigrants by ancestral heritage. Using data from the 1995–2011 waves of the Tobacco Use Supplements of the Current Population Survey (TUS-CPS), we examine variation in current smoking status among first-, second-, and third/higher- generation black immigrants. Specifically, we investigate these differences among all black immigrants and then provide separate analyses for individuals with ancestry from the English-speaking Caribbean (West Indies), Haiti, Latin America, and Africa—the primary sending regions of black immigrants to the United States. We also explore differences in smoking behavior by gender. The results show that, relative to third/higher generation blacks, first-generation black immigrants are less likely to report being current smokers. Within the first-generation, immigrants who migrated after age 13 have a lower probability of smoking relative to those who migrated at or under age 13. Disparities in smoking prevalence among the first-generation by age at migration are largest among black immigrants from Latin America. The results also suggest that second-generation immigrants with two foreign-born parents are generally less likely to smoke than the third/higher generation. We find no statistically significant difference in smoking between second-generation immigrants with mixed nativity parents and the third or higher generation. Among individuals with West Indian, Haitian, Latin American, and African ancestry, the probability of being a current smoker increases with each successive generation. The intergenerational increase in smoking, however, is slower among individuals with African ancestry. Finally, with few exceptions, our results suggest that intergenerational gaps in smoking behavior are larger among women compared to men. As additional sources of data for this population become available, researchers should investigate which ancestral subgroups are driving the favorable smoking patterns for the African origin population.

Introduction

Migration researchers have begun focusing on the health outcomes of black immigrants, a population of increasing importance for understanding the health trajectories of the U.S. black population as a whole. A growing body of research has found that black immigrants, like other immigrant subgroups, report better health and have lower rates of disability, obesity, and mortality than their U.S.-born counterparts (Bennett, Wolin, Askew, Fletcher & Emmons, 2007; Elo, Vang & Culhane, 2014; Hamilton, 2014; Hamilton & Hummer, 2011; Mehta, Elo, Ford & Siegel, 2015; Singh & Siahpush, 2002). These favorable health outcomes, however, tend to diminish across generations, with second-generation immigrants (U.S.-born individuals with at least one foreign-born parent) having worse health outcomes than first-generation (foreign-born) immigrants (Hendi, Mehta & Elo, 2015). Prior studies, which primarily focused on the Latino(a) population, have identified changes in health behaviors as one of the primary factors that negatively influence the health trajectories of immigrants as their tenure of U.S. residence increases and across generations (Acevedo-Garcia et al., 2010; Alcántara, Molina & Kawachi, 2014; Antecol & Bedard, 2006; Kimbro, 2009; Kondo, Rossi, Schwartz, Zamboanga & Scalf, 2016; Lopez-Gonzalez, Aravena & Hummer, 2005; Pérez-Stable et al., 2001; Tong et al., 2012; Trinidad, Pérez-Stable, White, Emery & Messer, 2011). This study examines the association between generational status and one important health behavior among blacks: tobacco smoking.

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http://dx.doi.org/10.1016/j.ssmph.2017.01.007

Smoking is the primary cause of a number of illnesses, such as cancer and cardiovascular disease, and is the leading cause of preventable deaths in the United States (CDC, 2008; O'Malley, Wu, Mayne & Jatlow, 2014). Researchers have suggested that the lower incidence of smoking among the foreign-born is a primary determinant of immigrants' mortality advantage over their U.S.-born counterparts (Blue & Fenelon, 2011; Fenelon, 2013). Prior studies have found that most immigrant subgroups, including black immigrants, are less likely to smoke than their native-born racial/ethnic counterparts upon arrival in the United States (Acevedo-Garcia, Pan, Jun, Osypuk & Emmons, 2005; King, Polednak, Bendel & Hovey, 1999; Singh & Siahpush, 2002; Siahpush, Singh, Jones, & Timsina, 2009). Smoking rates among immigrants, however, tend to increase as their tenure of U.S. residence increases (Acevedo-Garcia et al., 2010a; Alcántara et al., 2015; Kuerban, 2016; Leung, Ang, Thumboo, Wang, Yuan & Koh, 2014; Pérez-Stable et al., 2001; Singh & Siahpush 2002), a factor often thought to produce a convergence in health outcomes between immigrants and the U.S.-born. While a number of studies have investigated changes in smoking behavior among first-generation immigrants, several gaps exist in the extant literature on smoking, particularly among blacks in the United States.

First, few studies have examined smoking differences among foreign-born blacks who migrated to the United States as teens or adults (first generation) and those who migrated as children (known as the 1.5 generation). Relative to individuals who migrated later in life, those who came to the United States as children have spent their formative years in the United States. Thus, they might be more likely to adopt the host country's smoking norms rather than those of their origin countries. Consequently, it is important to understand the ways in which age at migration shape smoking behavior among first-generation blacks in the United States.

Second, due in large part to data limitations, few studies have investigated ancestral health disparities among second-generation black immigrants, which conceals the increasing heterogeneity of the second-generation black immigrant population. Immigrants from the Caribbean have historically comprised the overwhelming majority of the flow (and stock) of black immigrants to the United States. Since the year 2000, however, the number of black immigrants arriving from Africa has surpassed the number of arrivals from the Caribbean (Anderson, 2015), suggesting that the fraction of second-generation black immigrants of African ancestry is likely to increase significantly in the coming decades. Among first-generation immigrants, pre-migration smoking norms vary considerably across the primary source countries (Bilano et al., 2015; Zhao, Palipudi, Ramanandraibe & Asma, 2016). Thus, the process of social adaptation into U.S. smoking behavior might vary considerably among second-generation immigrants depending on their parents' place of birth (Leung, 2014). Understanding how smoking patterns vary by generational status among blacks by regions of origin/ancestry could also provide valuable insights into how the health behaviors and health outcomes of the black population are likely to evolve in the coming decades.

The current study investigates intergenerational patterns in current smoking behavior among blacks in the United States. Specifically, using data from the 1995–2011 waves of the Tobacco Use Supplements of the Current Population Survey (TUS-CPS), we examine intergenerational variation in smoking patterns among first-, 1.5, second-, and third/higher- generation black immigrant men and women. We also explore whether intergenerational smoking patterns vary among blacks by ancestral heritage, including the English-speaking Caribbean (West Indies), Haiti, Latin America, and Africa.

Background

A large literature has documented that some immigrant subgroups have more favorable health and mortality profiles, particularly upon arrival in the country, than their U.S.-born counterparts (Elo, Mehta, & Huang, 2011; Hamilton, 2014; Hamilton & Hummer, 2011; Singh & Siahpush, 2002). Black immigrants' mortality advantage is particularly striking.[1] Singh and Siahpush (2002) showed that black immigrants have a lower risk of all-cause mortality compared to both U.S.-born blacks and non-blacks, regardless of nativity. These health and mortality advantages, however, tend to decline as immigrants' tenure of U.S. residence increases; a process termed the "healthy immigrant effect" (HIE). Prior research has suggested that selective migration (e.g., individuals with the best health profiles in the origin country are more likely to move to the United States) and immigrant cultural practices that promote good health behaviors play a significant role in producing immigrants' initial health advantage (Jasso, Massey, Rosenzweig & Smith, 2005). Researchers have argued that changes in health behaviors, particularly smoking patterns, are one of the primary factors that generate the decline in immigrants' health as their tenure of U.S. residence increases (Gorman, Lariscy, & Kaushik, 2014; Kuerban, 2016; Siahpush et al., 2009). Singh and Siahpush (2002) showed that while newly arrived immigrants were 52 percent less likely to smoke compared to their U.S.-born counterparts, these nativity advantages decreased to 32 and 18 percent, respectively, for those residing in the United States for 10–15 and more than 15 years.

Age at time of arrival

Another important but less studied source of variation in smoking behavior among foreign-born blacks is age at the time of immigration. Research has suggested that individuals who immigrated to the United States as children played a limited role in the migration decision. Consequently, if the decision to move among immigrants is strongly correlated with both good health and favorable health behaviors, those who came to the United States at younger ages might be less favorably selected on good health behaviors than those who migrated as adults. Moreover, studies have also shown that smoking habits tend to form at relatively early ages and are heavily influenced by family- and community- level contexts (Harrell, Bangdiwala, Deng, Webb & Bradley, 1998; Lipperman-Kreda, Grube & Friend, 2014). A number of studies have also found that children who migrate prior to becoming teenagers are at an increased risk of substance abuse or having psychiatric disorders (Breslau et al., 2007a; Breslau, Aguilar-Gaxiola, Borges, Kendler, Su & Kessler, 2007b). Consequently, first-generation immigrants who arrive in the United States during childhood might be more likely to smoke relative to those who migrate during adulthood.

To our knowledge, no prior studies have examined smoking behavior among black immigrants who arrived in childhood, also known as the 1.5 generation. Studies of Latino and Asian immigrants, however, have found that age at migration is significantly associated with smoking behavior (Kimbro, 2009; Wilkinson et al., 2005). For example, Kimbro (2009) investigated differences in smoking and binge drinking among U.S.- and foreign- born Latinos, with a focus on the role of age of migration. She found that foreign-born Latinos were less likely to smoke or binge drink than their U.S.-born counterparts. Moreover, relative to individuals who migrated earlier in life, foreign-born individuals who migrated later in life were less likely to engage in poor health behaviors. These patterns were especially pronounced among women.

Generational differences in smoking

Research has found that smoking patterns also change across immigrant generations (Acevedo-Garcia et al., 2005; Kopak, 2013; Singh & Siahpush, 2002). There are a number of potential explanations. First, studies have shown that parents transmit social norms

[1] One important exception is mental health. For black immigrants from majority black countries, the stress of migration has been shown to be associated with schizophrenia, depression and other mental health outcomes (Bourque et al., 2011; Cantor-Graae et al., 2005).