Tobacco Use in Minnesota:
Perspectives from Cambodian, Hmong, Laotian, and Vietnamese Communities

APT-FCM
Asian Pacific Tobacco-Free Coalition of Minnesota

BlueCross BlueShield of Minnesota
An Independent Licensee of the Blue Cross and Blue Shield Association

MPAAAT
Minnesota Partnership for Action Against Tobacco

SEARCH
Southeast Asian Refugee Community Home
Tobacco Use in Minnesota: Perspectives from Cambodian, Hmong, Laotian, and Vietnamese Communities

Results from the Qualitative Research Component of the Diverse Racial Ethnic Groups and Nations (DREGAN) Project

A Participatory Research and Action Project

March 2006

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The aim of the Diverse Racial Ethnic Groups and Nations (DREGAN) project is to work with Minnesota’s Cambodian, Hmong, Laotian, and Vietnamese communities to reduce the harm caused by tobacco in those and other ethnic and minority communities. The DREGAN project collaboration involves each of those communities, as represented by the Asian Pacific Tobacco-Free Coalition (APT-FCM) and Southeast Asian Refugee Community Home (SEARCH), plus Blue Cross and Blue Shield of Minnesota (Blue Cross) and the Minnesota Partnership for Action Against Tobacco (MPAAT). The project is funded jointly by Blue Cross and MPAAT. The DREGAN project has three components: qualitative research, to better understand the unique cultural characteristics of tobacco use in each community; quantitative research, to determine the prevalence of tobacco use and other health risk behaviors; and pilot intervention projects designed to test innovative programs to reduce tobacco use in these communities.

This report presents results of the qualitative research portion of the project. The report has two basic goals. Our first goal is to reflect back to Minnesota’s Southeast Asian communities an accurate picture of the beliefs and attitudes surrounding tobacco use among them. This complex and multidimensional picture was culled from extensive, semi-structured interviews with a broad cross section of formal and informal leaders in Minnesota’s Southeast Asian communities. Through ongoing collaboration with the Southeast Asian communities, we attempt to avoid stereotyping, to accurately portray the diversity as well as the commonalities that exist among Southeast Asians in Minnesota, and to focus on the communities’ assets as well as their vulnerabilities.

Our second goal is to help the general community to understand the unique cultural characteristics that influence tobacco use in Minnesota’s growing Southeast Asian communities. To accomplish that goal, this report includes some general background on the four major Southeast Asian communities in Minnesota and describes relevant aspects of Southeast Asian culture for those who are less familiar with it. By providing the opportunity for Southeast Asian leaders to share their insights and stories in their own words, we also hope to help people in the general population to better understand the problem of tobacco use from the perspective of Southeast Asians.

We hope that this report will have immediate applicability for Southeast Asians and non-Southeast Asians alike who are engaged in reducing tobacco use. This report contains insights that can empower leaders and policy makers to act now to reduce tobacco use in these Southeast Asian communities. But this report is only a beginning. The fruitful collaboration that led to this report will continue to build on these insights.

We are grateful to the many community leaders who took time to share their perspectives and understanding of their community, and to the community members who participated in this research as interviewers and colleagues. This rich portrait of beliefs and behaviors about smoking and tobacco use within Minnesota’s diverse Southeast Asian communities would not exist without the willingness of those many individuals to share their insights and experiences.

Sincerely,

The DREGAN Project Team
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1. Tobacco use threatens the health of Minnesota’s diverse Southeast Asian communities.

As the leading cause of preventable death in the United States, tobacco use poses a serious threat to the health of Minnesota’s growing Southeast Asian population. Over 5,600 adult deaths in Minnesota are smoking related, and smokers shorten their lives by an average of 12.7 years. The U.S. Surgeon General has identified smoking as a cause of ten types of cancer, four cardiovascular diseases, several respiratory diseases, reproductive complications, and other effects, such as cataracts, low bone density, and general diminished health status. Lung cancer is the leading cause of cancer death among Southeast Asian men, and they have higher rates of lung cancer death than whites. Nonsmokers suffer as well; secondhand smoke causes death in nonsmokers due to lung cancer and coronary disease, as well as increasing children’s risk for middle-ear infections, asthma, bronchitis, and Sudden Infant Death Syndrome. Moreover, smoking was responsible for $1.98 billion in excess medical care expenditures in Minnesota in 2002.

2. What is the participatory research and action component of the DREGAN project?

The goal of this portion of the Diverse Racial Ethnic Groups and Nations (DREGAN) project was to understand and then share the complex meaning that tobacco has in the Cambodian, Hmong, Laotian, and Vietnamese communities. Beginning in 2002, researchers from the Asian Pacific Tobacco-Free Coalition of Minnesota (APT-FCM), Southeast Asian Refugee Community Home (SEARCH), the Minnesota Partnership for Action Against Tobacco (MPAAT), and the Center for Prevention at Blue Cross and Blue Shield of Minnesota (Blue Cross) worked collaboratively with the DREGAN Southeast Asian Community Advisory Committee, a committee of representatives from several local research and advocacy organizations. This group worked together to produce the qualitative interview study that is the focus of this report. In addition, this group continues to collaborate and is working on a subsequent quantitative survey to assess the prevalence of smoking and on field programs to reduce the harm of tobacco within these communities.

The DREGAN project used a community-based participatory research (CBPR) approach, a “collaborative approach to research that equitably involves . . . community members, organizational representatives,
and researchers in all aspects of the research process.” This approach starts with the premise that community members most affected by health disparities need to participate in the design and conduct of the research process so that the process generates results that are meaningful and relevant to the community. The principles of CBPR include:

- recognizing communities as units of identity,
- building upon the strengths of communities,
- encouraging collaboration,
- maintaining equitable working relationships through every step of the research process,
- disseminating findings to all partners, and
- creating a long-term commitment among all partners.\(^{11}\)

The DREGAN Project began with a qualitative research project to better understand the unique cultural characteristics of tobacco use in Southeast Asian communities. The primary objectives of the qualitative study were to understand:

- the social context and cultural meaning of tobacco use in the Cambodian, Hmong, Laotian, and Vietnamese communities;
- the social and cultural barriers to smoking prevention and cessation; and
- the community assets upon which tobacco reduction efforts could build.

This project is particularly important since most existing research on smoking among Southeast Asians tends to treat “Asians” and “Pacific Islanders” as a homogenous group rather than separately examining self-defined communities.

3. Why is it important to study tobacco use among different Southeast Asian communities?

Although Minnesota’s Southeast Asian communities have much in common with Minnesotans in the general population, they also have different vulnerabilities to tobacco use and different barriers to quitting smoking.

Cambodians, Hmong, Laotians, and Vietnamese come from countries where rates of smoking for men are much higher than in the United States. International surveillance data show very high rates of smoking among men in Vietnam, Laos, and Cambodia.\(^{12}\) (See Table 1.)

High rates of smoking have been observed in some immigrant communities of Southeast Asians in America. United States national and local data, while limited, similarly show higher rates of smoking among men of Cambodian, Laotian, and Vietnamese ancestry, relative to United States–born white men.\(^{13,14}\) Recent surveys of Cambodian and Vietnamese communities, conducted as part of the Racial and Ethnic Approaches to Community Health (REACH)\(^{15}\) study funded by the Centers for Disease Control and Prevention, estimated rates of smoking that were much higher than the estimated national aggregate of “Asians and Pacific Islanders” found in the Behavioral Risk Factor Surveillance System (BRFSS).\(^{16}\) In the REACH study, the Vietnamese data include telephone surveys conducted mostly in Vietnamese during 2001 and 2002 in Los Angeles, Orange, and Santa Clara Counties, California. The Cambodian data reflect in-person interviews conducted mostly in Khmer during 2001 and 2002 in Lowell, Massachusetts. Many community members believe that surveys such as these, conducted face-to-face and/or using native languages, are more likely to produce accurate, and substantially higher, prevalence rates for recent immigrant groups. (See Table 2.)

### Table 1.

<table>
<thead>
<tr>
<th>Adult Smoking Rates (%) in Southeast Asian Nations</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnam (1995)*</td>
<td>72.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Laos (1995)**</td>
<td>41.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Cambodia (1999)**</td>
<td>66.7</td>
<td>10.0</td>
</tr>
</tbody>
</table>

*19–92 years  
**15 years and older  
Tobacco Control Country Profiles 2003\(^{12}\)

### Table 2.

<table>
<thead>
<tr>
<th>Adult Smoking Rates (%) in the United States</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodians (Lowell, MA)*</td>
<td>50.4</td>
<td>10.9</td>
</tr>
<tr>
<td>Vietnamese (L.A., Orange, Santa Clara Co., CA)*</td>
<td>30.4</td>
<td>0.9</td>
</tr>
<tr>
<td>Asians and Pacific Islanders (national aggregate)**</td>
<td>14.7</td>
<td>7.3</td>
</tr>
<tr>
<td>United States general population**</td>
<td>24.9</td>
<td>20.4</td>
</tr>
</tbody>
</table>

*Racial and Ethnic Approaches to Community Health (REACH)\(^{15}\)  
**2002 BRFSS data\(^{16}\)
At this time, valid prevalence rates of smoking among Southeast Asians in Minnesota do not exist. This qualitative research provides important insights to help design a future face-to-face quantitative survey that will be conducted to determine smoking prevalence in Minnesota’s Cambodian, Hmong, Laotian, and Vietnamese communities.

Southeast Asians in the United States may experience different risk factors for smoking.

- Among new immigrants, those with more education and higher social status may be more likely to smoke, unlike the general American population.\(^\text{15}\)
- Acculturation (or the process of becoming “Americanized”) can lead to more smoking among Southeast Asian women and youth.\(^\text{13, 17–21}\)
- Trauma experienced by Southeast Asian refugees due to war, forced labor, loss of country, property, and loved ones; and resettlement may put them at risk for post-traumatic stress disorder and depression,\(^\text{22–25}\) which has been linked to smoking in other populations.\(^\text{26–29}\) These psychological problems may also make it more difficult for these smokers to quit.

Health care disparities may make quitting more difficult. Minnesota’s Southeast Asian refugee and immigrant populations are less likely than whites to receive adequate health care and to be aware of available services. Nationally, Asian Americans and Pacific Islanders are least likely to visit a physician compared with other ethnic groups\(^\text{30–32}\) and least likely to receive physician advice to quit smoking during their visits.\(^\text{33}\)

Language barriers may impede health promotion and smoking cessation. Many public health campaigns about the dangers of smoking do not reach the majority of Southeast Asians who are not fluent in English. Southeast Asians often do not have access to counselors and health care professionals who speak their languages, face a lack of appropriate interpreter services, and often have particular difficulties navigating the American health care system.\(^\text{34,35}\)

Southeast Asians may have different norms regarding tobacco use, different beliefs about the causes of health and illness, and often have less knowledge about tobacco’s health risks. Smoking is an individual act, but always one that occurs in a specific social and cultural context. Smoking may have similar impacts on the bodies of all smokers, but its meaning to the smoker and those around him or her may be very different. Smoking may mean very different things to an elderly Vietnamese man who has been smoking since early adulthood and who comes from a country where the majority of men smoke than it does to a young Hmong woman who smokes in secret, and whose family may feel disgraced if they find out that she smokes. When tobacco-control advocates talk about the need for “culturally
appropriate” ways to help smokers quit, they refer to these differences in meaning. But determining these cultural differences is difficult because it requires a basic understanding of the norms and cultures of immigrant communities, both in their homeland and in the United States.

For instance, due to different religious and cultural traditions among Southeast Asian groups, there may be different attitudes about the suffering and illness caused by tobacco. Some may see disease as inevitable and unavoidable. Some Hmong, for example, place great emphasis on fate, and may consider life-saving health care ineffective because the length of one’s life is predetermined. A cultural value on stoicism and a history of distrust of Western medicine also may lead people to avoid seeking health care.

In addition, studies have shown that Southeast Asians in the United States have less awareness of the health consequences of smoking compared with the general population, which has been exposed to decades of public health campaigns and Surgeon General warnings emphasizing the dangers of smoking.

Different cultural norms and communication styles mean that standard prevention and cessation strategies may not be effective in these communities. Public health messages are most effective when they are tailored to the key motivations, values, and levels of knowledge within the community. Specially tailored messages may be particularly important for Southeast Asian refugees and immigrants, whose values and motivations may differ from those of many Americans.

The tobacco industry disproportionately targets Asian Americas and Pacific Islanders, both in the United States and in their countries of origin. Moreover, recent Southeast Asian immigrants may be particularly vulnerable to such marketing efforts because they know less about the dangers of smoking.

The tobacco companies explicitly target nonwhite communities.

Recent research has documented many ways in which the tobacco industry strategically targets nonwhite communities. The 1998 Surgeon General's report, Tobacco Use Among U.S. Racial/Ethnic Minority Groups, describes how tobacco companies historically have curried favor with racial/ethnic communities by providing financial support to cultural, political, and educational institutions, and social services and civil rights organizations.

Tobacco products are among the most-advertised products in the United States. Tobacco industry advertising and promotion encourage smoking initiation, particularly among youth. Advertising leads people to believe that smoking is “a socially acceptable, safe behavior and may produce new perceptions about the functions of cigarette smoking in social situations,” all of which increase the risk of starting to smoke.

An increasing amount of advertising is targeted to nonwhites, particularly youth and women. According to the Surgeon General’s report, “Targeted tobacco advertising presents images of success, wealth, happiness, and sophistication, all of which are attractive to racial/ethnic groups, perhaps particularly in contrast with other, less flattering images of those communities presented by the news media.”

In examining the effect of acculturation on the increase in smoking among segments of Minnesota’s Southeast Asian communities, it is important to consider the impact of the tobacco industry’s strategic targeting of Asian American and Pacific Islander (AAPI) communities, including marketing strategies designed to capitalize upon particular community attributes. These attributes include high rates of smoking in Asia, a strong desire to become a part of American culture, and a strong focus on the family and community.

For example, an RJ Reynolds study concludes that AAPIs’ desire to succeed in America and “effectively assimilate into U.S. culture/lifestyles” will lead to a “high level of identification with these products and symbols which they view as ‘American.’ Importantly, this identification leads to . . . brand loyalty.” The study went on to recommend that “actions should be taken to ensure that RJR is the first tobacco company to specifically target this group” and recommended that strategies build on the AAPIs’ strong sense of community identification by using Asian models and sponsoring AAPI events, such as “golf, motor sports, music, film, dance, and gambling.”

Documents also reveals that the tobacco industry also targeted specific groups of AAPIs who are vulnerable to smoking, such as youth and women, and advised marketers to, “investigate the possibility of utilizing men and women and targeting youth in advertising strategies . . . The literature suggests that Asian-American women are smoking more as they believe that they should enjoy the same freedom as men.” Awareness of these well-researched strategies underscores the need for equally sophisticated tobacco-control initiatives to counter such efforts.
Southeast Asian communities also possess unique strengths that are not common in the general population, which tobacco prevention and cessation efforts can leverage.

Most Southeast Asian communities strongly emphasize the needs of the family relative to the individual. For instance, Asians tend to be more likely to consult with and consider the impact of their decisions on the entire family, compared with members of the general population. This cultural value may underlie findings showing that Asian Americans are more likely to have smoke-free homes than white Americans and that Asian-American smokers are more likely than white smokers to want to quit to keep their children from being exposed to smoking.

Asian-American parents also have been shown to have more influence over their children than white parents. This parental influence contributes to lower smoking rates among Asian-American youth relative to whites, although it diminishes with acculturation of the children. Parental influence also wanes in some families in which children take on the role of translators for their non-English-speaking parents, reducing the capacity of the family to be a shield against the influence of the larger society.

Traditionally, Southeast Asian societies place high value on behaving properly so as not to hurt the reputation of one’s family, including one’s ancestors. This cultural emphasis on appropriate behavior can be a powerful asset upon which smoking-prevention and cessation programs can build.

Other cultural values also have the potential to aid tobacco-control efforts. For example, Buddhists emphasize avoiding addictive and harmful substances and refraining from hurting others.

Presently there is a lack of knowledge about how to develop culturally sensitive tobacco-control strategies for Minnesota’s Southeast Asian communities.

Published research in this area is scant: A recent review found only two published studies on tobacco-cessation research that targeted any Asian American or Pacific Islander population. Many of Minnesota’s health care and tobacco-control advocates and professionals have limited knowledge of the cultural issues surrounding tobacco use in these communities.
4. How this study was designed and conducted.

A multidisciplinary team of researchers designed and conducted this study. (See “Collaborating Organizations,” page 43.) Members of all four communities served as project advisors, interviewers, interviewees, and as key members of the research team. These community members actively participated in every phase of the research process, from development of the interview protocol, to the analysis of the results, to the preparation of this report. By working closely with community partners, the DREGAN project was able to gain momentum within each community and develop good working relationships.

Design of the study.

Bilingual community members received training and conducted face-to-face interviews with sixty formal and informal community leaders. They were interviewed in person in English or in their native language by the interviewers, who established rapport with their interviewees and then used a semi-structured interview guide to conduct the interviews. The interviewers were coached and encouraged to probe for explanations, interpretations, and deeper meanings. The interviews typically lasted ninety minutes. Due to the skill and persistence of the interviewers, these leaders provided a rich window into the social context and cultural meaning of tobacco use in their communities. After the interview, each person filled out a brief demographic survey and received a nominal gift for his or her participation.*

Selection of interviewees.

The Advisory Committee identified twenty-eight women and thirty-two men (eight men and seven women each from the Cambodian, Hmong, Laotian, and Vietnamese communities), based on their leadership in the community. Some of the leaders, particularly among the women interviewed, were informal leaders, widely recognized but lacking formal community leadership roles. These leaders included many elders and some younger leaders from each community, and were selected because they were believed to know their communities well and to have cultural expertise of some kind. As a group, they had lived in the United States from six to twenty-eight years, on average for eighteen years. Their ages ranged from twenty to sixty-eight, with an average age of forty-six. Of the sixty community leaders interviewed, seventeen were former smokers, three were current smokers, and thirty-six had never smoked. Forty-seven were interviewed in their native languages.

Data analysis.

A seven-member community research team analyzed the data collected through the interviews.** Findings from interviews with four interviewees are not included in this initial report. First, all of the interviews were transcribed and, where needed, translated into English and reviewed by another bilingual researcher to assure the accuracy of the translation. Transcripts of the interviews were then coded into topic documents, in which quotations were classified according to a coding scheme that captured the key topics discussed in the interviews (e.g., effects of smoking on the body, social norms for smoking, etc.). These quotations were tagged with codes that indicated gender, country of origin, smoking status, level of English-language proficiency, and the interviewee’s role in the community. Names and other identifying information were deleted to assure the confidentiality of each interviewee.

A snapshot of our “key informants”

The insights of this report come from interviews with men and women who were chosen because they were informal or formal leaders in their communities and, as a group, could offer expert insights into their communities. Interviewees included teachers, social workers, substance abuse counselors, an employment counselor, heads of community organizations, students, volunteers, and retirees who play active roles in community activities. From the Cambodian community, interviewees included Christian and Buddhist spiritual leaders. Interviewees from the Vietnamese community included a former journalist in his sixties, a twenty-year-old student, several highly educated women who worked as engineers and scientists, and a female factory worker who persuaded her husband and children to quit smoking. Hmong interviewees included clan leaders, a housewife in her late forties, and a young woman who works in a youth tobacco program. Among the Laotian interviewees were a former military officer, a woman in her late fifties who holds a leadership position in one of the local Lao organizations, and a young woman who works with the Lao Women Association. Some interviewees are former smokers; others have been unable to quit. Some interviewees—usually women—described how they convinced family members to quit smoking.

* The study design was reviewed and approved in advance by an institutional review board (IRB).
** Findings from interviews with four interviewees are not included in this initial report.
The research team then worked to generate key findings based upon the topic documents. Working together, researchers identified major themes in each topic document, supported by interviewee quotations. Further analysis sought to interpret and place these themes into cultural and social context, relying on the intimate knowledge of the Southeast Asian team participants and the social-scientific expertise of other team members. The team sought to retain the diversity of experiences, opinions, and ideas that were expressed, in order to avoid oversimplifying the complex reality that was presented in the interviews and to avoid stereotyping. The team also sought to identify differences by subgroup, such as gender and language proficiency. The research team held three meetings with the interviewers to validate and further interpret the major findings. The interviewers agreed with all of the key findings but identified some important nuances and offered additional information that was incorporated into the theme documents.

The research team also conducted a literature review on tobacco and Asians/Asian Americans and on various topics pertaining to Asian Americans, including health care and health beliefs. These findings provided reference and further context for conclusions, and in certain cases allowed the team to assess the similarities and differences between this and other studies.

Limitations of this study.

By design, the interviewees were not selected randomly to represent their communities. Instead, the persons interviewed were recognized leaders who were believed to have extensive involvement in and knowledge of their respective communities. Interviews sought to capitalize on the unique social and cultural knowledge of the interviewees in order to learn as much as possible about their cultures, and the role of smoking in their communities. Further, the small numbers interviewed within the four communities limited the research team’s ability to draw some conclusions about different subgroups. However, enough interviews were conducted that the research team found convergence on all of the key themes identified in the research. Because of this design, this study cannot be used to estimate the rate of smoking among members of these communities. Future large-scale community-wide surveys will document the range and distribution of tobacco-related attitudes and behaviors across a broader cross section of the community.

5. How this report is organized.

The findings from this study are organized into four sections as described below.

Part I: Stories about Tobacco in the Homeland

The report first explores how tobacco was used and regarded in the homelands of these community members in order to provide a context for understanding present-day beliefs and norms about tobacco use in Minnesota.

Part II: The Effects of Acculturation on Tobacco Use

Next, the report explores the often dramatic “culture clash” regarding the meaning and use of tobacco experienced by Southeast Asian immigrants as they confronted new knowledge, beliefs, and formal and informal norms about tobacco use in the United States. As immigrants and their children experience the process of acculturation—moving back and forth between the culture of their homeland and the new cultures of Minnesota and the United States, adopting and rejecting aspects of both—how does this affect their beliefs, norms, and behaviors related to smoking? The report also examines how the experience of acculturation might lead to greater or lesser vulnerability to the harm of
tobacco for different subgroups within the community, such as youth, women, men, and the elderly.

**Part III. The Association Between Acculturation and Quitting Smoking**

In this section, interviewees directly describe the cultural barriers that may hinder smoking-cessation efforts. They also share their insights into the factors necessary for such efforts to be successful in their communities.

**Part IV. Creating Culturally Competent Tobacco Control Programs**

This final section offers implications of these findings for tobacco-control efforts. The report presents a framework for understanding the types of interventions that might most effectively target different segments of Southeast Asian communities based upon age, gender, and level of acculturation. It also describes specific strategies for building on the cultural assets and norms of Southeast Asians. Finally, the report discusses changes—from within and outside of these communities—that would decrease the harm of tobacco to these communities.

### 6. Background on Minnesota’s diverse Southeast Asian communities.

Twenty-five years after the war in Vietnam ended, Census 2000 counted about 1.8 million persons of Cambodian, Hmong, Laotian, and Vietnamese ancestry residing in the United States. These Southeast Asians, representing many refugees from that war and subsequent immigrants, have established some large communities throughout the country through internal migration. Minnesota had about 84,000 residents identifying themselves in these groups, according to Census 2000. The following table shows their distribution. (See Table 3.) This section, which is derived from secondary sources and not from the interviews, offers a brief introduction to each of these communities.

<table>
<thead>
<tr>
<th>Southeast Asians in Minnesota and the United States</th>
<th>Minnesota</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodians</td>
<td>6,533</td>
<td>206,052</td>
</tr>
<tr>
<td>Hmong</td>
<td>45,443</td>
<td>186,310</td>
</tr>
<tr>
<td>Laotian</td>
<td>11,516</td>
<td>198,203</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>20,570</td>
<td>1,223,736</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84,062</strong></td>
<td><strong>1,814,301</strong></td>
</tr>
</tbody>
</table>

Source: United States Census Bureau, 2000 Census, using race/ethnicity alone or in any combination.

**Vietnamese-Americans.**

Vietnamese Americans came to the United States in four waves. The first group of Vietnamese refugees fled American-supported South Vietnam in 1975 after the fall of Saigon (now Ho Chi Minh City). Most were government officials, military officers, scholars, and other people of means and influence—typically people who lived along the seashore of Vietnam. These refugees most often came with their families. After 1975, a second wave of Vietnamese refugees (sometimes known as “boat people” because many escaped on small boats) were resettled in the United States. Then in the 1980s, the United States instituted the Orderly Departure Program (ODP), which brought many political prisoners and their families, Amerasians (children of both American and Vietnamese parentage), and sponsored immigrants who were allowed to leave Vietnam. Many of these immigrants were relatives of people who had come to the United States previously. Finally, the Humanity Orderly (HO) program began in 1990, and brought political prisoners who spent at least three years in “re-education camps.” Approximately one-third of Vietnamese-Americans immigrated to the United States only during the last decade. In comparison with the earlier waves, these recent immigrants tend to be less educated and more economically disadvantaged.

**Khmer- (Cambodian) Americans.**

In 1969, the United States began a heavy bombing campaign on the fertile rice fields of Cambodia in an attempt to fight the North Vietnamese army. Many farmers and peasants were killed, and those who survived fled to the cities. In 1975, the Khmer Rouge took control of the country and undertook a radical “utopian” revolution that involved dismantling institutions and persecuting those with even modest socioeconomic status. All inhabitants of the capital, Phnom Penh, were forced to move to the countryside. Between 1975 and 1979, more than one million people were executed, were worked to death on “collectives,” or died from illnesses or starvation. Those who survived the “killing fields” of the Khmer Rouge reign tended to be from rural backgrounds and had little formal education. In 1978, the Khmer Rouge was toppled by the
Vietnamese army. Many Khmer people fled once again, this time escaping to refugee camps in Thailand, where they spent months or years. Most were finally relocated in the United States.

**Laotian-Americans.**

Laos is a landlocked country bordered by China, Vietnam, Thailand, and Cambodia. Laos has been home to the “lowland Lao,” as well as some seventy ethnic minority groups. The highland groups of the Hmong, Mien, and Karen are best known. The Lao are ethnically and culturally distinct from each of the ethnic groups, and each of these ethnic groups is distinct from the others. After the start of the war in Vietnam, Laos became a refuge for North Vietnamese soldiers and was subsequently bombed in a secret campaign conducted by the United States. Between 1964 and 1972, approximately 2.1 million tons of bombs were dropped on Laos, thus making it one of the major battlegrounds in the Indochinese conflict.

Laotian-Americans emigrated from what was the Kingdom of Laos, which became the People’s Democratic Republic of Laos after the takeover by the Communists in 1975. Many Laotians fled across the Mekong River to Thailand, where they were held, often for years, in refugee camps. Eventually, these refugees were resettled in the United States.

**Hmong-Americans.**

The Hmong are an ethnic group that migrated to the highland regions of Laos, Thailand, and Northern Vietnam from China in the nineteenth and early twentieth centuries. The Hmong were relatively isolated from the rest of the world in the rough terrain of the mountains. They survived as a nomadic hill tribe for generations through shifting cultivation, raising livestock, and gathering food in the forest. Their existence changed dramatically during the war in Vietnam, when they came into contact with soldiers and, through them, with the international community. In Laos, the United States gained Hmong support in exchange for protecting them from their local enemies. Many Hmong fought the Communist insurgents on behalf of the United States.

With the overthrow of the Laotian government, many Hmong fled, along with other Laotians, to Thailand. Through this dangerous journey, it is estimated that over one-third of the Hmong lost their lives due to starvation, disease, land mines, chemical defoliants including Agent Orange, and drowning. Because the Hmong offered support to the United States during the war in Vietnam, after the war a few Hmong were able to go to the United States or France directly. Most Hmong, however, spent anywhere from two to fourteen years in refugee camps in Thailand before being resettled. Minnesota’s Hmong community is one of the largest in the United States, and it welcomed thousands of new refugees from the Thai refugee camps in 2004.
Since most Southeast Asians in Minnesota are refugees and immigrants, it is important to understand tobacco use in their homelands. What do members of the Cambodian, Hmong, Laotian, and Vietnamese communities remember about the acceptability of smoking in their homelands, the role of tobacco, and the social restrictions that governed its use? The stories told by the interviewees reflect their memories of life in the homeland, which may date back several decades. The purpose of hearing these stories was not to learn about smoking in present day Vietnam, Laos, or Cambodia. Rather, the intent was to better understand the cultural meanings of tobacco that these immigrants brought with them to the United States.

The interviewees’ views about tobacco use in Southeast Asia were varied, as they are about this subject in the United States. This variety makes it difficult, if not impossible, to characterize one “Southeast Asian view” of tobacco. That realization underscores the need for ongoing, in-depth study of the multiplicity of attitudes, knowledge, and behavior about tobacco in Southeast Asian immigrant and refugee communities, as well as in their homelands, insofar as it affects people’s experiences once they arrive in the United States.

Did the communities differ on tobacco use? Data analysis initially looked at the findings of each community separately, then across the four communities. Comparing findings across communities revealed many similarities in the role tobacco played in the homeland. For example, in all four communities, tobacco was a valuable—in fact, a prestige—product in the homeland, and was used in various rituals and for healing. However, there was a strong distinction between the ways in which the Hmong viewed regular smoking relative to the other three groups. Daily smoking was commonplace and socially acceptable for Cambodian, Laotian, and Vietnamese men. In contrast, the Hmong traditionally disapproved of regular smoking, except for the elderly and clan leaders. This finding is consistent with research showing that Hmong refugees in Thailand were less likely to use tobacco than Southeast Asian refugees from other countries. The report presents the commonalities shared by the four groups, as well as those basic findings that differentiate the Hmong. Other, more subtle differences between the four groups will be explored in future academic publications.
1. Tobacco was integral to the homeland culture of the Cambodians, Laotians, and Vietnamese.

In Cambodia, cigarettes were offered to guests during their coming to visit, during celebrations of merit-making, and celebration of food offerings to Buddhist monks. Cigarettes were usually put in a nice tray to offer. During a meeting for government employees or officials of any sector, cigarettes were offered as part of protocol. I participated in several meetings of the provincial department heads. They always had cigarettes as part of protocol. Cambodian officials smoked in front of the public. For example, in Kep [a Cambodian city on the coastline], I participated in a meeting with the governor of the city. He and other officials smoked 555 [a brand of cigarettes].

– Cambodian man in his 60s, in the United States for 28 years

Leaders in the Cambodian, Laotian, and Vietnamese communities told stories about how tobacco was highly valued in the homeland and was an integral part of the culture. As an object of value, tobacco was used to signify the social status of the smoker. Tobacco also played an important role in ceremonies and religious rituals, in maintaining social relationships, and in healing the sick. Although considerably less acceptable traditionally among the Hmong in daily social situations and for personal use, tobacco did have a ceremonial and medicinal role.

For Cambodian, Laotian, and Vietnamese men, regular smoking was common and acceptable.

As in many parts of the world, smoking tobacco was and remains common and acceptable for Cambodian, Laotian, and Vietnamese men. For instance, a Laotian man, himself a former smoker, talked about how widespread smoking was for men:

Most of the people smoked when they reached the grown-up age. I am not sure if that was an approval to smoke or not but that seemed to be what happened. Our parents smoked. The elders rolled the tobacco and brought it to the temple to give to the Buddhist monks because it was part of our culture. It was a normal thing to do in Laos.

– Laotian man in his 60s, in the United States for 12 years

Similarly, according to a former smoker from Vietnam,

Cigarette smoking is a very common thing, very normal thing for the Vietnamese people. People do not get any bad reputation about their smoking. Who would say anything? People have their right to smoke.

– Vietnamese man in his 30s, in the United States for 20 years

Smoking was widely associated with manhood. A Laotian male smoker believed that “98% of them would smoke just to avoid being judged as real men or not, and just to be in crowds or feel like they belonged.”

A Cambodian elder agreed, recalling,

Through my knowledge, when I was a single youth, if you didn’t know how to smoke or drink, you were not a man. So if we wanted to join a group, a meeting, we needed to know how to smoke and to drink, you see.

– Cambodian man in his 50s, in the United States for 21 years

Another Cambodian man pointed out that there were contradictory messages about smoking and masculinity. This man agreed that men associated smoking and masculinity. But, as he put it, “a man doesn’t show a girl that he loves cigarettes” because he would not want to communicate that he loves cigarettes more than her.

Tobacco was used to maintain social relationships.

Widespread practices of sharing valuable tobacco or cigarettes illustrate how tobacco was used to maintain social relationships in Southeast Asian cultures. As a Cambodian leader related, in the homeland tobacco was “about guests greeting, making a connection, building a relationship, offering to each other, which are good activities.” A Laotian man recalled that smoking tobacco was integrally connected with social gatherings:

When there was a festival or a time when you went to the temple or in someone’s house after the meal, in our culture older people would gather and start to smoke tobacco. Getting together [and] then smoking [was] the happiest time they would have. It symbolized the unity of the people when you visited other people.

– Laotian man in his 40s, in the United States for 12 years
The importance of sharing tobacco with friends, guests, and business associates attests to the premium put on harmonious social relationships and on the importance of being polite and showing respect. A sixty-year-old woman recalled helping her mother carefully arrange a bamboo tray with betel nuts and tobacco leaves for her grandfather during her childhood in Vietnam. This memory illustrates not only the importance of honoring one's elders but also the cultural importance of tobacco.

**Tobacco signified the social status of the smoker.**

Interviewees recalled that machine-rolled cigarettes, particularly those with filters, were expensive consumer items in Southeast Asian countries. Imported cigarettes, especially American brands, were luxury items. Leaders from all four communities described how expensive cigarettes sent a message about the smoker's wealth and social status. A Cambodian interviewee explained that, because of their high value, “cigarettes became a product that could give a different status to its user.”

A Laotian former smoker recalled that a box of factory-produced cigarettes carried associations of money and prestige:

> Oh, the filter cigarettes in the box! We were a poor country and no one was wealthy [enough] to smoke a very good brand of cigarettes. When you smoked a cigarette with a filter, it made you look cool, smart, and people tended to like that kind of stuff. Mostly rich people had a chance to smoke cigarettes and to show other people.

— Laotian man in his 40s, in the United States for 12 years

One Cambodian man described in great detail how people showed off their smoking skills:

> When people were using the small pipes, they took very good care, made it very clean, which meant they wanted to show their skills of smoking. It was a custom or a way to show off to other people that they had experience with smoking more than other people. And I believe that the city people, sometimes, smoked from the pipes to show others their class or quality, that they had more skills of smoking than others.

— Cambodian man in his 40s, in the United States for 14 years

**Tobacco appeared frequently in ceremonies and rituals.**

Interviewees from all four groups provided examples of the use of tobacco during the engagement and wedding ceremony. For example, when preparing for a wedding in Cambodia, one would need to buy cartons of cigarettes to greet relatives and friends who helped organize the traditional ceremony in the house and to serve to guests at the evening banquet, following an elaborate cultural etiquette governing the precise nature of this transaction. In Vietnam, where one's family ancestors are worshiped and their blessings sought, cigarettes were often present on the altar, offered symbolically along with other valued items to please the ancestors. At Vietnamese weddings, often cigarettes were routinely offered to guests as favors both before and after the event. While not distributed to guests, cigarettes were often present at Laotian Buddhist and Confucian wedding ceremonies, as one type of offering to revered ancestors. A Laotian interviewee detailed the role of tobacco at a wedding:

> In a wedding, we only distributed cigarettes to everyone when we first arrived at the bride’s house. When distributed, it came in a pair, not singly. We distributed to all people that came to the bride’s house, such as aunts, uncles, brothers, sisters and so on. After passing cigarettes to everyone, then it’s appropriate for us to ask the bride’s family about the wedding. If you did not offer cigarettes to someone [it meant that] we disrespected that particular person. For example, if you offered everyone a pair of cigarettes and skipped anyone, such as a brother, uncle, or aunt, then you disrespected that person. The daughter's family would question, “Why didn’t you offer cigarettes to this particular person? Is there anything wrong?” Sometimes you would end up paying a fine before the family could begin the wedding.

— Laotian man in his 60s, in the United States for 23 years
Tobacco was used for medicine.

Much as in the United States and in Western Europe historically, the Cambodians, Hmong, Laotians, and Vietnamese believed that tobacco had medicinal properties. For example, tobacco leaves could be applied to a wound to stop the bleeding or applied to insect bites to stop the itching. Tobacco also was used to relieve headaches, stomachaches, arthritis, and toothaches; many people chewed a wad of tobacco and betel nuts to prevent tooth decay. In addition, some people recalled that native healers used tobacco to help cure the sick. As one Laotian interviewee told us,

Some people believed that ghost spirits make them sick. The priest would chew tobacco and spit at an ill person to help [the sickness] go away. Sometimes they used cigarettes for the offering to ghost spirits so that people would be left alone. Especially people who lived out in the rural area, they believed in [the] supernatural, and when a family member was sick they thought the offering would help make it go away. It depended on who believed in it because in our homeland we have many different cultures, but city people tended not to believe in the supernatural.

– Laotian man in his 60s, in the United States for 30 years

Beliefs about the medicinal properties of tobacco led many to value it highly. According to a Cambodian interviewee,

In the homeland, tobacco was associated with other herbs that had medicinal value. People saw only positive effects of that product: to cure loneliness, depression, lovesickness, and to produce a feeling of well-being. It was considered [an] herb having superior quality. That is the reason why it was one of the items used in cultural and ritual celebrations.

– Cambodian man in his 60s, in the United States for 30 years

However, smoking was restricted to adult men and generally was not acceptable for women and youth.

Interviewees also agreed that smoking was unacceptable for women in their homelands. Social norms did not allow women or girls to smoke because tobacco was considered a dirty product that did not fit their idealized image of purity and wisdom. With a few exceptions, most women who smoked were “looked down upon” and “thought of as indecent” and might even be shunned by good society. According to a male Cambodian leader,

If you were a female and smoked, that woman was not good. That was a city woman. And that was a woman who had no good occupation, you see. The woman who smoked . . . [was] a woman they don’t want to associate with. A hooker! The woman was . . . in a bad society.

– Cambodian man in his 50s, in the United States for 21 years

Another Cambodian interviewee elaborated on an exception to these rules, explaining that although “It is really taboo for women to smoke, for elderly women, it’s okay for them to chew betel nuts or chew tobacco.” Youth were not allowed to smoke, and some interviewees described efforts to distance smokers from children in order to discourage them from trying it. Interviewees recalled that smoking for youth was regarded as a very bad thing in the homeland. Youth who smoked were seen as being disrespectful to their parents, elders, and families. As a Vietnamese leader explained,

Whatever you said or did, in Vietnam, youth under eighteen years old were not encouraged to smoke. This was not really a legal rule, but it was an unwritten rule followed by people in general. So if people saw a youth smoking, they would perceive it as something bad, as a thorn poking in their eyes.

– Vietnamese man in his 30s, in the United States for 20 years

A Laotian woman interviewee expressed similar thoughts:

Smoking in my native land was considered a normal thing to do for adults or the man of the house. For young adults, they would be considered bad people. In order for it to be acceptable, young adults had to be at least twenty years or older; otherwise, parents had the right to punish them.

– Laotian woman in her 20s, in the United States for 14 years
Smoking became acceptable when a boy became a man, and starting to smoke was often considered a part of the rite of passage to manhood. For example, according to a Vietnamese former smoker,

*When a grown-up boy wanted to show that he was mature, he smoked . . . to show that he was a grown-up, that he no longer was a boy. And sometimes, they wanted to show [that] they fully lived their own life.*

— Vietnamese man in his 30s, in the United States for 20 years

In the homeland, tightly knit communities were able enforce these informal restrictions about who could smoke. Interviewees remembered social norms around smoking being enforced collectively. One woman explained,

*In Cambodia, children are basically raised by the community. In the community everybody [is] your parents. So you are worried about other people telling on you. For example, if I smoke and my neighbor sees me smoke, they might go tell my mum or my dad, and I could get in trouble.*

— Cambodian woman in her 30s, in the United States for 21 years

**2. Tobacco played a role in the Hmong culture but traditionally was not used regularly.**

Among the Hmong, daily smoking in the homeland was relatively uncommon. A Hmong woman leader estimated that “out of one hundred people about four or five people smoked. That’s it. Or out of one hundred people [there were] about only one or two that smoked, but only really old people.” One male leader observed,

*Men at age fifty to sixty years old and above were the tobacco users, but the young ones’ parents did not encourage them to smoke. I have never seen young men smoking cigarettes or putting ashtrays around. I only saw the old people smoking either water pipes or cigarettes.*

— Hmong man in his 50s, in the United States for 12 years

The elders perceived smoking tobacco as a privilege and believed that it numbed the pains of old age. Yet, relatively few Hmong achieved this advanced age due to a limited life expectancy, so very few people smoked traditionally.

Historically, the Hmong considered tobacco an item too precious to be used for ordinary consumption. Tobacco was prized for its commercial value, and was cultivated and sold to buy farm animals, vegetables, and clothing. Because tobacco was a source of income for the Hmong, smoking the tobacco one cultivated was considered inappropriate for everyone but the elderly. It reflected poorly on the reputation of the smoker and his family. Tightly knit Hmong communities were able to enforce these informal prohibitions against smoking.

Nevertheless, tobacco was used on special ceremonial occasions. The Hmong regularly used tobacco as an integral part of wedding ceremonies and funerals, as a way to honor participants, the shaman, or the funeral director. Tobacco was also used in spirit healing or spirit-calling ceremonies, and for medicinal purposes. As two community leaders explained,

*Elders and the clan leader used it for traditional practices like weddings and funerals, but smoking on a daily basis, I don’t believe we saw that.*

— Hmong woman in her 20s, in the United States for 24 years

*Traditionally in the Hmong community we used tobacco as part of the wedding ritual to show respect, but [the] majority of the Hmong people didn’t smoke. Very few people smoked cigarettes for pleasure.*

— Hmong man in his 60s, in the United States for 22 years

Daily tobacco use was introduced to the Hmong by the United States Central Intelligence Agency agents and American soldiers during the Vietnam War. According to several Hmong leaders, the Americans offered cigarettes to the Hmong men they recruited to fight with them. A common use for cigarettes was to help pass the time and to stay alert during long periods of sentry duty.
3. Some people began smoking in the homeland during conditions of war, forced labor, and social and political unrest.

Many people link smoking with stress, thinking that smoking is a way to relieve stresses caused by difficulties in one’s life. Interviewees often pointed to the many sources of stress in their lives, including the war in Vietnam and subsequent dislocations they experienced. A common view was that many people began smoking, or smoked more, as a way to cope with these enormous stresses. The events to which they referred touched and continue to affect everyone in the Southeast Asian communities in Minnesota. The wars included the civil war in Cambodia, the war in Vietnam leading to the fall of Saigon, and the Secret War in Laos.

Following these wars came forced labor camps, exile, loss of status, extreme poverty, refugee camps, and the hardships of immigration and starting a new life in a foreign land. Most of the Southeast Asians now living in Minnesota were either born in Southeast Asia and are survivors of these wars or were born in the difficult period that followed, often in refugee camps. Younger members of these communities who were born elsewhere, including in the United States, often continue to be affected by the difficult experiences of their elders.

Interviewees described many different ways in which these traumatic events may have led to more smoking. For example, according to one interviewee, the Hmong elders blamed the start of daily smoking on what they called the “American war.” He observed that people who did not join the military were less likely to become heavy smokers. Because sons of men in the military also smoked to emulate their fathers, the Hmong who were involved in the war and their children were more likely to become smokers.

Cambodian community leaders described how many people began smoking during the difficult times under the Khmer Rouge regime, when many people were forced to live in primitive conditions:

Lots of people learned to smoke, including myself. We believed smoking would scare the mosquitoes away at night. Sometimes, we taught our children to smoke by ourselves, leading them to a smoking habit, especially during the Khmer Rouge regime, when we had a difficult time. And sometimes, some other people thought that smoking could make them relax.

– Cambodian man in his 40s, in the United States for 14 years

The ideology of extreme egalitarianism practiced by the Khmer Rouge, in which men, women, and children were considered “equal” led them to distribute cigarettes to everyone. Reflecting on this experience, a Cambodian leader said,

I saw a dangerous act committed by the Khmer Rouge. They distributed cigarettes to the children. Children and women smoked openly. Some said that they used cigarettes as a solace, by flying their mind along with the smoke.

– Cambodian man in his 60s, in the United States for 21 years

A Vietnamese man believed that social unrest and unemployment after the fall of Saigon in 1975 led to an increase in smoking:

Before 1975 people smoked because they wanted to imitate each other and show off . . . But after 1975, the number of smokers even increased for the following reason: The unemployment rate was high. When people are unemployed, they smoke more.

– Vietnamese man in his 60s, in the United States for 10 years

Part I: Summary

Tobacco was integral to the culture in the homeland for the Laotians, Vietnamese, and Cambodians. Tobacco was part of ceremonies and rituals, was used to maintain social relationships, and was also used for medicine. In these Southeast Asian cultures, tobacco was a prestige item, and often signified the social status of the smoker. Although tobacco was valued in all four communities, the Hmong had more negative attitudes toward regular smokers compared with the Cambodians, Laotians, and Vietnamese. Among the latter three groups, regular smoking among men was commonplace and acceptable; however, smoking was definitely unacceptable for women and youth. Some Southeast Asians began smoking during conditions of war, forced labor, or the social and political unrest that followed war.
Interviewees’ memories of how tobacco was used and regarded in the homeland provide compelling evidence of how deeply tobacco use is embedded in a specific cultural and social context. When immigrants come to the United States, they are immersed in a completely different cultural and social context, and they experience some degree of “culture clash” as they encounter attitudes, beliefs, and norms that differ—sometimes dramatically—from those of their homeland. This section begins by depicting the cultural conflict regarding tobacco that Southeast Asian immigrants experienced when they came to the United States.

Over time, Southeast Asian immigrants and refugees acculturate to life in the United States. This process of acculturation occurs at different rates, depending on individuals’ proficiency with English and on the nature and extent of their interaction with members of the general population socially, in school, and in the workplace. Their exposure to American media also influences the rate of acculturation. Over time, this culture clash tends to diminish, but not disappear, as immigrants find ways of negotiating between their native culture and the culture of their new country. This process of acculturation and adaptation to life in the United States influences tobacco use for different subgroups within Southeast Asian communities—such as men, women, and youth—in both positive and negative ways.
1. Immigrants experience clashing cultural views and norms about tobacco.

If I gave you a cigarette, that meant I respect you . . . [The] cigarette in Laos was a symbol for honor and respect and that was why it wasn't used as much [there] too. In the United States it's not as important anymore because you can [get] it anywhere.

– Hmong woman in her 20s, born in the United States

In the United States, cultural norms regarding tobacco use have shifted dramatically from the first half of the last century—when tobacco use was ubiquitous and the harm of tobacco was not well understood—to the present day, in which the harm of smoking is widely acknowledged. Americans who have lived in this country over the past half-century had decades to understand and accept these new norms. Refugees, however, went virtually overnight from societies in which smoking was widely accepted to a society in which smoking was already on the decline. The interviewees identified several dramatic shifts that these immigrants faced regarding tobacco.

From little knowledge of tobacco’s harms to the knowledge that “smoking kills.”

Many leaders contrasted the lack of scientific knowledge in their homeland about the health risks of smoking to the plethora of information available in the United States about the dangers of smoking and exposure to secondhand smoke. For example, one Vietnamese leader contrasted the experience in the homeland with the United States, where “the television always broadcasts noisily that smoking causes this, causes that.” According to a Laotian interviewee,

In our homeland smoking is normal and they don’t have any research about how smoking is dangerous to our health. But smoking in Minnesota isn’t normal because we have already learned that smoking is very dangerous to our health and body.

– Laotian woman in her 50s, in the United States for 22 years

From smoking as a positive symbol conveying welcoming, honor, and high social status to smoking as social stigma.

Because of the high value placed on tobacco in Southeast Asian countries, and especially on commercially produced cigarettes, Southeast Asian immigrants experienced a clash in cultural perspectives when they came to the United States. Cigarettes played an important ritual role throughout Southeast Asia in giving thanks and honoring ancestors, guests, and social contacts. In the homeland, men conveyed their high social position by smoking imported cigarettes. But immigrants quickly learned that in the United States, cigarettes do not carry these symbolic messages. To the contrary, interviewees said that smokers in the United States are regarded as ignorant and rude. Two Cambodian men expressed this very clearly:

In Minnesota, most people, young and old, have perceived the harmful impact of smoking. So, if anyone keeps smoking, he or she should be classified as an unlikable person and ignorant. Society would not accept this person. In Cambodia, a smoker’s value depends on the value of [his] cigarettes. It seems that expensive cigarettes ennoble the smokers into a high-class status. In this country, no matter how high the price of [one’s] cigarettes, the value of smokers may not be as high as their cigarettes.

– Cambodian man in his 60s, in the United States for 21 years

The difference is [that] in Cambodia you could smoke if you wanted to. That was normal, you see. Nobody criticized you. But here, we do not welcome those who smoke. When they need to smoke, they smoke alone, you see.

– Cambodian man in his 50s, in the United States for 21 years
From being able to smoke “anywhere” to having to smoke away from others.

Southeast Asian immigrants also experienced the striking change of living in countries in which smoking was something one routinely engaged in with others as a social activity, to living in a country in which smokers are banished from the room and are often sent to smoke outside. A Laotian man, a former smoker, elaborated on this contrast:

In our homeland most of the people smoke, but in America most of the people don’t smoke. So, in Minnesota the smokers feel that they are doing wrong to other people by smoking because in America we know smoking is bad for your health and the health of the people close to you, [because] even if they don’t smoke they [are] still exposed to the smoke. In America, the smokers have to go away from other people to smoke. They don’t smoke in the house because the children or the nonsmokers would smell the smoke. They can’t smoke in the car. Whenever they need to smoke they have to go elsewhere. In Cambodia, there was no discriminated place for smoking. They could smoke everywhere: in the house, on the street in the crowd, in the office, and in most working places.

– Cambodian man in his 40s, in the United States for 6 years

From smoking being for “men only” to the idea that “anyone can smoke,” even women and youth.

Some leaders recalled their initial shock at seeing women and children—who would never smoke in their homeland—smoke openly in the United States. As one interviewee explained,

I think, in Laos, if you saw a woman smoke, people would talk about it, and then that person would feel ashamed of smoking, but in this country and in Minnesota, like the mainstream culture, women, children, everybody smokes.

– Hmong woman in her 30s, in the United States for 20 years

2. Acculturation may decrease tobacco use.

Members of the four communities negotiate these often-clashing perspectives between the homeland and the United States as they begin to adopt American values and become more integrated into mainstream American society—the process referred to as “acculturation.” In the course of acculturation, Southeast Asians in Minnesota have had to grapple with the new and conflicting messages about smoking. From the standpoint of reducing the harmful effects of tobacco, acculturation has both positive and negative consequences. On the positive side, acculturation brings greater awareness of the health risks of smoking, both to the smoker and to nonsmokers who are exposed to secondhand smoke, as well as awareness of norms that limit the acceptability of smoking in the United States. Many interviewees described how this new awareness has led to changes in community practices related to smoking.

Acculturation leads to more pressure on male smokers to change smoking behaviors.

The majority of Cambodian, Laotian, and Vietnamese interviewees told us that, although their communities in Minnesota do not disapprove of men who smoke, they do have negative views about smokers who smoke around others. This breach of etiquette seems to strike at the core cultural value of respect for others. According to a Laotian man,

If the question is, “Does the community look down on the person who smokes?” The answer is probably not. The smoker usually knows enough not to smoke in front of other people. They usually go somewhere outside and away from people to smoke even when it’s in the cold or hot weather. It’s acceptable. That does not disgust the community.

– Laotian man in his 60s, in the United States for 12 years

A Vietnamese woman echoed this belief:

The only thing that matters is that we are not harmed by anyone else. If a person’s smoking affects us, then we may complain. Otherwise, if the smoking person is not a member of our family, and if he or she is smoking outside in the street, and we are just walking by, we should say it’s their own business. So we are not poking our nose into their business. It’s their own health.

– Vietnamese woman in her 30s, in the United States for 12 years
However, a few interviewees expressed strong, negative attitudes toward smokers. Several interviewees viewed smokers as selfish, such as this Cambodian man who described having a “bad feeling” toward men who smoke, a feeling that he doesn’t have a deeper thinking; a feeling that he is sometimes only thinking [of himself]. He just smokes to fulfill his needs but doesn’t think about others, especially relatives or his surrounding family.

– Cambodian man in his 50s, in the United States for 21 years

Other community members, particularly women, described aversion to the unpleasant smell and appearance of smokers. A Vietnamese woman echoed the view of many women interviewees when she noted that

. . . another bad thing about smoking is that smokers often have a dirty and unhealthy image. Smokers and everything surrounding them are so smelly. When you enter the smoker’s bedroom, [or] just be by their bed, it smells really bad.

– Vietnamese woman in her 50s, in the United States for 3 years

In their homelands, women with these kinds of negative attitudes about smoking had relatively little recourse to influence the men with whom they lived. Some interviewees suggested, however, that acculturation to American society can lead to greater gender equality as women enter the workforce and gain more power in their domestic relationships. Consequently, some wives feel empowered to pressure their husbands to quit smoking, or at least to refrain from smoking around the family.

Acculturation raises awareness of the health risks of tobacco use and reduces tolerance of smoking.

Some interviewees painted a negative picture of smokers’ physical health and appearance:

You get lung cancer and your gums get all black and [you get] yellow teeth. More likely you get cancer and stuff like that.

– Laotian woman in her 20s, in the United States for 12 years

They don’t look like normal people. They are not healthy, [they’re] kind of pale, and have purple lips.

– Vietnamese woman in her 20s, in the United States for 12 years

They smell, their mouths stink, they have yellow teeth, their lips become black, their fingers become yellow. A smoker usually has a different voice [and] their skin looks very loose. And it can cause cancer.

– Cambodian man in his 50s, in the United States for 21 years

Some Southeast Asians may have held these types of negative attitudes toward smokers in their homelands, but only feel free to voice these concerns in the United States, where smoking is less socially acceptable and where there is more information about the dangers of smoking and secondhand smoke. For example, according to one interviewee, in his native Laos,

There were some people who did not agree with smoking but would not say anything about it to avoid hurting each other's feelings; we were being polite and very sensitive about it.

– Laotian man in his 60s, in the United States for 23 years

After living in the United States, a Vietnamese woman described how she has become less tolerant of smokers because of her greater understanding of the health risks involved:

I realize that I feel discomfort when I meet and communicate face-to-face with a number of Vietnamese friends who smoke, maybe because my acceptance of smoke has been changed. I can no longer tolerate the cigarette smoke as much as I did in Vietnam. Now I feel more uncomfortable. I realize that I have a runny nose and watering eyes when I find myself among a smoking crowd. So, I have to get away from the smokers. This is not only a concept that smoking is bad, but that smoking is harmful to our health.

– Vietnamese woman in her 40s, in the United States for 20 years
Less acculturated Southeast Asians still lack awareness of smoking-related health risks.

Despite growing awareness among many people in these communities, other people, especially those who are elderly or less acculturated, still lack even a basic understanding of the dangers of smoking. As a Laotian leader explained,

*Most of our people don’t know what causes them to be sick. When [two older men in my community] got sick, they knew that he had lung cancer [but had] no explanation as to what caused that. Nobody would say that it was because he had been smoking for over twenty years. Even his family wouldn’t say “he had been smoking for over twenty years and that’s why he has cancer.”*

– Laotian man in his 30s, in the United States for 19 years

This lack of knowledge was corroborated by a Hmong leader who told us, “Everyone seems to hear rumors that smoking is not good, but they do not know exactly what it is that is not good.”

A Vietnamese leader made a similar observation:

*In general, the Vietnamese people in the United States still have the Vietnamese psychology. When they discuss about smoking, and about the sicknesses caused by smoking, they would have only a general idea that smoking is harmful to health, and that it may cause cancer. They would not talk about details because they won’t know any details on this issue. Some people make the observation that many elderly people, still living towards their hundredth year, have been smokers all their life.*

– Vietnamese man in his 50s, in the United States for 8 years

A Laotian leader shared an example of how some in his community misunderstand the cause of sickness.

*Some people had quit for five to six months and then died of cancer, or have diabetes. I had seen three or four friends who died because they quit smoking rapidly. Within five to seven months of their quitting, some people get diabetes, then cancer, without any reason, so it’s hard for people to decide to quit.*

– Laotian man in his 60s, in the United States for 23 years

When asked about the effects of smoking, interviewees placed emphasis on the physically apparent manifestations of smoking, such as yellow nails, discolored skin, weight loss, and coughing. By contrast, effects of smoking that are less visible, such as cardiovascular disease, were less likely to be mentioned. This suggests that even relatively well-informed community leaders may be unaware of or discount the early and less visible damage that smoking may cause. Indeed, some interviewees described how community members ignored the health risks of smoking until they became seriously ill. For example, a Cambodian former smoker said that he “ignored the danger until I was told by my doctor that I needed surgery. The disease was the effect of smoking. I did not care about anything until then.”

Another area of misinformation is the belief that homegrown tobacco and tobacco smoked through a water pipe is safer than commercially produced cigarettes. Some community members believe that commercially produced cigarettes contain additives that cause addiction. According to a Hmong smoker,

*[In Laos] . . . you don’t have to use any pesticide or chemical to help grow that tobacco. We don’t mix tobacco with chemicals, a lot of time and especially when you smoke it in a pipe, you don’t even mix it with paper at all. We don’t have scientific proof, but a lot of the elders feel more safe if you smoke that way.*

– Hmong man in his 50s, in the United States for 13 years

**Acculturation raises awareness of the dangers of secondhand smoke.**

Interviewees said that in Southeast Asia, there was little, if any, awareness of the dangers of secondhand smoke. Most interviewees believed that living in Minnesota led to greater awareness of the dangers of secondhand smoke. As a Hmong leader said,

*I know that they have commercials on TV that it’s bad. You can still develop lung cancer or other health problems just by secondhand smoke.*

– Hmong man in his 30s, in the United States for 22 years

This growing awareness of the dangers of secondhand smoke is leading more Southeast Asians to have a very
negative opinion of those who smoke around others. As a Cambodian man explained,

*If you smoke, you won’t lose your reputation; that is your choice. But we need to smoke in the smoking area. We would not smoke among nonsmokers. But if you dare to smoke [around nonsmokers], you may lose your reputation because they breathe your smoke, you see.*

– Cambodian man in his 50s, in the United States for 21 years

Indeed, recognition that smokers hurt innocent bystanders has led several community members to take a particularly negative view of smoking itself. This Cambodian leader’s condemnation of smokers is a good example of the kind of change in attitude experienced by many:

*I think smoking is a bad activity for myself, for the society, especially for the family. If the husband smokes, the whole family has to smoke too. It doesn’t mean that they have to smoke, but the smoke from his cigarette blows all over the house. So the family has to breathe in the tobacco flavor which will cause [them] to have the diseases.*

– Cambodian man in his 50s, in the United States for 21 years

Several interviewees pointed to the impact that differences in weather and housing have on people’s awareness of secondhand smoke. As they noted, smoke from other people’s cigarettes was not as bothersome in their homelands because people smoked in well-ventilated spaces. Many Southeast Asians immigrants recognized that Minnesota’s well-insulated indoor spaces make smoking indoors unpleasant to others, even if they were not aware of the actual health risks posed by the smoke. As a Cambodian interviewee explained:

*We understand that smoking in Minnesota is a more disturbing act than in Cambodia. Due to the cold weather here, people live in the house with windows closed almost all the time. In our homeland, we had windows opened most of the time. Then, the odor from smoke could find its way to the outside easily. Here the smoking odor is so confined in the closed house and disturbs everyone, including nonsmokers. So, we have to be well aware that, although we don’t hear a direct complaint, in Minnesota most people are disturbed by our smoking.*

– Cambodian man in his 60s, in the United States for 21 years

In fact, a former smoker from Vietnam suggested that the consequences of secondhand smoke trapped inside houses might cause smokers to think about quitting:

*The way the houses are constructed in this country, the heating system during the winter, or venting system, air-conditioning during summer, will keep the cigarette smoke indoors for a very long time. These are big issues for smokers to rethink.*

– Vietnamese man in his 50s, in the United States for 8 years

**Less acculturated community members lack awareness of the dangers of secondhand smoke.**

For example, a Vietnamese woman said that many smokers in her community are unaware of the harm their smoking causes their children, noting that parents do not have the knowledge and do not think about the harm caused by their smoking to their children.

A clear example of the lack of awareness of the dangers of secondhand smoke was offered in this interchange between one interviewer and a Hmong community leader:

*Q: What effect do you think smoke from another person’s cigarette has on a person’s body and health?*

*A: The one that doesn’t smoke will probably not have any problems in their body and health because that person is not smoking.*

– Hmong woman in her 20s, in the United States for 20 years

The aspect of the secondhand smoke message that seems to resonate the most is the idea that secondhand smoke is bad for children or pregnant women. As a Vietnamese leader explained,

*I really think that even with the current publication of the numerous flyers on smoking and secondhand smoking, this issue is not a real concern for the Asian people in general. Except this specific situation: If the smoker has a family with young children, it would be better for the children’s health if the smoker does not smoke in the house.*

– Vietnamese man in his 50s, in the United States for 8 years
Over time, acculturation changes the informal rules of appropriate tobacco-related behavior.

Many interviewees explained that sensitivity and politeness were highly valued in their culture. Over time, this premium placed on sensitivity leads many Southeast Asians to adjust their traditional notions and practices of smoking, reflecting increased adoption of American ways. One important marker of these sometimes subtle changes is the decreasing use of cigarettes in community rituals. A Hmong woman leader told us,

I don’t think a lot of people use cigarettes for ritual ceremonies in Minnesota anymore because [they] found out that that’s not really professional or that it’s not good. And so I think a lot of people in the community are changing the way that they use cigarettes to socialize.

– Hmong woman in her 20s, in the United States for 20 years

As another example of these changing norms, a Cambodian man described how he and others are changing the traditional practice of distributing cigarettes at weddings:

As our ancestors taught us, we should follow the winding stream when we enter the river’s journey. In America, there are some restrictions for smoking. The dangerous impact of smoking is often publicized on TV. We understand it. Therefore, in the wedding ceremony, where we used to serve guests with cigarettes, we offer candies as a symbol of thanksgiving. I did it in my daughter’s wedding. I encountered some objections, but I went ahead using candies instead of cigarettes. It’s less harmful.

– Cambodian man in his 60s, in the United States for 20 years

Formal and informal rules about smoke-free spaces in Minnesota resonate very strongly with many Southeast Asians, who come from cultures that stress the importance of showing consideration for others and avoiding a loss of respect for one’s family and clan. The recognition that one’s smoking may be disapproved by Americans may elicit feelings of shame and disgrace, leading to behavior change, as poignantly illustrated by this Cambodian interviewee:

I used to smoke before because I used to work as a constructor to build roads, bridges. When I came to Minnesota, I worked at the [name removed] Company. The [name removed] Company had its own good rules, in which they don’t allow the smokers to smoke in a workplace. They did allow them to smoke outside. Then I felt ashamed. And I understood that when they do good things, I have to respect them and follow them. And it is not only a benefit to the community but to [the] individual. That is why I decided not to smoke anymore.

– Cambodian man in his 60s, in the United States for 20 years

Another Cambodian male leader, also a former smoker, explained how men in his community might refrain from public smoking in Minnesota so as not to bring disgrace to themselves and their families. He noted, however, that these men may continue to smoke in private:

When a husband smokes, the bad odor disturbs his wife. She often discourages him from smoking. And her attitude of dislike grows. It is a disgrace for a husband. As for the youths, they would have encountered the same situation; disgraced by the elders. Therefore, both youths and general individuals are afraid of losing face and respect. Then they would not smoke in public. They would do it in a private place so that other people in the community cannot see them, and they cannot look down at them. They would escape the lecture and reproof on the harms caused by smoking.

– Cambodian man in his 40s, in the United States for 6 years

The changing norms around smoking and secondhand smoke are leading to changes in the often subtle rules governing smoking in social situations. These rules, which are subconscious and rarely stated outright, require community members to be highly sensitive to others’ expectations. As one Hmong leader illustrated, unstated norms have evolved that discourage smoking in
other people’s houses, yet it remains rude to tell a guest that he or she may not smoke in the host’s home:

The person who smokes has to know that in order to respect the family that they go visit, not to smoke in their house, because the host family or the family who invites you to go to their house, they’re not going to tell you that, “Hey, it’s not acceptable in our house.” Even though it’s not acceptable in their house, they’re not going to say it directly to that person. That would be disrespectful toward their visitor. So the visitor has to know by him or herself that it’s not acceptable. You have to create that rule for yourself, not what they create for you.

– Hmong woman in her 20s, in the United States for 22 years

Thus the high value placed on politeness in Southeast Asian cultures often means that hosts will not tell their guests to refrain from smoking, even if the smoke bothers them. Another interviewee elaborated,

In general, the Cambodian families [are] usually polite. They just say it is OK [to smoke]. But they don’t want you to smoke, because they don’t want the smoke.

– Cambodian man in his 50s, in the United States for 21 years

One community leader described how he deals with visitors who smoke:

Our Hmong people—it is complicated. Actually, I do not want someone to smoke in the house because the smoke cannot vaporize and the smell lasts too long in the house. If a visitor is a regular smoker and wishes to have an ashtray or wants me to buy cigarettes, I can try to fulfill it, but the truth is it is not ideal. [I] just try to please the person so that he does not feel resentment.

– Hmong man in his 50s, in the United States for 12 years

However, a few interviewees said that they no longer follow these norms of politeness and will tell guests outright not to smoke. For example, a Cambodian woman told us, “I think that is very rude to smoke. Like I said, I kick them out if they smoke in the room.”

In many Southeast Asian communities, it is becoming less acceptable to smoke in closed-in settings, particularly around children, pregnant women, and elders with health problems. As a Vietnamese former smoker explained,

Smoking at social gatherings still occurs but smokers are expected to smoke away from nonsmokers. Yes, tobacco is still used in our celebrations. But, at many places, smokers are asked to sit separately. Many nonsmokers do not like to smell the cigarette smoke.

– Vietnamese man in his 70s, in the United States for 27 years

A Cambodian woman leader echoed the view of many when she said,

Our culture won’t allow smoking around elder people or babies . . . Sometimes, it affects our health. Like elder people [and the] sick, it makes them weak because of the strong smell. Plus it [is] hard to breathe because of the smoke. If we have someone sick in the house and someone smokes cigarettes, it makes them worse.

– Cambodian woman in her 40s, in the United States for 17 years
3. Acculturation may increase tobacco use among women, youth, Hmong, and new immigrants.

Younger children that would not normally smoke in our homeland do smoke here. And especially girls: I know girls would not get away with smoking in our homeland and they do get away doing that here. [Here it is] the other way around. Older people tend to quit smoking, younger people want to start smoking.

– Cambodian woman in her 30s, in the United States for 21 years

The process of immigration, adjusting to life in the United States and absorbing aspects of American culture, is definitely not all positive in terms of reducing tobacco use. On the negative side, acculturation puts certain members of the community at increased risk for smoking. Moving from small villages and communities to large metropolitan areas leads to the loosening of “social control.” Women and youth, who would never have dared to smoke in their tightly knit village where their smoking would be the subject of gossip, have many more opportunities to smoke without judgment from their community. This may also be particularly true for younger Hmong in Minnesota, who now have places where they can smoke away from the eyes of their elders, unlike in the homeland.

Additionally, the greater economic and social equality that exists for women in the United States sometimes translates into women feeling free to smoke, an association reinforced by cigarette advertisements. Younger people similarly may adopt smoking as a way to fit in with their peers and become “American.”

Finally, acculturation also brings a great deal of stress, which may lead immigrants to smoke. Refugees, who have already experienced a great deal of trauma before arriving in the United States, now have the extra pressure of learning a new language, finding employment and housing, adjusting to very different American values, and coping with a different pace of life. Some of those immigrants talked about finding solace in smoking.

Acculturation may lead to more smoking among women.

When our Vietnamese people immigrated to the United States, we had communication and exchange with the American world. We have learned many good things, but we have also learned a lot of bad things. The young ladies nowadays seem to adopt the concept of freedom, so they think they should have the right to smoke just as their brothers, and [they] would not worry about their reputation.

– Vietnamese woman in her 40s, in the United States for 20 years

To the dismay of many community members, more women are now smoking, particularly younger and less traditional women. The community leaders tended to attribute this change to the increasing influence of American culture and the decreasing influence of traditional Southeast Asian culture, including the influence of the family and community. A Hmong woman recounted a story that provides a vivid example of how perceived freedom from community restrictions may lead women to smoke:

The other day I was at a park and we ran into a family and the husband was smoking. And when we walked around the park, we ran into the family again and the wife was smoking, too. She was in her late thirties and I thought wow, that’s a surprise, because she’s speaking Hmong to her kids, and that’s really rare. Now if she was in Laos, because it was more restricted and more looked down upon by the elders, she would not have been smoking.

– Hmong woman in her 20s, born in the United States

The increase in smoking among Southeast Asian women was seen as part of the process of these women becoming “Americanized,” that is, adopting values of freedom and gender equality, which some interviewees associated with smoking. As a male Cambodian interviewee explained, female Southeast Asian
immigrants have moved from a male-dominated society to a new American culture that emphasizes individualism and equality. He explained that many of these women now work outside the home in order to provide additional income to the family, which gives them more power to deal with their husbands. From this man’s perspective, some women—particularly younger, less traditional women—use that power to do things that they had not done in the homeland, such as smoking. A woman from the Hmong community expressed a similar view:

For example, I have seen some girls smoke outside a building. You hardly saw that between the 1980s and 1990s, and that’s the Hmong community in Minneapolis and St. Paul. Back then, you hardly saw any of them [smoke], now you do. It’s part of the transition that we are getting more and more Americanized. The perception that we are being American and [have] freedom [to] do whatever we want . . . misleads a lot of communities and their interests.

– Hmong man in his 50s, in the United States for 13 years

Younger, unmarried community members in particular may be more likely to smoke. According to a Cambodian man who was interviewed, married women have a tendency to be more conservative and are more inclined to follow traditional rules, whereas young girls are expected to more easily embrace the new culture. As he observed, “Married women play an important role in Asian society, by being the gatekeeper of cultural values and tradition or an agent for change.”

Acculturation may lead to more smoking among youth.

The difference I notice is reverse between ages from old to young. Elderly Hmong people seem to be [smoking] less but younger people (kids) smoke the most. It’s opposite from our homeland.

– Hmong man in his 30s, in the United States for 22 years

Moreover, according to many interviewees, in the United States parents have less influence over their children than they had in Asia. As a Cambodian interviewee bemoaned, “[smoking among youth] . . . is not acceptable in our community, but the parents couldn’t do much due to the convenient access to cigarettes. They can buy them or get them from friends. This is becoming a part of the parents’ stress.”

Another Cambodian leader contrasted children’s situation and attitudes in the United States with those of children in Cambodia:

I think it’s peer pressure . . . maybe because they think it’s cool to smoke. In Cambodia, children are basically raised by the community. Here children are raised by the parents and most of the time parents are busy working or busy doing something else. And so they are not being taken care of, or you know, as much as in Cambodia. In Cambodia, everybody is watching out after you or after the children. It’s kind of an unstated rule that other parents or adults can scold the young children. If I see some other children smoke here, I cannot just go give them advice about this and that. But in Cambodia you can get in really big trouble by your parent even though your parent doesn’t see you doing it directly but somebody else tells your parent if you are doing it.

– Cambodian woman in her 30s, in the United States for 21 years

Some interviewees characterized their community as being in a “state of flux” in which some members want to hold onto traditional values, whereas others want to adopt American ways. The less traditional community members who realize that others in the community disapprove of their smoking may negotiate this issue by refraining from smoking in their home and community and smoking only with their peer group. As one Hmong woman explained,

I don’t think it’s acceptable to have elders and parents see youth smoking. I mean that is still looked down upon and it’s still a bad reputation on themselves and on the kids. Because they won’t want other members of the Hmong community looking down on them and saying “they’re youth that smoke.” That’s a way of losing face in the community. I do have some siblings, younger siblings, that would smoke. But they won’t smoke at my house just because they respect me and won’t want to make me lose face.

– Hmong woman, age unknown, in the United States for 23 years
Acculturation may lead to more smoking among the Hmong.

Smoking appears to be increasing among the Hmong community in Minnesota, as tobacco is no longer restricted to ritual or healing purposes as it was in the homeland. However, despite this perceived increase in smoking, Hmong Minnesotans continue to hold a negative view of smokers. One Hmong woman shared her perspective:

> It seems to me that someone who is smoking not [for] traditional practices or rituals but as a trend or a phase is . . . only happening in today’s society.
> – Hmong woman, age unknown, in the United States for 23 years

Another Hmong leader believed that community members picked up smoking from the larger United States culture. She observed that smoking is

> . . . becoming a practice in this country. It’s not just the Hmong people but people from all ethnic backgrounds smoking, so cigarettes become a practice for some people. It’s more acceptable for people. Even though they know it will cause more health problems, people still accept [it].
> – Hmong man in his 30s, in the United States for 22 years

The observation that acculturation may increase the prevalence of smoking among the Hmong is clearly an important topic. Additional research is required to explore factors that may put particular segments of the community at risk for tobacco use, as well as factors that may prevent the Hmong from taking up smoking as they acculturate.

The stress of acculturation may put immigrants at greater risk for smoking.

A widely perceived myth about smoking, encouraged by advertising and popular culture, is that smoking can relieve stress. Immigration is a major source of stress. One Cambodian community leader commented on the phenomenon of new adult smokers among recent immigrants:

> I saw a lot of people who first came here start to smoke who never smoked before. I think it’s the stress of adjusting to a new place and trying to survive in a new culture and it leads them to seek comfort in smoking.
> – Cambodian woman in her 40s, in the United States for 27 years

Refugees may turn to smoking to relieve stress associated with immigration, acculturation, and the trauma associated with war and relocation. As another Cambodian man described,

> Back in the homeland there was a war, suffering, and hardship. When we are here, we have a lot of stresses. Some people came here without knowing any English. They don’t speak English. They don’t know how to drive and cannot go out like others, so they are always staying home, like the rabbit in its cave. When they stay inside for so long they will have a lot of stresses and they don’t have any other ways [except] pulling cigarettes to smoke.
> – Cambodian man in his 60s, in the United States for 20 years

These hardships may be particularly difficult for more recent refugees and for the elderly, who may experience prolonged stress due to social isolation and limited language ability. According to a Hmong leader,

> Almost all my friends who had never smoked back home . . . started to smoke here because of stresses. Many of our elderly people smoke to reduce stress.
> – Hmong man in his 60s, in the United States for 22 years
One Hmong interviewee suggested that the concept that tobacco relieves stress is an American idea:

*In Laos [tobacco] wasn’t used as much when you’re stressed. But here in the United States, it’s mainly used when you’re stressed or you couldn’t handle what you’re doing.*

– Hmong woman in her 20s, born in the United States

However, as mentioned in Part I, others described how some people began smoking in their homeland in response to war, social unrest, and unemployment.

**Part II: Summary**

When Southeast Asians come to the United States, they experience clashing cultural views and norms about tobacco. Smoking comes to be viewed more as a problem and a stigma than as a status symbol; immigrants are confronted with a great deal of new information about the health risks of smoking. Smoking around others is seen as rude rather than a way to maintain social relationships. Finally, smoking is no longer restricted to men.

Acculturation has positive and negative effects on patterns of tobacco use among members of Southeast Asian communities. On the positive side, acculturation leads to more pressure on male smokers to change their smoking behavior, and also to greater awareness of the health risks of smoking and exposure to secondhand smoke. Still, many people remain unfamiliar with these health risks or understand them only superficially. Acculturation also increases the pressure on smokers to smoke away from others. On the negative side, acculturation may increase smoking among women, youth, and the Hmong. Additionally, the stresses associated with acculturation may lead some community members to begin smoking and may make it more difficult for them to quit.
The insights provided by community leaders reinforce the need to develop stop-smoking interventions that take into account both the specific vulnerabilities to tobacco use and the specific barriers to quitting that these Southeast Asian communities face. Part III of this report highlights findings that will be critical to consider in designing effective efforts to reduce the harm caused by tobacco in these communities.

1. **Acculturation leads some smokers to want to quit.**

As their communities become further exposed to messages about health risks and adopt American antismoking sentiments, many Southeast Asian smokers become motivated to quit. According to one interviewee,

> **Vietnamese men in the United States—most of them want to quit smoking. I won’t say fifty percent of men but almost. An example is my brother-in-law in our family—he also quit smoking. I have another cousin who did the same. And my own older brother—he used to smoke a little but now he quit completely. Why? They know that their health is very important here. If they cannot go work, how could they pay the bills? That’s the first thing.**

> – Vietnamese woman in her 30s, in the United States for 12 years

Many of the community leaders identified the family and community as important influences on a smoker’s decision to quit. This Cambodian interviewee described how the community in the United States now reinforces the importance of quitting:

> **Quitting will make you become a good person; no sicknesses and very healthy. [The person who quits] will gain respect from neighbors, not only from the smokers. Even the nonsmokers will also respect you. They would understand that you do the good thing.**

> – Cambodian man in his 60s, in the United States for 20 years
2. Access and awareness barriers to culturally and linguistically appropriate services may prevent smokers from getting help to quit.

As in other studies that find barriers faced by minority communities in obtaining health care, many interviewees mentioned barriers of awareness, access, and the lack of culturally and linguistically appropriate services to help smokers quit. For example, many leaders are unaware of existing cessation resources and are unsure where they would send someone from their community who wanted to quit smoking, especially when that person does not speak English. As a Hmong male leader said,

"Talking about antismoking efforts, I do not know much about them. I personally do not know that we have programs to help, or where to get training for strategies in preventing these issues. The Hmong community has not yet had the programs and no one has concern about cigarette problems affecting the Hmong community . . . nothing has been done."

– Hmong man in his 50s, in the United States for 12 years

The lack of educational materials in the native language of their communities was seen as a major barrier to the awareness and use of stop-smoking medications. According to a Laotian woman,

"I think if we asked ten people, only two would know [about nicotine replacement treatment and Zyban]. They know from other people like myself. I didn’t find out from the Health Department; I found out from the community . . . they don’t know about these. They don’t even know where the products are being sold. They don’t know how to use them. They can’t follow directions on how to use them. There should be help from the [mutual assistance] associations or have some kind of grant funding to help us learn about these products and resources so that we know what these things are. Right now, we only know that Target and Kmart [discount stores] carry them but we don’t know what the products look like."

– Laotian woman in her 30s, in the United States for 24 years

Similarly, a Cambodian woman leader said,

"To my knowledge, people in our community did not pay attention to that product because it is not in their language. I believe if they understood how the product will help them, they might be willing to use it."

– Cambodian woman in her 40s, in the United States for 18 years

3. Cultural barriers prevent smokers from seeking help and using stop-smoking medications.

Members of Southeast Asian cultures place a great deal of importance on maintaining the reputation of oneself and one’s family and avoiding the “loss of face,” or public shame. The community leaders reported that many smokers avoid seeking help because they are afraid of losing face.

In the case of the Hmong, where daily smoking was traditionally culturally disapproved, seeking help to quit is seen as shameful because one has to admit that he or she is a smoker. As a Hmong leader explained,

"When you ask for help [people] will label you as a bad person, as a person who has a low life. So it’s not easy for people to come forward. It takes courage."

– Hmong man in his 30s, in the United States for 12 years

For the Cambodians, Laotians, and Vietnamese, smoking remains largely acceptable, as long as others perceive the behavior as a “habit” and not an “addiction.” A Vietnamese former smoker explained that although acceptable in Vietnam, smoking was not shameful if it was simply a “habit” that could be stopped at any time. However, the culture viewed addicted smokers who could not quit at will very negatively. As a Cambodian man pointed out,

"If you ask for help from a doctor because you are sick, it is not shameful. If you smoke and you are not addicted, it is not shameful. What is shameful is the addicted smoker."

– Cambodian man in his 60s, in the United States for 30 years
Vietnamese and Cambodian interviewees explained that addiction, along with “womanizing,” drinking, and gambling, is considered one of the four major vices. Cultures influenced by Buddhism and some other Eastern religions perceive addiction as shameful because the addict cannot use his mind to control his behavior. In Buddhism, the mind is seen as a vehicle to enlightenment and is therefore the most important part of a person. Thus, an addicted smoker demonstrates a “weak mind.” Another Cambodian, a former smoker, underscored the importance placed on mental control:

> The will to quit is the way to success. I said, “do not let mind be your master, but be the master of your mind.”

– Cambodian man in his 60s, in the United States for 28 years

Yet another Cambodian former smoker illustrated this cultural belief with a scathing indictment of smokers who lack the willpower to quit:

> Some people cannot stop and produce the excuse that they can live without this or without that, but not without cigarettes. No. I don’t believe it! I want to prove that it is not real. It’s up to us. [If] you don’t know how to control yourself, you don’t know how to discipline yourself, and you don’t know how to educate yourself.

– Cambodian man in his 60s, in the United States for 20 years

This cultural perspective creates a major barrier to quitting for many smokers, for it makes it particularly difficult for them to admit their addiction to themselves and to others.

This premium placed on self-control also may lead to discouragement among those who fail at their first attempt to quit smoking. Publicly failing to quit when one is trying to do so confirms that one is addicted and lacks self-control.

Smokers, then, are extremely reluctant to come forward when trying to quit. As a Vietnamese man explained, “Smoking is not a private act, but quitting is,” suggesting an additional reason why asking for help to quit smoking is considered shameful. Seeking help to quit, especially from anyone outside one’s own family, amounts to an admission of this addiction and lack of willpower.

The belief that quitting is a matter of mental control may also prevent smokers from seeking and using stop-smoking medications as an aid to quitting. A male Vietnamese former smoker provided another strong illustration of this belief:

> I think those smokers who have successfully quit smoking said they could quit because they have a strong mind. The majority of the smokers do not believe in these [nicotine] replacement products.

– Vietnamese man in his 50s, in the United States for 8 years

In this context, it is unsurprising that medications that help smokers deal with their physical addiction to nicotine are viewed as appropriate largely for the “desperate” or those who are “out of control.”

An additional cultural barrier may prevent Southeast Asians from seeking services, such as a stop-smoking telephone helpline, to support a quit attempt. According to some, asking for any type of help outside one’s own family is considered shameful in Southeast Asian cultures. One Hmong leader told us,

> There is the problem with losing face and your reputation if someone actually sees you in person and tries to help you with your problems. Most Hmong people are kind of private and they want to keep their problems within the family or within themselves. So I think there’s a reluctance there to really seek support that way.

– Hmong woman, age unknown, in the United States for 23 years

Similarly, a Cambodian leader explained that Cambodians . . .

> . . . are a very private people. We don’t want other people to know about our problems or issues. I don’t think people in the community are willing to seek help from other people.

– Cambodian woman in her 30s, in the United States for 21 years
4. Culturally sensitive stop-smoking interventions build trust, employ sensitivity, and protect smokers’ privacy.

We have to be very sensitive. Usually, the truth hurts. So we have to be very sensitive to gain people’s attention. These people are very stubborn.

– Vietnamese man in his 60s, in the United States for 10 years

Because of the shame and potential loss of face involved with seeking help to quit smoking, it is critical that any interventions respect the smokers’ privacy and gain smokers’ trust. Many interviewees, such as this Hmong leader, explained that a cornerstone of trust is relationships:

Build relationships and also talk about their problems, of which smoking is only a small part. That way [smoking] will gradually come out. Then you may lead them to other resources.

– Hmong man in his 50s, in the United States for 13 years

Several interviewees, such as this Vietnamese leader, emphasized the importance of sensitivity and the need to avoid the appearance of criticism, which could cause smokers to lose face:

We have to be sensitive. We should not act as if we are criticizing them, so they will come to see how this is harmful, or [not] advantageous to them. We won’t say things like, “This man is smoking like that. He will die soon.” No, saying something like that is wrong. We have to guide them, show them all of the evidence. “Here, this is the picture of your lungs. If you smoke, you will look like this, and they will look like this.” We would not say, “smoking is bad.” We cannot say so.

– Vietnamese woman in her 30s, in the United States for 12 years

A Hmong leader voiced a similar perspective on the importance of politeness and sensitivity:

First, we should ask people if they’re smoking. If they do [smoke], we should say, “Even though you are already smoking it’s okay, but would you be willing to find a way to quit? If you could quit, we would like you to quit.” Then that person will be able to share with you his or her thoughts. But if you would just say, “smoking cigarettes stinks [and] makes you sick” then he or she will respond, “I spent money out of my pocket. Why [do] you stop me? Even though I’ll stink or [be] unhealthy that’s my problem. I don’t need you to tell me what to do.” The best way is to ask how he or she got into smoking and then ask if he or she is willing to quit or not. Try to emphasize the person’s reputation and the positive side of the person for quitting smoking. Then the person will give you a proper answer. We should be very gentle while we ask them.

– Hmong man in his 60s, in the United States for 17 years
A Hmong woman leader illustrated how one might approach smokers sensitively:

I think it’s your tone and also if you approach them in a good, positive attitude. Not only that, but it’s the way you call them by name. Trying to be respectful in our community you would not just call them by their first names. You say something like, “You know, uncle, if you have time, I would like to ask you a question about this and that, or about tobacco use. Do you have time?” You would call them either by aunt, uncle, or something that’s respectful, so that you don’t approach them just like a stranger out of nowhere.

– Hmong woman, age unknown, in the United States for 23 years

Community-centered interventions built upon trusted relationships are one way to help smokers avoid losing face. Several community leaders, like this Laotian woman, believed that such stop-smoking interventions based in the community would facilitate trust among community members:

Lao Center is a community. You know these people can do it. They know people in the community . . . [You need to use] somebody that they come to for help, somebody that they see around, that helps out through the community, like Lao Assistance Center, Lao Women Association, Lao PTA.

– Laotian woman in her 20s, in the United States for 23 years

Another strategy, the stop-smoking telephone helpline, provides the privacy and anonymity desired by community members. As one Hmong woman explained,

Sometimes there’s an issue of saving face and reputation. So if you didn’t meet them in person, and you didn’t tell them who you were, but you could speak their language, that would be just a great help. Because then you could give advice to them on what you can do and you can get some help to quit smoking anonymously over the phone.

– Hmong woman, age unknown, in the United States for 23 years

Another possible approach is to focus on helping the whole community rather than directly targeting individual smokers. This “indirect approach” could present information about stop-smoking resources in the context of a broader educational and awareness campaign directed at the entire community.

5. Family, community, and clan are key cultural assets to leverage in helping smokers quit.

Smoking and tobacco use doesn’t just affect the individuals who are smoking but affects children, unborn children, affects everybody in the family—the household—because everybody is breathing that [smoke]. And that affects the whole community because everybody within the Hmong community is related somehow and they care about what happens in their community. So the reputation (and mostly bad reputation) in regards to smoking just builds up. More and more people want to save face and they want their own people to do well and to be healthy, so I think it’s a great concern and issue for the community.

– Hmong woman, age unknown, in the United States for 23 years

Because Southeast Asian societies are comparatively “other-centered,” that is, focused on the needs of the family and community over the needs of the individual, successful stop-smoking strategies should emphasize quitting in order to benefit one’s family, clan, and community. For example, according to a Cambodian former smoker:

But now, our Cambodian community doesn’t use [tobacco] as a [part of our] culture. They changed and think about the profit to the community. They [people who quit smoking] will become a role model for the children in the future.

– Cambodian man in his 60s, in the United States for 20 years

The future of their children is of paramount importance to refugees who have lost a great deal in their lives. This often becomes a central focus for many immigrants. Interventions that show how quitting smoking will benefit one’s children will, in the words of one interviewee, “hit the jackpot.” When asked if smokers would be more willing to quit if they learned that adult smoking harms children, a Vietnamese former smoker answered:

Yes, I think so. We definitely should not, ought not, do anything to harm children. It’s a crime to harm children. We should not make smoking a normal habit for our children.

– Vietnamese man in his 50s, in the United States for 8 years
A Laotian former smoker shared a compelling story of how he was motivated to quit by thinking about the effect his smoking had on his family and children:

I thought it’s not good for me and for my health. It made me often tired all the time. I got sick often and I do have family. I have children and a wife. I have to be a good example for my children, so I stopped . . . My children and wife told me not to smoke too much and then I stopped right away.

– Laotian man, in the United States for 18 years

Although family members remain the key people who can ask smokers to quit, acculturation complicates the question of who in the family can ask. In traditional Southeast Asian cultures, elders or respected members of the community would tell members of their family or clan not to smoke, as illustrated by this comment from a Cambodian man:

[Respect for the] elderly, that is our Khmer culture. First, we need to respect God; second, respect parents; third, respect teachers. Only these people could tell us not to smoke. They will stop us from doing bad things.

– Cambodian man in his 60s, in the United States for 20 years

A Hmong woman leader expressed a similar view:

The clan leader and elders always have authority to tell—especially people in their clan or people within their community—not to smoke, because it gives you a bad reputation. It makes you lose face, makes your family lose face, so they’re generally the ones who are concerned about that. They usually tell people within the community not to smoke, and parents too tell their children.

– Hmong woman, age unknown, in the United States for 23 years

However, acculturation brings changes in the traditional family hierarchy. As a result, some children are now telling their parents to quit. Interviewees had polarized views as to the acceptability of this role-reversal, which may reflect different levels of acculturation. For example, a Laotian man said that anyone in the family could now tell another family member not to smoke:

The head of household or the wife can tell the husband, or the children can tell their father that it stinks and he should not smoke.

– Cambodian man in his 60s, in the United States for 18 years

Other interviewees, such as this Cambodian man, agreed that it happens, but expressed astonishment at this role-reversal:

Unlike kids in Cambodia, the kids in America dare to warn their parents who smoke about the harmful impact of smoking. They even dare to tell their parents to go outside and smoke.

– Cambodian man in his 60s, in the United States for 18 years

For some other interviewees, such as this Hmong leader, children telling parents not to smoke was unacceptable and rarely seen:

I probably never heard of the child telling his dad not to smoke, or to stop smoking.

– Hmong man in his 30s, in the United States for 12 years

Another Hmong man who is a smoker believed that it is unacceptable to ask elders not to smoke:

“So elders, a lot of them, say “Why can I not smoke until I die? Who cares about it? This is America. This is a hard life for all of us.” So you tend to [have] courtesy and respect for them. It is very, very complicated to teach an old dog new tricks.

– Hmong man in his 50s, in the United States for 13 years
Wives can play a role in getting men to quit. Several leaders, like one Vietnamese woman, believed that the wife “has the most important role in this because she can keep whispering by the husband’s ears. He has to finally give in.”

Acculturation may contribute to wives’ influence on persuading their husbands to quit. A Cambodian man explained that women in his community tend to acculturate faster than men. Consequently, they may be more attuned to health information about the dangers of smoking and to shifting cultural norms in which smoking is viewed more negatively. Moreover, many wives may have been disturbed by smoking in the homeland, but there they did not have the power to persuade their husbands to quit. In the United States, many women now work outside the home and have economic power inside the household, which may empower them to persuade their husbands to quit. A Cambodian man suggested,

*We can ask the wives to cooperate in working on helping the husbands to quit, because, in our culture, wives are considered to be the mothers of the house. We trust in this quality of wives. We normally dedicate our actions to the will of our wives. What she dislikes about what we do is what we need to rethink.*

– Cambodian man in his 60s, in the United States for 21 years

However, one of our interviewees suggested that greater gender equality in the United States might make women less effective at persuading their husbands compared to the homeland. A Vietnamese man explained that presently, in Vietnam, tobacco-control efforts successfully encourage wives to use “pillow talk” to get their husbands to quit. Wives are a huge influence in the family in Vietnam, and pillow talk is a driving force in decision-making. This man was unsure about whether a similar approach would work in the United States, because women’s increased economic and social power often leads to more conflict in the family and may diminish the effectiveness of pillow talk.

6. Physicians can help smokers quit but must develop an effective message on prevention.

Many studies have documented that physicians are less likely to offer stop-smoking advice and medical treatment to Asian Americans in comparison to European Americans, particularly in the case of less acculturated Asian patients. However, underlying these widely documented problems is a cultural issue about the role of physicians in prevention with Southeast Asian patients.

When asked who would be the best person to tell a smoker to quit, many community leaders recommended physicians, who were viewed as highly knowledgeable, well respected, and trusted. However, interviewees also listed a host of culture and access barriers that prevent Southeast Asian smokers from getting help from physicians to quit smoking.

On the positive side, many echoed the view of this Vietnamese man, who believed that doctors’ expertise made them extremely persuasive in getting smokers to quit:

*I think the most effective persons are doctors. I think the doctors are even more effective than a spiritual leader, because the doctors are the only persons who have the decisive power in this fight against tobacco. Doctors may prescribe something, and instruct the patient to take a pill of this before the meals, or a pill of that after the meals. The patient has to listen. For example, I know that you have some stomach problem, and I tell you to take this pill before the meals. Would you listen? You won’t, because I am not your doctor.*

– Vietnamese man in his 60s, in the United States for 10 years

Similarly, a Laotian former smoker said,

*The community wouldn’t be able to help [the smoker]. An organization could only help a little bit. The person that could help the most is the doctor, because everybody is afraid to die. If the doctor points out the fact that smoking could kill the person, [that person] probably would be more determined to quit smoking versus if he heard it from someone else.*

– Laotian man in his 60s, in the United States for 12 years

However, while physicians are highly respected, many
interviewees reported that people in their community often do not go to see the physician until they are seriously ill. In part, this is because they may have limited access to the health care system. In addition, in these cultures, the hospital has been thought of as a place to go only when one is very sick and is seen as a place to die. Similarly, physicians are for people who are already sick. In other words, Southeast Asians do not tend to associate physicians and hospitals with the concept of preventive health. As a Cambodian former smoker observed,

What I see is that the Khmer wait until they get sick. [They will not quit] until the doctor says, “If you smoke, you die, understand?”

– Cambodian man in his 60s, in the United States for 20 years

In other words, physicians are trusted sources for help, but since smoking is not seen as a “medical problem,” they are thought necessary only when serious symptoms emerge. As a Hmong man explained,

We don’t [go] directly to the doctor or ask for treatment [for smoking]. Besides, the treatment is a last resource because that is a stigma. So a lot of [smokers] stay away from it. This is the way the Hmong community has always done.

– Hmong man in his 50s, in the United States for 13 years

Clearly, there is a limited concept of preventive medicine, and physicians are associated with serious illness. Therefore, when a physician says, “You should quit,” some smokers may hear, “It’s OK to smoke until I have symptoms; then I should quit,” rather than the preventive message that is intended. The risk of being misunderstood in this way suggests the need for physicians to teach their patients about the importance of prevention in general and to explain the long-term impact of smoking on health.

Part III: Summary

Although acculturation increases smokers’ desire to quit, cultural barriers and barriers of access, awareness, and the lack of culturally and linguistically appropriate services prevent smokers from obtaining help and using stop-smoking medications. Cultural barriers include shame of addiction, fear of losing face, and the premium placed on mental control. To overcome these barriers, stop-smoking interventions must protect smokers’ privacy, build trust, and employ great sensitivity. Both community-based services and stop-smoking telephone helplines can help smokers avoid shame, the former by building on existing relationships of trust, and the latter by ensuring confidentiality and privacy.

Family, community, and clan are key cultural assets to leverage in helping Southeast Asian community members quit smoking. However, while family members remain the primary people who can ask smokers to quit, acculturation sometimes leads to role-reversals in which some children tell their parents to quit—a development that not everyone accepts. Finally, although physicians are highly respected and influential among Southeast Asians, physicians must overcome significant cultural and access barriers that lessen their effectiveness at helping Southeast Asians quit smoking.
Because acculturation involves a constant negotiation between the culture of the homeland and the culture of one’s new home, the people who are working to reduce tobacco use within immigrant communities have a challenging task. Creating “culturally appropriate interventions”—a logical idea—is complicated by the fact that the cultures of the Cambodian, Hmong, Laotian and Vietnamese communities are constantly shifting, as communities incorporate new aspects of Minnesotan and American cultures into their own. Community members’ beliefs about smoking are influenced by their homeland traditions as well as the multiple, often conflicting, array of smoking-related messages that they encounter in Minnesota. Such messages include the “No Smoking” signs in the workplace and public service announcements about the diseases that smoking causes, but also include targeted advertisements for cigarettes that associate smoking with success, and the sight of American children and women smoking openly in public.

To further complicate matters, different members of the community have different vulnerabilities based upon their level of acculturation, age, and gender, and will require different interventions. As the results illustrate, an elderly Laotian man who has been smoking since his twenties and who speaks little English has different needs than a second-generation Hmong woman in her twenties, who began smoking with her American friends. Even less is known about designing interventions for the more acculturated members of the Southeast Asian communities. Relatively acculturated community members have a greater involvement in the mainstream culture, yet are still influenced by their family and community.

To address this challenge, Part IV provides specific guidelines for designing strategies to lessen the harm of tobacco use in Southeast Asian communities. These suggestions have not been proven to work through scientific testing; however, they provide new ideas for developing culturally competent approaches that should be evaluated.
1. Develop strategies to counter the negative effects and build on the positive effects of acculturation.

The following table summarizes some of the insights on risk factors, protective factors, and strategies for tobacco control, organized by level of acculturation. The strategies in this table and the following sections are based on the implications of prior sections and on the explicit recommendations of the community leaders.

Table 4.

<table>
<thead>
<tr>
<th>Southeast Asians with Lesser Levels of Acculturation</th>
<th>Southeast Asians with Greater Levels of Acculturation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who are they likely to be?</td>
<td>Younger community members and those who interact more frequently with mainstream Minnesotans, often in school and/or in the workplace.</td>
</tr>
<tr>
<td>Potential risk factors that may encourage smoking</td>
<td>• Strong integration of tobacco in homeland culture.</td>
</tr>
<tr>
<td></td>
<td>• High prevalence of smoking among men in homeland.</td>
</tr>
<tr>
<td></td>
<td>• Little knowledge/many misconceptions about the dangers of smoking and secondhand smoke.</td>
</tr>
<tr>
<td></td>
<td>• Lack of culturally and linguistically appropriate stop-smoking programs and educational materials.</td>
</tr>
<tr>
<td></td>
<td>• Shame related to nicotine addiction is a major barrier to seeking help to quit.</td>
</tr>
<tr>
<td></td>
<td>• Little familiarity with concept of preventive health.</td>
</tr>
<tr>
<td></td>
<td>• Stress, social isolation, and/or depression may lead to smoking to offer perceived relief.</td>
</tr>
<tr>
<td>Potential protective factors that may discourage smoking</td>
<td>• Loosening of social restrictions that discourage smoking among youth, women, and many of the Hmong.</td>
</tr>
<tr>
<td></td>
<td>• For youth, greater susceptibility to peer pressure in the United States.</td>
</tr>
<tr>
<td></td>
<td>• Smoking may be associated with “being American” and being “free,” especially for women.</td>
</tr>
<tr>
<td></td>
<td>• Stressors that come with faster-paced, “American” lifestyle.</td>
</tr>
<tr>
<td></td>
<td>• Stressors that come from “straddling” two cultures.</td>
</tr>
<tr>
<td>General strategies for tobacco control</td>
<td>• Higher levels of knowledge about harm of smoking and secondhand smoke.</td>
</tr>
<tr>
<td></td>
<td>• Minnesotan/American norms in which smoking around others is increasingly unacceptable.</td>
</tr>
<tr>
<td></td>
<td>• Declining popular image of smokers in Minnesota/United States.</td>
</tr>
<tr>
<td></td>
<td>• May be more likely to seek and accept counseling and use stop-smoking medications for quitting.</td>
</tr>
<tr>
<td></td>
<td>• Increased freedom for women may empower them to institute smoking bans in the home and to persuade their husbands to quit.</td>
</tr>
<tr>
<td></td>
<td>• Consider culturally specific strategies that have been successful in general populations.</td>
</tr>
<tr>
<td></td>
<td>• Interventions might focus on the challenges of being a second- or third-generation Southeast Asian and having to straddle both American and Southeast Asian cultures.</td>
</tr>
</tbody>
</table>

- Norms against smoking for women and youth enforced by high levels of social control. |
- For Hmong, daily smoking was traditionally uncommon and culturally discouraged. |
- Tightly knit families, communities, and clans may help motivate smokers to quit/avoid smoking around others. |
- Cultural responsiveness to social norms, including new American norms that devalue smoking.

- Leverage cultural assets that support tobacco control. |
- Create stop-smoking and educational programs, that are consistent with traditional cultural values and health beliefs. |
- Change cultural traditions that work against tobacco control. |
- Create alternative rituals to substitute for the social bonding function served by smoking. |
- Increase access to and availability of culturally and linguistically appropriate services.
2. Tailor interventions to unique vulnerabilities of different segments of the community, based on level of acculturation, age, and gender.

Because acculturation has different effects on the smoking behavior of men and women, and youth and adults, a “one-size-fits-all” intervention will not be fully effective. Instead, interventions should target the risk factors for various vulnerable groups. The table below illustrates the complex relationship between community, age, gender, level of acculturation and risk of smoking, and suggests potential issues that members of these subgroups face.

### Table 5.

<table>
<thead>
<tr>
<th>Community</th>
<th>Age/ Gender</th>
<th>Greater Risk if...</th>
<th>Issues</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hmong</td>
<td>Everyone except elderly men</td>
<td>More acculturated</td>
<td>Acculturation may lead to adoption of smoking as an American custom. Issues differ by age and gender. (See below.)</td>
<td>(See below for age- and gender-specific strategies.)</td>
</tr>
<tr>
<td>Hmong</td>
<td>Elderly/older men</td>
<td>Less acculturated</td>
<td>Cultural respect for age may inhibit family members from pressuring elderly smokers to quit.</td>
<td>Address the social isolation and stress that may underlie smoking behavior and may be a barrier to quitting.</td>
</tr>
</tbody>
</table>
| Cambodians, Laotians, & Vietnamese | Elderly/older men | Less acculturated | • May be more likely to be hardcore, long-time smokers.  
• May be less likely to quit, more likely to smoke around others, less knowledgeable about the risks of smoking, and lack understanding of preventive health care. | • Improve access and reduce language barriers to obtaining help to quit.  
• Address the stress associated with immigration/relocation and social isolation, which may be a barrier to quitting.  
• Introduce activities that may serve the social bonding function that smoking served in the past. |
| Cambodians, Laotians, & Vietnamese | Young adult men (early 20s) | Less acculturated | Youth may begin smoking in early 20s as a sign of manhood and independence. | Target this age when men are most vulnerable to smoking initiation, which may be later than more acculturated and mainstream youth. |
| Cambodians, Hmong, Laotians, & Vietnamese | Male youth | More acculturated | Decrease in parental influence, increase in peer influence, and desire to adopt mainstream behaviors, such as smoking, makes acculturation a risk factor for smoking. | • Explore potential to combine mainstream interventions with interventions that address the issue of smoking as a strategy for becoming “Americanized.”  
• Emphasize the ways in which the tobacco industry targets youth and their ethnic community. |
| Cambodians, Hmong, Laotians, & Vietnamese | Female youth | More acculturated | In addition to all the risk factors for more acculturated male youth (see above), female youth, who have more restricted roles at home, may begin smoking as a way to rebel against social constraints. | Counter the idea that rebellion and independence can be achieved by smoking; present nonsmoking as a way to achieve independence. |
| Cambodians, Hmong, Laotians, & Vietnamese | Women | More acculturated | Relatively more acculturated women may smoke as a sign of independence, equality, and Western glamour. These messages are promoted by the tobacco industry. | Directly attack these industry messages with counter-marketing. |
3. Develop tobacco-control programs built upon traditional cultural values and beliefs.

Build tobacco-control efforts on traditional values of politeness, sensitivity, and the importance of acting in ways that benefit the family, community, and clan.

Show how smoking is a sign of disrespect to the individual smoker, the smoker’s family, and the community. Promote the message that not smoking in other people’s presence is a sign of respect. Emphasize benefits to family and community in addition to the benefits to the individual smoker. For example, smokers might be encouraged to quit so they can be healthy for their families and so they can be good role models and create better futures for their children.

Capitalize on the cultural importance placed on not harming others, particularly children, by focusing on the dangers of secondhand smoke.

Even with minimal understanding of the risks of exposure to secondhand smoke, most Southeast Asians appeared to be concerned about its effect on their children. Successful messages could build on this motivation by focusing on the negative impact that secondhand smoke has on vulnerable populations, such as children, the elderly, or pregnant women. Messages might also include the idea about respect for others in enclosed spaces and why smoke is particularly dangerous in the well-sealed homes that exist in Minnesota. In addition to the physical risks, messages might also focus on the discomfort of people who are near a smoker or the lack of respect that a smoker shows for others.

Pay attention to the unspoken, unwritten rules about negotiating smoking in social situations.

For example, suggesting that hosts simply ask outright that their guests not smoke in their homes might not be effective for the majority of the Southeast Asian communities in Minnesota. Instead, a prominently displayed sign that would hint politely at the proper conduct or the desire of the host might be more appropriate.

Work with families, clans, and community organizations to develop interventions and outreach.

Mutual assistance associations, temples, and churches form the infrastructure of these immigrant communities and are trusted sources of information and assistance.

Work through these established community channels to garner support from family members, friends, community leaders, clan leaders, priests, and monks. Work with them to send the message that smoking is not a personal matter but an issue that negatively affects the family and the future of the whole community. Promote the idea that tobacco control is the whole community’s responsibility.

Leverage the role of women in the household.

Support women’s influence in creating a smoke-free environment in their homes and helping family members quit smoking. This influence can help change cultural rituals that traditionally involve smoking.

Consider the impact of acculturation on the traditional family hierarchy.

Be aware of the important role that children can play in an immigrant family, while keeping in mind the diverse views on the acceptability of children telling family members to quit.

Establish trust, build relationships, and ensure privacy for stop-smoking interventions.

Develop culturally and linguistically competent services that operate on the basis of trust and confidentiality. Community-based services and stop-smoking telephone helplines are two different strategies to overcome the barrier of potential loss of face. Communication efforts should clearly emphasize the relative strengths of these different approaches. Specifically, community-based services offer an ongoing relationship with a trusted community member, whereas stop-smoking telephone helplines offer anonymity and privacy. Regardless of the specific approach, counselors should recognize the psychological risk taken by smokers when asking for help to quit and should help manage potential feelings of shame.
4. Tailor communication promoting knowledge about the harm of smoking to communities’ existing levels of knowledge.

Lack of knowledge about the health risks of smoking and secondhand smoke remains a barrier among Southeast Asians, particularly among the less acculturated and less well-educated. Because more recent Southeast Asian immigrants have had less exposure to public health campaigns than most mainstream Minnesotans, and because those immigrants have different beliefs about health and disease, mainstream messages about the long-term effects of smoking may lack resonance and impact.

Education is clearly needed about the long-term health effects of smoking. However, just as it has taken several decades of similar messages to take hold in mainstream American culture, it may take some time for those messages to fully penetrate the awareness of Southeast Asian community members, especially those who are less acculturated. In addition, more research is needed to better understand how people from these cultures think about health and disease processes. It is a mistake to assume that Southeast Asians share the same Western assumptions as mainstream Americans about the impact of smoking on the body, and these mainstream messages may not resonate at all.

Interviewees suggested some ways in which many Southeast Asians think about the impact of smoking on the body. They suggested concerns such as skin and fingernail discoloration, increased coughing or shortness of breath, and odor in houses and clothes. These perceptions offer a starting point for crafting prevention and stop-smoking messages. Instead of focusing on the less visible, long-term health consequences of smoking, interventions might focus more on the immediate and readily apparent health effects of smoking.

Interventions might also target some of the common misconceptions about the effects of smoking that exist in these communities, such as the following:

- Homegrown tobacco is “safer” because it has no additives.
- You’ll be able to “tell” if smoking is making you sick.
- The fact that there are 90-year-old grandfathers who smoked all their lives and never got sick means that smoking is not unhealthy.

Communication strategies need to account for the less acculturated, who may lack formal education, English-language skills, and literacy. For instance, since the Hmong language became a written language only recently, many Hmong who are fluent speakers cannot read or write it. Appropriate communication strategies for these Hmong may include pictures, videos, and informal education by fellow community members.

A longer-term approach could create appropriate interventions to promote the concept of preventive health and develop basic health literacy skills.

5. Address the social isolation and stress that may underlie smoking behavior for certain smokers and may be a barrier to quitting.

Many refugees and new immigrants have experienced a great deal of trauma and continue to experience a multitude of stressors. When designing stop-smoking efforts, consider the function that tobacco may be serving from the perspective of the smoker. Many smokers may be smoking for self-medication and stress-relief. To quit successfully, these individuals may require assistance to address the psychological or social problems they are attempting to treat with cigarettes.

6. Modify cultural traditions that work against tobacco control.

Work with Southeast Asian communities to “de-normalize” the use of tobacco over time. Be aware that tobacco is likely to have many positive associations for adult smokers because of its cultural significance and value in the homeland. Immigrants typically try to hold on to their cultural traditions, fearing a loss of identity in a foreign land. Yet, some traditions may need to be modified. Because tobacco served a multitude of positively perceived functions in the Southeast Asian homelands, communities might be encouraged to explore how to replace tobacco and cigarettes. For example, what could substitute for cigarettes as a gesture of hospitality or as a way to honor an ancestor? What other cultural rituals could mark young men’s entrance into manhood?

Some ideas are to promote tobacco-free community celebrations, to encourage the use of candies instead of cigarettes at weddings, and to promote images of men socializing without smoking. Communities also might
promote smoke-free public places, worksites, restaurants, and bars where Southeast Asians tend to gather. A community might encourage families to voluntarily ban smoking in their homes and cars.

7. Develop effective preventive messages for health care providers.

Health care providers need to become aware of the cultural barriers that prevent Southeast Asians from seeking help to quit smoking within the health care system. Physicians already have the respect of the community. They should capitalize on that respect to actively help smokers quit, and educate smokers about the value of nicotine replacement therapy. Physicians and other providers should work to develop an understanding of prevention with their Southeast Asian patients and become more proactive during office visits in identifying and encouraging patients to quit smoking. Providers must behave in ways to counter the idea that the only time one asks a doctor to help quit smoking is when one is already sick.

Because most Southeast Asians regularly bring their children to the doctor, pediatricians are in a unique position to educate parents about the health risks of smoking and secondhand smoke and to provide parents with appropriate stop-smoking resources. Lists of culturally appropriate resources could be developed and distributed to Minnesota providers.

Health plans and providers should partner with Southeast Asian community members to do a better job at smoking prevention and stop-smoking efforts. Such partnerships can help ensure that tobacco-control interventions are delivered in an appropriate and meaningful way.

Part IV: Summary

Sensitivity both to traditional cultures and to varying degrees of acculturation are critical to successful initiatives to reduce tobacco use in Southeast Asian communities. Strategies should counter the negative effects and build on the positive effects that acculturation has on tobacco-related behavior. In addition, strategies should be tailored to different segments of the community based on level of acculturation, age, and gender, and should be built upon traditional cultural values and beliefs. Interventions should leverage the cultural importance of behaving in ways that benefit the family, community, and clan, and should be designed to help smokers avoid the loss of face associated with seeking help to quit smoking. It is also critical to modify tobacco-related cultural traditions and for health care providers who treat Southeast Asian community members to emphasize prevention.
COLLABORATING ORGANIZATIONS

Asian Pacific Tobacco-Free Coalition of Minnesota (APT-FCM) is an organizational network representing the diverse Asian population of Minnesota. Originally established in 2000 with a grant from the Minnesota Partnership for Action Against Tobacco, APT-FCM is a nonprofit organization with a mission to unify ethnic Asian community efforts against tobacco while promoting health education.

Blue Cross and Blue Shield of Minnesota (Blue Cross), with headquarters in the St. Paul suburb of Eagan, was chartered in 1933 as Minnesota’s first health plan and continues to carry out its charter mission today: to promote a wider, more economical and timely availability of health services for the people of Minnesota. Its Center for Tobacco Reduction and Health Improvement was formed in 1998 in the wake of Blue Cross’s landmark lawsuit against and settlement with the tobacco industry. Renamed the Center for Prevention in 2005, the center oversees Prevention Minnesota, Blue Cross’ long-term initiative to make Minnesota a healthier place to live and work by reducing tobacco use and other risk factors for heart disease and cancer. Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association.

Minnesota Partnership for Action Against Tobacco (MPAAT) is an independent nonprofit organization that improves the health of Minnesotans by reducing the harm caused by tobacco. MPAAT serves Minnesota through its grant-making program, QUITPLAN™ services to help people stop smoking, and statewide outreach activities. It is funded with three percent of the state’s tobacco settlement.

Southeast Asian Refugee Community Home (SEARCH) is a diverse group of Pan-Asians (representing Cambodian, Hmong, Laotian and Vietnamese heritage) founded in July 1992. Founders understood the need and value in building bridges across ethnic community lines to effectively serve immigrants and refugees, while also filling gaps for culturally specific, employment-focused services tailored to unique language and cultural needs of immigrants and refugees in the new homeland of Minnesota and the United States. The mission of SEARCH is to assist Southeast Asian and other refugees and immigrants in becoming contributing members of their community. Since 2004, SEARCH has served East African refugees as well. During the agency’s 13-year history, several thousand Southeast Asians and East African refugees have been served in employment training, daycare provider, computer and youth services; and about 1,500 individuals have been placed into jobs. Since 2002, SEARCH has actively participated in the DREGAN Project with a mission to achieve measurable reduction in tobacco use in Minnesota’s Southeast Asian community through research and intervention.

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All interviewees spoke eloquently about their own experiences and their communities’ experiences with tobacco, in their homeland and in Minnesota, and we are indebted to them for the stories they shared.

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REFERENCES


