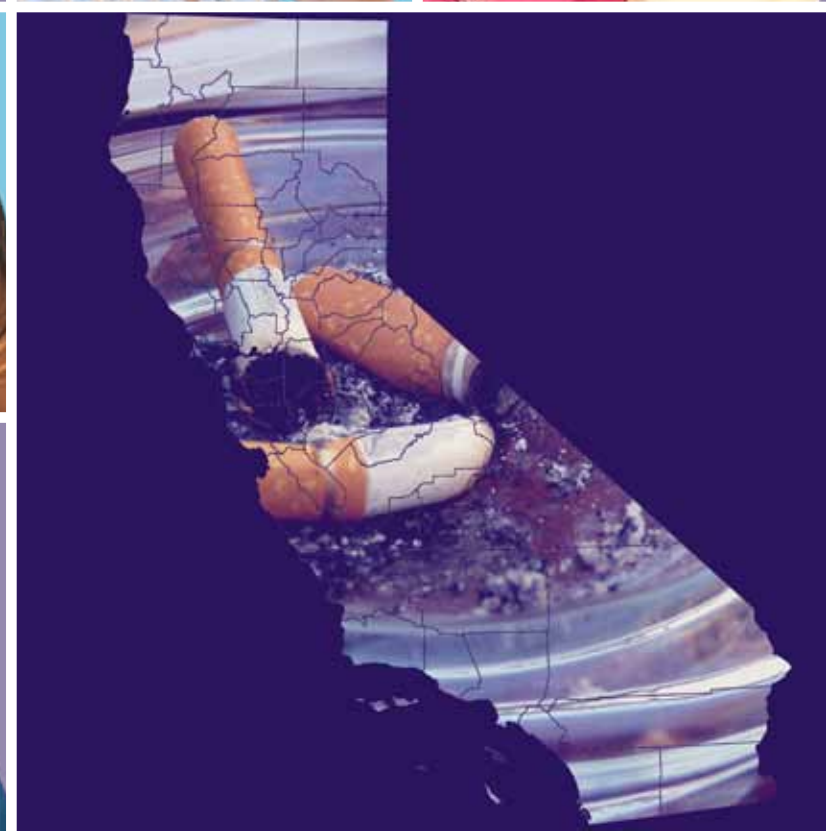




TOBACCO USE AMONG ASIAN AMERICAN, NATIVE HAWAIIAN AND PACIFIC ISLANDER COMMUNITIES IN CALIFORNIA

2012





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APPEAL

Asian Pacific Partners for Empowerment, Advocacy, and Leadership

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FOREWORD

Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPs) continue to face a disproportionate burden of tobacco use and tobacco-related disability, disease and death. Even though the historic Family Smoking Prevention and Tobacco Control Act gave authority to the Food and Drug Administration to regulate tobacco, rising concerns about the tobacco industry's marketing of unregulated little cigars and cigarillos and mentholated cigarettes present great challenges to addressing tobacco issues for AAs and NHP communities, and youth in particular.

While California has demonstrated leadership in the past with the funding of statewide surveys on specific Asian American subgroups (Asian Indian, Chinese, Korean and Vietnamese) and statewide ethnic tobacco control networks were funded in the 1990s and early 2000s, funding of comprehensive, culturally tailored tobacco control programs for AAs, NHPs, and other priority populations have declined over the past decade. This has resulted in the decreased ability of AA and NHP communities and other priority populations to mobilize on critical tobacco program and policy issues and a gap in advocacy and leadership for our communities.

We commend the Tobacco-Related Disease Research Program (TRDRP) for their long history in funding research to better understand the health, social, economic and political impact of tobacco use on California's diverse population since 1988. We also greatly appreciate TRDRP's commitment and leadership in supporting efforts to eliminate tobacco disparities which includes the funding of the **A**dvocacy and **D**ata dissemination to achieve **E**quity for **P**riority populations on **T**obacco (ADEPT) Project.

Through the ADEPT Project, APPEAL partnered with four organizations to synthesize and disseminate tobacco use data for seven priority populations in California. The ADEPT Project's goal is to educate these communities through the dissemination of critical and compelling tobacco control research and data in order to inform and guide the development of effective tobacco control program and policy initiatives.

We are also tremendously appreciative of our collaborative partnership with our ADEPT partner organizations:

the African American Tobacco Control Leadership Council (AATCLC), which works with the African American community; the Coalition of Lavender-Americans on Smoking & Health (CLASH), which works with the LGBT community; Break-Free Alliance, which works with the low socioeconomic status (SES) community; and the University of Southern California, which works with Hispanic/Latino and American Indian communities.

This report prepared by APPEAL provides an update on data from research conducted on tobacco issues impacting the AA and NHPI population. We continue to advocate for the need of disaggregated data analyzing the impact of tobacco on specific AA and NHPI subgroups and also for resources to disseminate this data, in order to guide the planning and implementation of effective program and

policy initiatives. This report also describes examples of effective strategies for creating change on tobacco through four levels of policy change. We also provide select policy recommendations on tobacco use impacting AA and NHPI communities. With the synthesis of new data about how tobacco impacts the AA and NHPI differentially and how we can best respond, we are better equipped to move forward in eliminating tobacco disparities and towards the vision of health parity in our communities.

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Executive Director

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PREVALENCE OF TOBACCO USE IN CALIFORNIA

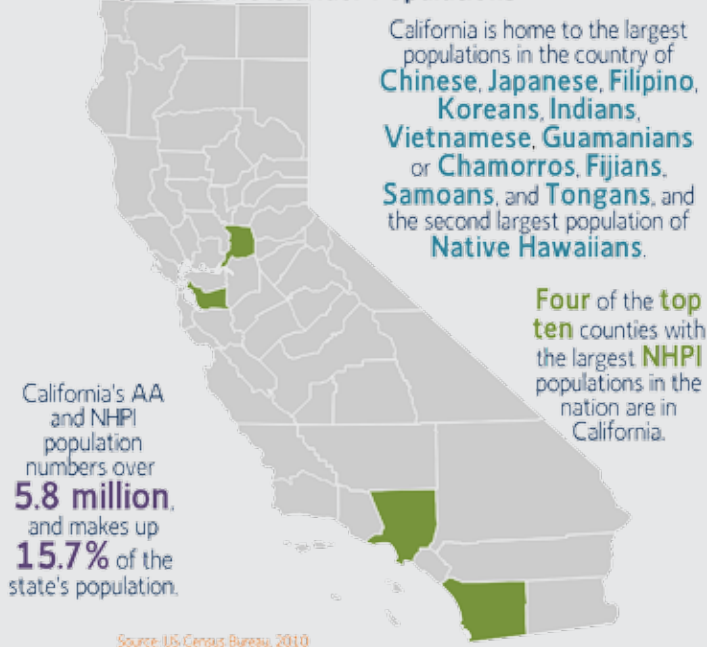
Tobacco continues to be a major issue for diverse Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities. Rates of smoking are very high among men in some Asian American subgroups and Native Hawaiian and Pacific Islander men and women. However, these high rates of tobacco use among some AA and NHPI communities are often masked by data limitations. Large sample and national studies often lump many ethnic groups together into an aggregate Asian American or Asian American/Pacific Islander category and/or they do not oversample for AA and NHPI respondents. In addition, many population-based surveys are only conducted in English, or do not collect or report data that is disaggregated into statistics on individual ethnic subgroups. Studies that include information on smoking prevalence rates for individual ethnic subgroups show that smoking prevalence rates for an aggregate Asian American category are misleadingly low and hide substantial variation between AA and NHPI subgroups.

Adult Tobacco Use

California has taken a lead in collecting disaggregated data in Asian languages for some studies, such as the recent iterations of the California Health Interview Survey (CHIS) and the California Tobacco Control Program (CTCP) Tobacco Use Surveys for Asian Indians, Chinese, Korean, and Vietnamese, which have captured some of the variation between different AA and NHPI groups. Asian American men with lower English proficiency are more likely to smoke than those with high English proficiency, which means that in-language surveys are critical for collecting accurate prevalence rates (Tang et al., 2005). For most Asian American groups, men have higher smoking prevalence rates than women. According to the 2009 CHIS, men's smoking rates among Pacific Islanders (36.3%) and Vietnamese (30.7%) are approximately double those of all men in California (17.2%), and are also high among Filipino (18.7%) and Korean (21.5%) men.

Some smaller ethnic groups are missed by population-based studies, especially those conducted only in English. Community-based research on these under-studied groups suggests that tobacco is a significant problem in

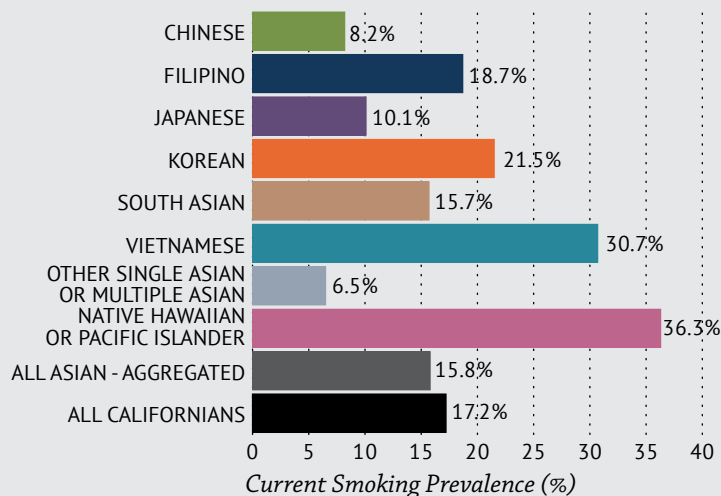
California's Asian American, Native Hawaiian and Pacific Islander Populations



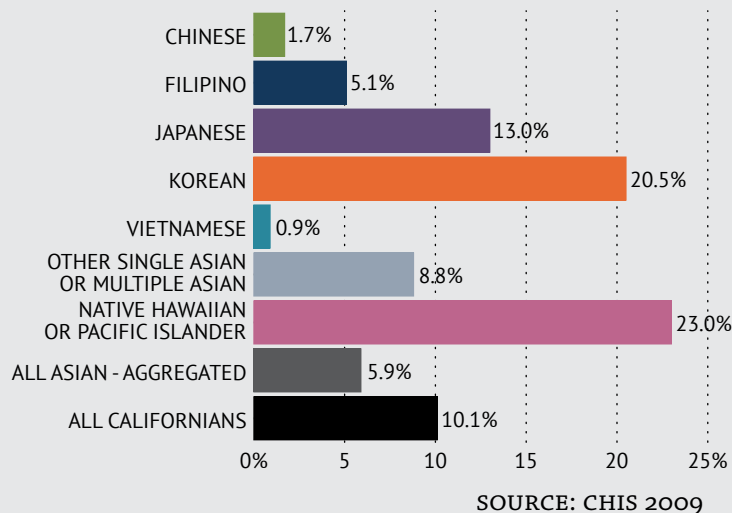
CALIFORNIA'S AA AND NHPI POPULATIONS

Asian Americans are the fastest growing group in the nation, and California is the home of the largest and most diverse population of Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPIs) in the country. According to the 2010 Census, Asian Americans, Native Hawaiians and Pacific Islanders in California grew from 4.2 million in 2000 to over 5.8 million in 2010 and comprise 15.7% of the state's population. California has the largest populations in the country of the six largest Asian groups—Chinese, Filipino, Indian, Japanese, Korean, and Vietnamese. Native Hawaiians and Pacific Islanders populations are also highly concentrated in California. It is the state with the largest populations of Guamanian or Chamorro, Fijian, Samoan, and Tongan, and the second largest population of Native Hawaiians. Four of the top ten counties in the nation with the largest NHPI populations were in California—Los Angeles County, San Diego County, Sacramento County, and Alameda County (Bureau of the Census, 2012).

SMOKING PREVALENCE - MEN



SMOKING PREVALENCE - WOMEN



SOURCE: CHIS 2009

many AA and NHPI communities, especially low income groups. A community-based study sponsored by a TRDRP Community Academic Research Award (CARA) grant estimates the smoking rate for Cambodian men at 24.4% (Friis et al., 2012). Assessments of tobacco use prevalence among understudied ethnic subgroups, such as Southeast Asian and Pacific Islander communities, are critical for understanding and addressing the tobacco-related health crisis in California.

Smoking rates among Asian American women, though traditionally low, are on the rise. The tobacco industry has increasingly targeted Asian women and youth—both in the United States and Asia (Muggli et al., 2002; Anderson, 2011). Korean women and Pacific Islander women smoke at a rate more than double that of the general population of California women (10.1%), 20.5% and 23.0%, respectively, and Japanese women smoke at a rate of 13.0% (CHIS, 2009). For Asian American women, research shows that the relationship between smoking prevalence and English proficiency is the inverse of that for men; Asian American women with higher English proficiency are more likely to smoke than those with lower English proficiency (Tang et al., 2005). Therefore, as women become more acculturated to US norms, they are more likely to be current smokers. This indicates that mainstream tobacco control efforts may not be effectively reaching these women.

It is important to note that rates of current smoking may not reveal the full scope of tobacco use among all ethnic populations because that data is based on cigarette smoking. The authors of the California Asian Indian

Tobacco Use Survey finds low rates of current smoking for women (1.9%) and men (8.7%), but also note that that statistic does not capture the use of other culturally specific tobacco products – such as paan masala, bidis, or hookahs – as well as cigars (McCarthy et al., 2005).

Like prevalence rates across AA and NHPI groups, patterns of smoking intensity also vary by group. In addition to having high rates of smoking prevalence, NHPIs are more likely to smoke on a regular basis; more than half of NHPI smokers say that they smoke every day, as compared to 23.5% of all California smokers (CHIS, 2009). In contrast, Asian American smokers are more likely to be light or intermittent smokers as compared to Whites. Within smoking intensity groups, most Asian American smokers report that they smoke fewer cigarettes on average than White smokers (Tong, Nguyen, Vittinghoff, Pérez-Stable, 2009). This data suggests that a one size fits all approach to cessation and other elements of tobacco control will not adequately address the different patterns of tobacco use in AA and NHPI groups, as they differ both from the general population, White smokers, and from smokers in other AA and NHPI ethnic groups.

Youth and Young Adult Tobacco Use

According to the U.S. Surgeon General, smoking among youth and young adults is of major concern because 99% of all long-term smokers in the U.S. begin smoking before the age of 26 (USDHHS, 2012). Patterns for youth smoking differ between AAs and NHPIs, and from the general population. Nationwide, Pacific Islander youth smokers



start earlier than any other ethnic or racial group, with 31.1% starting to smoke in grade school (Chen, 2003). In contrast, Asian American youth are more likely to start smoking later; rates of smoking for Asian American high school-aged youth (33.1%) are seven times higher than rates of smoking among Asian American middle school-aged youth (4.4%) (Kershaw, 2001). A variety of factors, such as acculturation, family functioning and self-image, academic stress, peer group influence, and other cultural factors, shape protection from and risk of smoking, as well as age of initiation among AA and NHPI youth—and these vary by group (Chen et al., 1999; Friis et al., 2006; Kaplan et al., 2008; Weiss et al., 2006).

AA and NHPI smokers, especially youth, are also more likely to smoke menthol cigarettes than the general population. Nationwide, 51.5% of Asian American youth smokers and 41.4% of Native Hawaiians and Pacific Islander youth smokers, aged 12-17 years, report smoking a menthol brand (Caraballo and Asman, 2011).

The emergence of other products subject to less regulation and taxes than cigarettes—such as little cigars and cigarillos—may be reshaping patterns of tobacco use among youth and young adults. The tobacco industry markets these products in ways that are appealing to youth, such as using candy-like flavorings and packaging (Carpenter

et al., 2005). Moreover, a TRDRP-funded study found that Southeast Asian youth consume tobacco in combination with other drugs, such as filling hollowed-out cigars with marijuana to make blunts, and that youth consider “smoking” as an activity that may interchangeably include cigarettes, cigars, and blunts (Lee et al., 2010). Youth and young adult smoking is a growing concern, especially since declines in youth and young adult cigarette smoking have slowed across the general population, and smokeless tobacco use declines have stalled nationwide (USDHHS, 2012).

Secondhand Smoke Exposure

Even if they are not smokers, Asian Americans and NHPIs are exposed at disproportionately higher rates to the carcinogenic chemicals in secondhand smoke at home, work, and in public places. A higher proportion of Vietnamese (56.1%) and Pacific Islanders (64.7%) are exposed to secondhand smoke inside the home everyday than the general California population (44.7%) (CHIS, 2009). Disparities also exist in enforcement of smoke-free policies within the home. Asian American women in California with lower educational attainment report more exposure to secondhand smoke in their homes as compared to Asian American women with higher education levels (Tong, Tang, Tsoh,

et al., 2009). Studies using cotinine levels in saliva—a biological indicator of exposure to tobacco smoke—show that Asian Americans in general, and Southeast Asian women in particular, either underreport their smoking status or have significantly higher secondhand exposure to tobacco smoke (Wewers et al., 1995). AAs and NHPIs also experience different levels of exposure to secondhand smoke at work and in public places, which may be a result of a reduced impact of smoking restrictions in their communities. As an aggregate group, Asian Americans and NHPIs have the second highest rate of exposure to secondhand smoke at work among any ethnic group in California, at 10.5%, and White Californians have the lowest rate of exposure at 9.7% (Max et al., 2012). Chinese and Korean Californians also report higher levels of exposure to secondhand smoke in restaurants (23.5% and 16.9%, respectively), as compared to 13% of all Californians (Carr et al., 2005a; Carr et al., 2005b). This suggests that indoor smoking restrictions are not being enforced at the same rate across communities, and that AAs and NHPIs face a higher risk for exposure to toxic chemicals where they live, work, and play.

INDUSTRY TARGETING

Internal tobacco industry documents show that American tobacco companies have targeted Asian Americans and Pacific Islanders in their marketing campaigns in order to expand their markets and counter declining rates of smoking. These predatory marketing campaigns aiming to attract AA and NHPIs to deadly products mean that tobacco-related disparities are important public health and social justice issues. Industry documents show that in a 1990 report, Asian market research specialists at Loiminchay advised Lorillard Tobacco Company that AA and NHPI communities were “predisposed toward smoking” due to high smoking rates in Asia and the Pacific Islands, and would be a “potential gold mine” for the tobacco industry (Muggli et al., 2002: 202). Tobacco industry executives and marketing consultants considered AA and NHPIs to be a desirable market because of the rapid growth of the community, concentration in urban areas, and growing purchasing power. The tobacco industry also targets young Asian American women as potential new smokers. An

internal document from Lorillard suggests a new strategy of marketing to Asian American women as members of that group might be “smoking more as they believe they should enjoy the same freedom as men...” (Muggli et al., 2002: 206). Soon after the Master Settlement Agreement, when new restrictions were placed on tobacco advertising and promotions, advertising campaigns by Phillip Morris’s Virginia Slims and Salem, among others, used culturally specific images of women of color and depicted smoking as a form of women’s empowerment. The tobacco industry has also increasingly targeted menthol cigarettes—which research shows are more addictive and more harmful than regular cigarettes—to youth and communities of color in the U.S. and in Asia (Lee and Glantz, 2011). Because of the negative health impact of tobacco products, when the industry targets their marketing efforts towards AA and NHPI communities, it is an important public health and social justice issue.



HEALTH IMPACT OF TOBACCO ON AA AND NHPI COMMUNITIES

As for all other groups, tobacco use is the single most preventable cause of death for Asian Americans, Native Hawaiians and Pacific Islanders. The top three killers of AAs and NHPIs in California—heart disease, cancer, and stroke—are associated with tobacco use (Ponce et al., 2009). Smoking increases the risk of cardiovascular disease—including coronary heart disease, congestive heart failure, and stroke—among those already suffering from hypertension and diabetes. Smoking interacts with these other diseases to increase the magnitude of harm to the circulatory system (Fagard, 2009). Heart disease is the leading cause of death for NHPIs and the second leading cause of death for AAs in California (Ponce et al., 2009). Nationwide, South Asian Americans are at least twice as likely (18-24%) to develop coronary artery disease in their lifetimes than White Americans (9%), despite low incidence

of traditional risk factors for heart disease (*Science Daily*, 2007). In California, cancer is the leading cause of death for Asian American men and women, and is the second leading cause of death for Pacific Islander men and women (Ponce et al., 2009). Tobacco use contributes to 80% of all deaths caused by lung cancer, and lung cancer is the leading form of cancer death among Asian Americans nationwide.

THE APPEAL FOUR-PRONG POLICY CHANGE MODEL

APPEAL's strategy for tobacco control—the Four-Prong Policy Change Model—identifies four different levels at which policy change can happen in order to achieve health parity for Asian Americans, Native Hawaiians, and Pacific Islanders (Lew, 2009). Examples of promising practices for the four levels of policy change—community, mainstream institutions, legislative, and corporate—are included below.

Community—At the community level, APPEAL and its partners work to make norm changes around tobacco use within AA and NHPI communities in which tobacco control has not been a high priority. The goal of community level change is to create an environment where tobacco is no longer acceptable within the community. Pacific Islander community leaders in San Diego County coordinated a campaign for the largest Pacific Islander event in the county to be tobacco-free. Key informant interviews with community stakeholders, such as festival participants (smokers and nonsmokers), faith-based leaders, and health professionals indicated that most people were supportive of a tobacco-free event. By leveraging resources such as culturally tailored smoke-free signage and brochures on the impact of tobacco in Pacific Islander communities, Mr. Jonathan “Tana” Lepule (Pacific Islander community leader) was able to present his findings to the Pacific Islander Festival Association (PIFA) Board of Directors. He emphasized that the festival is a “family-friendly” event and engaged support of non-traditional partners who had not traditionally been involved in tobacco control. As a result of this collective effort, the Pacific Islander Festival Association board voted unanimously to adopt a tobacco-free policy at the festival, in which smoking, sales of tobacco products, and tobacco sponsorship was not allowed.





Mainstream institutions– APPEAL works to ensure that AA and NHPI communities are included at all levels of the mainstream tobacco control movement, which has not traditionally prioritized AAs and NHPIs. Recently, APPEAL has encouraged the U.S. Centers for Disease Control and Prevention (CDC) to include ads tailored for AA and NHPI smokers in its 2012 “Tips from Former Smokers” campaign, which features graphic and compelling stories from former smokers who are now living with diseases and disabilities caused by smoking. The CDC placed ads from the “Tips from Former Smokers” campaign in Asian language newspapers in California, New York, and Texas with information on the multilingual Asian Quitline, which provides services for quitting smoking in Chinese, Korean, and Vietnamese by bilingual and bicultural counselors.

Since 2003, APPEAL has advocated that the California Tobacco Education and Research Oversight Committee (TEROC) prioritize tobacco-related disparities in its Master Plan for tobacco control. In TEROC’s 2012 Master Plan, “Saving Lives, Saving Money,” TEROC identifies achieving equity for all Californians across diverse populations as a key objective that must be addressed through all aspects of its work. This includes enacting policies to counter

industry targeting of priority populations, incorporating cultural competency and equity as core values, building capacity within priority populations, and ensuring inclusion through all levels of the tobacco control movement (TEROC, 2012).

Legislative–At the legislative level, APPEAL collaborates with partners to educate policymakers who may be unfamiliar with the issue of tobacco control or AA and NHPI communities. With support from TRDRP, APPEAL partnered with Families in Good Health (FiGH) to conduct a community based participatory research project. In this project, AA and NHPI youth identified positive and negative environmental influences on youth tobacco use in their communities. Along with other tobacco control advocates, youth researchers presented their findings to the Long Beach City Council to raise awareness around the ease of youth access to tobacco. In 2008, the Long Beach City Council passed a bill requiring licensing for tobacco retail outlets.

Corporate–While the tobacco industry is the ultimate focus of corporate level policy change, few successes have been made that have achieved meaningful changes to tobacco industry behavior. However, there are multiple

examples of corporate level policy change with local businesses. The South Asian Network (SAN) convened a task force of community representatives to develop an intervention that would increase compliance of the Stop Tobacco Access to Kids Enforcement (STAKE) Act among South Asian merchants in Los Angeles and Orange counties. In order to comply with the law, merchants must not sell tobacco products to those under 18, must ask for government identification before selling to a customer who appears underage, and post appropriate warning signs that display a contact number for patrons to call to report violations. Through focus groups, SAN learned that many members of the South Asian community did not know that South Asian tobacco products, such as bidis, paan, gutka, and zarda, are subject to regulations in the STAKE Act just like cigarettes. To increase knowledge on how to be compliant, fieldworkers distributed multilingual information kits that explained the provisions of the law and how it also regulates access to South Asian tobacco products. After the intervention, SAN found that both knowledge and

compliance with the law among South Asian merchants increased (Chhetry et al., 2008).

CONCLUSION

Tobacco-related disparities in Asian American, Native Hawaiian, and Pacific Islander communities are as multifaceted and nuanced as the communities that are affected by them. In order to successfully reduce disparities for AA and NHPI communities, there is a major need for comprehensive, culturally specific tobacco control efforts. This includes ensuring that the scope and complexity of tobacco use and tobacco-related health disparities in individual AA and NHPI subgroups are fully understood and continually monitored. Further, the community—including low income community members, youth, and those not fluent in English—must have parity in access to resources and the capacity to engage in tobacco control and to support policy change at different levels within the tobacco control movement.





TOBACCO CONTROL POLICY RECOMMENDATIONS TO ADDRESS TOBACCO-RELATED DISPARITIES IN AA AND NHPI COMMUNITIES

In June 2011, APPEAL unveiled a set of policy recommendations for federal, state and local partners on AA and NHPI tobacco control and other critical health issues. The following page contains selected tobacco-specific recommendations.

The goal of these recommendations is to provide a framework for what policymakers can do to prevent and reduce the use of tobacco and exposure to environmental tobacco smoke among the diverse Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) communities through a comprehensive, coordinated, culturally-tailored and community-effective approach to tobacco control.

Research and Data

1. Fund and conduct surveillance studies to monitor tobacco use for AA and NHPI population groups, including local and regional surveys or underrepresented (“hardly-reached”) groups
2. Use appropriate strategies to collect and represent AA and NHPI data including: disaggregating data by ethnicity and gender, using in-language methods, and appropriate sampling methods
3. Include AA and NHPI populations with other priority population groups when examining the effects of key and emerging tobacco control issues, such as: menthol and novel tobacco products, light and intermittent smoking, genetics of tobacco addiction, and tobacco industry marketing

Capacity Building (Infrastructure)

1. Provide continued funding for community-based leadership development of AA and NHPI tobacco control leaders
2. Develop and support the replication of model (promising and proven practices) tobacco control programs and policies for AA and NHPI communities including those focused on youth (ages 12-17) and young adults (18-25)

Mobilizing Youth against Tobacco Industry Targeting

1. Increase the representation of AA and NHPIs youth on key planning, advisory and decision-making bodies in state health departments, voluntary health associations and national tobacco control organizations
2. Fund programs that educate AA and NHPI communities about “new” tobacco products and other products such as menthol

Community Policy: Comprehensive Smoke-free Air

1. Develop policy change initiatives within AA and NHPI communities on tobacco (e.g. multi-unit housing smoke-free policies and community norm change activities) as well as initiatives that assist AA and NHPI blue collar service industry workers to promote clean indoor air
2. Fund sustainability programs that assist AA and NHPI small merchants and restaurant owners to comply with current smoking ordinances and legislation

Community Policy: Cessation

1. Increase access to free language-appropriate and culturally competent cessation services to anyone who needs it regardless of insurance status and offer counseling in languages other than English and Spanish
2. Help make cessation a regular part of health care by encouraging health care systems to:
 - a) Institutionalize cessation via adoption of the 2A's & R (Ask, Advise, Refer) of cessation
 - b) Support the Joint Commission on Accreditation for Health Care Organization's cessation measures
 - c) Advocate for Electronic Health Records to include cessation

Mainstream Institution Policy: Advance Parity for AA and NHPI Issues in the Tobacco Control Movement

1. Equalize media/promotional dollars on the federal and state levels to educate all communities (including AAs and NHPIs and other communities of color) about tobacco prevention and cessation that is language specific and culturally competent (i.e. FDA cigarette pack warnings)
2. Fund studies to measure readiness levels of national and state organizations to work with priority populations

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ABOUT APPEAL

Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL), founded in 1994, is a national organization working towards social justice and a tobacco-free Asian American, Native Hawaiian and Pacific Islander community. APPEAL's mission is to champion social justice and achieve parity and empowerment for Asian Americans, Native Hawaiians and other Pacific Islanders by supporting and mobilizing community-led movements through advocacy and leadership development on critical public health issues.

For information on how you can learn more and get involved, join the APPEAL PROMISE Network at: www.appealforcommunities.org/appealpromisetwork