

Immigrants/ New Americans

FACT SHEET



Immigrants and New Americans

The term “immigrant” is used for people who are foreign-born. It does not refer to legal status of entry into the U.S. as defined by the Immigration and Naturalization Service. In the U.S., 10.4% of the population or 28.4 million persons are foreign-born, based on 2000 census information.¹

National Facts and Trends

- The overall rate of smoking among immigrants is 21.6%.¹
- The rates vary from 4.6% among Indian immigrants to 21.4% for Japanese immigrants.¹
- Among immigrant populations men smoke more than women. Men from Japan smoke at a rate of 29.8%, South Korea 33%, India 8.1%, and Hong Kong, 9.7%.¹
- Except for Asian-American and Pacific-Islander immigrants, smoking rates are higher among native-born than among foreign-born counterparts.¹

Maine Facts and Trends

- The City of Portland, Public Health Division, has initiated a project to reduce health disparities among minority communities in Portland. Initial results and findings were obtained through a combination of in-depth interviews with individuals and focus group sessions.²
- While the data from the Portland study are qualitative and subjective in nature, there appears to be some striking differences between the 11 groups with respect to tobacco use among the four subcategories of individuals (adult males and females, teen males and females); for instance, among adults, the highest smoking rates appear to be among Serbo-Croatian men and women and Vietnamese men. These differences point up the need to tailor tobacco-related health messages to each community.²
- In most of the 11 Portland immigrant communities, adult men smoke at a higher rate than adult women. Seven of the 11 communities rank tobacco use as the number-one or number-two health issue for adults (there were six issues included for ranking). All 11 indicated that health messages delivered person-to-person would be most trusted in their communities, and in all but one ethnic/language group, the need for interpreters was high.²
- For every group in that study with a perceived high rate of smoking among adults (male and/or female), not only is the attitude about quitting negative, but also the desirability of quitting.²
- African immigrant men in Maine suffer from tobacco addiction in very large numbers. According to advocates, one determining factor for smoking among this population is an elevated social status associated with smoking. One man who spent time in a refugee camp in Kenya reports that African refugee men often trade the few personal possessions they have for cigarettes.³
- Cambodian and Vietnamese men in Maine smoke at alarming rates. Rates for these men are most likely influenced by overall community acceptance of smoking among men in their countries of origin. (The World Health organization reports a smoking rate of over 66% among men in Cambodia and over 50% for Vietnamese men.)³

- In most cases the pattern of use by male youths appears to follow the pattern of the adult males in that ethnic/language community.²
- Results from the Portland minority health study show that even among the ethnic/language groups with the highest rates of smoking—and even among the groups in which it is culturally acceptable for women to smoke—smoking during pregnancy is viewed as unacceptable.²
- Latino community advocates in Maine report moderate smoking among single men and a decreased rate among men with families, but they express the most concern with the number of children they see smoking. Unlike white communities where low-income individuals are most likely to smoke, Latino communities experience an increase in levels of cigarette use with improved socioeconomic status. Advocates suggest person-to-person instruction is a better approach to tobacco education than dissemination of written materials.³

The Story Behind the Facts: Why Is this Information Important

- Smoking status of immigrants may stem from shifts in lifestyle or cultural practices or may be related to age at immigration, socioeconomic status, generation, community characteristics, or English language ability.¹
- Health services that might include cessation are not easily available to immigrants. Barriers include confusion about eligibility rules, inability to communicate in English, fear that benefits will result in denial of green card, and concern that providers will report undocumented family or household members.⁴
- Most immigrants arriving after August 1996 are barred for five years (when they most need assistance) from Temporary Assistance for Needy Families (TANF), Medicaid, and State Children's Health Insurance (SCHIP). They have difficulty getting a social security number. They, therefore, may not have access to any medical help for quitting smoking. Exception are made for refugees and veterans.⁴

References:

¹ Baluja, KF, et al. "Inclusion of Immigrant Status in Smoking Prevalence Statistics." *Am J Public Health* (2003) 93: 642-646.

² Bankole, KB. "Tobacco Use, Physical Activity and Nutrition Among Portland's Largest Eleven Ethnic/Language Groups." City of Portland, Maine, Health and Human Services Dept., Public Health Division (PowerPoint presentation).

³ Maine Coalition on Smoking or Health. *An Initial Assessment of Tobacco Use and Tobacco-Related Issues Among Diverse Populations in Maine*. November 30, 2004.

⁴ Wiley, D. *Disparities*. Presentation to SOPHE 2002 Midyear Scientific Conference. Cincinnati, Ohio, May 4, 2002.



Appropriation #014-10A-9922-022

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, age, sexual orientation, or national origin, in admission to, access to or operation of its programs, services, activities or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Acts of 1964 as amended, Section 504 of the Rehabilitation Act of 1973 as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act. Questions, concerns, complaints, or requests for additional information regarding civil rights may be forwarded to the DHHS' ADA Compliance/EEO Coordinator, State House Station #11, Augusta, Maine 04333, 207-287-4289 (V) or 207-287-3488 (V), TTY: 800-606-0215. Individuals who need auxiliary aids for effective communication in programs and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinator. This notice is available in alternate formats, upon request.

HMP is a collaborative effort of the Maine DHHS (Maine CDC and Office of Substance Abuse) and DOE, supported primarily by the Fund for Healthy Maine and federal grants from the US CDC, Substance Abuse and Mental Health Services Administration, and DOE.