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Gender, acculturation, and smoking behavior among U.S. Asian and Latino immigrants

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ABSTRACT

In this paper we examine smoking prevalence and frequency among Asian and Latino U.S. immigrants, focusing on how gender differences in smoking behavior are shaped by aspects of acculturation and the original decision to migrate. We draw on data from 3249 immigrant adults included in the 2002–2003 National Latino and Asian American Study. Findings confirm the gender gap in smoking, which is larger among Asian than Latino immigrants. While regression models reveal that gender differences in smoking prevalence, among both immigrant groups, are not explained with adjustment for measures of acculturation and migration decisions, adjustment for these factors does reduce gender differences in smoking frequency to non-significance. Following, we examine gender-stratified models and test whether aspects of migration decisions and acculturation relate more strongly to smoking behavior among women; we find that patterns are complex and depend upon pan-ethnic group and smoking measure.

1. Introduction

Smoking prevalence is higher among U.S. men than women, but the gender disparity varies by racial/ethnic identity (Centers for Disease Control and Prevention [CDC], 2012). Among non-Latino whites, 22.5% of men and 18.8% of women smoke cigarettes, a relatively small gender gap of just 3.7 percentage points. Comparable figures for other groups are an 8.7 percentage point gap among non-Latino blacks (24.2% for men and 15.5% for women), and an 8.4 percentage point gap among Latinos (17.0% for men and 8.6% for women). While comparatively few Asian Americans smoke, the gender gap of 9.4 percentage points among Asians (14.9% for men and 5.5% for women) is larger than all other groups (CDC, 2012). These expanded gaps among Latino and Asian adults may be due to the large proportion of these populations who are immigrants; as such, their smoking behavior is likely shaped by gendered smoking norms in their countries of origin, migration decisions and immigrant selectivity, and acculturation – or the adoption of the behavioral patterns and beliefs of a surrounding culture (Bethel and Schenker, 2005; Choi et al., 2008).

Gender gaps in smoking may be substantial for Asian and Latino immigrants since many originate from nations where gender norms are more patriarchal and smoking among women is seen as socially unacceptable (Choi et al., 2008). U.S. immigrants generally adopt more unhealthy behaviors with increasing acculturation (Abraído-Lanza et al., 2005; Lopez-Gonzalez et al., 2005; Zhang and Wang, 2008), including increased smoking among women. However, among immigrant men, studies find either a weak but negative acculturation-smoking association (Kimbro, 2009; Perez-Stable et al., 2001; Zhang and Wang, 2008), no association

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(Abraído-Lanza et al., 2005; Shelley et al., 2004), or a positive association similar to female immigrants (Sundquist and Winkleby, 1999). The status shifts that accompany U.S. migration, including diminished female conservatism, may explain why smoking patterns change as they do (Parrado and Flippen, 2005), as research demonstrates that subsequent reception and location in U.S. society differ for men and women migrants (Donato et al., 2006).

To investigate these relationships, we utilize data on foreign-born adults drawn from the 2002–2003 National Latino and Asian American Study (NLAAS), examining how smoking prevalence and frequency differs by gender. We begin by examining whether gender-smoking patterns among Latino and Asian pan-ethnic groups are explained by adjusting for acculturation status (including measures that reflect orientation toward both U.S. and native-country culture), plus measures that reflect health-selection processes regarding the original decision to migrate. This is an important contribution of our work, as migrant smoking research has focused almost exclusively on how patterns vary by indicators of acculturation toward U.S. culture (the set of loosely-organized practices, symbols, and norms associated with a particular population; see Sewell, 1999). Within each pan-ethnic group we also adjust for country-of-origin since U.S.-based studies find differences in smoking prevalence and frequency, as well as variation in the size of the gender-smoking gap, by county-of-origin (Baluja et al., 2003; Chae et al., 2006; Perez-Stable et al., 2001). And because of the gendered nature of smoking behavior and the migration/acculturation process more generally, we then run gender-stratified models and test whether relationships among acculturation, migration decisions, and smoking differ for men and women within each pan-ethnic group.

2. Background

2.1. Acculturation and migration decisions

While early research conceptualized acculturation as a unidimensional process of assimilation, recent research emphasizes a bidimensional perspective that sees adoption of a new culture as a process occurring independently of origin-culture ties (Berry, 2003; Sam, 2006). Studies utilizing measures representing both new culture acquisition and culture-of-origin retention provide a more comprehensive assessment of the relationship between acculturation and health outcomes/behaviors (Abraído-Lanza et al., 2006). A bidimensional process offers several acculturation strategies that new immigrants may follow: assimilation strategies wherein migrants interact regularly with other cultures and separate from their origin-culture identity, separation strategies wherein migrants continue to value their origin culture and avoid interaction with others in the destination culture, and integration strategies wherein migrants maintain origin-culture ties while simultaneously interacting with persons in the new culture (Berry, 2003; see related taxonomy developed by Levitt, 1998).

Acculturation can involve the adoption of health-compromising behaviors among U.S. migrants, including smoking (Abraído-Lanza et al., 2005; Choi et al., 2008; Lopez-Gonzalez et al., 2005; Zhang and Wang, 2008). However, due to limited information available in most U.S. health surveys, acculturation is typically assessed with measures that gauge acculturation relative only to U.S. culture (e.g., duration of U.S. residence), ignoring the potential influence of country-of-origin orientation among migrants to influence health behaviors. For example, language preference and ability is one of the most commonly assessed acculturation measures, and operationalizing acculturation through language allows observation of biculturalism (bilingualism) as opposed to an acculturated/unacculturated dichotomy (Epstein et al., 1998; Fu et al., 2003). Immigrants who are linguistically isolated may have fewer opportunities to discuss smoking cessation with physicians or pharmacists. Conversely, bilingual immigrants may be less inclined to smoke to deal with migration-related stresses if their bilingualism allows them to maintain connections with both origin and destination cultures (Lee et al., 2000).

Additionally, the non-random nature of the original decision to migrate may operate to shape smoking behavior. Migrants are atypical in their health profile, as they enter the U.S. exhibiting healthier behaviors and better health outcomes when compared to the native-born and non-migrants in sending nations (Jasso et al., 2004). If variation exists in how much the migration decision was influenced by factors relating to smoking and health status more generally (e.g., seeking medical care), then these factors may also influence smoking behavior across migrant groups.

Thus, we hypothesize (H1) that indicators of orientation toward U.S. and origin-country culture, and the decision to migrate in the first place, are independently related to smoking behavior.

2.2. Gender, migration, and smoking

Men and women routinely make decisions within a context of constrained choices; even if health is a priority, decisions are not always healthy (Bird and Rieker, 2008). The concept of "constrained choice" informs how acculturation might have different influences on health behavior for migrant men and women. Within countries of origin, men and women are likely subjected to different smoking norms, contrasted to a more balanced exposure in the U.S. (Lopez-Gonzalez et al., 2005). Men may feel smoking is appropriate when interacting with male kin and coworkers and reflective of high social status, while women may be forbidden from smoking since many view it as activity reserved for men (Ma et al., 2004). Gender difference in smoking is often greater among origin-country populations than among U.S. immigrants. For example, the gender gap in smoking prevalence for Chinese adults living in the U.S. is wide (14.6% among males and 3.8% among females; An et al., 2008) but not nearly as wide as the gap in China, where 47% of men and only 2% of women smoke (World Health Organization [WHO], 2013). In contrast, smoking prevalence among men in Mexico is more than three times greater than women (27% vs. 8%; WHO, 2013), while the gender gap is smaller among Mexican Americans (although the size of the gap varies by study and sample; e.g., 25.0% vs. 10.4% in an 8-city study; Perez-Stable et al., 2001).

If women embrace enhanced independence after migrating, they may use increased freedoms and higher incomes to begin smoking despite the health risks. Female migrant networks often consist of similar-aged women who live in close proximity, where risky and nontraditional behaviors are encouraged (Curran and Saguy, 2001). Yet men typically do not experience the same enhancement in status after migration (and may face increased restrictions on tobacco use at work or social pressures to reduce/cease smoking). While previous studies demonstrate smoking increases with acculturation among women, studies find no concrete trend among Latino men – and even decreased smoking prevalence among Asian men (Bethel and Schenker, 2005; Zhang and Wang, 2008). We expand upon this literature by comparing how different dimensions of acculturation and smoking behavior operate for migrant men vs. women, and how markers of original migration decision shape gender disparities as well.

Indeed, decisions regarding migration may vary by gender, and thus have implications for migrant smoking patterns. Even though female migration is increasing, more men migrate to the U.S. and often for different reasons (e.g., typically employment for men and family reunification for women) (Donato et al., 2006; Hondagneu-Sotelo, 1994). If women have less say over the migration decision