

Center for Regulatory Effectiveness (CRE) assessment of
the following research report:

**“Do the Majority of Asian-American and African-American
Smokers Start as Adults? ”**

by

Dennis R Trinidad, Elizabeth A Gilpin, Lora Lee, John P Pierce

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Reference:

- a. Do the majority of Asian-American and African-American smokers start as adults? *Am J Prev Med.* 2004 Feb; 26(2): 156-8. Trinidad Dr, Gilpin EA, Lee L, Pierce JP.

Background

On June 22, 2009, President Obama signed into law the Family Smoking Prevention and Tobacco Control Act, which gives the Food and Drug Administration the power to further regulate the tobacco industry. One element of the law imposes new warnings and labels on tobacco packaging, with the goal of discouraging minors and young adults from smoking. The bill bans flavored cigarettes, including cloves, cinnamon, candy, and fruit flavors, with a special exception for menthol cigarettes. There is a need to investigate possible health hazards of smoking menthol cigarettes as well as cessation (quitting) efforts.

The Tobacco Products Scientific Advisory Committee (TPSAC) provisioned under the bill is to submit a recommendation on menthol cigarettes to the United States Secretary of Health and Human Services no later than March 23, 2012. The intent of this CRE assessment is to consider the merits and shortfalls of the study as well as present the reader with topics for further discussion and investigation.

The report at reference (a) was identified for review and public discussion due to its evaluation on the ethnic differences in the starting age of smoking. Ethnic differences in smoking habits including menthol smoking have been reported. The researchers presented the following primary results:

- Significant ethnic disparities in relation to when people start smoking, with the majority of Asians/Pacific Islanders (A/PI) and African Americans (AA) initiating as young adults.

Summary of Findings and Issues

The reported later starting age of smoking among A/PI could be caused by successful prevention.

The authors concluded “Prevention strategies should begin at a young age and continue throughout young adulthood, especially among ethnic minority populations” and “Further consideration of the different influences on later smoking initiation in ethnic minority populations may lead to suggestions to improve current smoking-prevention programs aimed at adolescents and young adults”. However, what is really observed in this study is that the starting age of smoking shift a little bit for A/PI. The authors claimed that the reason might be “the tobacco industry is effectively encouraging young adults to start smoking, thus reducing the impact of successful adolescent interventions”. However, a more possible reason is that successful prevention of earlier age smoking within A/PI make the starting age delayed. It is generally believed that family plays a bigger role in A/PI groups and it is not surprising that family rule is stricter in A/PI population. The authors did not explain why the tobacco industry only effectively (or more effectively) encouraging A/PI young adults to start smoking and claimed “Additional research is required to determine if young adult minority populations are being differentially targeted.”

The reported significant difference of starting smoking age among ethnic groups could be very limited.

The authors classified the starting ages of smokers into four age groups: 10-13, 14-17, 18-21, and 22-25 years old. By doing this, the authors transformed the continuous variable of age into categorical variable. Although this might help readers to see a simpler picture, they might fail to see the whole picture. Some information was lost while comparing the differences of age categories instead of age between ethnic groups. The more common method to describe continuous data is average and standard deviations. And traditional statistical method for continuous data comparison is ANOVA/Linear regression etc. For example, the peak of start smoking age shifted from 14-17 age groups of non-Hispanic Whites to 18-21 of Asians/Pacific Islanders. However the average age of starting smoking age could be 16.6 in non-Hispanic whites and 17.5 in Asians/PI. Although statistically significant, the difference between average start smoking ages of ethnic groups could be too small to be meaningful in real life. The authors should have presented the distributions of the ages among groups and conduct statistical analysis for continuous variable: age.

The authors didn't conduct any analyses to determine the reasons of different start smoking age among ethnic groups.

While start smoking age is a simple indicator, the factors that caused the difference among groups could be quite complicated and affected by multiple predictors. Factors such as gender, income, education, and culture traditions could all contribute to the difference. It is therefore hard to draw any conclusions about the reasons behind the observed differences as done in this report. The

suggested extending prevention in later young adult stage in A/PI groups by the authors although might not be based on any solid evidence.