A

TOBACCO REPORT

ON SOUTHEAST ASIAN

YOUTH

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INTRODUCTION

Due to the widespread misperception that Asian Americans have the lowest rate of tobacco use among all racial and ethnic groups in the United States, Asian Americans have historically been a low priority in the nationwide public health campaign against tobacco. However, with lung cancer the leading cause of preventable death among Asian American women over age 55, it is clear that Asian Americans are in great need of tobacco prevention and control efforts. Anti-tobacco programs must be designed not only to dispel the myth that Asian Americans do not smoke, but also to address the community misperceptions of smoking as socially appropriate and not life-threatening. In fact, nearly 1 in 5 Asian Americans are unaware of tobacco's links to chronic health conditions such as heart disease and emphysema.

To support the need for increased tobacco prevention and control efforts for Asian American communities, the National Asian Women's Health Organization (NAWHO) launched the first national multi-lingual assessment of tobacco use and exposure among Asian Americans in 1998. Entitled *Smoking Among Asian Americans: A National Tobacco Survey*, NAWHO's study revealed a new profile of Asian Americans as an at-risk population for tobacco use and exposure and showed extreme differences between racial and ethnic groups. The findings of NAWHO's survey revealed that Asian American men are smoking at much higher rates than previously reported; Asian American women are exposed to second-hand smoke nearly every day either at home or in the workplace; and most Asian American smokers begin their habits while they are teenagers.

While NAWHO's survey was a critical step in changing the public's perceptions of tobacco and Asian Americans, additional gaps in data remain, including new areas of need revealed by NAWHO's survey itself such as the young age of smoking initiation among Asian Americans. To continue to fill these gaps and address newly emerging tobacco areas, NAWHO set out to explore the attitudes and actions of Asian American youth toward tobacco, particularly Southeast Asian youth who are highly under-represented in tobacco research. The following report provides a summary and analysis of smoking history, access to tobacco products, exposure to second-hand smoke, attitudes about smoking, and perceived health risks among Southeast Asian youth as well as recommendations for future actions to prevent the debilitating effects of tobacco on this community.

LITERATURE REVIEW

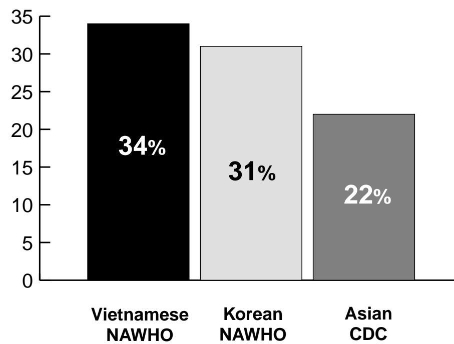
According to the United States Bureau of the Census, the Asian American and Pacific Islander (AAPI) population continues to be one of the fastest growing populations in the country, representing over 50 national and ethnic origins with distinct cultures and languages. (1) Despite this dynamic growth and diversity, debilitating stereotypes such as the "model minority" myth continue to limit social programs for this community. Federally funded national studies often mask the specific health needs of subgroups by limiting their focus to Asian Americans as a whole, thereby ignoring the diversity within this population. Additionally, most federal studies are conducted in English, effectively excluding significantly growing groups of Asian immigrants.

While smoking rates are on a decline in "Western" countries such as the United States, tobacco use continues to increase in Asian countries, mostly due to the widespread prevalence of cigarette advertising. The globalization of tobacco marketing and trade has impacted developing countries, such as Vietnam and Thailand, especially hard. The World Health Organization (WHO) estimates that nearly 80% of deaths caused by tobacco in the world will take place in developing nations. (2) While the negative health consequences of tobacco use are widely known in the West, the majority of the population in developing countries, including Asia, remains unaware of tobacco's extreme health hazards. Not only is awareness of health risks low, but social acceptance of smoking is extremely high. In many Asian communities, smoking has become a symbol of affluence and sophistication as well as hospitality and friendship where cartons of cigarettes are offered as gifts. Such attitudes toward tobacco have a far-reaching impact for the United States. Currently, an estimated three-quarters of the AAPI population in the United States is foreign-born and may bring with them the tobacco attitudes and behaviors of the strong smoking cultures in Asia. (3)

Despite conditions that would warrant increased attention to tobacco use and exposure among Asian Americans in the United States, little current data on tobacco exists for this population. Data available from the Centers for Disease Control and Prevention indicate that Asian Americans have the lowest smoking prevalence of all racial and ethnic groups at 16.9% (21.6% male, 12.4% female). (4) According to recent figures, nearly a quarter (24.7%) of all American adults are current smokers, with rates slightly higher for men (27.6%) than for women (22.1%). (5)

However, a closer look at the Asian American population shows extreme differences between racial and ethnic groups. In 1998, using innovative methods, NAWHO set out to prove that Asian Americans are an at-risk population requiring tobacco prevention and control efforts. With the same tobacco use questions used to generate national smoking prevalence levels which had documented low Asian American smoking rates, NAWHO conducted the first national, multi-lingual assessment to measure tobacco use and exposure among Vietnamese and Korean American men and women. The survey findings clearly showed that Asian American men are smoking at much higher rates than

previously reported. In fact, in contrast to the government reported Asian American smoking rate, the NAWHO study found that 34% of Vietnamese and 31% of Korean American men smoked. (6)



It also indicated that Asian American women are at high risk of tobacco related health problems from second-hand smoke both at home and in the workplace. Perhaps most alarming, NAWHO found that over half of the Vietnamese and a third of the Korean American smokers surveyed had tried their first cigarette when they were 18 or younger. (7) By applying a more accessible data collection method, NAWHO generated a more accurate - and alarming - representation of tobacco use and exposure among Asian Americans.

Not surprisingly, statistics on tobacco and Asian American youth are also minimal. Furthermore, what does exist, like existing Asian American adult data, may not fully explore the diversity of the Asian American population. For example, a recent national survey of youth in the United States found that AAPIs had a lower prevalence of smoking than their counterparts in all other racial and ethnic groups except African Americans. Among male high school seniors, the prevalence of smoking was 20.6% (compared to 33.4% among whites) and 13.8% (compared to 33.1% among whites) among female high school seniors. (8) However, a localized in-language study of Vietnamese youth found significantly higher smoking levels. (9) The study showed that Vietnamese males were as likely to smoke (27.9%) as white males (28.3%.).

In addition to the paucity of data on tobacco and Asian American youth, there is little available data on the overall challenges Asian American youth face in today's society. However, most health professionals acknowledge that the expectations of Asian American families appear to be high. For recent immigrants, young people become translators of

both language and culture for their elders. They also are often expected to succeed in school, care for aging relatives and/or young siblings, and work in family businesses. At the same time, advocates point out that the misleading identification of Asian Americans as the "model minority" clouds very real health issues for young people and their families — including poverty, involvement in gangs, mental health issues, and reproductive health needs. Of particular concern are other factors that increase risk for substance abuse. Studies have found that Asian American girls have the highest rate of depressive symptoms, and that girls with such symptoms have double the prevalence of risk behaviors and are more likely to turn to smoking for relief.

METHODOLOGY

From April to May 2000, 708 Southeast Asian youth between the ages of 13 and 18 were surveyed about their smoking history, access to tobacco products, exposure to second-hand smoke, attitudes about smoking, perceived health risks, and general demographic data. To administer these surveys, NAWHO partnered with two community-based health organizations to gather a convenience sample of Southeast Asian youth in California and Texas, home to the majority of the Southeast Asian population in the United States. The East Dallas Counseling Center (EDCC) in Dallas, Texas and the Khmer Society of Fresno (KSF) in Fresno, California were selected to administer the survey to Southeast Asian youth in their communities. Following training from NAWHO, these organizations administered NAWHO's surveys at various community outlets. These outlets were largely ethnic-specific community forums including Cambodian New Year celebrations; events at Laotian and Cambodian temples; local health and wellness events; cultural youth clubs and groups; and ethnic language schools.

NAWHO and its partners deliberately chose to disseminate the survey in these locations instead of more traditional data collection locations for youth such as public schools. While schools may have provided access to a larger number of respondents, NAWHO's unique data collection design focused on hard-to-reach youth respondents using trusted community leaders. These include youth who are not enrolled in school or do not attend school regularly, factors for risk behaviors such as tobacco use. By removing the survey from an educational environment, NAWHO also hoped to elicit increasingly accurate responses. In a classroom, respondents may not believe their answers are confidential and may suspect they will be reviewed by teachers or school officials. In addition to conducting the survey in trusted community venues, NAWHO's respondentswere also self-selecting and not forced or obligated to complete and return surveys. Participants were further offered incentives such as small prizes or the opportunity to enter a drawing for a grand prize.

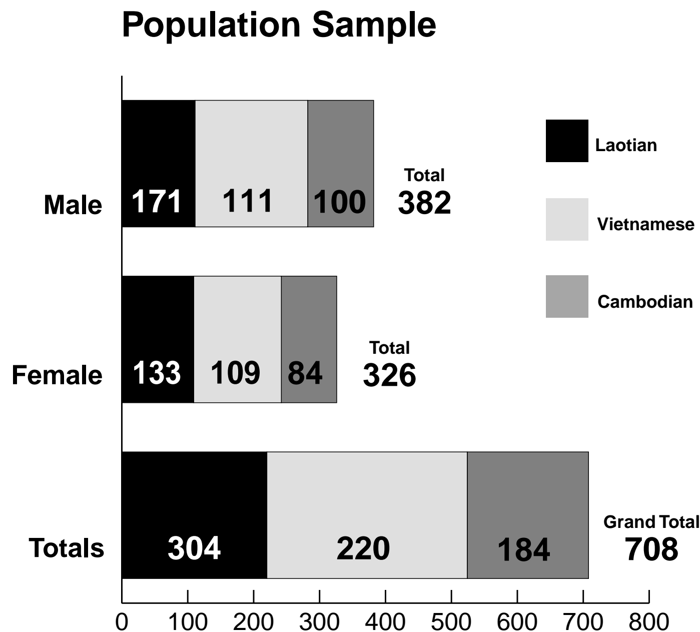
Though NAWHO's data collection method represents an innovative and culturally competent approach to reaching this community, various limitations of the design should be considered when interpreting the results of this report. The

survey was printed in English only and no translation was provided, thereby potentially limiting participation by youth who do not read or speak English very well. In addition, answers to NAWHO's surveys were self-reported and, therefore, may be limited in their accuracy and truthfulness. Although administered anonymously, the data may also include under-reporting or over-reporting in incriminating areas surrounding tobacco use by minors.

Moreover, survey respondents were limited to specific ethnic populations: Cambodian, Laotian, and Vietnamese in Dallas and Fresno counties. Therefore, this report does not claim to represent the whole of the Asian American population, or even the Southeast Asian population. Instead, this report should be considered a "snapshot" of these communities from which much can be learned about tobacco use and exposure.

KEY FINDINGS

While respondents do not constitute a random sample of all Southeast Asian youth in the Dallas, Texas and Fresno, California areas, findings are representative of English-speaking Southeast Asian youth of high school age — grades 7 through 12— and of Cambodian, Laotian, and Vietnamese descent. Notably, individual ages of respondents ranged between 13 and 18 and the majority (approximately 60%) of respondents was not born in the United States.



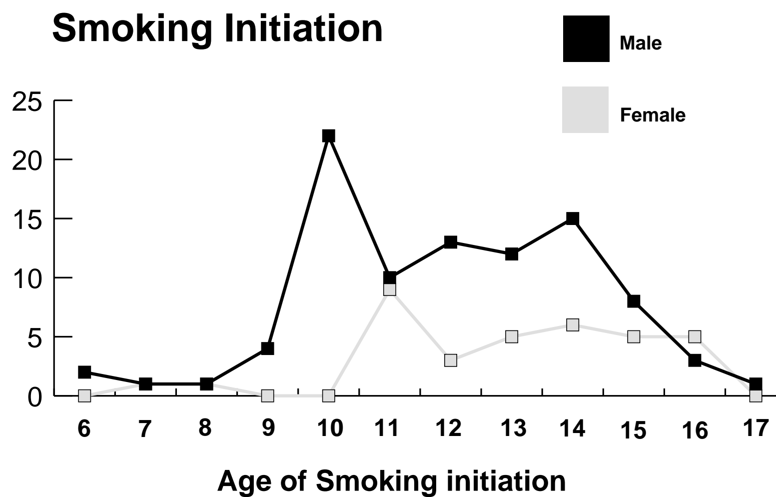
Little Awareness of Health Risks

Southeast Asian youth are not aware of the health risks associated with smoking. This is not surprising, given that they are immigrants from countries in which smoking is glamorized, and public health systems have neither the resources

nor the public pressure to focus on risks related to tobacco use for this population. Although the vast majority of youth surveyed (89%) know that smoking causes lung cancer, half were not aware of the risks for emphysema and bronchitis, and one-third were unaware of the risks for heart disease. Furthermore, 20% were unaware of the addictive nature of cigarettes, and another 36% believed that smokers can quit smoking at any time.

Starting Life-Long Habits Early

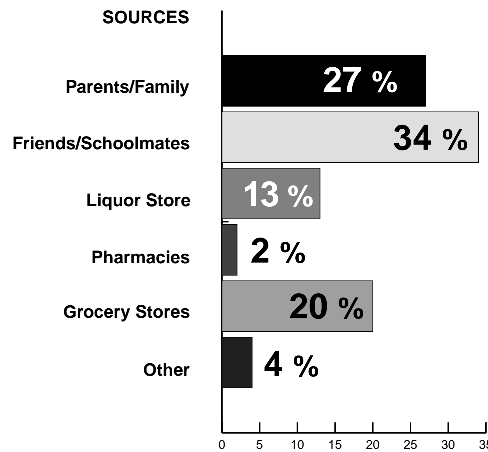
Southeast Asian youth follow national trends in smoking initiation, beginning life-long habits early. The majority of smoking respondents began smoking between the ages of 10 and 14. Notably, those who started younger, smoked more, and those who started later, smoked less. For example, boys who had initiated smoking at the age of 10 were also the group who smoked the most, whereas respondents who initiated smoking at the older age of 15 smoked less. Additionally, NAWHO found that boys smoked considerably more than girls and start much younger. Almost a quarter of the boys surveyed had tried smoking, while just over a tenth of girls had. Most respondents who started smoking at the age of 10 or younger were male, while girls tended to initiate smoking after age 10.



Access to Tobacco Products

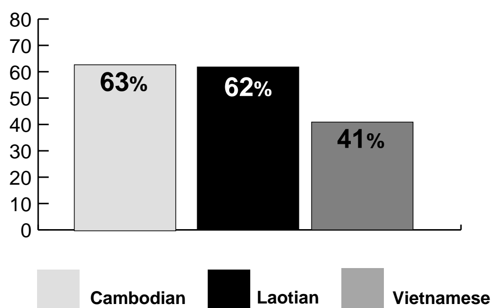
Most smoking respondents got cigarettes through their peer and family relationships. When smoking respondents were asked where they got their cigarettes, friends and schoolmates were cited 34% of the time, followed closely by parents or other family members (27%). While it is unclear whether they are actually given cigarettes by family members or just have proximity and easy access to them, this is a considerable source that makes it easy to circumvent age-related tobacco consumption laws.

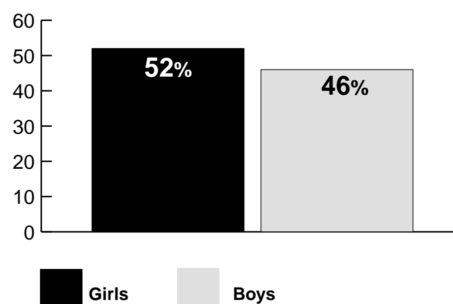
Respondents who bought cigarettes from a store purchased them from grocery stores (20%) and liquor stores (13%) most often. These results are in sharp contrast to existing studies that indicate that half of all youth smokers purchase their cigarettes from retailers or vending machines or by giving money to others to purchase cigarettes.



High Environmental Tobacco Smoke (ETS) Exposure

More than half (53%) of the youth surveyed indicated that they live with someone who smokes. A higher percentage of Cambodian and Laotian youth live with a smoker (63% and 62%) than Vietnamese (41%), and a higher percentage of girls (52%) live with a smoker than boys (46%). Living with a smoker increases exposure to tobacco smoke and health risks, whether the youth smoke themselves or not. This is particularly significant for girls who smoke much less than boys, but may be exposed to second-hand smoke more.

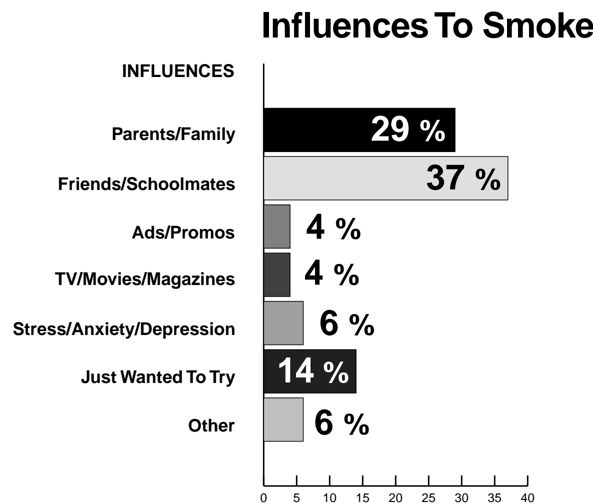


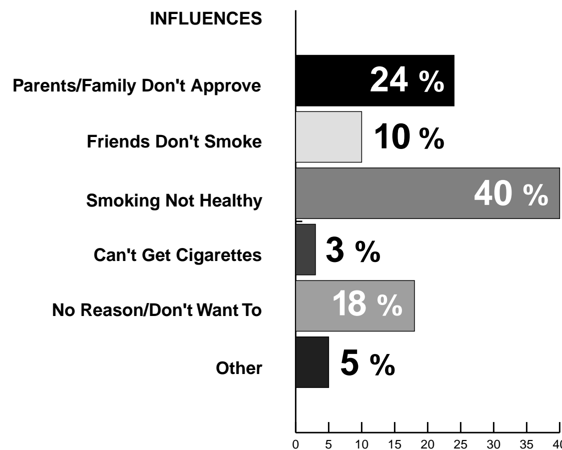


Smoking Influences

External social environmental factors did not heavily affect the smoking decisions and habits of respondents. When respondents who smoked were asked what influenced their decision to smoke, advertising/promotions and television/movies/magazines were each cited only 4% of the time. However, of those who cited these sources as smoking influences, close to 64% were girls and only 36% were boys, suggesting that specific marketing to young women may be having an impact in these communities. Lack of access to cigarettes (3%) was cited least often as an influence for not smoking.

Instead, the decision to smoke for these immigrant youth was influenced more by their peer and family relationships. Again, when asked what influenced their decision to smoke, respondents cited friends (37%) and parents and family members (29%) most often. It is not specified whether this takes the form of actual pressure or encouragement to smoke or whether the youth simply follow the example set before them in their personal relationships. A vast majority (79%) of those surveyed who said they have tried smoking also live with a smoker, suggesting that proximity to a smoker may influence smoking habits. Conversely, those respondents who did not smoke stated that their number one reason for not smoking was the knowledge that smoking was detrimental to one's health (40%). However, as many as a quarter of respondents do not smoke simply because their parents and family do not approve (24%).





Additional findings illustrate some of the particular vulnerabilities that Southeast Asian youth face as immigrants and adolescents. For example, over half of respondents (57%) stated that they did not think that smoking was "cool" or impressed people. This is not surprising, given that adolescents rarely admit to doing something merely to impress others. However, a high number of both boys (28%) and girls (21%) indicated that they smoked to relax and relieve stress, and almost a quarter of boys (24%) and a fifth of girls (20%) thought that smoking would help them stay thin or lose weight.

RECOMMENDATIONS

The NAWHO survey elicited a wealth of information that can lead directly to specific interventions. The following are recommendations for action by policy makers, program managers, community activists, and researchers:

• Develop basic education for Asian immigrant populations on the risks related to tobacco use. NAWHO's survey indicates that knowing the risks of smoking can have a positive impact on healthy behavioral habits. Given that Southeast Asian immigrant communities come from countries in which smoking is not seen as a negative habit, basic health education that introduces the concept of smoking as dangerous is needed. Additionally, these communities have been ignored by current national anti-tobacco campaigns. Missed opportunities for community education on tobacco risks should be identified and corrected. Cultural and community events as well as venues such as health fairs and ESL and GED classes could be utilized. These efforts must include education on both individual and second-hand exposure to tobacco use.

• Develop early and effective interventions with Southeast Asian immigrant youth. Given that early initiation of smoking is a risk factor for sustained and high levels of smoking in both youth and adulthood, early public education campaigns for these populations must be developed and implemented. Like the NAWHO survey, these efforts must be innovative in the ways in which they reach Southeast Asian immigrant youth. They must find youth where they are and must be language-, age-, and culturally-appropriate. They must also be accessible to both in- and out-of-school youth.

• Address sources of stress for immigrant youth. Given that almost a quarter of the smoking youth surveyed indicated that smoking relieved stress and helped them relax, intervention efforts should work with youth to identify and address sources of stress in their lives. Immigrant youth carry particular burdens, including heavy family responsibilities; learning new languages and skills; multiple work and school responsibilities; and cultural and identity issues. At the same time, like their adolescent counterparts from other racial and ethnic groups, respondents are affected by mainstream standards of beauty that, for example, value being thin. These factors make these youth vulnerable to smoking and should be addressed in anti-smoking education campaigns.

• Involve parents and family in intervention efforts. The NAWHO survey clearly shows both the positive and negative impact that parents can have in influencing the health behavior of Southeast Asian youth. Other research supports the idea that within this population, parental approval can strongly and positively influence youth behavior. Almost a quarter of non-smoking respondents said that their parents' disapproval influenced their decision not to smoke. Intervention efforts can build on this to increase parental knowledge on the dangers of their children smoking and to increase parental involvement in non-smoking initiatives for youth. Conversely, almost 80% of respondents who smoked lived with a smoker, and over a quarter of smoking respondents said that their decision to smoke was influenced by their parents. Parents who smoke must be educated about the dangers that they pose to their families by suggesting that smoking is positive by example; by keeping cigarettes easily accessible to their children; and by exposing their families to the very real dangers of second-hand smoke.

• Involve peers and communities in intervention efforts. Given that peers are key sources of both cigarettes and perceptions of acceptable behavior, it is important to recognize the influence Southeast Asian youth have over each other with regard to smoking habits. Additionally, other health interventions have proven the effectiveness of peer education in behavioral change. NAWHO has proved the utility of reaching communities through community events and community-based organizations. Given that existing national anti-smoking efforts have not effectively reached the youth in these communities, special efforts must be made to involve communities in the development and implementation of education initiatives.

NAWHO

The National Asian Women's Health Organization (NAWHO) was founded in 1993 to eliminate health disparities for Asian women and families. NAWHO's goals are to raise awareness about the health needs of Asian Americans through research and education and to empower Asian women and families as decision-makers through leadership development and advocacy. Through innovative programs and partnerships, NAWHO is increasing knowledge of breast and cervical cancers, expanding access to immunizations, changing attitudes about reproductive health care, and breaking the stigma around depression and mental health.

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APPENDIX: PARTNERS

To implement its data collection effort, NAWHO partnered with two community-based organizations that were in the best position to reach Southeast Asian youth communities. Each organization conducted NAWHO's youth smoking survey in their regional communities.

East Dallas Counseling Center (Dallas, Texas)

East Dallas Counseling Center (EDCC) is a non-profit, community-based, 501(c)(3) organization that targets low income and medically indigent youth and families in the Dallas-Fort Worth metro-plex. EDCC's mission is to provide its target populations the opportunity and the tools to live healthy lives free from substance abuse and/or psycho-social-cultural adjustment problems. EDCC services and programs are delivered by a culturally diverse staff who are fluent in one or more of the following languages: English, Vietnamese, Spanish, Chinese, Laotian, Cambodian, Thai, French, Bosnian, Kurdish, Arabic, and Somalian. EDCC professional staff are licensed or certified in their field of specialty such as social work, psychology, education, mental health, rehabilitation, and substance abuse.

Khmer Society of Fresno (Fresno, California)

Khmer Society of Fresno (KSF) was incorporated in 1995 with a mission to assist the Cambodian refugees to socially acculturate in the mainstream community in Fresno. It is the only Cambodian mutual assistance association (MAA) that directly serves critical need services such as interpreting/translation, cultural assimilation and information referral to an estimated 7,000 Cambodian refugees in Fresno County. KSF is currently administering three projects: employment placement, tobacco education outreach, and Medi-Cal outreach for the Cambodian and Laotian communities in Fresno County. KSF acquired its capacity building through collaboration with Fresno County.

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