

**A Qualitative Exploration of the
Tobacco Control Needs of
Colorado Asian American Pacific Islanders
(AAPIs)**

A Priority Population Statewide Needs Assessment

Conducted for Colorado STEPP
The State Tobacco Education and Prevention Partnership

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A Partnership of



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Supporting AAPI Organizations

Cambodian Organization of Colorado
Colorado Asian Roundtable
Colorado Chinese Language School
Colorado Cambodian Relief Association
Congregation of St. De Paul - Korean Catholic Church
Formosan Association for Public Affairs (*Chinese Association*)
Hindu Temple and Cultural Center of the Rockies (*Indian Association*)
Hmong American Association Center
Hmong Mennonite Church
ISKON (*Indian Association*)
Lao Roam Mit Association
National Asian American Pacific Islander Mental Health Association
Philippine American Society of Colorado
Ranum High School Multicultural Club (*Asian Multi-Ethnic*)
Refugee Program (*Colorado DHS, Office of Sufficiency*)
Vietnamese Elderly Association
Young Hak Presbyterian Church of Denver (*Korean Association*)

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A QUALITATIVE EXPLORATION OF THE TOBACCO CONTROL NEEDS OF COLORADO ASIAN AMERICAN PACIFIC ISLANDERS (AAPIs)

EXECUTIVE SUMMARY

There is a common misperception that Asian American Pacific Islanders (AAPI) are at lower risk of tobacco initiation, life-time use and tobacco-related diseases than other racial ethnic groups in the United States (NAWHO, 1998). Despite the fact that lung cancer is the leading cause of death among AAPIs (Chen and Hawks in Grace et. al., 2002), AAPI tobacco use has not been the subject of much research until recently.¹ Recent studies have revealed "[t]he lack of quantitative and qualitative data on the health and the health care practices of APIAs" (Ro, 2001), the instability of small sample size estimates (Grace et. al., 2002), and the need for culturally appropriate measurement of smoking behavior (Grace et. al., 2002; Yi et. al., 2002).

The purpose of this needs assessment was to initiate culturally appropriate information gathering processes, to improve upon the current state of knowledge concerning AAPI tobacco use. Specifically, the Colorado State Tobacco Education and Prevention Partnership (STEPP) contracted with the Asian Pacific Development Center to conduct a statewide needs assessment of AAPI tobacco control needs. The purpose of the needs assessment was to inform the development and implementation of AAPI targeted tobacco control efforts in STEPP's three goal areas: Reduce initiation of tobacco use by youth, Reduce exposure to environmental tobacco smoke, and Promote quitting among youth and adults. To accomplish this the needs assessment was designed to address two fundamental questions about AAPI tobacco use:

1. What are the social meanings and practices that surround tobacco use by Asian American and Pacific Islanders (AAPI)?
2. In what ways can cultural information about AAPIs and tobacco use build a base from which to address prevention, environmental tobacco smoke (ETS) and cessation?

Agency Partnership for the Needs Assessment

The Asian Pacific Development Center (APDC) of Colorado has a twenty-two year history of providing community-based clinical services and programs to Asians and Pacific Islanders (AAPIs) throughout the state. Offices in Denver, Aurora and Colorado Springs have enabled APDC to tap AAPI networks and to respond to needs statewide. The mission of APDC is to empower AAPIs and all Coloradans through the promotion of understanding and the appreciation of cultural diversity.

The tobacco control needs assessment conducted for STEPP, and described in this report, has provided APDC with the opportunity to further enhance its AAPI networks and to begin capacity building around tobacco issues within AAPI communities. APDC's role in this study was manifold: 1) to ensure culturally appropriate and relevant instrumentation and interpretation of findings, 2) to recruit and support bicultural, bilingual *peer-to-peer researchers* from among the nine largest Asian ethnic communities in Colorado, 3) to represent the tobacco needs assessment within Asian communities, and 4) to convene key stakeholders to begin a dialogue about tobacco issues within Asian communities.

¹ Please see the June 2002 issue of the American Journal of Public Health.

The needs assessment was designed and carried out in partnership with OMNI Research and Training, Inc. OMNI is an applied social science research firm that has been working with foundations, government and non-profit agencies in the areas of youth development, substance abuse prevention and treatment, juvenile and criminal justice, and community health and development, for over twenty-five years. Over the past several years, OMNI has worked with APDC in variety of capacities, including program evaluation and technical assistance. For the statewide tobacco needs assessment, OMNI played an important role in the development of the study and instruments, training and debriefing peer-to-peer researchers, conducting Asian health practitioner interviews, and analyzing and reporting the data.

The AAPI Population in Colorado

In Colorado, there is a small, but growing population of Asian American Pacific Islanders. With new Census categories, individuals identifying as an AAPI singly or in combination with another racial ethnic group now make up a little of 3% of the Colorado population. The City of Denver is the city with the largest number of AAPI residents (16,259). Denver is followed by the City of Aurora and Colorado Springs, respectively, in having the second and third largest AAPI populations. Altogether, nearly 40% of Colorado AAPIs live in one of these three cities.

Korean Americans represent the largest Asian ethnic group, followed closely by Chinese Americans and Vietnamese Americans. Nearly 64% of AAPIs speak an Asian or Pacific Island language in the home, and 32% of all Colorado AAPIs "speak English less than 'very well'" (Census category). According to the 2000 Census, nearly 20% of Coloradans born outside the U.S. emigrated from an Asian country.

Needs Assessment Process

This needs assessment was designed as a qualitative research study of the knowledge, attitudes, beliefs and values of AAPIs in Colorado. Four distinct and iterative stages of research were built into the needs assessment: AAPI health practitioner interview, AAPI community member interviews, a peer-to-peer research debrief, and the formation of a Colorado AAPI Tobacco Advisory Board to help guide culturally appropriate data interpretation. At each stage, AAPIs assumed significant roles in providing interview guide feedback, recruiting research participants, collecting and translating data, debriefing the research process, and assessing the cultural appropriateness of data interpretation. The provision of interpretation services was a key consideration during data collection activities. For additional information, please contact either APDC or OMNI Research and Training, Inc.

Factors Influencing the Social Acceptability of Tobacco

There are a few consistent trends that emerge from research on AAPI tobacco use:

- Studies show that smoking prevalence rates among Asian Americans vary by sex, so much so that the low use by AAPI women tends to have a "masking" effect on observable trends among AAPI men. (Grace et. al., 2002: 1013).
- Smoking prevalence varies depending upon country of origin, the number of generations lived in the United States, and socioeconomic status. No consistent trend about the relationship of these variables to tobacco use has been documented, however.

- AAPIs as a group tend to initiate tobacco use at a somewhat later age than other racial ethnic groups in the U.S. (Grace et. al., 2002: 1013).²

While these trends alone do not provide a great deal of information about AAPI tobacco use, they do begin to suggest some normative patterns that should help focus future tobacco research.

Interviews conducted as a part of this needs assessment illuminate some aspects of the beliefs and practices that shape AAPI group norms. They explored *Tobacco Prevalence and Practice in Countries of Origin*, *Tobacco Prevalence and Practices Among U.S. AAPIs*, *Family Influences*, *Tobacco Issues for AAPI Women*, and *Health-Related Beliefs and Experiences*.

Cultural and Health Implications for Tobacco Control

Cultures are complex; they change over time and when introduced into new social and geographic environments. The cultural and social environments of AAPIs, like that of other racial ethnic groups in the U.S., are replete with conflicting messages about tobacco use. The recent immigration of many AAPIs complicates this picture. There are language barriers, varying levels of knowledge about the health effects of tobacco, and different cultural lenses used by these groups to derive and attribute meaning to everyday experiences. The development of culturally appropriate and responsive tobacco control strategies that target AAPIs must be grounded in this diversity of experience. Moreover, they also must recognize that AAPIs may be fully acculturated or may only relate with *some* of the following beliefs and experiences discussed in the report. This section explores the implications of *Language Barriers to an Appropriate Level of Healthcare* and *The Broader Cultural Context of AAPI Healthcare Experience*.

Recommendations

Based on research conducted to date, the Asian Pacific Development Center and OMNI Research and Training recommend that the State Tobacco Education Prevention Partnership (STEPP) prioritize funding for capacity building within AAPI communities and leadership development to promote tobacco control.³ "...[L]ower perceived risks regarding smoking-related cancers and chronic diseases and a pervasive lack of readiness for change in smoking behavior among Asian American smokers" (Grace et. al., 2002: 1019) signify the importance of capacity building for health education. Related recommendations in this section focus on community-based and culturally appropriate strategies for capacity building and the development of targeted educational messages. APDC and OMNI anticipate that outlined efforts will require infrastructural development within a centralized and existing agency that has made in-roads in local, ethnic-specific institutions, that can facilitate coalition building and resource sharing across AAPI ethnic subgroups, and that can respond to technical assistance and language service needs statewide.

- ❖ The AAPI Tobacco Advisory Board, peer researchers, and participating AAPI health practitioners advocated strongly for the delivery of health education and tobacco

² Some differences have been observed between different Asian Pacific Islander ethnic groups (e.g Cambodian...). It is also important to observe that later initiation does not equate with lower risk of future use (NAWHO)..

³ The Asian Pacific Partners for Empowerment and Leadership (APPEAL), a national AAPI network established to address tobacco control, has reached similar conclusions about prioritizing community capacity building and AAPI leadership and infrastructural development (2002: 4).

information to Asian American Pacific Islander communities. Collectively, they identified the following topics on which to focus community outreach and education efforts:

- The risks associated with tobacco use,
 - Coping mechanisms and ways to manage stress, and
 - Health-related services and resources available.
-
- ❖ The AAPI Tobacco Advisory Board and participating AAPI health professionals observed that health education efforts targeting the AAPI community need to invest in the translation of materials and messages into major Asian languages represented within the State.
 - ❖ Culturally responsive tobacco-related information is needed, based on the needs assessment. Delivery of this information should come from local ethnic leadership in partnership with health experts.
 - ❖ Testimonies of other AAPIs may help create a collective sense of vulnerability to tobacco health-related problems and a desire to take action as a group.
 - ❖ Community gatherings and events provide important opportunities to share health-related information and to culturally “unmark” tobacco use in these social settings.
 - ❖ With respect to health education messages, healthcare professionals and peer researchers recommended raising awareness about the effects of second-hand smoke on the family, to appeal to AAPIs’ commitment to the family as a core strategy to promote cessation and changes in use patterns.
 - ❖ AAPI healthcare professionals recommended that AAPI newspapers become a media outlet for anti-tobacco campaigns.
 - ❖ Employing famous AAPI movie stars (such as Johnny Dep and Keanu Reeves) as advocates against smoking and tobacco use will help “break the association of smoking with success” that advertisements help create in countries of origin, while providing youth in this country with important role models and contradicting evidence about the “coolness” of tobacco use.
 - ❖ The AAPI Tobacco Advisory Board recommended that AAPIs receive consistent messages within their communities about the effects of tobacco on lifespan. Living a long and healthy life was deemed to hold particular cultural significance for AAPIs.
 - ❖ Peer researchers and the Tobacco Advisory Board indicated a growing need for culturally appropriate messages to target cigarette use among single women. Targeted messages for elder women and tobacco chew and betel nut also were indicated.

PURPOSE

There is a common misperception that Asian American Pacific Islanders (AAPI) are at lower risk of tobacco initiation, life-time use and tobacco-related diseases than other racial ethnic groups in the United States (NAWHO, 1998). Although higher smoking prevalence among Southeast Asians is often acknowledged (American Lung Association, 2002; U.S. DHHS, 1998), and despite the fact that lung cancer is the leading cause of death among AAPIs (Chen and Hawks in Grace et. al., 2002), AAPI tobacco use has not been the subject of much research until recently.⁴ Recent studies have revealed "[t]he lack of quantitative and qualitative data on the health and the health care practices of APIAs" (Ro, 2001), the instability of small sample size estimates (Grace et. al., 2002), and the need for culturally appropriate measurement of smoking behavior (Grace et. al., 2002; Yi et. al., 2002). Moreover, researchers have begun to conclude that, "by and large, city and state tobacco prevention programs are failing to reach members of the Asian American community." (Grace et. al., 2002: 1013).

The purpose of this needs assessment was to initiate culturally appropriate information gathering processes, in order to improve upon the current state of knowledge concerning AAPI tobacco use. Specifically, the Colorado State Tobacco Education and Prevention Partnership (STEPP) contracted with the Asian Pacific Development Center to conduct a statewide needs assessment of AAPI tobacco control needs. The purpose of the needs assessment was to inform the development and implementation of AAPI targeted tobacco control efforts in STEPP's three goal areas: Reduce initiation of tobacco use by youth, Reduce exposure to environmental tobacco smoke, and Promote quitting among youth and adults. To accomplish this the needs assessment was designed to address two fundamental questions about AAPI tobacco use:

3. What are the social meanings and practices that surround tobacco use by Asian American and Pacific Islanders (AAPI)?
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AGENCY PARTNERSHIP FOR THE NEEDS ASSESSMENT

The Asian Pacific Development Center (APDC) of Colorado has a twenty-two year history of providing community-based clinical services and programs to Asians and Pacific Islanders (AAPIs) throughout the state. Offices in Denver, Aurora and Colorado Springs have enabled APDC to tap AAPI networks and to respond to needs statewide. The mission of APDC is to empower AAPIs and all Coloradans through the promotion of understanding and the appreciation of cultural diversity.

APDC's services to AAPIs in the state have evolved. Beginning in 1980, APDC focused its attention on providing mental health services and social service adjustment services to Southeast Asian refugees that suffered from injuries and trauma as a result of war, incarceration under regimes, and/or incidents that took place during escape. In 1982, APDC was certified as a Specialty Mental Health Clinic by the Colorado Division of Mental Health, and was contracted by the State to

⁴ Please see the June 2002 issue of the American Journal of Public Health.

provide bilingual/bicultural outpatient mental health services to all Asian and Pacific Island groups. Since 1985, APDC has expanded its services by attracting Federal, State, local and private foundation funds to meet the growing needs of the Colorado AAPI community. APDC's services now include:

clinical services for children and youth,
gang prevention, cancer prevention,
immunization, parenting classes,
domestic violence services, victim assistance,
perpetrator counseling, DWI groups,

peer leadership, after-school programs,
youth mentorship, case management,
tobacco prevention and community
education, and services to the elderly.

APDC also operates an Interpreters Bank that provides interpretation services - in over 30 different Asian and non-Asian languages - to hospitals and other health care agencies, social services, juvenile and criminal justice agencies, school systems, and private businesses.

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THE AAPI POPULATION IN COLORADO

In Colorado, there is a small, but growing population of Asian American Pacific Islanders. The 2000 Census counted 95,213 Asian Americans and 4,621 Pacific Islanders, among the State's total population of 4,301,261. As the table shows below, AAPIs represent 3.1% of the State's total population when one includes individuals that categorize themselves as AAPI in combination with another racial ethnic group.

Table 1: Total Colorado Population and Racial Ethnic Sub-Populations

Total	White	Hispanic	Black	Native Americans	Asian American Pacific Islander	Other
4,301,261	3,560,005	735,601 (of any race)	165,063	44,241	99,834	
	74.5%	17.1%	3.8%	1%	2.3%	7.2%
	or 85.2% in combination with others		or 4.4% in combination with others	or 1.9% in combination with others	3.1% in combination with others	8.5% in combination with others

Source: U.S. Census Bureau, Census 2000

The following table provides a breakdown of the major Asian ethnic groups residing in Colorado. As these tables illustrate, Korean Americans (16,395) represent the largest Asian ethnic group, followed closely by Chinese Americans (15,658) and Vietnamese Americans (15,457).

Table 2: 2000 Census Data on the Major Colorado Asian Ethnic Groups

Total	Korean	Chinese	Vietnamese	Asian Indian	Japanese	Filipino	Other Asian ⁵
95,213	16,395 (17.2%)	15,658 (16.5%)	15,457 (16.2%)	11,720 (12.3%)	11,571 (12.2%)	8,941 (9.4%)	15,471 (16.3%)

Pacific Islanders often are included as a part of the larger racial ethnic group, Asian American Pacific Islanders. However, their population size outside of Hawaii and U.S. territories tend to be much smaller than Asian American ethnic groups. The following table provides a breakdown of the primary Pacific Islander ethnic groups that have settled in the State.

Table 3: 2000 Census Data on the Major Colorado Pacific Islander Ethnic Groups

Total	Native Hawaiian	Guamanian or Chamorro	Samoan	Other Pacific Islander ⁶
4,621	1,435	1,124	931	1,131

The Colorado counties with the largest AAPI populations are listed in the table below. As this table indicates, Colorado AAPIs tend to live along the front range. Smaller populations reside in Larimer (3,917 Asian Americans, 193 Pacific Islanders) and Douglas (4,404 Asian Americans, 97

⁵ "Other Asian" represents the number of individuals within smaller Asian ethnic groups, in addition to the number of individuals that fall within a combination of two or more Asian ethnic groups. The 2000 Census does not yet have numbers available for the different groups making up the "Other" Asian category. However, 1990 Census data and 1999 projection estimates suggested that Camodian, Laotian, and Hmong would be among the larger ethnic groups comprising this category.

⁶ The text for footnote 1 also applies here as well to Pacific Islanders.

Pacific Islanders) Counties as well. The concentration of Colorado AAPIs along the front range should not be surprising, as the majority of AAPIs in the nation reside in more urban areas.

Table 4: Colorado Counties with the Largest AAPI Populations

Denver County	Jefferson County	El Paso County	Arapahoe County	Adams County	Boulder County
16,259	12,445	14,355	19,845	12,096	9,086

The City of Denver (also the County of Denver) is the city with the largest number of AAPI residents (16,259). Denver is followed by the City of Aurora (12,567) and Colorado Springs (10,943) in having the second and third largest AAPI populations. Altogether, nearly 40% of Colorado AAPIs live in one of these three cities.

It is also significant to note that, according to the 2000 Census, nearly 20% of Coloradans born outside the U.S. emigrated from an Asian country. Moreover, nearly 64% of AAPIs speak an Asian or Pacific Island language in the home, and 32% of all Colorado AAPIs "speak English less than 'very well'" (Census category). Overall, in Colorado, 15.1% of residents speak a language other than English in the home and 6.7% less than "very well". Statistics about the number of "foreign-born" and English proficiency are commonly used indicators of acculturation.

NEEDS ASSESSMENT PROCESS

This needs assessment was designed as a qualitative research study of the knowledge, attitudes, beliefs and values of AAPIs in Colorado. Four distinct and iterative stages of research were built into the needs assessment. At each stage, AAPIs assumed significant roles in providing interview guide feedback, recruiting research participants, collecting and translating data, debriefing the research process, and assessing the cultural appropriateness of data interpretation. The provision of interpretation services was a key consideration during data collection activities.

The effect of the needs assessment process was the initiation of ethnic-specific and cross-cultural discussions about AAPI tobacco use. This section briefly reviews this needs assessment process. Please see the attachments for interview and data collection training materials. For additional information, please contact either APDC or OMNI Research and Training, Inc.

The first stage of the research process was to invite AAPI health practitioners to share their perspectives on the prevalence of tobacco use among AAPIs, barriers to healthcare, and culturally appropriate strategies for promoting prevention and cessation. Research began with this group to build greater awareness of AAPI health practices and concerns before approaching community members. Health practitioners were purposively selected and represented a range of health care professions and Asian ethnic groups. Across the 14 health care professionals interviewed, at least four major ethnic groups were represented: Chinese (n=4), Korean (4), Vietnamese (2), Pacific Islander (2), and unknown (2). These professionals also represented varied areas of expertise in the health care field, including mental health (e.g., counseling and clinical psychology), alternative medicine (e.g., acupuncture and herbal medicine), dentistry, nursing, pediatrics, and family medicine. Six of the health care professionals interviewed had trained and/or practiced outside of the U.S.

The second stage in the needs assessment process was the identification and training of bicultural, bilingual peer-to-peer researchers for the purposes of data collection in their ethnic communities. Peer-to-peer researchers were identified from the nine largest Asian ethnic groups in Colorado. Generally, one male and one female peer researcher were recruited for each Asian ethnic group. In three Asian ethnic communities, female peer researchers conducted interviews with both males and females from the community. A total of 70 interviews were conducted by peer researchers, lasting anywhere from 20 minutes to over an hour. Nearly two-thirds of these interviews were conducted in an Asian language and required translation.

A small group of peer researchers were convened to debrief the interview process and to reflect on their own observations as the third stage of the needs assessment process. Peer researchers were selected to ensure a mix of gender and ethnic group representation. During the debrief, peer researchers were encouraged to reflect on their own personal experiences as well and to identify new areas for needed study. This discussion was tape-recorded for later analysis.

The final stage of the needs assessment brought together a diverse group of individuals that cared about tobacco use in their communities. Ethnic representation, gender, occupation, and community leadership roles were considered in the establishment of the Colorado AAPI Tobacco Advisory Board. This group met for five hour period to provide feedback on emerging findings from the needs assessment, to reflect on AAPI tobacco control needs, and to begin identifying culturally appropriate tobacco control methods and messages. This discussion also was tape-recorded for transcription and analysis.

In addition to the multi-leveled involvement of AAPIs in the needs assessment process, another important strength of the needs assessment process was its targeting of non-English-speaking participants and recent immigrants. Drawing from different sources of information and creating a culturally responsive and iterative process were central strategies in the validation of needs assessment findings. Additional outcomes of the process included the introduction of tobacco control discussions across AAPI ethnic groups and the mobilization of AAPI leaders. The primary limitations of the study were the relatively small sample sizes of participants involved.

FACTORS INFLUENCING THE SOCIAL ACCEPTABILITY OF TOBACCO

There are a few consistent trends that emerge from research on AAPI tobacco use:

- Studies show that smoking prevalence rates among Asian Americans vary by sex, so much so that the low use by AAPI women tends to have a “masking” effect on observable trends among AAPI men. (Grace et. al., 2002: 1013).
- Smoking prevalence varies depending upon country of origin, the number of generations lived in the United States, and socioeconomic status. No consistent trend about the relationship of these variables to tobacco use has been documented, however.
- AAPIs as a group tend to initiate tobacco use at a somewhat later age than other racial ethnic groups in the U.S. (Grace et. al., 2002: 1013).⁷

⁷ Some differences have been observed between different Asian Pacific Islander ethnic groups (e.g Cambodian...). It is also important to observe that later initiation does not equate with lower risk of future use (NAWHO)..

While these trends alone do not provide a great deal of information about AAPI tobacco use, they do begin to suggest some normative patterns that should help focus future tobacco research. Interviews conducted as a part of this needs assessment illuminate some aspects of the beliefs and practices that shape AAPI group norms.

To explore AAPI beliefs and practices, it is important to consider countries of origin, in addition to the AAPI experience in the U.S. "Because a majority of AAPIs are immigrants and refugees, it is essential to understand the cultural context of tobacco and how that context influences acceptance (of tobacco), or lack thereof..." (Hong, 2001: 248). For this reason, recent immigrants (defined by the study as those individuals that had lived in the U.S. fewer than ten years) were an important group targeted by peer-to-peer researchers in their interviews with ethnic community members.

Tobacco Prevalence and Practice in Countries of Origin

Examining prevalence in countries of origin reveals a striking contradiction for U.S. AAPIs: East Asia, the Pacific and Central Asia are among the world regions with the greatest prevalence of smoking (Jha et. al, 2002), while as a group AAPI prevalence rates appear lower than other U.S. racial ethnic groups.⁸ Further, it is significant that the majority of countries of origin for AAPIs residing in Colorado have just recently begun to implement tobacco control policies and to provide health education about the effects of tobacco.⁹ Interview data collected by AAPI peer-to-peer researchers, and their own reflections on past experiences in countries of origins, confirmed that tobacco use was widespread in Asian countries.

Overall, needs assessment participants observed that tobacco use was commonplace in countries of origin. Interviews and the debrief with peer-to-peer researchers suggested that in many countries, like the Phillipines, smoking is a sign of socioeconomic and professional achievement. In addition, stories were related about the free supply of cigarettes provided to military personnel by Asian governments, such as Taiwanese, South Korean, and Chinese, to reward individuals for their service to the country. According to interviews and the peer researcher debrief, vending machines make cigarettes readily accessible to Asian children and youth, even in those countries that restrict underage use.¹⁰ Further, despite the overall low prevalence of cigarette smoking among Asian women, in countries such as the Phillipines and Korea, prevalence was reported to be increasing, especially among more educated and affluent young women.

"In Laos, for instance, after harvesting the rice and planting the rice, we'd have our meals and then smoke and chew (tobacco) and talk together for laugh and fun."

Interviews suggested that tobacco use was not only prevalent in countries of origins, but also culturally meaningful. As one Chinese American interview participant explained, "In China, at

⁸ Smoking among males was highest in East Asia and the Pacific, totaling an estimated 62% (Jha et. al., 2002)

⁹ Please see Attachment 2 for World Health Organization statistics and information on tobacco use in selected Asian countries.

¹⁰ This fact was confirmed by data compiled by the World Health Organization. Please see Attachment 2 for further information.

weddings there are many who smoke together, in fact, there are celebrations and ceremonies in which the bride offers others to smoke; however, they do ask if you smoke or not.” This also appeared to be common at weddings among the Hmong from Laos as well: “During the Hmong wedding ceremony, they always handed cigarettes to one another according to Hmong culture.” Cigarettes also were a central element of business meetings in countries like Japan and China, boding well for the partnership or business deal. Further, the Cambodian American Video Project of the Santa Clara County Public Health Department suggests that in Cambodia, tobacco is an important medium of exchange; it is offered when greeting guests and friends. As one needs assessment participant defined, “...[T]hose who offer smokers cigarettes is symbolic of honor for them.” These findings are supported by the observations of ...¹¹

Within countries of origin, the forms of tobacco consumed appear to vary, depending upon the percentage of the population residing in rural areas. While manufactured cigarettes dominate urban centers, in rural areas tobacco chew, “roll-your-owns” (also referred to as bidis in South and Southeast Asia) and betel nut are more common.¹² Other forms of tobacco consumed by Asians include pan masala, snuff, hookah, hookli, chutta dhunti and other tobacco mixtures featuring ingredients such as areca or betel nut.¹³ Generally, interview participants indicated that tobacco use was widespread and socially acceptable (for males) in countries of origin. Surprisingly, interviews also indicated that non-smoking tobacco and related chewing leaves, such as tendu or temburni, may be equally or more common among Asian women than men.¹⁴

"Well, I feel that the persons are accustomed to smoking cigarette feel the same way as the persons who eat betel leaves. When they have a cigarette, they feel good. If they do not have a cigarette, they feel stress or unhappy."

Within urban centers of Asian countries of origin, manufactured cigarettes appear to be associated with social mobility and status, as well as educational attainment and sophistication. As one needs assessment participant observed, “And, it’s almost like a semi-symbol of being more acculturated or more western....” Interviews and the debrief with peer-to-peer researchers indicated that smoking international brands of cigarettes in particular may connote Westernization, capitalism and/or affluence. In contrast, smokeless tobacco may be viewed as “for poor people.” Healthcare professionals and the Advisory Board observed that the glamour associated with cigarettes and the

¹¹ Hong (2001) explains, “For some developing countries (e.g. Vietnam and China), tobacco use is culturally accepted and is often considered an attribute of wealth. For other Asian and Pacific Rim countries (e.g. Cambodia), tobacco is used as a gift and is provided, much like alcohol, to guests in one’s home. In some Asian traditions, cigarettes are distributed at social gatherings and are used in healing practices” (248).

¹² Bidis are also known as beedis or beedies. Betel nut is the fruit of Areca catechu. It is usually sprinkled with calcium oxide, salt, and powdered root of licorice and served wrapped in a tobacco leaf, which is chewed (Yi et. al., 2002: 1009).

¹³ Chuttas and dhuntis are smoked in reverse fashion with the lighted end inside the mouth. While these forms of tobacco use were reported among Indians by the World Health Organization, interviews indicated that these also could be found among the older population in the Phillipines (chuttas or dhuntis). Tobacco leaf mixtures were reportedly common in Cambodia and Laos. APDC staff observed the use of various tobacco and other leaf mixtures within elderly groups hosted by the organization. However, there appears to be little research on the prevalence of non-smoking tobacco outside of India.

¹⁴ For example, participants related stories about a substance commonly chewed and spat by older Cambodian and Laotian women, making their mouths red. This is discussed further later in the report.

lack of information about long term consequences of smoking in many Asian countries, combined with relatively accessible tobacco and cigarettes, even among young children, increased the susceptibility of Asian countries to tobacco marketing campaigns. These factors create an environment in which it is easy to start smoking -- particularly when people do not realize how difficult it is to quit.¹⁵

"Especially the upper middle and upper class, it is a bit of a status symbol. The lower and lower-middle class smoke cheap cigarettes and chew lots of tobacco leaves."

"Many immigrants grew up with intense marketing campaigns in their environments for tobacco. Tobacco is often seen as a luxury item, such as brandy. [It] is seen as a neat foreign thing."

Tobacco Prevalence and Practices Among AAPIs

Needs assessment participants and previous research have indicated that the prevalence of tobacco is very high in countries of origin and that the social and cultural acceptance of tobacco use in these countries is a major contributor to the prevalence of smoking among AAPIs in this country. While different perspectives were expressed about the prevalence of tobacco use among males and females and across the generations (e.g., immigrants and their children's generation), participating healthcare professionals and the Advisory Board indicated that smoking was a significant problem for AAPIs. Korean providers, who were most likely to estimate prevalence rates during interviews, suggested prevalence rates among Korean Americans, anywhere from 60- 90%.

The association between certain brands of cigarettes and Americanism (e.g. Marlboro) may help explain some of the inconsistent findings regarding the impact of acculturation on AAPI tobacco use. Interviews with healthcare professionals also suggested that, despite anti-smoking campaigns in the U.S. and the stigmatization of tobacco use in many areas of the country, smoking may remain a convenient way for male immigrants to portray images of success – particularly, when language barriers and limited opportunities for financial success may bar other avenues. For male immigrants, in particular, anti-tobacco messages in the U.S. may create cultural conflicts concerning the gender role definition of men.

In general, peer interviews suggested that U.S. laws and policies on tobacco use feel very alien to recent immigrants. Participants observed that in addition to adjusting to a new language and environment, recent immigrants must also adapt to very different messages about tobacco use, including the stigmatization of smoking and the physical isolation of smokers from non-smokers at social gatherings. Despite negative messages about smoking, AAPI health practitioners and community participants suggested that the social isolation and language barriers experienced by many AAPIs contributed to continued use of tobacco, as a temporary means to alleviate these stressors.

¹⁵ This point emerged from some of the interviews conducted with community members and is confirmed by the Santa Clara County Public Health Department's Video Project, *Another Killing Field*.

"In the community of Cambodia right now, I can see more smokers or smoking people understand ... They all go outside; they don't smoke in the house... because they think bother people."

"For example, going to parties, I can't smoke indoor because it would smell for those who don't smoke; so, I'd go out and smoke."

"I feel sorry to Asian American who immigrate here, never been exposed to American mass media public education and stigmatized by smoking without receiving any education."

Peer interviews did suggest that the prevalence of smoking declines as AAPIs become acculturated to U.S. society. However, they also indicated that acculturation may make youth and women more susceptible to smoking. Moreover, AAPI interviews also revealed that tobacco use remained common for men at many cultural celebrations and social gatherings. As a needs assessment participant recounted, "We use it just for social events. Everybody probably smokes at social events. Business meetings, all those kind of types of events, and there's always some kind of smoking. At weddings, of course; you have them at the banquets, pretty much everybody smokes at banquets." Some additional comments about AAPI tobacco use in the U.S. are highlighted below.

"Well, I think that the setting, where Chinese typically use tobacco is in, in like, business meetings. Because when the Chinese people, they have their business meetings, they like to smoke. So if you go to a Chinese business meeting, you can see those Chinese men smoking, while they are talking. They're talking and smoking. And because some Chinese people, they think that cigarette, or nicotine, will help them to think better, to give them more inspiration."

"I see Hmong typically use tobacco when they meet each other at the party or at the wedding time."

"I see them smoking during parties, prayers, or Filipino gatherings and parties, mostly."

"When Japanese customers come to our restaurant, I usually provide an ashtray, and then they start smoking as soon as they have seats, and they smoke a lot, like one cigarette after another."

As previously discussed, for many Asian Pacific Islanders living in countries of origin and in the United States, smoking is culturally associated with masculinity and financial success. Interview data indicated that, for men, smoking with business partners or in social gatherings can be viewed as an important ritual or simply as a habitualized behavior. The cultural link between smoking, masculinity and financial success suggest that smoking is more appropriate for men in their thirties and forties, however, than for young men. Yet, this gender role definition may place AAPI male youth at greater risk of tobacco use initiation during adolescence.

"Big part of our culture especially for males to smoke, and I feel that that's probably one of the big reasons why Vietnamese people smoke is because ... to be a man and stuff, you have to smoke, and any kind of business that you do with anybody, you have provide them with cigarettes."

"Sometimes too in the Japanese community, especially with men, business is conducted with alcohol and smoking, a lot. ... And if you don't join in, that's not a good sign."

"But, you know, you go to functions and see guys smoke all the time. ... [G]ranted they may not be young men, like in their teens or anything, but you see a lot of the older men in their, you know, late 20s and 30s and so forth."

It is important to note that prevalence of tobacco use and related cultural practices may vary according to several factors:

- geographical region in the U.S. and majority group acceptance/prevalence of tobacco use in that area;
- the particular ethnic group that settled in the area;
- the events in countries of origin that propelled immigration and the tobacco policies present during that time period; as well as
- the number of generations that members have resided in the U.S.

Moreover, smoking may be an infrequent behavior among some AAPIs, as some interviews suggested, reserved for special occasions. For example, a needs assessment participant commented that "Asian Indians are generally well qualified. I have seen party smokers in the U.S. in its ranks. The same people may not smoke otherwise." Whatever research may conclude about the prevalence of tobacco use among AAPIs, it is important to note that it is a strong cultural norm in many ethnic communities.¹⁶ The needs assessment revealed a high level of the social acceptance of male smoking and its role in social gatherings.

¹⁶ A recent needs assessment conducted by APITCC of Los Angeles County found that 78% of Vietnamese viewed see tobacco use as a cultural norm.

Family Influences

The cultural importance of family and extended members was reflected in interviews with ethnic community members, interviews with AAPI health practitioners, and the debrief with peer researchers. Overall, however, ambivalence emerged across many of these data sources regarding the role of family in youth initiation of tobacco use. On the one hand, sources indicated that in countries of origin, and within families that have members born outside of the U.S., it is common for children and youth to be surrounded by immediate and extended family members that use tobacco. Further, there was evidence suggesting that smoking may be seen as a prerogative of elder relatives.¹⁷ In countries of origin, children may even purchase cigarettes or light them for older family members.

On the other hand, it was generally believed that positive and strong family values should discourage youth and single women from smoking, as they would be violating parent wishes and behaving in ways that would bring shame to the family. The use of tobacco, particularly by women, would reflect negatively on her marriageability, and negatively on the entire family. Moreover, there was some evidence that smoking might be inappropriate for youth, who did not yet work and earn money independently to pay for their own cigarettes. Despite these influences, smoking by single women and youth may be increasing in social acceptability among certain ethnic groups (NAWHO, 1998).

"And, and they talk about who's going to make a good wife and not a good wife, that not the kind of thing that you want to display as a young woman ... [I]t looks crude, it looks disrespectful to your family. ... It is a reflection of your parent, your heritage. ... Your community's opinion matters."

"(I've) always had the impression from my parents, my community, and even ... that it was just –was not proper for young women to smoke. It was just not something that you did. ... Like it was something that I knew was more acceptable for the older women."

"Because in our country, he still a student at that time and then you didn't earn any money yet you can't smoke."

Participating healthcare professionals and Advisory Board members identified parental smoking as a major factor influencing smoking among young people, due both to the modeling of the behavior, as well as to the increased accessibility of cigarettes through parents and relatives. Even more important, according to these participants, was the influence of peer pressure and the desire to fit in with majority youth. AAPI youth may be particularly susceptible to peer pressure, caught in a cultural divide between the conflicting values of the Eastern cultural background of their elders and the Western social milieu of their peers. Finally, healthcare professionals also

¹⁷ This finding was confirmed by Hong's (2001) work (249).

acknowledged that targeted marketing to youth and the accessibility of tobacco products in the AAPI community are issues that youth confront in Colorado, just as their parents and other relatives may have in their country(s) of origin. According to one provider:

"If you go down to Federal [Boulevard], there is tobacco advertising everywhere. I can go to a store on Federal and buy loose tobacco. [I] went to an Asian market, and they were selling loose tobacco in a plastic bag. Asian market vendors need education. It's too accessible for young people."

Tobacco Issues for AAPI Women

As previously indicated, the needs assessment found important gender differences in tobacco use. Typically, research on tobacco use within countries of origin focuses on the gap in smoking prevalence between Asian Pacific Islander men and women. Little research appears to document the chewing of tobacco leaves by women in these countries, although in India, among women in a number of regions of the country, tobacco chewing is as prevalent as it is among men (World Health Organization, www.cdc.gov/tobacco/who/usa.htm). While overall a low percentage of Asian Pacific Islander women smoke tobacco,¹⁸ tobacco chew, betel nut and other forms of non-smoking tobacco and related chewing leaves may be very widespread in countries of origin. The needs assessment indicated that chewing tobacco was acceptable for older women in countries of origin, as well as for elder women in the U.S.

"Laotian culture is not acceptable for the women smoke. They look you down and you feel ashamed and it's kind of bad. They look at you like prostitute or something if they smoke."

"All the women when getting old they chew."

"For my, around my age 40 up, we [women] can chew tobacco and then we eat the chestnut.... Asian mostly women choose that. That is more acceptable (than smoking)."

"Because from 40 up, women in Cambodia think that your mouth kind of plain white. They want to see a little of red in your mouth. Like you have lipstick; they don't use lipstick. ... [T]hey eat that leaf and they become red and then it look white and red."¹⁹

¹⁸ There are some important regional exceptions to these trends. For example, please see data compiled on India by the World Health Organization. Also, peer interviews suggested that these trends may also extend to Southeast Asian countries, such as Laos, or particular ethnic and social groups within the region.

¹⁹ In Cambodia and Laos, a special mixture was chewed to turn women's mouth red, to create a more beautiful appearance.

These trends raise interesting questions about tobacco use among AAPI women, particularly when coupled with strong cultural norms against cigarette smoking in many countries of origin and strong U.S. cultural norms against the chewing of tobacco by women. Even though women appear to initiate tobacco use later in life than men, the chewing of tobacco may be viewed as an entitlement of older age and the achievement of a particular social status in countries of origin. How do recent immigrant women negotiate cultural clashes regarding the gendered appropriateness of tobacco chew (by Asian women versus American men)? How do these conflicting cultural norms impact tobacco use among AAPI women – is it reasonable to assume that tobacco use among AAPI women simply disappears? How might these issues affect AAPI women’s likelihood to self-report tobacco use accurately? Tobacco advertising targeting women and media images of sophisticated, independent women smoking only further complicate these issues by challenging the traditional roles of women in countries of origin.²⁰

[Women] don't go in the party; at the party they don't smoke. They smoke at home.

"And, when we have film from western countries like, you know, from Europe, the United States, that shows in the cinemas and things like that. ... I mean the young girls, you know, hang together and smoke like; they pretend, you know, to be movie stars."

"...[T]he Laotian the same thing; they feel ashamed to answer the question for you to come and interview. At the first, they don't want to participate, you know.... [W]omen and smoke is kind of like, you know, in the community is not good faith for you smoking. But, when I explained to them is not like investigate you for, you know, anything and just like so finally they answer."

Health-Related Beliefs and Experiences

As previously discussed, information about the health effects of tobacco use is limited in many Asian countries of origin. Awareness of the effects of tobacco may vary even within ethnic groups (e.g. Chinese that have recently immigrated versus Chinese Americans that have lived for several generations in the U.S.). Among Asian ethnic groups that have more recently immigrated to the United States (Vietnamese, Cambodian, Laotian), tobacco may be seen as a benign, if not “natural”, habit. Researchers have observed that, overall, many AAPI communities lack an understanding of the health risks associated with tobacco (Grace et. al., 2002: 1013).

"Just from nature you know."

²⁰ NAWHO (1998) has observed a growing smoking trend among Vietnamese and Korean American women. Specific locations, such as Korean American bars, NAWHO indicates, have become culturally marked as socially acceptable areas for women to smoke.

Furthermore, beliefs about health may impact how some Asians/Pacific Islanders view tobacco-related disease and preventative measures. Interviews with community members indicated that a number of individuals believed that whether they were healthy or sick would not be impacted by tobacco. These individuals and Advisory Board members explained that disease can be seen as a predetermined condition. Participating healthcare professionals and peer researchers also indicated that among some AAPI ethnic groups, disease will be understood as a “curse” on one’s family or, at least, a negative and shameful reflection on one’s family.

"[S]moking causes cancer. But if you smoke in a healthy way, I think it's okay. Well, it is usually, if somebody does not have a good health, when they smoke, they may have some problems. If somebody who has a good health, they smoke, and they are okay. There is no problem."

"That's because of we don't have the media and also we don't have a physical exam.... In the country-side they don't have hospital.... Sometime they may die by cancer, and they just think, oh bad ghost you know, take your spirit or whatever."

"People with this fatalistic attitude, that your life is your life and it's set up, and, and you know, what happens it is a curse and people, Asian people, I think are superstitious and I don't think that from my experience and in my family that seems like that would, like, you know, smoking would change your life. If you have an illness, you're going to have an illness."

When asked about the factors that put Asians/Pacific Islanders at increased risk for tobacco use, healthcare professionals talked about the emotional and psychological stress these populations experience due to social isolation, resulting from language barriers, acculturation and prejudice. Community interviews, peer researcher experiences, professional opinions of healthcare providers and Advisory Board members all indicated that smoking was widely used by AAPIs as a means to cope with and reduce stress. Moreover, cigarettes were described as providing a necessary “emotional connection” or providing an “emotional release”.

One healthcare professional explained, “New immigrants think that if they use tobacco, it will help them with psychological problems (stress, culture, job, relationships, etc.).” Yet another provider linked smoking to psychological issues linked to experiences of war, hunger, persecution and torture. The prevalence of stress indicated across sources of data stands in contrast to the great value that Hirayama and Hirayama (1986) have observed in traditional Asian cultures placed on social order and control of emotions and feelings (in Hong, 2001: 249). This needs assessment found that smoking provides AAPIs with a culturally meaningful, socially acceptable mechanism for keeping emotions in check.

"Yeah, they get depressed, and they think that cigarette is very helpful to them. ... They come to America; they have a lot of problems, the family, financial. And the marriage problem, so maybe smoking to help them."

"I think that way because after I smoke it I feel good. I am not angry. I am not upset. And when someone talks to me, I am happy."

Collectively, these data and confirming research suggest that much of the available information on AAPI tobacco use in the U.S., particularly among those who were born outside of the U.S., may be over-simplistic. For APDC and OMNI, several important research questions have emerged concerning tobacco use among AAPIs: Do survey efforts culturally bias AAPI data on tobacco use, focusing on smoking prevalence versus more "natural" options such as chewing leaves and betel nut – or by emphasizing individual use versus the symbolic sharing and exchange of tobacco in many AAPI ethnic communities? How does the definition of "adult smoker" (usually over 18 years of age) impact prevalence rates, especially among AAPIs who appear to initiate use later in life, once having reached a particular social status? Are there reasons to question the validity of AAPI self-report data – considering limited English proficiency, conflicting cultural norms (especially gendered messages and practices surrounding tobacco use), and the social desirability of acceptance within the majority culture.²¹

CULTURAL AND HEALTH IMPLICATIONS FOR TOBACCO CONTROL

Cultures are complex; they change over time and when introduced into new social and geographic environments. The cultural and social environments of AAPIs, like that of other racial ethnic groups in the U.S., are replete with conflicting messages about tobacco use. The recent immigration of many AAPIs complicates this picture. There are language barriers, varying levels of knowledge about the health effects of tobacco, and different cultural lenses used by these groups to derive and attribute meaning to everyday experiences. The development of culturally appropriate and responsive tobacco control strategies that target AAPIs must be grounded in this diversity of experience. Moreover, they also must recognize that AAPIs may be fully acculturated or may only relate with *some* of the following beliefs and experiences.

Language Barriers to an Appropriate Level of Healthcare

Peer researchers, members of the AAPI Tobacco Advisory Board, and the AAPI healthcare practitioners all identified language barriers as a major obstacle to tobacco education and cessation services. Other researchers also have observed "a serious lack of translation services for APIAs in health and social services settings" and the importance of linguistically appropriate health services in assuring access to care (Ro, 2001: 5). Those AAPI healthcare practitioners interviewed, for whom AAPIs made up a quarter or more of their patient/client population, indicated that language

²¹ "Asian Americans are generally reluctant to provide researchers with personal information" (Grace et. al., 2002: 1019 - 1020).

assistance was a major need. These interview participants indicated that between 65–90% of their AAPI clients/patients as requiring this type of assistance.

"I deal with immigrants. They are limited as they do not know what [services are available. They] need [help identifying] the resources. If more providers [could] speak the language, that would help."

A number of healthcare practitioners explained that language barriers often make adults dependent upon their children for translation. One provider described, "Language is one barrier. When you go to someone outside of the family or community, it is stressful for the family. You have to bring kids to translate. [This] breeds feelings of helplessness." Having to rely on children to translate and convey information to health care professionals serves as an obvious barrier to accessing needed resources and services. On one level, when elders must rely on the youngest generation of the family to navigate the medical system, this undermines the cultural position of elders. Further, it reinforces the disempowerment less acculturated members of the family may already be experiencing and makes these family members vulnerable to the loss of face, because of the inability to communicate effectively. On another level, having a child as the main resource for conveying health-related information can stifle an adult family member's ability to access adequate health care. These adults may be hesitant to address sensitive health issues or to ask for help from someone outside of the family, in front of their children. Effective tobacco control strategies will need to address these language barriers and empower adult decision making about tobacco use.

"People who are immigrants are probably more comfortable with Asian providers. For these clients, a non-Asian expert would not get too much information. Asians may feel that they won't be understood [culturally or in terms of language], and so may be hesitant to explain what's bothering them. It is a loss of face to struggle [to explain] what is wrong."

The Broader Cultural Context of AAPI Healthcare Experience

The need for more effective communication between medical professionals and AAPI patients emerged as a central theme in interviews with health practitioners. Further, these interviews indicated that in many ways the U.S. medical system contradicts or invalidates the values and traditions of AAPI cultural belief and value systems. AAPI health practitioners identified cultural competency among medical staff as a prerequisite to engaging AAPI patients more authentically and proactively in the healthcare process and in options for addressing tobacco dependency.

Doctor-Patient Relationships

Underlying social norms and expectations that frame the exchange of information between patients and healthcare providers can be in direct conflict with one another. One provider, for example, described how many Asians/Pacific Islanders may be hesitant to probe for additional information or to ask questions of healthcare professionals in deference to their expertise. Medical professions in the United States, in contrast, practice within a very different culture, one in which

patients have become increasingly consumer-conscious and, at times, aggressive about gathering information to inform decision-making independent of medical advice/recommendations.

"In Asia, patients tend to trust their healthcare providers. They do not ask many questions and assume the provider has their best interest at heart ... Doctors in the U.S. wait for questions. If questions are not asked, then providers may not provide extra information. They assume everything is clear and understood."

Time restrictions in managed care systems may magnify language and culture differences and the role these can play in creating disparities in healthcare access. By limiting healthcare visits to 15 minutes or less, managed care systems may constrain the opportunities of medical doctors to insure patient understanding. Healthcare practitioner participants explained that AAPI patients often interpret time restrictions and the exclusion of family members from doctor visits as a lack of caring about their health and well-being. As one healthcare practitioner defined, AAPI patients may very well view the U.S. healthcare system as impersonal and generic – “like fast food.”

The Role of Family in Healthcare Decision-Making

Showing an interest in and engaging the family is an important component of establishing a relationship with an AAPI patient or client. AAPI health practitioners underscored the need for medical professionals to understand family dynamics and the centrality of the family in health-related decision-making. While Western culture values privacy, interview participants described how the AAPI family, if excluded from the medical decision-making process, may sabotage help-seeking behaviors and medical treatment.

"The idea [in the U.S.] is to deliver medical services to an individual with privacy. [This is] important in American culture. But, with the Asian culture, you may get better results if the family is included. Individuality/privacy is not such a big deal as family importance."

One health care professional, however, warned that the family's involvement can also serve as a barrier to a patient's willingness to convey sensitive information (e.g., about taboo subjects). As discussed before, this may be a particularly salient issue when a parent must rely on a child to translate. Healthcare liaisons, interview participants suggested, can serve dual roles as cultural mediators and translators, facilitating the exchange of information between patients and providers, while maintaining a sense of inclusiveness and respect for the family.

Illness as a Taboo

Cultural inhibitions against discussing certain health issues or concerns publicly (or even within the family) serve as another barrier to communication and, consequently, to accessing needed health care services. In some cases, “[t]here is a not a precedent for going to someone outside of the family. It’s hard because there is a loss of face – talking about things that are wrong.” Cancer and

mental health issues were highlighted in providers' comments as taboo subjects that would bring shame on the family if disclosed publicly.

"Some cultures don't want to talk about cancer – [are] very superstitious [about talking about it]. ... I'm a Buddhist. My aunt has cancer and doesn't want to talk about it because it is negative. (Buddhists try to talk about the positive.) You also don't talk about it because of shame – cancer is viewed as a curse on the family."

This provider emphasized the need to talk about cancers and other diagnoses in strictly medical terms in order to avoid some of the stigma associated with certain conditions. He/she remarked, "That may affect feeling so much shame about it – may make it more acceptable." The taboo placed on serious illnesses may limit the information available about the health effects of tobacco and the sense of efficacy that individuals feel in affecting their own health outcomes.

AAPI Health Practitioners' Perspectives on Tobacco Dependence Treatment Standards

Counseling and pharmacotherapy are widely promoted to facilitate tobacco cessation in the U.S. Healthcare interview participants, however, highlighted the cultural inappropriateness of both strategies. Specifically, participants shared that AAPIs tend to be suspicious of "talk therapy." Although a few providers acknowledged that AAPIs need to have ways to leverage other sources of social support besides the family, overall providers felt that AAPIs would tend to resist one-on-one counseling (because it does not engage members of the family) and support groups (because of the stigma associated with sharing psycho-social and emotional issues outside the family). Interviews indicated that participation in counseling would be a public acknowledgement that something was wrong and, therefore, would potentially bring shame on the family. There was a strong tendency expressed by needs assessment participants to quit smoking through self-development of mental strength. Yet, clearly, the stress that underlies much of the individual tobacco use among AAPIs must be addressed.

"Many Asians don't have a clue about mental health and/or therapy. In the culture, there isn't a word for psychologist. There's also a stigma against getting mental healthcare. It's better to keep things in the family. Asians don't know what is supposed to happen in therapy. I've had Asian clients who have said, 'Just tell me what to do.'"

In general, healthcare professionals interviewed felt that pharmacotherapy would be more readily accepted than counseling, because Asian American Pacific Islanders are "solution-focused." Although pharmacotherapy such as nicotine patches might constitute a "quick fix" that would be appealing to AAPIs, some community and healthcare professional interview participants indicated that AAPIs may be suspicious and concerned about the side effects associated with taking medications. Interviews suggested that AAPIs might be much more receptive to treatment options that are perceived as more natural, such as herbal medicine and acupuncture. While the U.S. Public

Administration does not recommend these treatment options as effective tobacco cessation strategies, healthcare professionals should consider their cultural importance and the possibility of “parallel services”.²²

An obvious tension exists for many AAPIs in seeking health care in this country. Although AAPIs hold expert knowledge in high esteem, members of these populations frequently do not know about the services and resources available. Furthermore, health care professionals may be perceived as threatening and unapproachable due, at least in part, to barriers to effective communication. Interviews with community members and healthcare professionals illuminate the many cultural dimensions of health that may come into frequent conflict with one another. Belief systems about the root causes of illness (e.g., a curse or predetermined fate versus a biological process gone array), social norms and expectations that frame the exchange of provider-patient information, and perspectives on the cultural appropriateness of seeking certain types of help were some of the areas highlighted. These barriers can have significant consequences for health education and behaviors.

RECOMMENDATIONS

Based on research conducted to date, the Asian Pacific Development Center and OMNI Research and Training recommend that the State Tobacco Education Prevention Partnership (STEPP) prioritize funding for capacity building within AAPI communities and leadership development to promote tobacco control.²³ "...[L]ower perceived risks regarding smoking-related cancers and chronic diseases and a pervasive lack of readiness for change in smoking behavior among Asian American smokers" (Grace et. al., 2002: 1019) signify the importance of capacity building for health education. Related recommendations in this section focus on community-based and culturally appropriate strategies for capacity building and the development of targeted educational messages. APDC and OMNI anticipate that outlined efforts will require infrastructural development within a centralized and existing agency that has made in-roads in local, ethnic-specific institutions, that can facilitate coalition building and resource sharing across AAPI ethnic subgroups, and that can respond to technical assistance and language service needs statewide.

- ❖ The AAPI Tobacco Advisory Board, peer researchers, and participating AAPI health practitioners advocated strongly for the delivery of health education and tobacco information to Asian American Pacific Islander communities. Collectively, they identified the following topics on which to focus community outreach and education efforts:
 - The risks associated with tobacco use,
 - Coping mechanisms and ways to manage stress, and

²² Ro (2001) states that "APIA patients may first seek alternative, indigenous healers as the first line of health care or as parallel services" (17). For example, in South Asian communities, ayurvedic and homeopathic medicine are well known and used. In East Asian communities, use of acupuncture and traditional herbal remedies are common. There is little to no data, however, on the extent to which traditional medicine is used by itself or in conjunction with Western medicine (Ro, 2001: 17).

²³ The Asian Pacific Partners for Empowerment and Leadership (APPEAL), a national AAPI network established to address tobacco control, has reached similar conclusions about prioritizing community capacity building and AAPI leadership and infrastructural development (2002: 4).

- Health-related services and resources available.
- ❖ The AAPI Tobacco Advisory Board and participating AAPI health professionals observed that health education efforts targeting the AAPI community need to invest in the translation of materials and messages into major Asian languages represented within the State.
- ❖ Culturally responsive tobacco-related information is needed, based on the needs assessment. Delivery of this information should come from local ethnic leadership in partnership with health experts.
- ❖ Testimonies of other AAPIs may help create a collective sense of vulnerability to tobacco health-related problems and a desire to take action as a group.

"We need API testimonies instead of American patients. Asians may feel more of a connection."

- ❖ Community gatherings and events provide important opportunities to share health-related information and to culturally "unmark" tobacco use in these social settings.

"Asians may be resistant to accepting information from the doctor's office. So, providing a place in the community to share information may be an alternative that people can connect with."

- ❖ With respect to health education messages, healthcare professionals and peer researchers recommended raising awareness about the effects of second-hand smoke on the family, to appeal to AAPIs' commitment to the family as a core strategy to promote cessation and changes in use patterns.

"Most Asians care for, and place a primacy on, their families. So, you could stress how smoking does not only harm the person who smokes, but also their children and other relatives that live in the household."

- ❖ AAPI healthcare professionals recommended that AAPI newspapers become a media outlet for anti-tobacco campaigns.
- ❖ Employing famous AAPI movie stars (such as Johnny Dep and Keanu Reeves) as advocates against smoking and tobacco use will help "break the association of smoking with success" that advertisements help create in countries of origin, while providing youth in this country with important role models and contradicting evidence about the "coolness" of tobacco use.

- ❖ The AAPI Tobacco Advisory Board recommended that AAPIs receive consistent messages within their communities about the effects of tobacco on lifespan. Living a long and healthy life was deemed to hold particular cultural significance for AAPIs.
- ❖ Peer researchers and the Tobacco Advisory Board indicated a growing need for culturally appropriate messages to target cigarette use among single women. Targeted messages for elder women and tobacco chew and betel nut also were indicated.

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Attachment 1: National AAPI Organizations and Resources for Tobacco Control

For a list of local resources, please see the acknowledgements for the community leaders and organizations that helped make the Colorado AAPI Tobacco Control Needs Assessment possible. Below is an initial list of additional organizations and resources focused on tobacco use among AAPIs. This list should not be viewed as comprehensive, but rather as a work-in-progress.

APPEAL	Asian Pacific Partners for Empowerment and Leadership. Oakland, CA.
APITCC	Asian and Pacific Islander Tobacco Control Coalition. Based in Los Angeles.
ATECAR	Asian Tobacco Education and Cancer Awareness Research at Temple University.
Asian Quitline	A specialist service set up to meet the needs of South Asian smokers in the U.K. (International)
NAWHO	National Asian Women's Health Organization.
The Southeast Asian Prevention Network	A project of the Lao Family Community of Minnesota, Inc. and the United Cambodian Association of Minnesota, Inc.

Attachment 2: Statistics on Tobacco Use in Asia¹ Compiled by the World Health Organization

Country	Trends	Highlighted Tobacco Policy
Cambodia	<ul style="list-style-type: none"> • In 1995, almost 80% of the population was rural. • Primarily consume tobacco grown in Cambodia. • Tobacco is consumed in the form of bidis (hand-rolled cigars), tobacco chew, and cigarettes. • In the early 1990s, it was estimated that 80-90% of men smoked and 2-10% of women smoked. 	<ul style="list-style-type: none"> • Since 1993, there has been a ban on tobacco advertising on the public broadcast media, but this does not on private television stations. • There are no health warnings on tobacco products. • There are no bans on sales to minors. • There are partial bans on smoking in hospitals, health facilities, government offices, workplaces, restaurants and public transport.
China	<ul style="list-style-type: none"> • China is the largest producer and consumer of tobacco in the world. • A 1984 survey found that rates were highest among government staff, peasants and workers (60-66%). Lowest for students (27%). • Highest prevalence occurs between 45-49 for men and 60-64 for women (1984 survey). 	<ul style="list-style-type: none"> • The China National Tobacco Corporation (the state tobacco monopoly) employs over a half million staff, 10 million farmers, and 3 million retailers. • In 1992, health warnings on cigarette packs were required by law. • There are bans on use by minors. • Bans on use in public places and advertisements.
Japan	<ul style="list-style-type: none"> • Although male smoking prevalence has declined significantly since 1966, when it peaked at 84%, over half of adult males (59%) were still smoking in 1994. • Female prevalence was estimated at 14.8% in 1994. 	<ul style="list-style-type: none"> • Non-governmental organizations have been campaigning against tobacco since the 1970s. • 1984 Tobacco Business Law with the stated purpose of promoting sound development of the Japanese tobacco industry. • Smoking by minors under 20 has been banned since 1900, but vending machines are widespread. • Advertising is allowed. • No tar or nicotine limits.

¹ Statistics are listed for the countries of origin of the largest ethnic groups in Colorado only. Pacific Islanders are not listed in the table as they represent a large number of different territories, including Hawaii, a U.S. State. Hmong are an ethnic group from Laos and, therefore, are not discussed in the table.

Country	Trends	Highlighted Tobacco Policy
Korea	<ul style="list-style-type: none"> • In 1985, it was reported that approximately 42% of the adult population in North Korea smoked (very few women, however). • Overall smoking prevalence has declined slightly. In 1989, 68.2% of adult males smoked and 6.7% of adult females. • Prevalence in South Korea is lowest in professional groups and students (55%), and highest in agriculture, fishing, transportation, communication and miners (74-82%). 	<ul style="list-style-type: none"> • The cigarette market in South Korea is dominated by the state tobacco company. Until the mid-1980s, foreign cigarettes were banned. • The number of cigarette vending machines has increased dramatically since 1998; however, they have been banned in Seoul since 1995. • Health warnings about smoking were strengthened in 1989. • Smoking is banned in hospitals, health facilities, and public transportation (with the exception of inter-city trains which have separate non-smoking cars).
Laos	<ul style="list-style-type: none"> • In 1995, 78% of the population was rural. • No national prevalence study has been undertaken. A 1995 pilot study in the capital, Vientiane, found smoking prevalence of 41% for males and 15% for females. • Among certain minority groups, the prevalence rates for men and women are thought to be as high as 70-90%. • Rural people reportedly use cigarette smoke to repel mosquitoes; malaria is a major cause of death. 	<ul style="list-style-type: none"> • In 1995, a committee for Tobacco or Health was established by the Ministry of Health. The aim is to increase public awareness, decrease tobacco consumption and assist in introducing legislation. • There are some voluntary measures to restrict smoking in hospitals, public transport, and other public places. • Since 1995, regulations forbid teachers and students from smoking and drinking in schools.

Country	Trends	Highlighted Tobacco Policy
Phillipines	<ul style="list-style-type: none"> • The imports of cigarettes have increased significantly since 1990. • According to a 1987 national prevalence study, 43% of adult males and 8% of adult females smoked. • In 1987, 63% of male and 37% of female physicians smoked. • 1987-88 data indicated that 40% of boys and 19% of girls aged 10-14 were daily smokers. At ages, 15-19, 38% of both males and females were found to be regular smokers. 	<ul style="list-style-type: none"> • Most action against tobacco has been community based. • Media coverage and debate on the effects of smoking. • There are no law prohibiting sales to minors. • Loose cigarettes are sold by street vendors, who are usually children. • In 1995 , it was mandated that all public and private schools and colleges become smokefree. • Tobacco advertising is freely allowed. • The Consumer Act of 1992 required that health warnings be implemented by 1994. There have been obstacles to implementation.
Viet Nam	<ul style="list-style-type: none"> • In 1987, it was reported that 70% of tobacco was consumed as cigarettes and 30% as pipe tobacco. • In 1987, 40% of cigarettes are roll-your-own. • By 1993, tobacco consumed as cigarettes had risen to 93%, with 98% of these manufactured. • Consumption of international brands is mostly limited to foreigners and the wealthy. • A 1995 survey in Hanoi, Ho Chi Minh City, and two rural areas found that 73% of men and 4% of women (over 18) were smokers. 	<ul style="list-style-type: none"> • By law, foreign-controlled cigarette factories are prohibited in Viet Nam. However, these firms have been given approval to control pricing, marketing and distributing of their brands manufactured in Viet Nam under license. • Since 1987, the government has been active in examining tobacco control. • In 1991, a partial ban on tobacco advertising was implemented. • There are no bans on sales to minors. • No tar and nicotine limits. • No bans on smokeless tobacco. • In 1995, the Ministry of Health prohibited smoking in all health facilities and offices.

Country	Trends	Highlighted Tobacco Policy
India	<ul style="list-style-type: none"> • Only about 20% of the total tobacco consumed in India (by weight) is in the form of cigarettes. • Bidis account for about 40%, with the rest divided among chewing tobacco, pan masala, snuff, hookah, hookli, chutta dhumti and other tobacco mixtures featuring ingredients such as areca nut. • Chuttas and dhumtis are smoked in reverse fashion with the lighted end inside the mouth. • It is estimated that 65% of all men use some form of tobacco - 35% smoking, 22% smokeless, 8% both. • Prevalence among women varies by region - 15% to 67%. • Overall prevalence of bidi and cigarette smoking among women are 3%, while smokeless tobacco use is similar to that of men. • Tobacco use varies by groups: Sikhs do not use tobacco at all; Parsis use very little. • Smoking rates tend to be higher in rural areas than urban areas. However, smoking tends to be a status symbol among urban educated youth. 	<ul style="list-style-type: none"> • Tobacco advertising has been banned in state-controlled electronic media, but is not restricted in newspapers and magazines. A proposal for a total ban is under consideration by the Indian Government. • Health warnings have been required on cigarette packets since 1975. • In 1990, the government prohibited smoking in all health care establishments, government offices, educational institutions, and transportation.