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A Critical Examination and Revisioning of Minority Health Frameworks, Research Methodologies, and Intervention Models Addressing South Asian American Health Disparities

By

Arnab Mukherjea

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Public Health

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Patricia A. Morgan, Chair
Professor Susan L. Ivey
Professor Lonnie R. Snowden

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Abstract

A Critical Examination and Revisioning of Minority Health Frameworks, Research Methodologies, and Intervention Models Addressing South Asian American Health Disparities

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Public health focuses on promoting health and preventing disease at the population level. More recently, the enterprise of public health in the United States has emphasized the importance of understanding and eliminating disparities in health indicators among racial and ethnic minority populations. Federal surveillance systems often aggregate all ethnic groups originating from Asia into a singular category, despite tremendous diversity of cultural features, demographic characteristics, and historical patterns of migration in the United States. Moreover, mainstream institutions have deemed members of this ethnic community as a "model minority" and as such, not a high priority for public health and social service endeavors. This is especially true for the South Asian community—individuals with origins from Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and other areas of the Diaspora—for which a lack of attention on health prospects is evident within the field of public health. In addition, much of this positive ascription is internalized by community members and, as a result, public concern about issues of health and social inequities are often absent. This is despite evidence of disparities in adverse outcomes pertaining to cardiovascular disease, cancer, and specific forms of violence, among other disparities.

With these considerations in mind, the objectives of this dissertation are to: (1) examine multilevel (e.g., social, cultural, organizational, behavioral) influences on understanding and addressing disparities of tobacco-related disease and violence among South Asians in the United States; (2) elucidate considerations for conducting health disparities research and/or implementing targeted intervention strategies among South Asian American communities; (3) assess the ability of culturally-oriented and/or community-based minority health frameworks to adequately identify and impact the health and well-being of South Asian populations in the United States.

To accomplish these objectives, the dissertation is comprised of two qualitative studies which examine the cultural context of tobacco use and the organizational response to specific forms of violence among South Asians in the United States. The first study elucidates unique considerations in conducting health surveillance research measuring the prevalence and impact of culturally-valued behaviors strongly associated with preventable conditions. The second study examines how organizations—individually and collectively—respond to stigmatized yet preserved patterns of behavior which have adverse health and social consequences. By focusing

on existing disparities, these studies highlight directions for more nuanced research and identify multiple targets for intervention for current issues of public health concern. Concurrently, study findings provide insight into areas where contemporary minority health frameworks may benefit from critical reflection, revision, and expansion.

Study results indicate that cultural values and social position are key determinants of knowledge, at-risk behavior, and preservation of normative structures associated with disproportionate indices of poor health. Situational identity and a reluctance to associate with disenfranchised minority populations seem to supersede awareness and articulation of health and social consequences related to behavior and prospects of community well-being. These patterns are pivotal in enhancing modalities of public health research and practice in understanding and addressing excess burdens of illness and injury in this rapidly-growing minority population. Moreover, public health frameworks focusing on minority populations don't often account for these unique considerations as they pertain to cultural identity, social position, and ethnic distinction.

Dissertation study findings and analyses demonstrate a necessity for heightened attention to creating surveillance measures which adequately and accurately assess culturally-specific contexts of behavior. They also highlight the complexities of designing and implementing strategies—in the absence of prescriptive approaches—which target cultural norms as a primary determinant. By understanding and incorporating these considerations in research and practice, public health endeavors may achieve more success in its worthy goal of eliminating racial and ethnic disparities. Furthermore, these studies may also highlight conceptual and practical attributes which have considerable overlap with other emergent populations. Commitment to an ongoing awareness and incorporation of dynamic cultural contexts—especially among understudied populations—will enable the field of public health to truly have a significant impact on all communities which depend on its success.

Acknowledgements

The completion of this dissertation would not have been possible without resources of funding, time, and the expertise of many. This section details the entities that made this work a reality.

The two studies requiring primary data collection were only made possible with research support from following institutions: (1) National Cancer Institute; (2) Asian American Network for Cancer Awareness, Research and Training (Cancer Center; University of California, Davis); and (3) Health Research for Action (School of Public Health; University of California, Berkeley).

The first two entities provided funding, administrative oversight, and technical assistance for the research-oriented South Asian tobacco study. Moon S. Chen, Jr—Principal Investigator of the Asian American Network for Cancer Awareness, Research, and Training—deserves special recognition for his support and advocacy of ensuring that funds were procured for research activities and professional development. Other members who provided valuable mentorship and guidance are Tung Nguyen and Dileep G. Bal.

Funding for the practice-oriented violence study was made possible through a grant from Health Research for Action. Financial and human resources were pivotal for collecting the vast quantity of qualitative data needed in this study. Health Research for Action's Co-Principal Investigator, Linda Neuhauser, and Director of Research, Susan L. Ivey, were instrument in making these resources available to ensure this study was completed.

Many organizations also made this research possible. Facilities were offered at no cost for data collection from many organizations, including Chicago's Hamdard Center, Devon Bank, School of Public Health at the University of Illinois, Chicago, Illinois Institute of Technology, and the University of Chicago. In the San Francisco Bay Area, the Center for Public Health Practice in the School of Public Health at the University of California, Berkeley, and the India Community Center provided complementary facilities for data collection. Chapman University in Yuba City, CA, also ensured that pro-bono space was available for research activities in this vicinity.

A number of dedicated individuals also donated their time, expertise, and support to make this dissertation possible. In no order of importance, they include Ami Shah, Sharmila Rao Thakkar, Chris Zala, Susan Patel, Irving Loundy, Kiran Siddiqui, Linda Groetzinger, Davinder Deol, and Asha Bajaj. Though they must remain unnamed, key informants and focus group participants were the key source of contextual information and critical feedback needed to ensure that this dissertation was truly reflective of the community it is meant to serve.

This dissertation would not have been made possible without the dedication and commitment of the faculty members associated with this doctoral project. They include members of the author's Qualifying Examination Committee—D. Malcolm Potts, Emily Ozer, Susan L. Ivey, Irene Bloemraad, and Abhijeet Paul—who ensured an appropriate theoretical

framework, rigorous relevant research protocol, and appropriate community contexts. Most importantly, the author's Dissertation Committee Members were instrumental in ensuring that this dissertation was completed in the manner necessary to fulfill its intended objectives. Lonnie R. Snowden provided invaluable methodological expertise and recommendations for the conceptualization of each study and the overall dissertation. Susan L. Ivey made sure that social, structural, and biological premises were consistent with scientific bases of health and well-being while also providing suggestions for inclusion of frameworks not initially considered. Patricia A. Morgan was instrumental in making sure that the studied were held to the highest standards of qualitative research and meta-analyses were appropriate for critical assessments and the overall potential contribution of the dissertation to the field of health disparities research. All Committee Members entertained and invited conception, implementation, and critical analysis of the entire body of work encompassed in this dissertation. Despite the tremendous scope of work, they encouraged that this work was completed to the fullest extent possible, to ensure that the author's professional development was maximized and commitment unfettered.

Dedication

Although this dissertation is meant to be a largely academic exercise, it has a profound purpose in my life. As a member of the community whose health prospects are examined in this research, I have been personally impacted by the issues detailed in this paper. I know firsthand that many of my fellow South Asians not only experience consequences of the increasing rates and severity of health disparities in our community, but also are at a loss of how to address these issues. Barriers to health improvement and social well-being—from the field of public health, public and private institutions, researchers and practitioners, and dominant community perspectives—have been cited repeatedly by my friends, family, and colleagues as reasons for the unexpected demands and sorrow resulting from poor health and loss of quality of life. It is easy to criticize the lack of attention and resources paid to issues of equity and social justice; it is more difficult to try and create systemic change at multiple levels in order to make an impact. It is my hope that this dissertation provides a springboard for me and others who are dedicated to ensuring health parity for South Asians, in collaboration with other affected populations.

However, my own ability to start on this lifelong journey would not have been possible by those who have dedicated and sacrificed much to allow me to realize my professional potential and pursue my personal dreams. Professionally, I must emphasize the role that Malcolm Potts, Susan L. Ivey, and Patricia A. Morgan have played in ensuring my success. These three individuals have not only pursued every possible avenue to make sure that resources and opportunities were abundant for my graduate training and professional development, they also risked their formidable reputations and influence for me to gain access to environments and endeavors that I would otherwise not have been able to avail of. Outside of serving as my most primary influences on all of my educational pursuits, they always treated me as an equal and supported me wholeheartedly every step of the way. This dissertation is a small but significant symbol of their endless dedication to mentorship, support, and development of the next generation of health leaders.

The success of one does not simply revolve around their professional networks. Without the encouragement and sacrifice of my family members, professional accolades hold little chance of success. My parents—both of who have been impacted by the issues laid out in this dissertation—have been a constant reminder of positive value of the South Asian family orientation. They have not only been my primary source of financial support throughout most of my academic career, they have exhibited an unwavering commitment to ensuring that my lifelong objectives are met in a manner consistent with my values. To Prasun and Tripti Mukherjea, I not only dedicate this dissertation, but also my current and future work to eliminate the conditions which they have experienced and suffered firsthand.

Finally, one beacon stands higher than all the other tall structures in my life. My wife, Surupa Mukherjea, has sacrificed her own career pursuits and social familiarity to join me in marriage and life as I complete this experience and move onto future academic pursuits. Words on a dedication page in a dissertation can in no way encapsulate the tremendous gratitude and love I feel for someone willing to forgo so much to accommodate my own professional and personal determination. Outside of my inability to ever reciprocate fully, I hope that this and future work will help improve the collective health and well-being of the population to which we both belong. Social change begins with the sacrifice of many; she is one who truly lives up to the ideal that I hold for our entire community.

Preface

What started off as an exploratory assignment for a course requirement has culminated in the completion of this dissertation. Although the initial objective of this academic exercise was to concurrently acquire and demonstrate mastery of subject matter, a personal fascination and community commitment was borne out of the process. This endeavor has profoundly elucidated what it truly means to be a member of the South Asian community in the United States, and the privileges and consequences that are afforded therein.

Embarking on this doctoral research process has illuminated the wonder, complexity, and satisfaction of improving health among culturally diverse communities. More importantly, it has been a source of defining and redefining social identity and revealed the true meaning of collective responsibility. These understandings have been realized and spoken about for generations. However, unless one truly immerses themselves in the social realities faced by impacted communities, one cannot definitely understand how social, cultural, interpersonal, and cognitive process interact dynamically to produce positive or adverse health prospects.

Although this dissertation may primarily serve an academic purpose, the hope is that others may utilize and critique it to improve the health of all minority populations in the United States. To that end, this dissertation is a testament to the promise and potential that the field of public health has in understanding and affecting the conditions which facilitate optimal health. It also serves as a reminder that even a mythical "model minority" is only as privileged as its most disenfranchised members. Hopefully, the conclusions of this dissertation highlight some nuances which are of utility to not only South Asians, but other communities who may suffer from similar influences and consequences.

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Chapter 1

Introduction

FOCUS OF THE FIELD OF PUBLIC HEALTH ON REDUCING AND ELIMINATING RACIAL/ETHNIC DISPARITIES

In recent history, the field of public health has begun to focus on inequities in health. Not only have disparities in access to and quality of health care been investigated, but significant attention has been paid to the social, economic, political, and cultural influences which contribute to between-group differences in health and well-being (Thomas et al., 2006; U.S. D.H.H.S., 2000; U.S. D.H.H.S., 1991). With its emphasis on population-based preventive health, the field of public health in the United States has been most concerned with examining differential health indicators in racial/ethnic groups, although disparities among different sexual identities, gender, educational levels, and socioeconomic status have also been investigated (Eberhardt & Pamuk, 2004; Smedley et al., 2003; Marmot, 2004; Adler & Marmot, 1999; Harrison, 1996; Baker, 1993).

In the United States, most large-scale research studies and intervention programs have utilized six major race or ethnic groupings, defined by the United States Office of Management and Budget: White, Black/African American, American Indian & Alaskan Native (A.I.A.N.), Asian, Latino/Hispanic, and Native Hawaiian & Other Pacific Islander (N.H.O.P.I.). More recent surveillance systems have adopted a "some other race" or "multiple race" category (U.S. Census, 2000). The separation of Asians from Pacific Islanders is also a modern development, as both of these populations had been grouped together in pre-2000 United States Census classifications. Although other parameters of community identity may be more pertinent in understanding social determinants of health, the current movement in major public health institutions is to eliminate disparities impacting racial and ethnic minority populations in the United States (U.S. O.M.B., 2007; A.P.H.A., 2006; U.S. D.H.H.S., 2005).

Many new public health models assume that the role of culture is inherently beneficial, without critically examining the benefits and consequences of preservation. Relevant sociological literature has suggested the within the racialized United States hierarchy, African-Americans assume the "lowest rung", and that other ethnic minorities may follow their trajectory (due to a multitude of historical and social influences). However, the relatively recent presence of South Asians and other Asian subgroups and their ascription as "model minorities" may contradict these assertions. The consequences of perceived success may have culminated in these groups trying to differentiate themselves—economically, professionally, educationally, culturally—from their more disadvantaged minority counterparts (McGowan & Lindgren, 2003; Wong et al., 1998). As such, processes of social identity formation and maintenance may have unique influences on the preservation or abandonment of culturally-valued behaviors impacting health. Distinct patterns of immigration and pathways of incorporation provide a mechanism to understand the complex patterns of assimilation and acculturation adopted by South Asian in the United States.

The purpose of this dissertation is to examine the intersection of social position and cultural systems on disproportionate indices of health impacting the South Asian population in

the United States. Using relevant social, historical, and demographic patterns as a backdrop, this dissertation will elucidate the complexities of conducting research and implementing programs to address significant health disparities among this rapidly-growing population. Moreover, using the results of two qualitative studies, this dissertation will assess contemporary minority health frameworks for adequacy and comprehensiveness to ensure optimal health among this understudied community.

UNIQUE CONSIDERATIONS IN UNDERSTANDING HEALTH DISPARITIES WITHIN THE ASIAN/PACIFIC ISLANDER CONTEXT

Although there is diversity within all of the Census-classified racial/ethnic groupings, the heterogeneity of the Asian demographic identifier is substantial. The Asian racial category encompasses individuals from over fifty countries and regions, each with distinct and multiple histories, traditions, and cultures (U.S. N.L.M., 2007). In addition, individuals with origins in Asia speak over 100 official languages and thousands of dialects, and practice over 20 established religions (U.N.E.S.C.O., 2007). As of 2006, approximately 14.7 million individuals of Asian descent live in the United States, making up 4.9 percent of the national population (A.P.I.A.H.F., 2009). Given the linguistic, religious, and cultural diversity that comprise the Asian identifier, the utilization of a superficial demographic category serves little purpose. For public health specifically, this umbrella categorization masks severe disparities in certain Asian subgroups while overemphasizing inequities for others. For instance, Hepatitis B is largely seen as an Asian health issue, whereas in reality, it is severely overrepresented in Chinese and Southeast Asian communities (e.g. Laos, Cambodia, Malaysia, Thailand) (A.L.C., 2005). Koreans have the highest incidence and mortality from stomach cancer of any ethnic group (Parker et al., 1998). In contrast, diabetes is disproportionately prevalent among South Asians and cardiovascular disease is the largest cause of mortality (S.A.P.H.A., 2003). Although combined demographic and health data serve a political purpose, leading national and regional Asian American health institutions have repeatedly called for disaggregation of information in order to understand important nuanced differences between Asian subgroups. In response, the 2000 Census and other major health surveillance systems have begun to separate the Asian category by major subgroups.

DEFINITION OF "SOUTH ASIAN"

South Asians—individuals with origins from Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and other regions of the Indian subcontinent, as well as other areas of the Diaspora (e.g., Fiji, Trinidad, Africa, England, Canada, United States)—are the second largest Asian American group (A.P.I.A.H.F., 2009). South Asians constitute almost three million residents in the United States and are 20 percent of the Asian American population. In addition, they are the one of the fastest growing minority populations in the United States (A.C.S., 2005). Despite large diversity within the South Asian population, this subgroup maintains more demographic similarities than differences, as opposed to their other Asian counterparts. This is largely due to generations of common colonialization and political oppression as well as cultural similarities in belief systems and behavioral patterns, despite relatively recent political and religious volatility within the Indian subcontinent (Waters & Ueda, 2007). In addition, differential migration

patterns (such as "intermediate" and multiple destinations of immigration) may contribute to additional differences between South Asian subgroups. Despite these important differences, there is a significant amount of demographic overlap pertaining to language, religion, region of migration, as well as other social and cultural variables associated with health behaviors and outcomes.

BACKGROUND AND SIGNIFICANCE

Identification of South Asian subgroups in United States History

The ancestor of the current United States Census began in 1790 and this national survey has continued to collect data on a decennial basis including its most recent iteration in 2000. Until 1840, the only categorical "race" data collected was grouped into "White" and "Slave". These categories were revised and expanded to include "colored", "mulatto", and various other distinctions based on the proportion of blood which was "colored" ("quadroon", "octoroon", etc.) in the mid-1800s (Bennett, 2000). The first Asian subgroup, "Chinese", made its appearance on the U.S. Census in 1860 (U.S. Census, 1973). In 1930, in addition to other Asian categories (Chinese, Japanese, Filipino, and Korean), the first South Asian subgroup was defined in the U.S. Census as "Hindu" (Bennett, 2000). Ironically, this was a religious identifier, as opposed to the other categories, which were based on region of origin. In 1960, the "Hindu" category was eliminated and reappeared in 1980 as "Asian Indian", although other South Asian subgroups were not included in the choices for "race" (U.S. Census, 1973). However, all Asian subgroups, irrespective of reporting, were aggregated into an "Asian" category. In 1990, this was formally redefined as "Asian/Pacific Islander" and served as one of five major racial groupings. The 2000 Census was the first to offer disaggregated Asian options for respondents.

Creation of Asian/Pacific Islander (API) Demographic Category for Data Collection in U.S.

The creation of the Asian/Pacific Islander (API) demographic category became the major grouping under which data for this racial group were collected. More recent efforts have succeeded in separating "Asian" from "Native Hawaiian or Other Pacific Islander" (Barnes & Bennett, 2002). Various data collection instruments, including national health surveys, often used this major group, despite tremendous regional, religious, regional, political, and cultural diversity (U.S. O.M.B., 1997). Although differential attempts were made to disaggregate various API subgroups, ultimately, these data are either re-aggregated into one category or result in categorical information that is non-comparable, due to differences in emphasis on which subgroups are disaggregated. For instance, individuals with ethnic origins in the contemporary "Middle East" have been differentially classified as "Caucasian", "Asian", "Other", or "Mixed Race", depending on the specific instrument and/or the temporal or political environment in which this information was collected. One of the most pertinent issues, in this regard, was the method in which information about individuals and communities of South Asian origin was collected, categorized, and analyzed.

Definition of South Asian as an API subgroup

South Asians have had a presence in the United States dating back to the late 1800s, arriving on merchant ships for trade or as indentured servants. In the first wave of documented immigration, almost 7,500 men migrated from the Indian state of Punjab—most of whom were of the Sikh religion—and settled in California and other parts of the western United States (McMahon, 2001). The Immigration Act of 1917 created a major barrier for certain migrant groups, including the region of South Asia. The Act's successor in 1924 prohibited wives, children, and other family members from reuniting with those have recently arrived in the U.S (Leonard, 2007). This resulted in a unique culture of "Mexican Hindus" emerging in Yuba City and the Imperial Valley in California, as South Asian male immigrants seeking family life married into the largely Mexican community (Leonard, 1989). South Asians—not considered "White" or of African descent—were denied citizenship rights and its associated privileges until the 1946 Luce-Cellar/Celler Bill was enacted (Melendy, 1977). This policy lifted bans on immigration from the South Asian region (Chan, 1991). In 1965, the Immigration and Naturalization Act expanded the quota of South Asians allowed into the U.S. by relaxing immigration policies for skilled, highly-educated professionals (Waters & Ueda, 2007; S.A.P.H.A., 2003). Dubbed "the Indian Brain Drain", over 85,000 scientists, doctors, and engineers migrated to the U.S. between 1966 and 1977 (Prashad, 2000). The culmination of this wave of immigration occurred with the reunification provisions of the 1965 Act, which allowed extended family members to immigrate. The final influx of immigrants began in the 1980s, where the expansion of the information technology industry influenced immigration policy by facilitating the entry of more skilled professionals as well as students (S.A.P.H.A., 2003). It should be noted that these South Asians are not officially considered immigrants due their restricted visa status (e.g., work or school-sponsored visas), but play important roles in American society. Like their earlier counterparts, a considerable proportion of these more recent migrants also assume highly skilled capacities in the U.S. workforce. However, due to a number of circumstances—such as the failure of the dot-com sector and subsequent economic downturn—larger numbers of lesser educated South Asians assumed roles in the service sector, such as taxi drivers, convenience store employees, line workers, motel clerks, and gas station attendants. Unlike their more established counterparts, these immigrants reflected a shift in demographic profile representing more socioeconomic disadvantage and less professional and educational training (Rangaswamy, 2007; S.A.P.H.A., 2003).

As of 2000, most South Asian Americans were residing in eight states, the bulk of whom settled in California. The vast majority of South Asians are of Asian Indian descent (over 90 percent). The Asian Indian population in the United States more than doubled between 1990 and 2000. Although the actual population of the other subgroups was significantly smaller than the South Asian majority, the other subgroups grew at a substantially significant rate—as great as 249 percent for Bangladeshis in the United States between 1990 and 2000 (S.A.P.H.A., 2003). However, most demographic and health-data have been collected, albeit in a limited fashion, for Asian Indians in the United States.

PAUCITY OF SOUTH ASIAN DATA COLLECTION

Identification issues

The majority of South Asian information has been collected under the aggregated rubric of Asian and/or Pacific Islander. In recent calls from researchers and health advocates for disaggregated data, most surveillance mechanisms included an "East Indian" category to discern Asian Indians from Native Americans (termed "American Indian") (O'Neill, 2007). All other South Asian subgroups were collected under the "other Asian" category, in with individuals from Nepal, Sri Lanka, Pakistan, Bhutan, and Bangladesh, and other minority Asian subgroups, were aggregated (O'Neill, 2007; U.S. O.M.B., 1997). These issues in categorical data collection prevented the understanding of specific demographic patterns and issues of concern for the entire South Asian community.

Given the politically volatile history of South Asian countries—such as the partition of the Indian subcontinent by religious and linguistic parameters—many members of South Asian communities outside of the Asian Indian majority were reluctant or opposed to identifying themselves as such (Waters & Ueda, 2007). Compounding this issue was the fact that many individuals who were born in the subcontinent prior to 1947 (when all of South Asia was considered part of or territorially affiliated with India) would identify as Asian Indian; however, the subsequent generation born to these individuals may identify themselves as ethnic representatives of the "new" countries of origin, such as Pakistani or Bangladeshi. The amalgam of these factors has considerable implications for collecting accurate demographic information as well as trend data.

It is also important to note that the "South Asian" demographic identifier did not originate from the community itself. This consideration may have influences on public health surveillance mechanisms, intervention strategies, and evaluation methods, especially those that are participatory in theory and practice (Tastsoglou, 2006). In fact, the term "South Asian" was used in academic communities the late 1920s to distinguish then Indian regions from their Middle Eastern (e.g. Iranian) counterparts (Brown, 1964). After the partition of the India, area studies involving the subcontinent were redefined as South Asian, to distinguish themselves from disciplines concerning Southeast Asia. This label began its popular usage to describe this population in the late 20th century; its adoption by community members for self-identity is questionable.

South Asian subgroup diversity

South Asians are a tremendously diverse group, in terms of religion, culture, and language. This diversity encompasses seven countries and many more Diasporic groups with over 30 official languages and countless spoken dialects, seven major religions, various generational statuses, and numerous caste and other social distinctions (U.N.E.S.C.O., 2007; S.A.A.L.T., 2007). There are also significant similarities in culturally-valued behavioral patterns, and normative roles of elderly, women and children, and stigmatization of certain subgroups, such as the Lesbian/Gay/Bisexual/Transgender (LGBT) community and mentally-ill. These characteristics were created and often perpetuated by influential and reputable individuals representing these cultural subgroups (S.A.P.H.A., 2003). Thus, creating public health efforts

based on a monolithic "cultural profile" proves to be a complicated endeavor for health promotion purposes. Any efforts to understand South Asian-specific health issues must also make further inquiry with respect to a variety of in-depth cultural and demographic variables for nuanced research and intervention strategies. This will facilitate the comparability of subgroups within the South Asian community in the United States, based on "internal" and distinguishing parameters influencing health. For the purposes of this dissertation, "South Asian" will refer to individuals in the United States with *direct* migratory origins from Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka, as self-defined by the South Asian Association for Regional Cooperation (S.A.A.R.C.).

A "model minority" label has been ascribed to South Asians residing in the United States, mainly due to the influx of skilled and educated immigrants resulting from the 1965 Immigration Act. However, there are significant socio-demographic characteristics of relevance to health which belie this attribution. For instance, an estimated 12 to 18 percent of South Asians in the United States lack health insurance (greater than the 10 percent rate for non-Hispanic Whites) (K.F.F./A.P.I.A.H.F., 2008; Families USA, 2001). Another estimation concluded that 40 percent of South Asians under the age of 65 lacked a usual source of care (compared to 36 percent for Whites) (Brown et al., 2000). Depending on subgroup, between 19 – 50 percent of the South Asian population was found to be limited-English-proficient (LEP) (S.A.A.L.T., 2007). At least 20 percent of South Asians lived in households with annual incomes less than $12,500 (S.A.A.L.T., 2007). Another study found that 9 percent of South Asians were unemployed (Barkin, 1997). As indicated earlier, much of the data before the year 2000 was focused on Asian Indians and thus, demographic information of crucial interest for public health regarding other South Asian subgroups are largely absent. This bimodal distribution of educational and professional attainment, as well as other demographic indicators, is crucially important to understanding the true social landscape of South Asian American health, including the appropriate means of surveillance and intervention.

Available health data

Outside of insurance status, there exists a significant paucity of South Asian health data, as compared to other Asian/Pacific Islander subgroups and other minority communities (S.A.P.H.A., 2003). Much of the information available related to South Asian health predominantly addresses the epidemiology of specific diseases and is largely limited to the Asian Indian population in the United States (S.A.P.H.A., 2003). Research has demonstrated that cardiovascular disease (CVD) is the primary cause of death for Asian Indians in the United States and the rate of diabetes is extraordinarily high compared with other minority communities (Palaniappan et al., 2010; Enas, 2005; Palaniappan et al., 2004, Uppaluri, 2002; Anand et al., 1998; Enas et al., 1996; Wild et al., 1995; Patel & Bhopal, 2007). Other major disparities exist in prevalence of site-specific cancers, polycystic ovary syndrome, and tuberculosis among migrant South Asian populations as well as in the native subcontinent (Chandrasekar et al., 2007; Rodin et al., 1998; Ahluwalia, 2006; Zaidi et al., 2004). Subgroup specific information—both for ethnic communities and others (youth, elderly, LGBT)—is markedly absent, although there is information emerging about the prevalence of health-related disparities. These data include examination of specific forms of abuse (domestic, intimate partner, and family violence) among South Asian women and gay men, as well as substance abuse patterns (particularly alcohol)

among certain regional subgroups (Changrani & Gany, 2005; Raj & Silverman, 2002; Wickramasinghe, 1995; McKeigue & Karmi, 1993). Interestingly, although HIV/AIDS is reported to be at near pandemic proportions in India and other areas of the subcontinent, there is little investigation of this sexually transmitted infection in South Asian communities living in the Diaspora (S.A.P.H.A., 2003).

There have also been a number of documented health successes for South Asians residing in the United States. These include a relatively low infant mortality rate (4.5 per 1,000 live births) and a high life-expectancy (85.1 for the seven states with the largest API populations; 84.3 for Californians of Asian Indian descent) (Ohtsuka & Ulijazek, 2007; Hayes & Johnson, 2004; Hoyert & Kung, 1997). Understanding which factors contribute to positive outcomes is important to encourage health promoting behaviors in this community.

Gap in health indicator information/risk factor profiles/behavioral determinants

Outside of incidence and prevalence data attached to these specific health conditions, the majority of risk factor information regarding these diseases is concentrated on biologic etiology. For example, much of the public health literature focuses on lipid abnormalities, adipose distribution, metabolic disturbances, and insulin-related dysfunction, as it pertains to cardiovascular disease and diabetes (Deedwania et al., 2007; Lovegrove, 2007; Raschke et al., 2006). There is a lack of parity in behavioral determinants and socio-cultural influences on potential behaviors that contribute to existing health disparities (S.A.P.H.A., 2003). In the meager behavioral health research that exists, much of the risk factors concentrate on "Western" profiles, not taking into account significant culturally-relevant factors. Lack of gynecological screening practices has been traditionally examined in health policy and administrative frameworks, such as access-to-service and insurance status. However, at the community level, perceived causes of breast, ovarian, and cervical cancer have been associated with sexual promiscuity (Basu & Mitra; 2006; Grewal et al., 2005). In addition, acculturation scales and other instruments are not adequately tailored to the experiences of this relatively recent immigrant group and subsequent generations (Rahman & Rollock, 2004). Similarly, many intervention strategies are based on theories traditionally utilized in minority health which are not appropriate—in some cases, counterproductive—for the unique issues that exist in the South Asian community in the United States. Successful programs addressing health and social conditions are often grounded in fidelity to community-informed intervention designs. However, these efforts are largely divergent from existing theoretical and conceptual frameworks informing public health. The following examples illustrate these claims.

POTENTIAL REASONS FOR EXISTENCE OF GAPS IN HEALTH RESEARCH AND INTERVENTION STRATEGIES

Illustration of research gaps

Despite a high rate of cardiovascular disease and oral cancer, both of which are tobacco-related diseases, the majority of researchers have concluded that tobacco does not explain the excess burden of these diseases in the South Asian population. This assertion is based on the fact that most tobacco-prevalence surveys inquire about use of "Western" products, such as cigarettes

and snuff (Tang et al., 2005; Enas & Senthilkumar, 2001). This mode of instrumentation incorrectly results in a finding that tobacco use is low in this population. Although use of cigarettes, snuff, and other "Western" products may indeed be low, the use of culturally-indigenous tobacco products, such as *bidis, paan, paan masala, guthka,* and *zarda* are known to be used frequently by members of the South Asian American community, based on observational studies and local surveys (Changrani et al., 2006; Glenn et al., 2009; Changrani, 2005). This is exacerbated by the fact that there are distinct social and cultural equivalencies regarding frequency and quantity of use. Thus, actual prevalence of *all* tobacco products and *accurate* frequency and quantity of use has not been ascertained. It has been demonstrated in studies in the native subcontinent and other migration destinations that tobacco use prevalence is, in actuality, very high, resulting in a more consistent association between the at-risk behavior and health outcome (Khawaja et al., 2005; Rahman et al., 2005; Gupta & Ray; 2003).

A similar corollary can be seen in the role of diet and its implications for cardiovascular disease and diabetes. This is most pertinently seen in the assumption that vegetarian diets commonly used by many South Asians are healthy despite the fact that much of these traditional diets usurp the utility of vegetable vegetable consumption by over-cooking and ample uses of saturated oils, clarified butter or *ghee*, sugar, and other ingredients and methods which are contrary to health promotion (Singh 1999; Kamath et al., 1999).

Illustration of practice gaps

In addition to surveillance and other public health methodology issues, intervention strategies— often modeled after "best practices" in other communities or based on established theoretical frameworks —may be ill-equipped to address health issues of concern to the South Asian community appropriately. Moreover, fidelity to these well-intentioned interventions may actually exacerbate existing disparities and create additional negative influences on community health and social well-being.

One key illustration is the issue of specific forms of violence among South Asian American communities. In addition to epidemiological issues in determining actual prevalence of South Asian IPV, the few data available in the United States have been consistent with those conducted in other South Asian migrant communities (Raj & Silverman, 2002; S.A.P,H.A., 2003; Adam, 2001; Heise et al., 1999). These studies have demonstrated abuse—namely intimate partner, domestic, and family violence—and associated consequences to be a large public health issue in this population. This determination is commensurate with the number of abuse victims seeking resources and support from service providers who serve South Asian communities in the United States (Abraham, 2002; Merchant, 2000, Vaid, 1989). In addition, the number of organizations serving this population is relatively high and increasing. However, it should be noted that these programs predominantly provide medical and social services, that is, they are utilized when the problem has already occurred, which hardly falls within the purview of the emphasis on primary prevention which governs public health. Given the magnitude and severity of specific manifestations of violence among South Asian communities, public health professionals have posited various public health strategies for interventions and programs which could potentially reduce its burden on South Asian communities.

Much of the literature addressing South Asian issues of violence are based on theoretical constructs—behavioral or sociological—which attempt to address the complex nature of

perpetration and victimization. However, as with many other prescribed strategies, there are ideological assumptions made about the health issue and/or community, based on work done in similar settings. Most of the violence-related literature suggests that this socially-deviant behavior is primarily perpetrated by males; the response should be grounded in a feminist and/or empowerment approach which restructures the polarity of power between males and females (Campbell et al., 2002). Health professionals and social workers have recommended and implemented male-involvement components in certain minority communities (Crooks et al., 2007; Bent-Goodley, 2001, Maciak et al, 1999). However, those targeting the South Asian community don't include a male-involvement component. Similarly, research also suggests that these forms of abuse most often occur in communities that are severely disenfranchised. As a result, socio-ecological approaches involving capacity-building and policy-level change are commonly purported solutions to mitigate the adverse socio-economic influences on abusive behavior. These remedies include punitive consequences from the criminal justice system and immigration enforcement entities (which may lead to a number of unintended consequences not envisioned by advocates and embraced by community members). Although these recommendations are important and are informed by evidence from other minority communities, they often lack attention to specific socio-cultural characteristics maintained by South Asians, even after migration (Abraham, 2000; Rahim, 2000; Abraham, 1999; Dasgupta & Warrier, 1996; Gordon, 1989).

These forms of abuse have been entrenched and culturally-sanctioned in South Asian communities for many generations (Goel, 2005; Merchant, 2000). Accordingly, recognizing the collectivist community orientation of South Asians, the social and political repercussions of legal consequences, and the role of men and children in addressing the cultural context of violence are integral to any successful intervention strategy (Triandis, 1996). Moreover, a common assumption that all minority communities are monolithic in their level of disenfranchisement overlooks the important notion that South Asians are considered (both from the mainstream population as well as within the community) a "successful" minority. South Asians may consider this perceived "success" to be a result of adherence to certain cultural values. In this case, it may be due to strict discipline and reverence to elders as well as the patriarchal head of the family.

Similar situations can be seen when examining the low rate of reproductive cancer screening and the rising rate of polycystic ovary syndrome in South Asian women or the practice of safe-sex measures by members of the South Asian LGBT population (Grewal et al., 2004; Ratti et al., 2000). Marginalization of various subgroups by the community, coupled with a purposeful inattention to certain social behaviors and attitudes, often result in an inability for health professionals and community advocates to accurately design and implement culturally-appropriate intervention strategies.

Adequacy of contemporary minority health frameworks in addressing South Asian issues

Underlying these public health issues regarding research and practice is a markedly absent set of conceptual frameworks which adequately capture the nexus of cultural identity, behavior, and outcomes among the South Asian community. Given the relatively recent immigration of South Asians into the United States, the most predominant theories of immigration fail to capture the South Asian context of migration. Specifically, economic

"push/pull" models attempting to explain rationale for and time of migration don't fully account for the exponentially increasing numbers of South Asian Americans who do not identify as Asian Indians (Whitwell, 2002). Similarly, U.S. policy influences on South Asian migration patterns are largely understudied (S.A.A.L.T., 2005). Moreover, major theories of integration, such as "straight-line assimilation" and "segmented assimilation" frameworks, make assumptions about minority priorities in a new host country that may not be completely applicable to South Asian American communities (Alba & Nee, 1997). Given that relative positions of immigrants (socioeconomic status, educational attainment, occupational pursuits, among others) are a strong indicator of upward or downward social mobility, including health indicators, it is important that shortcomings of existing explanatory models be critically assessed before assuming their complete validity. These theoretical analyses, however, are beyond the scope of this dissertation.

In addition to theories of immigration and assimilation/acculturation, other social characteristics of importance must also be discussed. The most overarching philosophical discourse surrounding ethnic community typologies are the conceptual distinctions of individualist vs. collectivist populations. South Asians generally fall under the conceptual umbrella of collectivism, which states that "the group" (defined by collective associations of family, community, and ethnic commonality) is the fundamental unit of concern, and supersedes the concerns of individuals (Triandis, 1996). With respect to public health, this observation holds great importance for research and practice.

Many contemporary models, such as "community-based participatory research" and "cultural competence", embrace self-defined community issues and concerns, as well as cultural traits as the starting point for improving the health and well-being of minority populations (Lum, 2003; Minkler & Wallerstein, 2003). However, even such progressive ideologies sometimes fail to take into account that external ascriptions of success and internal protection of community cohesion—even at the expense of detrimental health outcomes and human right violations—may result in community priorities that are unaligned with basic ethical principles. The mythical "model minority" label placed on South Asians may often preserve certain cultural values and behaviors as a means of social identity maintenance. In other words, cultural features not otherwise having significant social value in the region of origin may serve as distinctive expressions of identity against more "unsuccessful" minority populations. Concepts of solidarity and empowerment are usually juxtaposed against social realities and pursuits of ethnic minorities who are severely disenfranchised. Coupled with the earlier assertion that the "Asian/Pacific Islander" demographic identifier is socially constructed and not self-defined by subgroups that make up this category, these minority health models and their core assumptions must be critically examined before assuming their applicability among all culturally-diverse groups.

DISSERTATION OBJECTIVES

With these considerations in mind, this dissertation has the following overarching objectives:

1) To examine multilevel (e.g., social, cultural, organizational, behavioral) influences on understanding and addressing disparities of tobacco-related disease and violence among South Asians in the United States;
2) To elucidate considerations for conducting health disparities research and/or implementing targeted intervention strategies among South Asian American communities;
3) Assess the ability of culturally-oriented and/or community-based minority health frameworks to adequately identify and impact the health and well-being of South Asian populations in the United States

This dissertation utilizes three distinct studies—two involving primary data collection and one employing a critical analysis—to accomplish these objectives. The specific objectives and deliverables of each research study will be detailed in the subsequent chapters of this dissertation. Summary descriptions of each study are presented below:

Creating a Culturally-Specific South Asian Tobacco Module: Considerations for Health Surveillance among Emerging Minority Populations in the United States

Although South Asians exhibit tobacco-related health disparities, the preponderance of research suggests that the excess burden of disease cannot be explained by tobacco use. However, most surveillance systems do not assess the contribution of culturally-specific forms of tobacco use to disproportionate rates of cardiovascular disease and site-specific cancers. Using qualitative methods, this study examines the use of non-traditional tobacco products—including modes of ingestion and cultural equivalencies—by South Asian communities in the United States. Moreover, it explores various social and cultural factors, as defined by community members that influence the use of tobacco within this population. Findings from qualitative phases of the study are used to create a South Asian Tobacco (SAT) Module, designed to supplement the Adult Tobacco Survey (ATS) validated by the Centers for Disease Control and Prevention (CDC). The SAT Module was cognitively-tested by community members to ensure that survey items captured relevant cultural contexts and used appropriate phrasing and terminology. The final study deliverable has tremendous utility for generating data about the *true* prevalence of tobacco use among South Asians in the United States and identification of key social and cultural determinants of tobacco-related behavior. In addition, the research process itself identifies methodological considerations for designing behavioral risk surveys in this and other understudied populations. Moreover, the study elucidates nuanced considerations for assessment of existing frameworks in acknowledging social milieus within which culturally-valued health behaviors are adopted and maintained.

Examining Organizational Responses to Violence among South Asian American Populations: Implications for Public Health Practice Targeting Understudied Communities

Empirical data and anecdotal evidence suggest that certain forms of abuse—intimate partner violence (IPV), domestic violence (DV), and family violence—are a significant public health concern among South Asian communities in the United States. Considerable theoretical and ideological premises have been postulated to explain the reasons for, scope of, and situations which manifest themselves in abusive behaviors. However, the scientific literature is inconsistent in its presentation of problem definition, philosophical approaches, and institutional responses to addressing this issue. In spite of these observations, groups exclusively or predominantly targeting violence among South Asians in the United States continue to grow in number and expand in scope. Despite the absence of prescriptive practice-based frameworks, these South Asian anti-violence organizations (SAVOs) have significant influence in defining an agenda which intends to reduce the rates and severity of violence among this population. This study uses qualitative methods to examine how SAVOs were created and function, investigate how these organizations arrive at their problem definition and associated approaches, and evaluate intra-organizational consistencies between mission statements, program activities, and self-defined criteria of success. Concurrently, this study explores the interaction and influence of these organizations among each other, and assessed alignment across SAVOs with respect to purpose, function, and indicators of evaluation. The final analysis articulates how individual organizations and coalitions define a public health agenda in the absence of evidence-based strategies and expressed community concern. Ultimately, research findings shed nuanced insight on the philosophies and processes employed to address stigmatized issues among the South Asian American population. Furthermore, this study underscores unique attributes in addressing such "hidden" yet significant concerns among populations which are ascribed a positive group image among the racial hierarchy found in the United States.

A Critical Examination of Culturally-Informed and Community-Based Approaches in Understanding and Addressing South Asian Health Disparities in the United States: Future Directions for Public Health Research and Practice among Understudied and Emerging Populations

The field of public health has placed considerable emphasis on addressing and eliminating racial and ethnic health disparities. Many contemporary frameworks have been formulated and supported to achieve this goal, such as "cultural adaptation, "cultural competence", and "community-based participatory research". These approaches are based on a premise that racial and ethnic disparities can truly be understood through the lens of culture and articulated by the communities who experience their impacts. Although well-intentioned in their application, these frameworks—as a component of a larger public health agenda—maintain their own assumptions and expectations. Many of these notions are based on conjectures of oppression, prioritization of health promotion and social justice, and mobilization around racial and ethnic identity. This study presents a meta-synthesis of findings from the tobacco and violence research (Chapters 2 and 3, respectively). Moreover, this analysis critically examines the assumptions and objectives of selected minority health frameworks as they pertain to common findings among these two studies. Based on this assessment, this study highlights

areas where these frameworks may be revisioned or expanded to ensure that they truly meet their goal of addressing and elimination disparities among *all* racial and ethnic minority populations.

Although each study has its own distinct research objectives, methods and findings are interrelated and ultimately inform methodological and programmatic considerations for future paradigm development relevant to improving South Asian health. Equally as important as the final conclusions are the processes utilized to accomplish the objectives of each research study. These processes are meant to elucidate unique considerations when addressing health issues in other understudied populations, especially those communities which do not fall under the traditional definition of "disenfranchised minorities" yet exhibit substantial health issues of concern (e.g. other Asian and Pacific Islander subgroups and populations from the Middle East). In addition, this dissertation aims to identify conceptual and practical domains relevant for improving minority health prospects. Incorporation of these considerations in revisioning and/or expanding these frameworks may allow an inclusive and comprehensive approach to improving community health and ultimately, eliminating health disparities impacting *all* racial and ethnic minority communities.

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Chapter 2

Creating a Culturally-Specific South Asian Tobacco Module: Considerations for Health Surveillance among Emerging Minority Populations in the United States

INTRODUCTION

Tobacco use is the single most preventable cause of death in the United States and leads to increased risk of lung, oral (including laryngeal, pharyngeal, esophageal), pancreatic, and cervical cancer (U.S. D.H.H.S., 2004). In addition, use of tobacco is a significant risk factor for cardiovascular disease, including heart attack, cardiac arrest, and stroke (Bartecchi et al., 1994). It is estimated that the overall health care costs attributed to smoking tobacco is $189.5 billion in the United States between 2000 and 2004 (WY. S.A.C., 2009); this does not take into account costs related to other uses of tobacco. In 2000, tobacco use accounted for 18 percent of all deaths in the United States (Mokdad et al., 2004).

Despite reductions in overall use by the general U.S. population, tobacco use varies dramatically across racial/ethnic populations, especially among Asian subgroups (C.D.C., 1999; Friis et al., 2006; Yu et al., 2002; Kim et al., 2005; Eyre et al., 2004). The Surgeon General's Report found that among the four major groups, smoking prevalence was lowest for Asian Americans and Pacific Islanders (U.S. D.H.H.S., 2004). However, research involving studies of disaggregated Asian subgroups have described alarming rates of smoking: 71 percent for Cambodian males, 34 percent for Chinese men, and between 26 to 39 percent for Korean men in the United States (Friis et al., 2006; Yu et al., 2002; Kim et al., 2005). Although smoking rates for Asian American females are lower than their male counterparts, tobacco use among women, especially among immigrants, increases with migration and acculturation in the U.S. (Kim et al., 2007; Lee et al., 2000). Most large scale prevalence studies of South Asians in the United States—the second largest Asian American subgroup—have found low rates of smoking, compared to other Asian subgroups and the general U.S. population (Tang et al., 2005; C.D.C., 2004; McCarthy et al., 2004).

Research has demonstrated that cultural contexts largely shape the diversity of products, methods, and patterns of tobacco use found across the globe (Unger, 2003). Smoked tobacco products come in various forms and may be consumed through external devices, such as pipes, to facilitate smoking. Moreover, much of the tobacco is consumed through non-smoking means, such as inhalation through the nose or by use of chewable products (Mackay & Eriksen, 2002). With a few exceptions, however, current methods in tobacco research have not taken into account these cultural influences and therefore, may not take into account ethnic-specific demographic and behavioral variables.

For South Asians—individuals with origins in Bangladesh, Bhutan, India, Pakistan, Maldives, and Sri Lanka—the cultural contexts of tobacco use are especially distinct. Tobacco use in South Asia is evident in the earliest reports of recorded human history and manifests itself in different products and behavioral patterns through time (Reddy & Gupta, 2004). There exists a wide spectrum of tobacco products and apparatuses unique to the Indian subcontinent, as well as distinct modes of ingestion utilized to facilitate tobacco consumption. In fact, the use of cigarettes in South Asia was not widespread until the 1930s, and remains a small fraction of the

total tobacco consumed in the native subcontinent. Moreover, use of culturally-specific tobacco has successfully penetrated into many aspects of the South Asian social fabric, including purported medicinal and health benefits, value ascribed to celebratory and traditional purposes, and integration into rituals and other ceremonial aspects (Reddy & Gupta, 2004). Tobacco also plays a key role in the normative hierarchy of South Asian culture, where reverence to elderly and men may have strong influences on prevalence of use and permissibility. As seen in other immigrant populations in the United States, these engrained attitudes, beliefs, and behaviors—as part of the larger cultural context surrounding tobacco use—may be preserved and even reinforced as a means of maintaining social identity in a new dominant society. For the purposes of health disparities research, assessing the prevalence of use of culturally-specific products has great implications for determining the true risks imparted by tobacco and informing targeted behavioral and community-based interventions.

In spite of these cultural determinants, most of the available data regarding tobacco prevalence and attributable risk are based on "Western" products, such as cigarettes and chew tobacco. Thus, the contribution of non-mainstream and culturally-specific smokeless products to high rates of tobacco-related disease (site-specific cancers, pulmonary dysfunction, cardiovascular disease) is largely unexamined in the United States. This is particularly true about the South Asian community in the United States, for which the vast majority of tobacco use most likely does not include cigarettes and forms of "Western" chew tobacco. In addition, little is understood about the consequences of secondhand smoke to community members who have sustained involuntary exposure as a byproduct of tobacco use indigenous to the Indian subcontinent (e.g., *hookah* use in family and cultural settings). These considerations have led health researchers and practitioners to emphasize the implementation of surveillance systems which accurately capture the distinct prevalence and patterns of tobacco use among South Asians in the United States (including differences by subgroup), potential relationships with associated health outcomes, and contexts of use related to cultural values, beliefs, and knowledge (Changrani & Gany, 2006).

This paper describes the creation of a South Asian Tobacco (SAT) Module designed to supplement validated state-level adult tobacco surveys. Similar to processes adopted to create culturally-specific modules for the Hispanic/Latino and Native American populations, the described study used both primary and secondary data sources to create and conduct preliminary testing on a South Asian survey instrument. In contrast to approaches which make minor modifications to existing instruments to preserve properties of validations, this study utilized qualitative methods to glean the complex milieu in which tobacco behaviors are adopted and maintained. By soliciting meaningful input from community members in diverse ethnic enclaves, triangulated with data from other surveys and research conducted in the South Asian subcontinent, the study optimizes the potential of the SAT Module to capture relevant characteristics of tobacco use among South Asians in the United States. As health disparities related to tobacco use persist among this population, the creation of a community-based, cognitively-tested instrument has great implications for assessing the true contribution of tobacco and identifying multi-level targets for intervention and evaluation.

Accordingly, the purpose of this study is to create a module which not only assesses use and frequency of commonly-used products, but also measures the influence of larger social and cultural factors in the prevalence of use. Specifically, it uses existing research and instruments to inform qualitative inquiry with the following aims: (a) Determine which culturally-specific

tobacco products are available and commonly-used by South Asians in the United States and evaluate health and regulatory warnings of available products; (b) examine environments which facilitate or encourage use of culturally-specific or mainstream tobacco products by South Asian community members; (c) gather and analyze contextual data regarding the cultural rationale, beliefs, values, and knowledge ascribed to tobacco use by South Asian Americans, and ascertain differences by subgroups using qualitative methods; (d) augment any gaps in qualitative data collection and analysis to achieve saturation of themes relevant for targeted inquiry; (e) develop tobacco survey prompts which accurately capture the scope and frequency of tobacco use by South Asians in the United States; (f) cognitively test developed prompts to evaluate cultural and metric equivalence and to assess comprehensiveness of survey items; and (g) construct a culturally-appropriate South Asian Tobacco (SAT) Module as a supplement to validated state-level adult tobacco surveys.

BACKGROUND / PREVIOUS RESEARCH

Definition of South Asian

South Asians are defined as individuals and communities with origins from Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and other regions in the Indian subcontinent (S.A.A.R.C., 1985). South Asians number approximately three million in the United States and constitute 20 percent of the Asian American population (second largest subgroup) (A.P.I.A.H.F., 2009). Moreover, they had the highest growth rate of any minority group during the last intercensus period (106 percent from 1990-2000), with some subgroups reporting increases as high as 249 percent (Bangladeshis) (A.P.I.A.H.F., 2002).

South Asians are a tremendously diverse group, encompassing over thirty official languages, seven major religions, and distinctive caste and socially-prescribed roles (U.N.E.S.C.O., 2007; S.A.A.L.T., 2002). Despite the great diversity within this world population, this subgroup still shares a common geopolitical history of colonial oppression and migration patterns throughout the globe. South Asians also maintain a large overlap in belief systems and behavioral patterns, rendering them considerably distinct from their other Asian counterparts (Waters & Ueda, 2007; Min, 2006). This demographic similarity has resulted in a push for data collection using South Asian as an ethnic variable by many surveillance systems. In addition, South Asians have been designated as an "at-risk" special population in Healthy People 2010, which emphasizes reductions of health disparities among certain racial and ethnic minorities (Rajeshwaria et al., 2005).

Tobacco use among South Asians

South Asians are known to use a number of culturally-specific products which contain tobacco. Among many others, commonly-used products include *bidis, hookah, zarda, guthka, paan,* and *paan masala* (Reddy & Gupta 2004)[*]. *Bidis* are smoked products, usually hand rolled in a dried tendu leaf with no filter, which come in many forms and with varied tobacco content.

[*] Although many more culturally-specific tobacco products are used globally by South Asians (see Table 1), the items selected for description in this section are based on observational research conducted in commercial outlets and other ethnic venues where these products were found to be readily available.

One study found that *bidis* contain 21.2 milligrams of nicotine per gram of tobacco, compared to 16.3 mg/g and 12.2 mg/g in commercially-available filtered and unfiltered cigarettes respectively (Malson et al., 2001; Pakhale & Maru, 1998). Researchers have found that other carcinogenic ingredients exist in higher levels of concentration in *bidis* (Pakhale et al., 1990; Hoffman et al., 1974). In addition, *bidi* smokers inhale more harmful chemicals due to the less porous and poor combustibility characteristics of the leaf wrapping (Rahman et al., 2005). *Bidis* are imported to the United States—legally and illegally—where they are available in a variety of flavors and cost less than traditional cigarettes. In addition to being seen as exotic and a "natural" alternative to smoking cigarettes, these attributes also appeal to youthful consumers, and may serve as a gateway substance leading to other forms of tobacco and drug use (Fisher 2000; Yen et al., 2000). In contrast, *bidis*—which account for 40 percent of all tobacco consumption in India—are smoked by poor, illiterate, and malnourished South Asians in the native subcontinent (Rahman & Fukui, 2000).

Another form of tobacco increasing in popularity among South Asians is flavored tobacco smoked through water-based apparatuses, known as hookahs (Mir, 2009). *Hookahs* operate by having charcoal-heated tobacco smoke pass through a water filtration device and then inhaled via a pipe (Gatrad et al.,, 2007). This method of smoking is common among Islamic South Asians and is often used during family and social gatherings (Rice et al., 2006).

Tobacco is also used commonly by South Asians in smokeless form. One popular product, *paan*, consists of tobacco, betel nut, perfumes, and sweetening agents, which are assembled into a funnel like shape and sealed into a quid with lime paste (Reddy & Gupta, 2004, Strickland, 2002). This homemade product is placed in the back of the mouth and slowly expelled, resulting in a dark salivary excretion. *Paan* use is popular at South Asian religious festivals and community celebrations and is socially accepted even among children. The prevalence of *paan* use in South Asia is estimated to be between 20 – 40 percent (Gupta & Ray, 2003).

Another popular form is known as *guthka* (*guthkha* or *gutka*). *Guthka* is a powdered or granulated mixture of tobacco, betel (areca) nut, catechu (betel extract), lime, and flavoring agents (Changrani et al., 2006; Pai, 2002; N.C.I./C.D.C., 2002). This manufactured product is available in brightly colored tins and candy-like packets, often appealing to children (Waldman, 2002; Patel & Graydanus, 1999). In India, *guthka* is used commonly by members of all socioeconomic strata (Changrani, 2005). The prevalence of *guthka* use has been reported to be as high as 50 percent in South Asia (Gupta & Ray, 2007). *Guthka* is exported to many international destinations, including the United States, where it is readily available in South Asian ethnic enclaves and cultural events (Changrani & Gany, 2005; Knight, 2002). *Paan masala* is identical to *guthka* in its constituent ingredients, although it is perceived as a more refined and sophisticated class of chewable tobacco product. In addition, *paan masala* can be distributed in a non-tobacco form, although many of its other principal ingredients (betel nut) are known to have detrimental health consequences (Blank et al., 2008). Both *paan masala* and *guthka* are ingested orally by placing these products in the inner gum and allowing the resultant secretion to enter the bloodstream through oral tissues. Avoiding the stigma of smoking, both *paan masala* and *guthka* are easily portable and able to be consumed in large quantities without notice (Changrani & Gany, 2005).

Niswar is also a smokeless form of culturally-specific tobacco used among South Asians. *Niswar* consists of dried tobacco, slaked lime, ash from tree bark, and a multitude of flavoring

agents (N.C.I./C.D.C., 2002). Like other smokeless products, *niswar* can be consumed orally or alternatively, it can be rolled into a ball and inhaled through the nasal cavity (Avon, 2004; Raval et al., 2002). Although *niswar* is identified scientifically as "Indian snuff", it has many colloquial names based on region of use and language. Given this diversity, there is no systematic examination of *niswar* use prevalence in South Asia.

Tobacco-related health disparities

The use of South Asian tobacco products is linked to a variety of adverse health outcomes. Use of *bidis* has been proven by researchers to contribute to cardiovascular conditions, such as myocardial infarction and hypertension (Pais et al., 2001; Gupta et al., 1995). In addition, studies have demonstrated that oral cancers involving the tongue, gums, mouth, larynx, esophagus, as well as lung cancer are attributable to *bidi* use (Rahman & Fukui, 2000; Sankaranarayanan et al., 1989; Nandakumar & Anantha, 1996; Gupta & Boffetta, 2001). Use of *hookahs* has significant associations with lung cancer, respiratory illness, low birth weight, and periodontal disease (Akl et al., 2010). Similarly, *paan, paan masala,* and *guthka* use is associated with adverse health consequences, such as oral, pharyngeal, and esophageal cancers, as well as precancerous conditions (oral leukoplakia, oral submucous fibrosis) (Changrani et al., 2006; Changrani & Gany, 2005; Gupta & Boffetta, 2001; I.A.R.C., 2004; I.A.R.C., 1985; Trivedy et al., 2002; Gupta & Nandakumar, 1999; Mehta & Maner, 1993; Shah & Sharma, 1998). *Niswar* use shares these cardiovascular and cancer risks, as well as contributing to peptic ulcer disease and functional changes in the nasal mucosa (Sohoo & Nisar, 2009; Sapundzhiev et al., 2004). In India, over 80,000 new cases of oral cancer are diagnosed each year and account for 30 percent of all cancer cases *globally* (Saranath, 2005). The prevalence of cardiovascular disease in India is estimated to be approximately 11 percent (Nishtar, 2002). Data for cancer and cardiovascular disease in other South Asian countries is notably absent in the literature.

Outside of the United States, research conducted in other countries with large South Asian migrant populations have found that this ethnic group is at higher risk for tobacco-related disease than indigenous populations (Auluck et al., 2009; Warnakulasuriya et al., 1999; Zain et al., 1997; Ali et al., 1996; Warnakulasuriya, 2002; Cox, 2000; Van Wyck et al., 1993). Many of these outcome statistics are attributable to culturally-specific tobacco use, such as *bidis, paan, paan masala, guthka,* and *zarda*. For instance, studies on tobacco and betel nut, the two major ingredients in most of these smokeless products, have shown they act synergistically as a major carcinogen (Nelson et al., 1999). It has been hypothesized that other ingredients present in these chewed products, such as lime paste, contribute to the progression of oral cancer (Nair et al., 1992). These forms of tobacco also sit next to vulnerable tissues for longer periods of time and therefore, facilitate the rapid onset and progression of pre-cancerous conditions in established and long-term users. The high rates of oral cancer are consistent with culturally-specific usage patterns in the native Indian subcontinent, where 35 – 40 percent of the total tobacco consumed is in smokeless form (Gupta & Ray, 2003).

Given the recent inclusion of South Asian subgroups in data collection systems, the available data regarding tobacco-related cancer prevalence is reported among national origin groups and/or in specific regions within the United States. Coronary heart disease is the leading cause of mortality among Asian Indians in the United States and California, although data are unavailable for other South Asian subgroups (Palaniappan et al., 2010; Hoyert et al., 1997).

However, studies in the United Kingdom and other destinations of immigration have demonstrated that Pakistanis and Bangladeshis have comparable cardiovascular risks to those seen among Asian Indians in the United States (Sheth et al., 1999). Lung cancer is the second and third highest incident cancer for Asian Indian/Pakistani men and women in the United States, respectively; this cancer was also the second most common gender-neutral (excluding prostate and breast) cancer for South Asians in California (Miller et al., 2007). In terms of oral cancer, there is a relative paucity of data regarding this site-specific cancer among South Asians in the United States. Preliminary analyses suggest that although rates are lower than those in the native subcontinent, incidence is higher for certain South Asian subgroups than in the general U.S. population and Asians/Pacific Islanders (Jain et al., 2005; Kumar et al., 2007).

Domestic studies and limitations

Although substantial research is available for South Asian tobacco prevalence and associated health consequences in the native subcontinent, prevalence estimates of culturally-specific tobacco product use in the United States are largely absent in the literature. Many of the available data regarding attributable tobacco risk are based on smoked products. Most health research and demographic surveys sample predominantly Asian Indians and are conducted primarily in English, thus not capturing a considerable and diverse segment of the South Asian population in the United States. Most importantly, these surveys did not inquire about culturally-specific tobacco products commonly used by South Asians, both globally and in the United States. Therefore, the contribution of non-mainstream and culturally-specific smokeless products to related disparities, such as site-specific cancers, is largely unexamined. In addition, little is understood about the consequences of secondhand smoke to community members who are exposed to tobacco products indigenous to the Indian subcontinent (e.g., *hookah* use in family and cultural settings).

Only four studies which examine tobacco use among South Asians in the United States have been identified (McCarthy et al., 2004; Glenn et al., 2009; Mukherjea et al., 2003; Chagrani et al., 2006). Three of these studies were confined to singular local enclaves and were limited by the scope of populations sampled (e.g., only certain regional subgroups or solely immigrants) or were enveloped in larger risk factor assessments (such as for CVD). The fourth study was a statewide random digit dial telephone survey of Asian Indians in California. In addition to being limited to only one South Asian ethnic subgroup, the survey instrument contained prompts which didn't often discern between distinct tobacco products (e.g., *paan* vs. *paan masala*) or were conducted in regionally-bounded languages (e.g., only North Indian dialects, such as Hindi, Punjabi, and Gujarati). The surveys utilized in each of these studies were formulated by research teams with little systematic input (e.g., qualitative inquiry, cognitive testing) from community members and/or "adapted" from large-scale surveys validated for the general population, thus not capturing unique cultural contexts of tobacco behavior pertinent to South Asian American communities.

However, findings from these studies do suggest that rates of culturally-specific tobacco among South Asian Americans are indeed high. The California Asian Indian Tobacco Survey found that 19.4 percent and 15.5 percent of respondents currently used *paan* and *guthka* "on some days", respectively (McCarthy et al., 2004). A community assessment in Los Angeles found indigenous tobacco use rates among South Asians to be between 15 – 23 percent; use of

paan masala among Pakistanis was over 54 percent in this study (Glenn et al., 2009). Similarly, one study examining cardiovascular health among Asian Indians in Northern California found 24 percent of respondents used *paan masala* (Mukherjea et al., 2003). Researchers studying *guthka* use among South Asian residents in New York City found usage rates of 67 percent and 77 percent by Bangladeshis and Gujaratis (a regional Asian Indian population), respectively (Changrani et al., 2006). Differences were found by gender, urbanicity, and location of initiation in these three studies. This is concordant with rates found among South Asian subgroups in England (Atwal et al., 1996; Summers et al., 1994; Shetty & Johnson, 1999). In addition, research conducted among South Asians in the United Kingdom found widespread use of *paan, paan masala,* and *guthka* among immigrants, a pattern that continues into the second generation (Vora et al., 2000). In addition to generational status, these international studies found differences in type of product used and frequency of usage by region of emigration, religious affiliation and gender.

These findings suggest that there may be differences by South Asian subgroup, residence, religion, and socioeconomic class. These products are readily available in South Asian ethnic enclaves in the United States, and use is deemed socially acceptable by some community members, even among children. Many South Asian migrants are unaware of the health consequences of indigenous product use; some even attribute benefits of consumption (Shetty & Johnson, 1999). These observations have raised concerns among public health and dental practitioners regarding tobacco use among South Asians (Knight, 2002; Virasami, 2002).

Purpose of this study

Specific data for Asian and Pacific Islander populations continue to be sparse, despite the recent disaggregation of subgroups in national surveillance systems and in the California Health Interview Survey data collection. Many data are only available for Asian Indians, thus not capturing a considerable and disenfranchised segment of the South Asian American population. Although Asian Indians make up the majority of the South Asian population in the United States (approximately 90 percent), their socio-demographic characteristics—many of which are associated with certain health indicators, including behavioral risk—are more favorable than their other ethnic counterparts. Understanding the full continuum of socio-cultural health beliefs and knowledge will facilitate an inclusive orientation to accurate data collection strategies producing data pertinent to the entire South Asian American population.

The substantial similarities among this ethnic population—in terms of cultural identity formation, historical experiences, and social and behavioral patterns—merit utilizing an aggregated South Asian demographic category for the purposes of health research, including measurement of tobacco-related disparities. Future analyses of South Asian health data may warrant examination across other demographic categories which supersede ethnic identity (e.g., religion), but use of a "South Asian" variable for research purposes provides a baseline of disaggregated racial/ethnic data informing such directions for future research.

Culturally-specific tobacco surveys have been developed for other minority populations which have unique cultural value ascribed to tobacco use, such as the Hispanic/Latino and Native American populations (C.D.C., 2006; C.D.C., 2003). These federally-sponsored surveys used community-based qualitative methods to ensure that survey prompts accurately reflected cultural patterns of tobacco use as understood by members of their respective racial/ethnic

communities. Moreover, these instruments also use survey items which originate from validated sources, thus allowing comparability between measures for surveillance between populations, both intra- and inter-ethnically.

Accordingly, the purpose of this study is to develop a culturally-appropriate survey instrument which accurately and comprehensively measures the risk imparted by all forms of tobacco use among South Asian communities in the United States. Using the Centers for Disease Control and Prevention's state-level adult tobacco surveys as a framework, the purpose of this South Asian Tobacco (SAT) Module is to supplement the information gathered by this standardized behavioral risk survey. Using qualitative methods for survey design and testing, this study utilizes findings from multiple sources to ensure that survey items capture the cultural context and spectrum of tobacco use by South Asians in the United States. The outcome of this research is an instrument which supplements existing state-level federal surveys, while ensuring that culturally-specific patterns of tobacco use are captured in population-based datasets. This information is pivotal to assess relationships with South Asian health disparities, and inform interventions with target community knowledge, beliefs, and behaviors which contribute to disproportionate burdens of disease. Specifically, the domains of measurement in the SAT Module include types of culturally-specific products used and modes of ingestion, tenure and frequency of use, knowledge and beliefs associated with use (including perceived risks and benefits), social and cultural influences on usage and cessation, as well as detailed demographic characteristics. Given the community-based orientation of this study, the SAT Module ensures that survey items and phrasing are consistent with terminology and interpretations that reflect the contextual understanding and use of these tobacco products by South Asian communities in the United States.

THEORETICAL FRAMEWORKS

The theoretical underpinning of this study is that community health prospects are tied to a dynamic interplay of individual, family, community, environmental, social, and structural factors. This perspective—defined as a social ecological model—underscores the multidisciplinary and interdependent relationships between complex influences which ultimately determine health status for communities and individuals (McLaren & Hawe, 2005). Other models are equally valuable for examining these social behaviors, such as social cognitive theory (Gochman, 1997). However, the amalgam of factors contributing to culturally-specific tobacco patterns among South Asians are numerous and complex; thus, sufficient detail for each construct, dimension, and interaction is beyond the scope of this paper. This section focuses on one highly pertinent aspect of this study's conceptual basis: the role social identity theory in affirming culturally-valued behaviors.

As emphasized in social ecological models, individual behaviors are situated within macro-level factors which include interpersonal relationships (e.g., family, neighborhood, community) and institutional contexts (e.g., environmental, political, economic, and social structures). One pivotal conceptual framework informing behaviors within a cultural milieu is social identity theory. Complementing individualistic approaches to understanding behavior, social identity theory analyzes roles of self-conception as they relate to group membership, group processes, and intergroup relations (Burke, 2006). Individuals conceive themselves to be a member of a group which construes and evaluates themselves to share attributes distinguishing

them from other people. Accordingly, this approach focuses on concepts of social identity and group formation, categorization and individual depersonalization, distinctiveness and motivation, intra-group cohesion and intergroup relations, as well as community conformity and social norms (Hogg, 2004). Although all of these factors have relevance to this study, the most pertinent component is the domain focusing on conformity and norms and their influences on social behaviors.

As a result of self-categorization and depersonalization processes, agreement on in-group and out-group prototypes produces conformity to normative structures as a mechanism of defining group membership (Abrams & Hogg, 1985; Paulus, 1989). One major influence on cultural norms is assimilation to attitudes, beliefs, and behaviors which are consistent with core group contexts. Specifically, it is the self-identification with group norms which prescribe individual behavior (Terry & Hogg, 1996). However, equally as powerful is differentiation and distancing from groups for which ascriptions and norms share little or no overlap with in-group interests and impressions (Abrams et al., 1990). Especially for recent immigrant communities in a new dominant society, attitudes and values with little distinguishing purpose in the native region may hold greater value for social identity preservation. For this study's purpose of understanding South Asian tobacco patterns in the United States, theoretical concepts influencing culturally-specific behaviors are imperative to creating survey measures which assess related attitudes, beliefs and knowledge.

These theoretical considerations are not independent of each other. As the field of tobacco research attempts to eliminate tobacco-related disparities, theoretical approaches to surveillance must take into account the intersection of individual behavior and social identity processes. Most approaches within this field examine a singular cultural influence on tobacco use. However, one multilevel and transdisciplinary model has been formulated, which takes into account micro-, meso-, and macro-level influences within a socio-cultural context (Unger et al., 2003). This framework examines relevant micro-level variables (genetics, addiction), meso-level factors (peer influence, identity formation), and macro-level considerations (tobacco marketing to minority populations, policies prohibiting certain forms of tobacco use), and their interactions with shared beliefs, behaviors, and norms which define a specific cultural milieu. Most of these considerations have been applied to public health practice and policy in attempting to reduce the prevalence of tobacco use among disproportionately impacted communities. As the United States becomes increasingly diverse, measuring at-risk behaviors among understudied and emerging minority communities must also adhere to contextually-relevant methodologies. Although it has been demonstrated that South Asians demonstrate distinct patterns of tobacco use within the native subcontinent and other destinations of migration (e.g., England, Canada, and Fiji), the unique position assumed by South Asians in the United States—such as socioeconomic status, external ascription of "model minority", and bimodal distribution of health indicators—merits a qualitative inquiry which informs survey design and implementation (Reddy & Gupta, 2004; S.A.P.H.A., 2003; Chagrani & Gany, 2005).

RESEARCH DESIGN

The study utilized three sources of data to create the SAT Module. The research protocol began with an exhaustive review of the literature to develop a detailed baseline database of tobacco products commonly used by South Asians globally. The literature review also

identified other sources of secondary data focusing on prevalence studies used to assess tobacco use among South Asian populations in the United States.

The predominant aim of the proposed study is to interpret aspects of human activity, with key objectives of generating contextual description and explanations for culturally-driven behavior. Thus, the research orientation most appropriate for this type of inquiry is a qualitative one (Crabtree & Miller, 1999). Qualitative research enables a topical examination for understanding the context in which behavioral patterns arrive and evolve. Researchers have stressed the importance of examining the role of cultural context in shaping tobacco use patterns, especially among racial/ethnic minorities (Unger et al., 2003). As such, community input regarding such patterns is pivotal for the creation of culturally-appropriate and meaningful survey prompts. Accordingly, the most substantial source of data was collected in the form of qualitative focus groups, conducted in three different South Asian ethnic enclaves in the United States; each round of focus groups was conducted on two separate occasions.

All materials related to human subjects—consent forms, recruitment flyers, and interview guides—were reviewed and approved by the Committee for Protection of Human Subjects at the University of California, Berkeley. A summary of methods and details of the temporal sequence of data collection and analysis are detailed below and in the following sections.

Summary of Methods

In order to clearly understand the diverse array of products used by South Asians, the first stage of research entailed a comprehensive review of scientific databases (e.g.,, PubMed, Google Scholar, tobacco control repositories) to gather details of the breadth and depth of tobacco use. Common terms for culturally-specific products were also submitted to non-scientific search engines to collect information about common brand names, commercial manufacturers, and export destinations outside of South Asia. This information was systematically analyzed to create an inventory of South Asian tobacco products. This detailed database included scientific nomenclature, community-based labels, and popular brand names for each product, as well as constituent ingredients, methods of ingestion, and country/region of origin. Health consequences attributable to usage of each product were also included in the product inventory.

Based on the findings from this repository of South Asian tobacco products, a focus group interview guide was created for the first phase of qualitative inquiry. As this phase of data collection was exploratory in nature, the interview guide contained open-ended questions regarding types of products commonly used by South Asians in the United States (including those predominantly used by subgroups), different modes of ingestion, and "dosage units" of use which were understood by community members. Additional domains of inquiry included perception of risks and benefits associated with use of identified products, social and physical environments which facilitated or impeded use, and community-based stigmas and allowances ascribed to certain products.

The study utilized focus groups to generate formative data in preparation for designing the SAT Module. These focus groups were conducted in three ethnic enclaves around the country, each of which represented socially and demographically distinct South Asian communities. In order to maximize candor, the study aimed to separate participants by gender, generational status, and for immigrants, length of time in the United States. Participants were sought using a variety of recruitment vehicles, including posted flyers in South Asian

commercial areas and ethnic outlets, active solicitation through community-based organizations and electronic listservs comprised of large South Asian participants, and announcements on ethnic media (such as South Asian radio programs). Interested community members were screened for pertinent demographic characteristics for assignment into one of the multiple focus groups conducted in each region. Concerted efforts were made to maximize representation of diverse religious backgrounds and region of ethnic origin. Eventual focus group participants were selected based on inclusion criteria pertaining to knowledge and use of South Asian tobacco products to ensure that qualitative data reflected a practical knowledge of the cultural context of tobacco use. Upon completion of this phase of qualitative data collection, audio-recordings of focus group content were transcribed into text, and analyzed using qualitative software (Atlas.TI). Informed consent regarding focus group participation and audio-taping was procured by adhering to policies mandated by the Committee for Protection of Human Subjects at the University of California, Berkeley.

Qualitative data collected through the formative phase of research was analyzed using deductive methods. Using a pre-defined typology, content analyses were performed on primary sources of formative data with a focus on South Asian tobacco products available in the United States, methods of ingestion and "dosage units", beliefs and attitudes ascribed to use of specific products, and social environments facilitating or impeding use. Upon completion of qualitative analyses, extensive examinations of existing surveys were conducted in order to glean information relevant to survey prompt development. Surveys examined in the triangulation process included one instrument implemented statewide in California and three questionnaires utilized in New York City, Los Angeles, and Yuba City (CA); all of these assessed tobacco use among South Asian communities. It merits mentioning that survey instruments were reviewed *after* primary data analyses were completed in order to ensure that data generated by community-members were the predominant sources of content incorporated in the SAT Module. In other words, existing survey instruments were examined solely for structural properties (e.g., question stem phrasing, skip patterns) pertinent for development of the SAT Module.

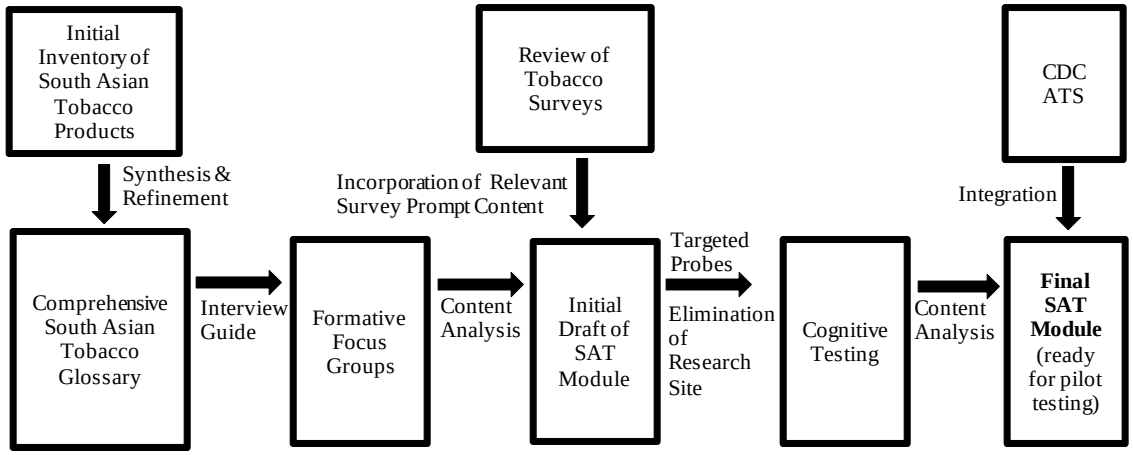
Given the study's purpose in creating an ethnic-specific supplement to the state-level Adult Tobacco Survey (ATS) validated by the Centers for Disease Control and Prevention (CDC), the initial version of the SAT Module was designed to be integrated into the ATS. As such, the SAT Module utilized identical sectional categories and consistent phrasing of survey items to ensure comparability with the government survey. Additional questions pertaining to culturally-specific tobacco use mimicked the structural and vernacular properties of prompts found on the ATS to the greatest extent possible. However, emphasis was placed on creating survey items that measured variables directly related to cultural contexts of tobacco use, as this was the primary objective of the study.

After an initial draft of the SAT Module was created, the study utilized cognitive testing methods to assess the substantive properties of the instrument. It merits emphasizing that this phase of qualitative data collection did not employ formal cognitive interview processes, which are usually accomplished through one-on-one interviews (Ouimet et al., 2004). Rather, the purpose of this stage of qualitative inquiry was to identify interpretation of questions and response options and/or variations in language and terminology by a larger and more diverse group of community members. As such, cognitive interviews were conducted in the form of focus groups, utilizing the same methods employed in the formative phase of qualitative data collection (e.g., recruitment, screening, and assignment of participants into groups separated by

gender, generational status, and length of time in the United States). A notable exception was the elimination of Yuba City (CA) as a research site, as preliminary analyses found that use of culturally-specific products was virtually non-existent among this ethnic enclave. This phase of qualitative research entailed focus group participants reviewing the entire SAT Module, providing input regarding clarity and cultural interpretation of initial prompts, and articulating recommendations about consolidation or expansion of survey items in each modular section. For instruments of this nature, group administration followed by a discussion of the experience has been deemed sufficient to meet the minimal standard of identifying survey content issues (DeMaio et al., 2006). The study employed a largely "concurrent" cognitive approach, in which participants underwent a process of "thinking-aloud" and verbalized their thought processes while reviewing each survey item (Morales, 2000). This technique was augmented with verbal probes and follow-up questions to clarify particular aspects of survey items and response categories. Respondents also engaged in a "debriefing" process in which retrospective comments were solicited about any specific prompts or the instrument as a whole. Focus group audio-recordings were transcribed into text and analyzed using qualitative software (Atlas.TI). Transcripts were coded for recommendations that arose across multiple focus groups and evaluated for substantive contribution to refining the instrument. The final phase of the research protocol was a critical refinement of the SAT Module, based on conceptual and technical suggestions generated through the cognitive interview process.

A graphical summary of the research protocol is summarized in Figure 1.

Figure 1



Detailed Protocol and Associated Findings

As the overarching objective of this study was to create the SAT Module, this section will detail findings relevant to creation, development, and preliminary testing of the instrument. Specifically, detailed methods and associated findings will be presented in chronological order relative to their impact on design of the SAT Module. These will include results from analysis of both secondary (tobacco glossaries and existing tobacco surveys) and primary (exploratory and cognitive focus groups) sources of data. It merits noting that findings from qualitative analyses

also provided larger insights to the cultural context of tobacco use beyond the primary objective of instrument development. However, those conclusions are beyond the scope of this paper and will be reported elsewhere.

Initial inventory of products

The use of tobacco in South Asia has a lengthy and complex history. In addition to indigenous tobacco use across its many diverse regions, the multiple colonizations of the Indian subcontinent have resulted in use of numerous forms of tobacco, varied modes of ingestion, and diverse belief systems associated with use (Reddy & Gupta, 2004). In order to create a comprehensive glossary of all known South Asian tobacco products, a search was conducted among scientific literature databases and tobacco control organizations to create an initial list of tobacco products used commonly by community members. Based on search results, a preliminary inventory was created, containing nine smoked products and 26 smokeless items. Smokeless products were defined as those which were consumed by chewing, sniffing, or any means of absorption through oral and nasal cavities other than smoking (N.C.I./C.D.C., 2002). In addition, six items not containing tobacco, but which were commonly used with smoked or smokeless products, were also included in the initial inventory.

Comprehensive glossary of products

Based on the initial list of South Asian tobacco-related products, a database was created which summarized key details about each item. Prior to glossary development, products deemed to be not exclusively or predominantly exclusive to South Asia were eliminated from consideration. These products—six in total—include cigarettes, cigars, pipes, snuff, and other forms of tobacco used globally or primarily outside of South Asia. In addition, certain items were consolidated if the initial review of definitions found two or more products to be synonymous with one another.

This phase of secondary data analysis entailed creating a detailed database which included the following information for each product: name (scientific term and labels used by community members), constituent ingredients, and methods of ingestion. If multiple definitions arose for any given product, those were also highlighted in the database. For instance, the study found a notable disagreement regarding whether *paan* was universally accepted as a product containing tobacco. The database also collected demographic information, such as common usage of specific forms of tobacco among certain South Asian subgroups or regional areas, when available. In total, 27 distinct tobacco products (six smoked and 21 smokeless) and four separate, but related, non-tobacco items were included in the detailed South Asian tobacco glossary (Table 1).

FORMATIVE RESEARCH

Participants for the first phase of qualitative research were recruited from South Asian ethnic enclaves in the following cities and surrounding suburbs: Chicago, IL; San Francisco, CA; Yuba City, CA. These research sites were selected based on South Asian population density and distinct demographic characteristics.

Table 1

SOUTH ASIAN TOBACCO GLOSSARY			
Scientific / Common Label (Alternative Terms)	**Definition (including constituent ingredients)**	**Native Region of Use**	**References**
SMOKED			
Bidi / Beedi (Biri)	Tobacco (usually sundried flakes or dust from dark tobacco leaves) with optional flavoring (vanilla, licorice, stawberry, cinnamon, chocolate, clove or other flavors) hand rolled and tied together in a dry green or brown tendu/temburni leaf and smoked wit	All of South Asia	Gottlieb, 1999; Gupta et al, 1990
Chillum	Tobacco in a straight, conical pipe made of clay, held vertically, and smoked (requiring a deep pulmonary effort)	North India, Pakistan	Jawaid et al, 2008; Reddy & Gupta, 2004
Chutta	Coarsely prepared homemade roll made from tobacco leaves. Often inhaled while keeping the glowing end of the tobacco product inside the mouth (called "reverse smoking")	Andra Pradesh, Tamil Nadu, Orissa (India)	Reddy & Gupta, 2004; Pindborg et al, 1970
Dhumti	Conical cigar, self-manufactured by smokers by rolling tobacco leaf in the leaf of another plant; can be "reverse smoked"	Goa (India)	Reddy & Gupta, 2004; Bhonsle et al, 1976
Hookah / Hukka (Narghile / Arghile / Goza)	Apparatus from which charcoal-burnt tobacco smoke, often with added flavorings, is passed through water and inhaled through a tube	India, Pakistan, Bangladesh	Reddy & Gupta, 2004; Nuwayhid et al, 1998
Hookli	Clay pipe from which sundried flaked or powdered tobacco, moistened with molasses, is smoked	Gujarat (India)	Reddy & Gupta, 2004; Sivaramakrishnan, 2001
SMOKELESS			
"Creamy Snuff"	Tobacco toothpaste made from finely ground tobacco mixed with aromatic substances such as clove oil, glycerine, spearmint and menthol, used as a dental astringent	India	I.A.R.C., 2007; Reddy & Gupta, 2004; N.C.I./C.D.C., 2002
"Red Tooth Powder" (Lal Dantmajan)	Fine red tobacco powder mixed with herbs and flavoring agents, used as a dentifrice	India	I.A.R.C., 2007; Sinha et al, 2004; N.C.I./C.D.C., 2002
"Tobacco Water" (Tuibur / Hidakphu)	Liquid extract, made by passing tobacco smoke through water until the preparation turns cognac in color and has a pungent smell, used as a mouthwash	Mizoram (India)	Phukan et al, 2005; Reddy & Gupta, 2004
Bajjar (Tapkir / Tapkeer)	Bajjar is dry snuff applied commonly by women on teeth and gums	Gujarat (India)	I.A.R.C., 2007; Reddy & Gupta, 2004; Sivaramakrishnan, 2001
Dohra	Wet mixture of tobacco, areca nut and catechu, consumed orally	North India	Sinha, 2004

Table 1 (con't)

SOUTH ASIAN TOBACCO GLOSSARY			
Scientific / Common Label (Alternative Terms)	**Definition (including constituent ingredients)**	**Native Region of Use**	**References**
SMOKELESS (con't)			
Gudhaku / Gudakhu / Gudaku	Tobacco paste consisting of powdered tobacco and molasses, applied to the teeth and gums	Bihar, Orissa, Uttar Pradesh, Uttaranchal (India)	I.A.R.C., 2007; Reddy & Gupta, 2004; Sinha, 2004
Gul	Pyrolysed mixture of tobacco powder, molasses, and other flavoring ingredients, used as a dentifrice	Central and Eastern India	I.A.R.C., 2007; Sinha et al, 2004; Bedi & Jones, 1995
Gundi (Kadapan)	Mixture of cured tobacco, coriander seeds and other spices (each fried separately and made into coarse powder before combining), scented with a resinous oil	Gujarat, Orissa, West Bengal (India)	Sinha, 2004
Guthka / Gutkha / Gutka	Mass-manufactured tobacco product (sundried or roasted) with betel nut, catechu, and added flavoring, finely chopped or ground in powder form and ingested through oral tissues or swallowed	Bangladesh, India, Nepal	I.A.R.C., 2007; Gangwal, 2001; Gupta, 1999
Hogesoppu	Tobacco leaf with flaked tobacco embedded, ingested orally	Bangladesh, Karnataka (India)	Sinha, 2004
Kaddipudi	Crushed tobacco stalks and petioles are molded into blocks, bricks, and sticks with sugar molasses and water, ingested orally	Karnataka (India)	Sinha, 2004; Bedi & Jones, 1995
Khaini (Chada / Chadha / Sada / Surti)	Powdered tobacco and slaked lime paste are combined in palm of hand and formed into a ball, ingested through oral tissues	Bangladesh, India, Nepal	I.A.R.C., 2007; Murti, 1997; Bedi & Jones, 1995
Mainpuri Tobacco	Tobacco with slaked lime, finely cut areca nut, camphor, and cloves, chewed and expelled or swallowed	Uttar Pradesh (India)	Sinha, 2004; Reddy & Gupta, 2004; Cohen et al, 1971
Mawa (Kharra)	Preparation of thin shavings of areca nut with the addition of some tobacco and slaked lime, rubbed together, and orally chewed for 10-15 minutes	Bhavnagar, Gujarat (India)	I.A.R.C., 2007; Reddy & Gupta, 2004;
Mishri / Misheri / Masheri	Roasted preparation made by baking tobacco on a hot metal plate until it becomes a uniformly black powder, used as a dentifrice by applying to teeth	Maharashtra, Goa (India)	Reddy & Gupta, 2004; Mehta et al, 1972

Table 1 (con't)

SOUTH ASIAN TOBACCO GLOSSARY			
Scientific / Common Label (Alternative Terms)	**Definition (including constituent ingredients)**	**Native Region of Use**	**References**
SMOKELESS (con't)			
Niswar / Naswar / Nass ("Indian Snuff")	Sundried tobacco leaves, slaked lime, ash from tree bark, and flavoring and coloring agents are mixed together with water and rolled into balls; can be chewed or inhaled through nasal cavity	Pakistan, India	N.C.I./C.D.C., 2002; U.S. D.H.H.S., 1986
Paan (Bulath)	Slaked lime and catechu are smeared on a betel leaf, to which tobacco, betel nut, and flavoring is added; the funnel is folded over, resulting in a quid, which is placed in the mouth for use	All of South Asia	N.C.I./C.D.C., 2002; Bedi & Jones, 1995
Paan Masala	Commercial dehydrated preparation of areca nut, slaked lime, catechu, scented flavoring agents, and powdered tobacco; available in attractive packets for convenient portability; ingested through oral tissues or swallowed	All of South Asia	N.C.I./C.D.C., 2002; Reddy & Gupta, 2004; Gupta et al, 1990
Pattiwala	Sun-cured tobacco leaf used with or without lime	Uttar Pradesh (India)	I.A.R.C., 2007; Reddy & Gupta, 2004; Agrawal et al, 1983
Qimam / Qiwam / Kimam / Khimam / Kiwam	Tobacco leaves are processed by removing their stalks and stems, then boiled and soaked in rose water flavored with spices and additives; resulting pulp is mashed, strained, dried into a paste (or granules/pellets), placed in mouth and chewed	Bangladesh, India, Nepal	I.A.R.C., 2007; Sinha 2004; N.C.I./C.D.C., 2002
Zarda (Dokta)	Flaked tobacco leaves boiled in water with lime and spices until evaporation, dried and colored with vegetable dyes, generally chewed mixed with finely cut areca nut and spices	Bangladesh, India	I.A.R.C., 2007; N.C.I./C.D.C., 2002; Bedi & Jones, 1995
RELATED NON-TOBACCO ITEMS			
Bura Tamol / Tamol	Fermented concoction prepared by preserving raw areca nuts together with areca leaves in an underground pit with an inner lining of straw for four months	India	I.A.R.C., 2007; Reddy & Gupta, 2004; Sinha 2004
Catechu (Cutch / Kattha)	Astringent reddish-brown substance (residue of hot water extraction) often smeared on the betel leaf used to wrap the betel quid ingredients	All of South Asia	I.A.R.C., 2007; Reddy & Gupta, 2004
Chuna / Chunam	Lime or calcium oxide	All of South Asia	Reddy & Gupta, 2004
Supari	Areca (betel) nut	All of South Asia	I.A.R.C., 2007; Reddy & Gupta, 2004

Research Site Characteristics

The first wave of South Asian immigration into North America occurred in the late 1800s, largely comprised of Sikhs from the South Asian province of Punjab. Most of these migrants were farmers and ship workers (Min, 1995). These migrants entered the continent through Canada, and approximately 7,000 settled in the farmlands of California by the 1920s, including a large settlement in the adjoining cities of Marysville and Yuba City (Ingram, 2007). As these regions were very similar to farming conditions in Punjab, early immigrants quickly formed agricultural and economic cooperatives and grew into a significant monopoly in this industry (Gonazales, 1986). As a result of overt legislative and public acts of discrimination,early South Asian migrants were hesitant—and in some cases, actively resisted any efforts—to assimilate into the hostile mainstream society. For those early migrants able to produce subsequent generations born in the United States, concerted efforts were undertaken to remain an insular community with little integration with the dominant American culture. As a result, the South Asian population in Yuba City (and surrounding areas) maintains a distinct socio-demographic profile from communities arriving during later waves of migration. According to the 2000 U.S. Census, the number of South Asians—the vast majority of which are Asian Indians—has remained relatively constant since the early 1900s at approximately 8,000 and represents over 5 percent of the total population in Yuba City (U.S. Census, 2000). Of the population aged 16 and over, the unemployment rate is over 16 percent; almost half of employed South Asians work in the agricultural and manufacturing industry. The median South Asian household income was $39,349 and over 13 percent of families were under the federal poverty level. Almost half of South Asians in Yuba City have less than a high school diploma. Interestingly, only one-third of the population is native born, indicating that immigration into Yuba City has continued since the early 1900s. Similarly, 46 percent of the population speaks English "less than very well", indicating a high level of limited English proficiency.

Unlike their Yuba City counterparts, the vast majority of South Asian immigration into the United States occurred after 1965, when immigration quotas were relaxed and race was dropped as a criterion for entry into the country (Takaki, 1989). The passage of the Immigration and Naturalization Act (INA) of 1965 drew large numbers of skilled South Asians into the country, including doctors, engineers, and scientists with advanced graduate degrees (S.A.P.H.A., 2003). Since the INA, the rate of population growth has been remarkably high, and currently, South Asians are the most rapidly growing minority population in the country (American Community Survey, 2006). South Asians have settled in a number of ethnic enclaves around the country, including the Chicago and San Francisco metropolises. In fact, these two cities (and surrounding suburbs) have the second and third largest South Asian populations, respectively (U.S. Census, 2000). In both of these cities, the South Asian population has almost tripled since 1980, the first year that Census statistics are available for certain Asian subgroups.

Despite these similarities, these two urban regions have South Asian populations with distinct demographic characteristics. South Asians are the largest Asian subgroup in Chicago and the remainder of Illinois. In 2000, South Asians in Chicago and the immediate suburbs—comprised mostly of Asian Indians and Pakistanis—numbered almost 130,000 residents (S.A.A.P.R.I., 2005). Within the city limits, the South Asian population is 31,328, making up over 1 percent of total Chicago residents. Most of this ethnic population is concentrated (approximately 30 percent) in a district known as the West Ridge or, more popularly among community members, the "Devon Avenue" area. This enclave is saturated with South Asian businesses and street labels bear the names of historical figures in South Asian history. Given

the population density in this district, relevant demographic characteristics will be presented for the West Ridge.

Three percent of South Asians in this ethnic enclave are unemployed and of employed community members, approximately one-third work in the production (e.g., factory workers) and transportation (e.g., taxi drivers) industries. In addition, almost one-quarter of the population work in management of professional occupations. The median household income is $37,744. The percentage of South Asians living under the poverty level is roughly 20 percent, although estimates of family rates are too small to generate an analogous percentage. 25 percent of the South Asian community in West Ridge has attained a high school education or lower. Similar to other ethnic enclaves, this community is predominantly an immigrant one, with 84 percent of residents being foreign born. Reflecting this composition, almost half of South Asians in this ethnic enclave demonstrate limited English proficiency. It is worth noting, however, that a more affluent South Asian population is burgeoning in the nearby suburbs, with population demographics more indicative of an upper middle-class status. These areas also reflect the growth of suburban South Asian clusters, with the development of mini-ethnic shopping districts and election of South Asians into local government. However, the bulk of South Asians reside within the city limits of Chicago when compared to any single suburb.

Despite a similar migration pattern, South Asians residing in the San Francisco Bay Area—consisting of Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, and Sonoma Counties—represent a different socio-demographic profile than the community in Chicago. The primary illustration of this divergence can be seen in the population distribution within the San Francisco Bay Area. As opposed to a concentration in an urban center, the majority of the approximately 150,000 South Asians in the Bay Area reside in suburban areas surrounding Fremont and Sunnyvale in Alameda and Santa Clara Counties (Ahuja et al., 2004). As many immigrants arrived in this area to pursue highly-skilled jobs in the engineering, computer science, and biomedical industries, much of the settlement occurred in areas surrounding occupational hubs in Silicon Valley. As the population density grew over the past three decades, these regions now demonstrate the characteristics of ethnic enclaves, with culturally-concentrated neighborhoods and commercial areas. The unemployment rate for South Asians in the Bay Area is under five percent and most employed community members are in professional, scientific, educational, and retail industries (U.S. Census, 2000). The median family income was over $80,000, with a significant proportion of families making over $150,000 (Asian Pacific Fund, 2003). However, over 14 percent of South Asians in the Bay Area live in poverty. The overwhelming majority of community members in this region have a baccalaureate, graduate, or professional degree although a precise estimate is difficult to calculate based on sample size (U.S. Census, 2000). Given the relatively recent migration to the United States, over 75 percent of South Asians in the Bay Area are foreign born (Ahuja et al., 2004). However, only about one-quarter of this community has limited English proficiency.

For the three research sites, data about health insurance status was unavailable at the detailed race/ethnicity level. However, the research sites chosen for this study illustrate the range of historical and socio-demographic characteristics that reflect the diversity of the South Asian population in the United States. Many of these indicators have strong associations with access to health care and knowledge of health risks. Moreover, the representation of a diverse sample of South Asian participants in multiple regions is ideally suited for qualitative inquiry examining the variety of behaviors, beliefs, attitudes, and knowledge associated with use of tobacco among this population.

Sampling

This formative stage of research occurred between June – August 2009. Recruitment processes included posting written flyers in areas with mass concentration of South Asian community members (e.g.,, ethnic grocery stores, restaurants, commercial retail outlets, and social service agencies), electronic communication through web announcements and e-mail listservs of organizations with high volumes of South Asian participants, and through ethnic media (radio announcements). Cultural "gatekeepers" who hold considerable respect and influence in each ethnic enclave were identified; these individuals agreed to dissemination study information through their social networks. The recruitment processes were repeated multiple times in order to secure a large and diverse sample.

Interested participants were screened to determine eligibility. A total of 42 participants met in the inclusion criteria in the Chicago and San Francisco regions. They were subsequently assigned to one of six distinct demographic focus groups, based on gender, generational status, and length of time lived in the United States. The study sample was 57 percent women, 67 percent foreign-born (with 32 percent of immigrants having lived here less than ten years). The sampling strategy purposively targeted a diverse composition of South Asian participants. Consequently, study subjects included community members from Bangladesh, India, and Pakistan and represented the Hindu, Islamic, Jain, Christian, and Sikh religions. They ranged in age between 20 – 65 years, and had substantial diversity in terms of language capability and

Despite a multifaceted and targeted recruitment effort, not one participant in the Yuba City site met the inclusion criterion of having used one South Asian tobacco-related product at least once in their lifetime. As the population of South Asians living in Yuba City were largely Sikh and have lived in this vicinity since the 1800s, religious prohibitions and acculturative effects may have influenced community members' ability and willingness to participate. Upon consultation with researchers and cultural leaders, the inclusion criterion for Yuba City was revised to having knowledge of one or more South Asian tobacco products. In addition, focus groups were separated only by gender as this population largely lacks any immigrants. In total, 12 participants met the revised inclusion criteria, with exactly half of the sample being women. Findings from these focus groups will be reported separately from those in Chicago and San Francisco.

Focus groups were held in South Asian community centers and academic institutions convenient for participants to travel to. Each focus group lasted between 45 minutes to two hours and was audio-taped for transcription into text. All focus groups were conducted in English, although certain participants reverted to Hindi or Urdu to more accurately describe certain assertions.

Content analysis

The study enlisted a transcriber proficient in Hindi, Urdu, Bengali, and Punjabi to covert audio recordings into text. Transcripts were uploaded into ATLAS.ti and coded using preformed categories related to instrument development. These codes included product identification and description, modes of ingestion, and accepted units of product "dosage". In addition, content analyses related to knowledge, beliefs, and attitudes toward usage of specific products. The final domain of coding included social and physical environments which facilitated tobacco use, as well as ascription of certain products to specific South Asian subgroups.

In the San Francisco and Chicago regions, there was a fair level of agreement across certain domains. For instance, study subjects agreed upon the common usage of certain South Asian tobacco products identified in the glossary. These items included the smoked *bidis* and *hookah* as well as smokeless *paan, paan masala, guthka,* and *zarda.* Often identified by regional terminology, *niswar* (or Indian snuff) was also found to be popular.

In addition to a relative consensus on product types, subjects in these regions also largely agreed upon methods of ingestion as well as perceived risks and benefits attributed to use of certain products.

Product descriptions and Subgroup use

With respect to smoked products, participants confirmed the definitions and "dosage units" of *bidis* and *hookahs* found in the literature. There was general agreement about which South Asian subgroups were most likely to use *bidis* or *hookah*. For instance, *bidis* were largely seen as a product smoked by lower-class South Asians:

> "*Bidis* are normally used among very poor class of people." (SATF01: p. 23)

> "*Bidis* primarily cheap men's cigarette." (SATF08: p. 46)

Despite their Islamic origins, participants largely agreed that *hookahs* are becoming increasingly popular among second-generation South Asians of all religious and cultural backgrounds:

> "Yeah, that's like certain things are fading away, and then like *hookah*, I don't think my parents were ever big *hookah* people, or the family friends that I know, but for our generation, like *hookah* and things, our generation, they do more things that are culture associated." (SATF07: p. 41)

> "If I were to talk a little bit younger, like college grads, or nearing grads, or undergrads, or maybe just early grads, they're more into *hookah*, if they have to like go into (South Asian) social outings with their own friends, they'd probably pick *hookah* rather than *paan*, … *hookah* is the alternative smoke, because it's supposed to be less harmful." (SATF09: p. 28)

> "*Hookah* is among us now, our first generation (of South Asians in the United States)… I don t know who originated it, but I know I've seen even old Indian movies with hookah in the background… It was actually very common, from what I hear, like not from my grandparents but from my great-grandparents, it was very common. And it skipped three generations, I guess… I know. It got popular again…" (SATF10: pp. 20 – 21)

"Even though, you know, a lot of other people also smoke it (*hookah*), I think a lot more of the South Asian community do it because they're like, oh, well, this is our culture, so… And that's how they bond, actually, a lot of them bond through *hookah*." (SATF13: p. 28)

Certain subgroups were more likely to report use of culturally-specific tobacco products by other segments of the South Asian community. For instance, women reported higher usage of most products by men:

"Yeah, that would make me feel like it's unusual. Women, it's maybe 98 percent men, maybe 2 percent women. But in the cultural like weddings and all that, women they do have, especially the old ladies, and then the young ladies follow, they see the thing and they want to try that in the wedding ceremonies and all that thing." (SATF01: p. 35)

"I haven't seen any woman using these type of products, yeah. Mostly men." (SATF03: p. 13)

"Yeah, I just perceive it as being a not feminine trait, so it would just look kind of off." (SATF04: p. 11)

Similarly, South Asians born in the United States ascribed higher rates of use to their immigrant counterparts:

"Yeah, I would say that people in thirties, forties, fifties, they are more into this type of thing. Younger generation I haven't seen much. Sometimes I have seen young people taking *paan masala* and all, but this *zarda* and, I mean the *khaini* (form of tobacco) products, younger generation… I wouldn't see. Particularly the children who have been brought up here… Yeah, immigrants are more, those who have migrated in their twenties or thirties, they are more into this kind of thing." (SATF03: p. 14)

"I think it'd seem a little bit more out of character for someone who was born here and raised here to be doing that." (SATF04: p. 13)

"Immigrants would be the one who would be eating *paan* no matter what, and I think it's similar to Bangladesh, east Bangladesh, west Bangladesh. But then I was going to say more of it, it has to do with, again, if you have seen your father, your mother, your grandfather, your grandparents eating it, you'll get into the stream of eating it." (SATF06: p. 30)

"I think it's cultural. I don't know, I don't even know if they've just become accustomed to it because they've been around it, especially I've seen more grandparents using it, older generations using it." (SATF07: p. 20)

"I think immigrants would have preferably (*paan*) more popular(ly) than currently. My son may not keep it in the house…" (SATF08: p. 57)

"I'm not sure if the second generation, Indian Americans or South Asian Americans, necessarily use *guthka* as much." (SATF09: p. 29)

"Well, I think it depends on the person, like for myself, like I'm sure you guys are first-generation Indians, so we weren't really used to chewing on tobacco and stuff, whereas people that come over here to the country, it's like habit for them, after dinner, they'll put some in their mouth and stuff, and for us, I'll use it once in a while, say out of a blue moon, if my cousin comes, my cousin's husband is like, you want some? Yeah, sure." (SATF10: p. 15)

"But I feel like the big blue bottle (symbol of most popular brand of *paan masala*), it's more like the older generation. I don't see anyone our generation just eating *paan masala*, the blue bottle… But I feel like our generation eats it a lot less. Like if we had the option between ice cream and *paan* we would choose ice cream." (SATF13: pp. 35 – 36)

Both cigarette and cigar use were largely stigmatized among South Asian Americans, whereas knowledge of pipe use among community members was absent. Similarly, use of more "Western" smokeless products, such as snuff, was also reported as non-existent.

However, subjects in both Chicago and San Francisco reported common use of non-smoked and culturally-specific tobacco products. Specifically, descriptions of *paan masala, guthka, zarda,* and *niswar* (based on regional terminology) were found to be very similar to definitions reported in the literature. Respondents also agreed that *niswar* could either be chewed or sniffed through the nose. A major exception—consistent with the disagreement found in the literature—was whether *paan* is universally considered to contain tobacco:

"Same thing, *gutkha* same, there's and the dried *paan* and the fresh *paan*, the *gutkha* is a dried *paan*." (SATF02: p. 23)

"First you put the *paan*, and then secondly *kattha* and *chunna*. These three things are compulsory. After that, it changes. Some put *tambaku* (form of tobacco), some put *qimam* (form of tobacco), some eat it plain, some put *zarda*…" (SATF02: p. 35)

"(T)he person said, oh, I'm sorry, you didn't know there was tobacco in it. I'm like, how do I know, you just offered and I'm like, here's *paan*, and I just took it, not knowing, like I should have asked whether there was tobacco in it, or non-

tobacco or something, I didn't ask, I'm like, oh thank you, and I just ate it, oh my god, and I felt very dizzy, very uncomfortable after that, and I'm like, oh my god, I learned a lesson to ask before I eat." (SATF06: p. 15)

"That is in *paan*. They put all in *paan*. *Paan* is a special leaf, betel leaf, which are generally grown in the, you can say, Bihar, Bengal, and also the Raipur side, you know Raipur, and that is a, people have become addicted to it. Now what happens, there's nothing wrong with that leaf, but what they put is lime, they put tobacco, they put even, you'll be horrified to know, opium. They put lot of things." (SATF08: p. 9)

"Now one thing I may tell you, they don't, because it's not official, nobody has been able to analyze them, (*paan*) ingredients, nobody will be able to tell you. Everybody will tell you different story." (SATF08: p. 22)

"I feel like chewing tobacco would be a little bit more taboo than chewing *paan*, for some reason. I feel that way." (SATF13: p. 26)

Most participants did agree that, despite being a homemade concoction, *paan* was made by vendors and hardly by the individual consuming the product. As such, the actual ingredients being inserted into this product was not verifiable. In fact, one respondent commented that more sweetened *paans* had a higher likelihood of containing tobacco and used "masking agents" to hide the distinct taste of tobacco.

Another major disagreement regarding "dosage units" consistently arose among focus groups in both regions. *Paan masala* can be found in both single-dose packets as well as bulk-volume tins. The latter form is consumed by using a "spice teaspoon" to pour out incremental "doses" of *paan masala* and consumed directly from the tin. As such, participants disagreed as to which unit of usage was more common among South Asians Americans:

"Three, three...three doses. I mean it depends on the individual. Some people will open a small sachet, and then they will eat the whole thing. And some people will use it, open it, and use it... multiple times, so, it depends on the person." (SATF03: p. 8)

"Yeah. And, depending on the size, I mean, *gutkha* comes in one dose packet as well. And it comes in the bigger pouches as well, so it...Yeah." (SATF03: p. 10)

"You can use it again either individually (in packets), just like that, or…You can just take a little teaspoon, and like, a little bit, and (showing scooping gesture from a tin) this much, and just eat it like that, and you can get the flavor out of it and stuff…" (SATF06: p. 14)

> "It is half a teaspoon. Half a teaspoon *paan masala*. You have a little spoon in that box, and you take it. You can even use your fingers, and you have it in a bowl on your table and whenever you feel like, it's nice." (SATF11: p. 20)

> "I feel like it's a, I don't think you measure it (*paan masala*) out, like with a spoon, but I think what it ends up being is equivalent to a spoonful… Yeah, but it's not an exact amount, teaspoon, it's not, they don't take like a spoon and actually measure it." (SATF13: pp. 21 – 22)

The final disagreement concerned confusion regarding whether *paan masala* and *guthka* were ultimately expelled after oral absorption or swallowed. Although minor in scope, the final mode of consumption has impacts on certain health conditions, such as stomach cancer.

Perceived risks and benefits

Subjects in both regions exhibited a diverse array of opinions as to which products had negative health consequences. Some were clear about the risks of using products clearly defined to have tobacco as a major ingredient:

> "I think hygiene-wise, like in the ways it messes up your teeth, and how it's bad for you, I think a more educated person would take that into consideration when using it, or use it less frequently than someone who isn't as educated, grew up with it, and just kind of smokes it and has it around." (SATF07: p. 31)

> "(The tobacco products are) addictive. Cancer. Liver problems, digestive problems, ironically. Problems the mouth, I'm sure the mouth will become less sensitive…" (SATF09: p. 44)

For products which had more implicit connotations of tobacco—*paan*, and to a lesser degree, *paan masala*—the knowledge of adverse health consequences were more varied:

> "Can I tell you one thing? In *paan* itself is not dangerous to health, if you use paan, lime a little bit… And a little bit *supari*, it is good for digestion…" (SATF08: p. 13)

> "(*Paan* with) Tobacco has been used for pyrrhea… Pyrrhea is infection of the gums. And Ayurvedic medicines also use them. *Paan* and *supari*." **Another participant responds**: "Scientifically are of no use, they are only addiction, scientifically I am telling you." (SATF08: p. 68)

> "Yes, but they also eat, just take it separately, without the *paan*. I think that the *paan masala* is equally harmful, but some people think the *paan* is the most harmful thing, so they just take the *masala* separately." (SATF09: p. 15)

> "Yeah she says the *paan* is a source of calcium. For the mother. Even after age of thirty, everybody has to take calcium in this country. But there, they don't take. So most of the ladies are getting knee problem. That is being avoided, it was avoided before because we were very, continuously without any break, we were eating this (*paan*). It help us without our knowledge. Betel leaf contains calcium, the leaves. It's supposed to be nutritious too. It has some kind of nutrition." (SATF11: p. 25)

> "Now you're talking about this *paan masala*, I have it in a bottle near my chair, even when I'm watching TV, I take. It's just like a snack, maybe, like a candy… It's a harmless snack." **Another participant responds**: "Not that harmless…" (SATF11: p. 27)

> "*Paan* is a good thing. Even now, if you bring *paan*, I'll eat." (SATF11: p. 42)

Remarkably, many respondents indicated that use of certain products had purported health benefits. Some cited hypothesized antiseptic or astringent properties:

> "That is, people use this thinking that it's somehow beneficial, keeps the teeth clean or helps us with gas…" (SATF05: p. 31)

> "(*Paan*) is an astringent. Yean, an astringent. I know, because in the South, we use it (for that purpose)." (SATF08: p. 12)

> "It is not only digestive, it is sort of anesthetic. Local anesthetic… I don't know if you can call it a benefit, but it is like a mood enhancer." (SATF08: p. 65)

Certain study subjects were convinced that use of certain South Asian products was beneficial for digestion or as a breath freshener and oral cleanser. Yet others asserted that those products containing betel-nut (or *supari*) had cognitive benefits, such as increased alertness and improved memory.

> "Yes, refreshment is one, some people they use it as a digestive supplement." (SATF01: p. 31)

> "Yes *paan*. But those people who eat it because they have gas, or some 'pain' or they get 'relaxation', those people are a little different, they eat it for that reason." (SATF05: p. 32)

Although certain study subjects in both regions were quick to dismiss false claims, these purported benefits arose repeatedly across almost all focus groups in Chicago and San Francisco.

Social and Cultural Influences

Independent of the perceptions of risks and benefits directly related to health, there was a large consensus regarding the social and cultural value ascribed to use of certain products. For instance, *paan* was reported to have both a celebratory and traditional value:

> "Wedding, celebration, that becomes like, it's not a compulsory thing, but some people they have it, like culture, you know, if somebody wants it… but it's kind of like you can take it as a refreshing thing after meals so they don't get that food smell, some they have it as a feel-better sensation thing, and all that…" (SATF01: p. 21)

> "Yeah. They do. After dinner and all that, they sell *paan* and they have to have, some kind of like music time, entertainment, tea coffee or something." (SATF01: p. 33)

> "This *paan* thing, it's become a kind of tradition, just like people offer tea, people offer *paan*, it's a kind of hospitality." (SATF01: p. 32)

> "Like in our India, tea is a strong custom, in Gujarat. Wherever you go, tea is a must, tea and coffee are a must. Whether it's time for it or not, if you go to someone's house in the evening then you'll have to drink tea, if you get there at night, you'll have to drink tea. In Asia, mostly in all three countries, India, Pakistan, Bangladesh. It's the same thing with *paan*. Drink tea, then eat *paan*." (SATF05: p. 32)

> "…it's like a kind of fun, they are having fun with the *paan*, and they feel more cheerful, and like it gives a satisfaction, a satisfying feeling that you are concluding your meal, your food, with a tea and then *paan*, so that means it's bringing to an end of your… (a symbolic end of the event)…" (SATF06: p. 13)

> "Like I said, again, you can use it in your home, after your meals, you can eat it with friends when you go out, so just socializing." (SATF06: p. 25)

> "(W)hen you have weddings, so normally it's a customary, and it's a ritual, like she said. So then the groom's family, when they come and perform this ritual, they do – it's not like of course a beda, like a ready-made *paan*, but they will use the loose leafs also of *paan,* and just put a little *supari* in it and keep it there, or give it to someone, or just feed the bride, or something, so that's also used in rituals and ceremonies." (SATF06: p. 27)

> "For us, like my family I would say, whenever my parents have it, when somebody went to Devon, or somebody brought it, or there was a wedding or something, so it's like more of a delicacy. I mean I know it's not something that's

expensive or fancy, but you don't eat it all the time, so when you do eat it, it's nice to, when you do eat it, they sit down, and talk, and get *chai*, and eat it." (SATF07: p. 34)

"That's also an honor thing. They offer *paan*. It is a part of respect." (SATF08: p. 33)

"It is a part of every – at least the celebrations that I have heard about, prayers, *paan* and *supari* is almost a must. *Supari*, not being available so much, is not, but *paan* is a must." (SATF08: p. 53)

For many, use of culturally-specific products was a symbol of their ethnic and cultural identification as a South Asian, irrespective of whether they were born or visited there:

"I mean, it has become our identity, *paan*. So wherever we go, *chai, chaat, paan*, this has become identity… Yes, it's become our identity, definitely it's become our identity." (SATF02: p. 42)

"I mean yeah, in fact, most of these habits are among South Asians normally, so, being a South Asian, I mean, you try to imitate, or you try to get into, accompany, so yeah." (SATF03: p. 12)

"Rather than just the tobacco effect, I think it's just more of a connection to back home, or a cultural tie almost, 'cause I think like a lot of Indian people in the U.S. still want to hold onto the tie to back home. Or, you know, through their parents. And they're with other Indian friends, so it's like watching a Bollywood movie, kind of. That's what I think about that." (SATF04: p. 8)

"It's just a fun thing, that makes, that gives you a satisfying feeling, that I had the *paan*. It's just like entertainment, so when I come to Devon (Chicago South Asian district in West Ridge) sometimes, I'm like okay, I want to experience, after my *khanna*, my special tea, and then I want to eat the *paan*." (SATF06: p. 26)

"Maybe it, especially for the ones in America, like for my parents too, they do it because they used to do it when they were younger, back home, and then it kind of reminds them of home, like for us we have our own desserts…" (SATF07: p. 21)

"I'm sure they do, that's why they have it (*paan*) at gatherings. It is a sign of how close you are to your culture." (SATF09: p. 32)

"Yeah, remember India, and whenever we are together, enjoy *paan*… So something like I am using this *bindi* (South Asian decorative facial ornament). Yeah, identity." (SATF11: p. 37)

> "There might be a kind of positive association with *paan*. If you think about, like, Amitabh Bachchan (famous South Asian actor), and the song about *paan*, with a certain generation of South Asian men, it might be seen as something that… (is) cool… people who are being nostalgic." (SATF12: pp. 28 – 29)

Outside of identity, tradition, and celebration, use of these products were simply a way to socialize with members of the same ethnic community. Oftentimes, these products were used while participating in other culturally-specific events, such as viewing South Asian movies or sports, or gathering with community members to engage in culturally-specific entertainment (e.g., playing cards, dance clubs, board games).

Differences among Data Collection Sites

For the most part, community members in Chicago and San Francisco responded similarly in identifying and defining culturally-specific products used commonly in the United States. In addition, most reported similar community conceptions of impacts on health as well as the social and cultural determinants of use. Interestingly, participants in Chicago were more apt to report personal use of identified products, acknowledged actively seeking them in ethnic outlets, and emphasized the social value of indigenous tobacco in a cultural context. In contrast, community members in the San Francisco focus groups were more likely to ascribe use of products—especially those with more explicit tobacco content—to South Asian subgroups to which they did not belong. These respondents also articulated a more private use of culturally-specific products and maintained that they were usually found in domestic settings, such as family gatherings. Accordingly, there was less identification of ethnic outlets and public settings in which these products were available and visibly used. Nevertheless, these groups reported very similar patterns and contexts with respect to South Asian tobacco use.

However, participants in Yuba City reported dramatically different results. The most notable difference in findings was the lack of knowledge of most products identified in the Chicago and San Francisco focus groups. In fact, many respondents who indicated familiarity with certain products were largely incorrect in their definitions.

> "(*Hookah* is) like a small, it's like a deeva, you know, it's made out of clay, and they put some, you know, I saw ash, you know, it's burning." (SATF15: p. 4)

> "I think (*paan* is) a pickled something?" (SATF15: p. 1)

> "Is that (*paan*) the same as marijuana though?" (SATF15: p. 16)

> "Yeah, we were in Sacramento, I still remember the party. Because I was like in shock, I was like what is that, is that (*paan*) a drug, or what is it? You know what I mean, I started thinking to myself, why does he need it now?" (SATF15: p. 19)

"That's a weed we pray with… That's a *guthka*." (SATF15: p. 23)

"I thought that (a *bidi*) was a joint." (SATF15: p. 32)

Yuba City participants who were indeed accurate in their definitions cited their experiences or stories passed down from the native subcontinent as their source of knowledge. When probed about possible reasons why such products were not in use, the common opinion was that use of any form of tobacco was not sanctioned by the predominant religion that South Asians in this region subscribe to (Sikhism). Especially upon women, using such products would have dramatic social consequences on their inclusion within the local community:

> "See, I think there's one element – if you belong to a Sikh religion, it's still a taboo, I mean, you're not, openly you're not gonna be smoking… (They don't use) any product that you're gonna smoke, or… that can get you high." (SATF14: pp. 12 – 13)

> "Most of them (South Asians in Yuba City) are Sikhs. There are some Hindu families from Punjab, but not many. But there are some Punjabi Pakistani families. But when you say South Asian, so there's a big number of Sikhs. So most of the Sikhs here don't smoke." (SATF14: p. 13)

> "Indian families are really strict. You can't even touch a cigarette, I mean, if you touch it, again, that's a sin… In every Sikh family, you know, the majority of them, they have seen their elders not smoking, and they even tell their kids, you know, we're not supposed to do that, so they just keep learning, even from their parents." (SATF14: p. 23)

> "You're not supposed to drink anything, or you're not supposed to smoke, but you're not supposed to drink and inhale anything that alters your mind… in Sikhism." (SATF15: p. 10)

> "A bunch of guys – okay, imagine a bunch of *Sardars*, Sikhs, and smoking? Oh my God, everybody would have a fit." (SATF15:p. 58)

South Asian men in Yuba City also expressed disapproval of tobacco use; however, participants did admit that certain men in the community did smoke cigarettes, albeit "hidden" from other South Asians and the general public. Those who did use "Western" forms of tobacco were more likely to be younger and engage in doing so with members outside of their community.

> "I think yeah, but a lot of it's changed now too, like I think a lot of it's easier for us to see them, younger generations, where now I have friends that actually smoke openly at home, too, now… But they've started to do it at home, too, in

> front of their parents, where before you never saw that. And like if you even saw an Indian walking, they would just put it out and like, no, don't want them to smoke, but I think it's more openly now. I mean especially for us kids, I mean you see them everywhere, but I think for someone like my dad or someone else to say, it's different." (SATF14: p. 14)
>
> "It's like now, when I see somebody smoking, like the younger generation, it's like nothing… it would be more of a shock if I see an older guy smoking." (SATF14: p. 24)
>
> "In Sikh families I really haven't seen it, but just from hearing here and there, I think it's more widespread, the cigarette part, maybe the chew part too, than people are willing to do out in the open or to actually openly talk about, and I think that's evident through the advertisement of this study – if you use tobacco products and would like to participate in this study, call this number – not a single call." (SATF15: p. 66)
>
> "Yeah, because it'd shock people to see that. So if any females were to walk by with a cigarette in their hand, oh, that'd be…" (SATF15: p. 68)

The prohibition of any tobacco use is a cultural value that is seemingly passed down through generations, originating from this community's origin in the Indian and Pakistani states of Punjab. As such, the general consensus among South Asians in Yuba City is that adherence to this restriction allows them to maintain an authentic identity. As many respondents cited persistent forms of discrimination targeting their community specifically—in contrast to their San Francisco and Los Angeles counterparts in California—there was a consensus that this South Asian population needed to remain insular and protect themselves from outside influences which may invite shame from other community members. As such, use of any tobacco is highly stigmatized, resulting in a very different behavioral pattern than those expressed in the Chicago and San Francisco groups. Given the lack of public admission of any form of tobacco use, Yuba City was eliminated as a research site for future stages of qualitative inquiry.

In summary, the formative phase of qualitative inquiry provided meaningful data elucidating the cultural context of South Asian tobacco use. Findings from focus groups gleaned nuanced information regarding types of culturally-specific products commonly used, modes and cultural equivalencies of consumption, and community-level perceptions about risks and purported benefits associated with tobacco use. Moreover, content analyses generated pivotal representations about social influences and cultural values governing tobacco-related behaviors among the South Asian American community. Comprehension of these cultural patterns was paramount in developing the initial version of the SAT Module, as detailed in the following section.

INSTRUMENT DEVELOPMENT

Based on the content analyses conducted in the formative stages of research, study findings provided a baseline of information from which to create instrument prompts. However,

prior to any formal creation of survey questions, the study used other sources of data to inform the initial development of the SAT Module. The triangulation of secondary sources of data with study findings involved the review and examination of other instruments used to assess tobacco use.

Review of Tobacco Surveys

Prior to the initial drafting of the SAT Module, the Adult Tobacco Survey (ATS)— created by the Centers for Disease Control and Prevention (CDC)— most commonly used to generate population-level tobacco prevalence data was critically reviewed to inform instrument development. The study placed special emphasis on examining the content and structure of prompts used to determine frequency of use, behavioral patterns, modes of ingestion, and assessment of addiction. In addition, measures validated to assess health and social influences on initiation of use, maintenance, and cessation were analyzed for relevance in developing the SAT Module. Other constructs of relevance, such as parental involvement and age of first usage, were identified in order to ensure that they were adapted for inclusion in the SAT Module.

As the SAT Module is meant to capture the cultural contexts which influence tobacco behavior, the study relied on methodologies from other ethnically-specific surveys to inform instrument development. These included the Hispanic/Latino and American Indian Adult Tobacco Surveys, both of which were adapted from the CDC's original tobacco instrument. Specific attention was paid to the creation of survey prompts focusing on non-traditional products and measurement of cultural knowledge, beliefs, and attitudes related to tobacco use. In addition, methods utilized for cognitive-testing of constructs were extrapolated to guide subsequent stages of qualitative data collection.

The initial literature review identified four studies measuring different forms of tobacco among various South Asian subgroups. To ensure that the SAT Module included constructs not immediately apparent in the formative phase of qualitative inquiry, each of these instruments were obtained and reviewed for pertinent constructs. In addition to assessing phrasing of survey items, the study systematically examined the depth and breadth of demographic variables included in prior instruments to determine their utility for capturing distinct patterns among South Asian subgroups in the United States. These domains include gender, specific country of origin, language, religion, immigrant status, length of time in the United States, and other variables which may be combined to construct proxy measures of acculturation.

To create the initial SAT Module, the study triangulated these secondary sources of data with findings from the formative focus groups to develop multiple constructs. Modeled after the CDC ATS, these survey items were grouped into the following categories: (a) demographic variables; (b) type, frequency, and length of tobacco use; (c) perceived health risks and benefits; (d) cultural rationale for use, including reasons to cease; (e) social influences; and (f) parental involvement in facilitating or impeding use. The initial survey focused on seven South Asian products identified by focus group participants as those most commonly used in the United States. As certain products had small levels of differential interpretations in definition, the initial SAT Module incorporated headers preceding each section inquiring about a certain product. These definitions were created largely based on community-based input, supplemented with information from scientific sources. In order to ensure a seamless integration with CDC ATS, the sequence of modular sections paralleled those presented in the validated instrument.

In total, 186 questions were created and added into the initial draft of the SAT Module supplementing the 286-item CDC ATS. As the SAT Module was meant to supplement the ATS,

changes and additions were only made to supplementary sections. The only exception was the addition of specific demographic questions to the core section of the ATS to identify potential respondents as South Asian to ensure that the SAT Module was used with the appropriate population.

The significant length of the questionnaire was largely due to adapting validated constructs for the seven identified culturally-specific products. In order to potentially shorten the length of the initial survey, certain sections collapsed multiple products into singular sets of prompts, based on certain similarities. For instance, products sharing overlaps in modes of ingestion (e.g., smoked vs. smokeless) and constituent ingredients were grouped into one set of survey items to measure various characteristics as if they were a single tobacco item. An example is listed below:

E.3 **Smoking cigarettes, *bidis*, or *hookah/shisha* is physically addictive**

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

In addition, tobacco behaviors which didn't generate consistent agreement in the formative content analysis were presented with multiple versions in the initial instrument. The options presented were based on alternative interpretations generated in the first set of focus groups. The most common illustration surrounds the use of a smokeless product, *paan masala*:

B.10.1f **On the average, about how many packets of *paan masala* a day do you now chew?**

1-180 Number of *paan masala* packets
666 Less than one *paan masala* packet a day

777 Don't know/Not sure
999 Refused

ALTERNATE:

B.10.1f **On the average, about how many pinches (or teaspoons) of *paan masala* a day do you now chew?**

1-180 Number of *paan masala* pinches
666 Less than one *paan masala* pinch a day

777 Don't know/Not sure
999 Refused

As this instrument was the initial draft of the SAT Module, the study relied on community feedback through the cognitive focus group interviews to provide clarity on these and other issues. The following section details the process of collecting these qualitative data and presents findings pertinent to instrument refinement.

COGNITIVE TESTING

Sampling

The second phase of qualitative research employed identical recruitment and selection methods for securing participants with a few modifications. In addition to passive outreach strategies, a snowball sampling approach was used to recruit participants for this phase of data collection. This process entailed contacting community members who participated in the formative phase of data collection to request participation and recruitment of other potential participants through their South Asian social networks. Interestingly, only five individuals from the formative focus groups participated in the cognitive interview phase of the study. Equal emphasis was placed on purposively selecting participants that represented a diverse array of demographic characteristics, such as age, length of time in the United States (for immigrants), religious backgrounds, and self-identified region of South Asian origin.

In addition, based on the adamant lack of tobacco use found among Yuba City participants, this locale was not chosen as a research site for the second phase of qualitative inquiry. For the purposes of cognitive interviewing and instrument refinement, the value of input from South Asians not publicly reporting any form of tobacco use was deemed to be minimal.

Based on community feedback from the initial phase of qualitative data collection, sites for cognitive interviews were changed from community-based organizations located centrally in densely-populated South Asian enclaves, to locations near public transportation and free parking. Given budgetary limitations, the data collection sites were located primarily in academic institutions with convenient access. All universities chosen for cognitive interviews had significant South Asian student populations; approximately half of all participants were actually enrolled as students.

Participants were assigned to focus groups with identical demographic compositions to those of the formative phases of research. The only difference from the initial groupings was the consolidation of recent and established immigrants into a singular focus group, as separation did not seem necessary for the purposes of cognitive testing. A total of 46 participants met the inclusion criteria in the two research cities. 57 percent of the sample was women and 59 percent

were born outside of the United States. Cognitive interview participants included community members identifying as Asian Indian, Pakistani, Bangladeshi, and Sri Lankan. Participants described their religion as Hinduism, Islam, Sikhism, or Christianity. Ages of individuals meeting inclusion criteria were between 18 – 65 and exhibited considerable diversity in South Asian language proficiency (in addition to English) and types of culturally-specific products used. Each focus group lasted approximately an hour and was conducted in English. All cognitive interview focus groups were conducted between February and March, 2010. In addition to reviewing the entire instrument, participants were asked to pay special attention to areas in which the initial SAT Module might be truncated to reduce its length and time needed to fully complete it.

Content analysis

All content was transcribed into text by a multi-lingual South Asian student trained in transcription. Transcripts were uploaded into ATLAS.ti and coded for recommendations made by participants for substantive changes to the initial instrument. In addition, any constructs or areas where participants expressed confusion or disagreement were also coded to inform potential refinements to the instrument.

For the most part, community members involved in the cognitive interview process agreed that the breadth and depth of survey prompts were comprehensive and appropriate to assess culturally-specific tobacco behavior by South Asian Americans. Participants did not identify any additional products not included in the initial draft of the SAT Module. The following sections detail areas where the initial SAT Module was revised, based on clarifications and recommendations requested by focus group participants in both research sites.

Demographic Items

Participants recommended that the list of potential languages that survey respondents may select be expanded to include those spoken commonly by Sri Lankans and Pakistanis. In addition, many identified dialects spoken by individuals originating in the most recently established states in India. When probed, participants indicated that these languages were in common use among community members in the United States and thus, should be included in the final instrument.

Similarly, respondents also identified South Asian religions not included in the initial instrument. The major religions not included in the initial instrument were those practiced in regions near the India and Pakistan border—such as Baha'i and Zoroastrian faiths—but have little in common with Hinduism, Islam, and Sikhism, the primary three religions practiced in South Asia.

Culturally-Specific Products

Participants agreed that the definitions of the products were largely consistent with their own knowledge. However, one suggestion was repeated often across most of the focus groups. In order to facilitate an accurate interpretation of products by survey respondents, participants recommended that pictures of each product be included if the instrument was to be completed using written or visual (e.g., web-based) forms.

Another area which elicited confusion among many participants was the descriptor of the *hookah*. Although the terms *hookah* and *shisha* are used interchangeably, there are indeed significant differences in the definition of each, as illustrated below:

> "*Shisha* is the actual tobacco substance… *hookah* is the instrument… Mostly people smoke *shisha* because they think that they are not smoking tobacco." (SATC02: pp. 13 – 14)

> "I always thought the '*shisha*' was like the actual tobacco." (SATC10: p. 9)

In addition to the technical difference between these terms, respondents also expressed confusion about the description of *hookah* presented in the initial draft. Despite being extrapolated from validated surveys, respondents stressed the overly academic nature of the definition and suggested making it more detailed or eliminating it altogether. A pertinent observation made by many was that those who smoked *hookahs* would be familiar with it irrespective of any definition. Conversely, the exact detail of the descriptor would be irrelevant for those did not partake in *hookah* smoking. In summary, it was agreed that there would be very few people who actually engaged in smoking *hookahs* and were not familiar with the term used for the apparatus they were using.

Participants from underrepresented South Asian subgroups also identified regional synonyms used for commonly-used products, such as *paan* (*bulath vita* in Sri Lanka), and suggested that those be included in the definitions to eliminate confusion. Others indicated minor expansions or omissions of certain details to maximize clarity. One such suggestion was to use the verb "use" (as opposed to "chew" or "sniff") to ensure that products with multiple modes of ingestion were measured accurately. Similarly, with smoked products, participants also recommended that more academic terms, such as "inhalations", were replaced by language more comprehendible by South Asian community members, such as "puffs".

The most substantive input provided by participants, with respect to product definition, was to address the differential "dosage units" ascribed to *paan masala* usage. Although many alternatives were discussed, the option most largely agreed upon was to create an initial question which would guide the survey administrator to use the correct dosage unit to assess frequency. The modification is detailed as such:

B.10.1f **When you use *paan masala,* do you use it in packets or by the teaspoon provided in the tin?**

1. Packets
2. Teaspoons

7. Don't know/Not sure
9. Refused

B.10.1g On the average, about how many packets OR teaspoons [USE CORRECT DOSE UNIT BASED ON B.10.1f RESPONSE] of *paan masala* a day do you now chew?

1-180 Number of *paan masala* packets OR teaspoons
666 Less than one *paan masala* packet OR teaspoons a day

777 Don't know/Not sure
999 Refused

Outside of these suggestions, participants agreed that product definitions and modes of ingestion were accurate and easily interpreted by community members representing diverse South Asian backgrounds.

Health and Social Influences

The purpose of this survey domain was to capture the level of actual and perceived health knowledge (risks and benefits) associated with use of certain products. Moreover, this section also inquired about social and cultural reasons ascribed to product usage, including reasons to quit. To examine potential consolidation of products in order to shorten the survey, the initial SAT Module presented products in consolidated categories of smoked and smokeless products. Participants were asked to evaluate the utility of using these groups in order to capture relevant patterns of tobacco use.

In response to these groupings, there was a fair share of consensus around keeping each product separate, as it was agreed that each had a separate and unique context surrounding its use.

> "I think if people say that they don't consume at all then maybe they can be lumped but if they do consume a product then it would be better to know if they are aware of the health risks when they are consuming the product or not. For general population, if they don't eat any of the smokeless or smoke anything (or) if they say I don't touch any of these products, then you can ask them a general question. But if they are using *paan masala* but not using *guthka* then you need to know why he is using that, maybe he is not aware of the health risks." (SATC01: p. 17)

> "I think there's definitely a value and honestly… this is all I think and anybody can do …separating *paan* out cause you would be surprised how many people would say no I don't think it causes any. Because *paan masala* the awareness is there, it's been there for years, it's addictive you know but when you lump them together you are losing on the people who actually don't think *paan* is anything bad and there's loads…they think it's not bad so I could eat a little, it depends on if you are looking for that data. Yes, I think separating them all would be really useful to know which products to target." (SATC05: p. 17)

> "*Paan* and *paan masala* would be different, *guthka*, *zarda* and *niswar* would be different. And it's sad but *niswar* in our country is taken as a very uneducated class thing. So outside of the health benefits you won't do it because it's all the truck drivers who do it. So, it's just different. It's stigmatized." (SATC05: p. 29)

> "I mean cigarettes I feel like people who do use like *hookah* or *paan*, there is this argument that it is natural, like they don't mix chemicals or anything like they do in cigarettes." (SATC08: p. 14)

> "For example there are people who might see *paan* itself being addictive but they may not see *paan masala* being addictive." (SATC09: p. 20)

> "The question is though when you clump all those together, I wouldn't connect *paan* to nasal cancer, I would connect it oral cancer because it's oral not so much nasal. But when I think of *niswar*, I do think of nasal, I don't think they are together… Why are they put together?" (SATC11: p. 13)

> "I think that *paan masala* is so commonly seen in households so we don't think of it as addictive, and that out of all is the softer one; I find it surprising that it would be physically addictive but I can see why *guthka*, *zarda*, or *niswar* would be seen as addictive." (SATC11: p. 14)

Interestingly, this sentiment was more pervasive among immigrants, who were more likely to have familiarity with multiple South Asian tobacco products. Participants born in the United States often referred to definitions presented in previous sections of the instrument to suggest consolidated groupings; however, these recommendations were summarily dismissed by others more familiar with social and cultural knowledge and beliefs ascribed to individual tobacco items. One such illustration is detailed below:

> "*Paan masala* and *guthka* definitely will elicit different responses. Even I have eaten a *paan masala* but I would stay away from *guthka*. So it's fairly reasonable to say that usually once in a while somebody might chew a *paan masala* but if you ask if that person is non tobacco consumer then he might not consume tobacco or *guthka*. And it's hard to combine even *paan* and *paan masala* because *paan* is more like when you have it on and everything even the the kids eat it but the smaller children they are all kept away from *paan masala*. The regular consumers of *paan*, they use tobacco *paan* which are different forms than a *paan masala* because *paan masala* will be more of *supari* covered with the tobacco while in *paan*, along with other contents, you will basically have the *zarda* or the *chutney* (mixture) which has tobacco in it." (SATC01: p. 12)

As the purpose of the SAT Module is to measure variables which have differential prevalence, addictive, and behavioral properties, participants largely concurred that keeping each product separate would most likely result in a nuanced dataset reflecting independent associations with each culturally-specific item with other survey covariates and tobacco-related disparities. The only items that participants felt comfortable in keeping consolidated were cigarettes and *bidis*.

For the subset of questions examining conceptions of specific health risks and benefits, participants agreed upon the initial list of perceptions. In addition, many participants concurred on a number of additions, based on their own experiences with family and other community members. For health benefits, these response categories included inducing bowel movements, appetite suppression, and stress relief for smokeless products. The initial instrument did not include perceived health benefits for using smoked products, as validated adult tobacco surveys assume that most smokers are aware that usage doesn't confer any health benefit. However, participants were largely in agreement that a subset of response categories in this domain should be added for *hookahs* as the context of usage is divergent from smoking cigarettes and *bidis*.

> "Because even though when people advertise the health risks, it's always about cigarettes or *bidis*. The *hookah* really never comes up. So I think either people are completely not aware of the health risks of *hookah* or if they are equivalent to the smoking risks and how people perceive is I think even I don't know. Because there is no where you will see … the advertisements which run on television they will not bring up *hookah* as a form of smoking and what leads to the potential health risks of smoking. I think it's kind of the hidden chapter of smoking which is not highlighted. People may or may not be aware of exactly what they perceive of it as. Whether it's kind of the tobacco consumption they feel or is that they are not smoking they are just having steam. I don't know what really they perceive drinking *hookah* as." (SATC01: p. 15)

> "*Hookah* would be different cause every time I see people doing *hookah* they go out of their way to tell you it's not like smoking cigarettes, there's nothing wrong with it… Every time in every *hookah* lounge, even dorms in college they always say there's no health risk to it, there's no tobacco in it apparently so they don't think it's as bad as cigarette or *bidi*… And it's interesting culturally I think even growing *hookah* being more acceptable than cigarettes so people don't hide their hookah use but they hide their cigarette use." (SATC05: p. 15)

> "…but cigarette smoking is different than *hookah* smoking. So it's probably better for your survey purposes to leave it separately because it won't give you the response that you want." (SATC07: p. 7)

> "The '*hookah*' should be separated. That totally is a different perception." (SATC10: p. 17)

> "Actually I don't know about that. The first time I smoked hookah, I was under the impression that it was safer, less harmful than cigarettes." (SATC10: p. 26)

> "Cigarettes I don't think it's that big of a social thing as *hookah* is. So *hookah* is taken a lot lightly than cigarettes and bidis… And I think a lot of people would say don't know/not sure (to the question prompt) because the *hookah* was clumped in with it. Because they know that cigarettes and *bidis* cause this (specific health condition) but *hookah* may be not." (SATC11: p. 12)

As such, multiple respondents recommended the inclusion of the following response categories for perceived health benefits of *hookah* use: stress relief, less harmful (or safer) alternative to cigarettes or *bidis*, and aids sleeping. In addition, there was a number of response categories from smokeless products that participants felt were important to keep.

Most of the discussion related to health and social influences surrounded the descriptions of responses for social and cultural reasons to use individual products. Participants of all demographic backgrounds expressed a fair share of confusion regarding the term "cultural identity", as illustrated below:

> "'Do you identify yourselves with your roots' or 'what is being followed or being used in your country' that you would want to use here. 'What makes you feel at home or gives that sense.' Because why we go to Indian grocery stores and shop Indian try to make Indian food here because what we belief is what we consume in India is what we like and what we feel is a healthy food… Rather than 'cultural identity', 'do you feel yourself more of a part of South Asian community?'" (SATC01: p. 21)

> "And 'cultural identity' seems like sort of flimsy just like you are this so you do this when it's like in fact not heavily used throughout the entire population. I feel like if it's available, some people will use it and some people won't. So I don't really know in what context it's 'cultural identity'". (SATC03: p. 14)

> "And may be instead of cultural identity, have 'cultural tradition' because mostly like when I use a *paan* it's at a wedding or something after a big event where they have a buffet dinner and then they have *paan* as well. So that wouldn't be a religious event but more of a cultural event so 'cultural tradition' fits better." (SATC05: pp. 19 – 20)

To remedy this lack of clarity, participants suggested a more detailed and less academic construct, as depicted below:

E.3.7a. It helps me identify or puts me in touch with my South Asian background

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

Similarly, participants were largely in agreement that, although many of these products were often used in faith-based environments, the use of products had little or nothing to do with the religion itself:

> "To be absolutely honest, I don't really know which religion or spiritual tradition would require use of *paan* like I've never heard of one." (SATC03: p. 14)

> "I mean I am Muslim so I don't see any religious basis…" (SATC07: p. 9)

> "Cultural and social traditions is okay. Not religious and spiritual, if anything.. all religions prohibit… Yeah it's definitely not spiritual and definitely not religious." (SATC09: p. 27)

As such, it was recommended that this construct be revised to reflect both the celebratory and traditional value in a social and cultural context. In addition, participants agreed that celebration and tradition were two different concepts and that this measure be actually separated into two survey prompts. There were also suggested additions to the instrument, such as preference for taste or substitution for more harmful products.

Similarly, for social and cultural reasons to cease specific forms of tobacco use, participants concurred on the initial list of options and added their own recommendations. Notable suggestions included religious prohibitions, ascription to a lower socioeconomic class within the South Asian population, and impacts on personal appearance. As with the other sections, participants suggested that a parallel set of response categories be presented for ceasing *hookah* use.

In terms of potential skip-patterns utilized in the instrument, respondents suggested that many of the domains—especially perceived health risks and benefits—be asked even of non-users. Many felt that measures of knowledge and beliefs may be prevalent even among South Asians who don't use these products and as such, may provide valuable information regarding awareness of the community at-large.

Social Networks

For this domain, most respondents agreed that grouping smokeless and smoked products (with the exception of *hookahs*) was acceptable for the purposes of understanding how many of one's social networks engaged in any form of tobacco use. The specificity of the product itself did not supersede the value of shortening the survey.

However, for measures of community acceptability, the majority of respondents did revert to their recommendations of keeping products separate, as each tobacco item elicits a differential level of stigma from community members.

> "The thing with *paan* and *hookahs* and *shishas* are like…I mean this can be influenced because I've heard about them them but they are like most socially acceptable mild forms…you know as someone who's like a non-tobacco intaker [sic], those are the two that I'm most familiar with in my circle and the way we've seen them is always much more casual and informal." (SATC06: p. 25)

> "I'm just thinking out loud about it, now there's like a growing popularity of cultural acceptance of *hookah* lounges, not like (when) I grew up in the 80s." (SATC07: p. 12)

In the initial instrument, acceptability of use ascribed to socializing with other members of the South Asian community and during cultural events was presented in the same question stem; respondents largely agreed that these were two different concepts and should be separate prompts for each tobacco product.

Parental Involvement

By and large, respondents concurred that parents differentially allowing (or not prohibiting) their children to use culturally-specific tobacco had significant impacts on initiation of and sustained product use. Similar to previous sections, participants indicated that each smokeless product and *hookahs* had differential levels of permissiveness for use by children and as such, survey items related to parental allowances should be separated by product.

In summary, results from the cognitive testing phases of the research gleaned critical input regarding the comprehensiveness and clarity of content presented in the initial survey prompts. More valuably, participant feedback provided pivotal information regarding the differential social and cultural values ascribed to use of specific products. Content analyses from this phase of qualitative inquiry generated technical recommendations regarding modification of existing survey items while concurrently identifying culturally-relevant areas for instrument expansion. These findings provided keen insight regarding increasing the capacity of the SAT Module to accurately and comprehensively capture the complex contexts of South Asian tobacco use.

INSTRUMENT REFINEMENT

Based on the findings from content analysis of cognitive interviews, selected recommendations were incorporated into the SAT Module. In order to ensure that pertinent demographic variables were included for surveillance, findings related to language and religion suggestions were cross-referenced by national repositories to ensure that they were authentic variables (Grimes, 2000; Mittal & Thursby, 2006). Languages deemed to be distinct and not simply dialects of other major languages were included in the final instrument. Similarly, religions were added as specific response categories only if they were represented significantly among South Asian populations and were not subsets of larger faiths.

Other revisions and additions found in the content analysis were only incorporated if they met the following criteria: (i) comments represented subgroup perspectives not found in the formative focus groups, due to lack of inclusion; (ii) suggestions were repeated in one or more focus groups across both research sites; and (iii) recommendations arose in two or more focus groups in either Chicago or San Francisco. The purpose of these inclusion criteria were to ensure that instrument revisions were based on saturated themes and did not simply reflect the sentiment of one focus group without validation from another.

The most significant revisions to the SAT Module included having separate response categories for each South Asian tobacco product, unless clearly agreed upon otherwise by participants. Similarly, many response categories were added to the domain of health and social influences which reflected common perspectives found in the focus groups. Minor changes were made to question stems only if they did not deviate significant from CDC's validated ATS. In total, the final SAT Module had 300 additional questions (and two modified questions from the original CDC ATS). Table 2 presents these additions, categorized by survey domain.

The SAT Module utilized sectional domains identical to those in the CDC ATS. By using similar structure, sequence, and phrasing, the newly-developed instrument allows for comparability of results with the validated state-level survey. In addition to the CDC ATS domains, three additional sections were added to the SAT Module. As one of the study objectives is to create an instrument which assesses cultural beliefs and reasons facilitating or impeding tobacco use, it is imperative that the SAT Module contain sections that assess these variables. Modeled after prompts used in local South Asian tobacco instruments, the study formulated appropriate survey items based on the findings generated in both the formative and cognitive stages of qualitative inquiry. However, these additional questions preserved the structural and vernacular properties of the CDC ATS to ensure consistency across the entire SAT Module.

At first glance, the large number of additional questions may seem daunting for ensuring successful completion of the SAT Module by potential respondents. However, it should be emphasized that this value represents the total number of *potential* items that might be asked of survey respondents. More specifically, the entirety of questions included in the SAT Module would only be asked of South Asians who were current users of every culturally-specific product represented in the SAT Module. For every specific South Asian tobacco item not used by a given respondent, the length of the questionnaire would be reduced by approximately 41 questions, or 14 percent of the entire instrument. In other words, if a respondent did not use any of the products included in the SAT Module, approximately 280 out of the 300 questions would not be asked. Findings from both phases of qualitative research indicated that the likelihood of tobacco users consuming all of these products was very low. It also merits emphasizing that

Table 2

SECTION TITLE (FROM CDC ATS)	ADDITIONAL SAT MODULE ITEMS	MODIFIED CDC ATS QUESTIONS
CORE	**NUMBER**	**NUMBER**
General Health	0	0
Tobacco Use	0	0
Cessation	0	0
Second-hand Smoke	0	0
Risk Perception & Social Influences	0	0
Demographic Items	8	0
SUPPLEMENTARY	**NUMBER**	**NUMBER**
Demographic Items	4	0
Tobacco Use		
Smoking Initation in Young Adults	0	0
Smoking Patterns	0	0
Brand Use	0	0
Purchase Patterns	0	0
Other Tobacco Products	75	0
Intention to Smoke	0	0
Cessation	0	0
Interest in Quitting	0	0
Methods of Quitting	0	0
Health Care Provider Intervention	0	0
Environmental Tobacco Smoke		
Workplace Smoking	0	0
Attitudes Regarding Clean Indoor Air	0	0
Behavior Regarding Clean Indoor Air	0	0
Health & Social Influences	45	0
Comorbidity	3	0
Risk Perception	6	1
*Perceived Benefits**	57	0
*Reasons for Use**	36	0
*Reasons to Stop**	43	0
Social Influences	17	1
Policy Issues		
Youth Issues	0	0
Sponsorship & Marketing	0	0
Parental Involvement	0	0
Parent-Child Communication	6	0
Child's Smoking Status	0	0
Disapproval	0	0
Media Exposure	0	0
TOTAL	***300***	***2***

**These sections were not in CDC ATS and were modeled after sections from other tobacco instruments, based on relevance for SAT Module*

participants largely agreed upon the expansive nature of the survey—reinforced by content analyses in both stages of qualitative inquiry—resulting in the contextual breadth and depth of South Asian tobacco use being captured comprehensively during the eventual implementation of the SAT Module.

Despite these limitations, the final research product fills an important gap in tobacco surveillance among ethnic minorities and responds to recommendations, by researchers and practitioners alike, for a culturally-appropriate instrument which assesses the prevalence and patterns of use by South Asians in the United States. Given the uncertainty of future population-based surveillance by national and state-based health institutions, the SAT Module was developed in two formats: one supplementing the existing CDC ATS and an alternative version that can be used as an independent instrument among South Asian American samples. In order to ensure that community-based and policy-level interventions accurately target the multi-level influences on tobacco use among South Asians, it is paramount that surveys accurately capture the appropriate social, cultural, and behavioral measures. Drawing upon sources of data—most notably community-based input and testing—the SAT Module provides a comprehensive tool to generate this pivotal information.

LIMITATIONS

This study is largely limited by the fact that it was conducted as a doctoral dissertation requirement. As such, the research process was restricted in terms of the ideal amount of personnel and time needed to conduct a multi-site study. The doctoral candidate was responsible for all aspects of the scientific process, including background research, obtaining and analyzing secondary data, and all aspects of qualitative inquiry, such as recruitment of participants, facilitating focus groups, overseeing transcription, performing content analysis, and developing/refining the final instrument. In addition, he was primarily responsible for drafting the final manuscript for meeting his degree requirements and preparing it for publication. A longer timeframe and greater human resources would have improved the study's ability to increase the number and diversity of focus group participants as well as procure complementary sources of qualitative data. For instance, observational data about physical and social settings facilitating culturally-specific tobacco use would have served as a source of confirming or divergent cases for data found in focus groups. However, observational data illustrating commercial and cultural availability of South Asian tobacco products (included in this article) are consistent with content analyses of focus group data.

A significant limitation was the unanticipated consequence was a shift in CDC's instrumentation in tobacco surveillance. At the onset of this study, CDC utilized its ATS—consisting of core and recommended sections of questions—which individual states were able to utilize differentially based on funding and surveillance priorities. However, during the implementation of this study, CDC shifted its surveillance strategy to create a National Adult Tobacco Survey (NATS) for future assessment of tobacco prevalence across the entire United States. At the time of publication, the content, sections, and survey prompts of the NATS were unknown. With these considerations in mind, the SAT Module was designed to serve as an independent instrument if the structure of the NATS diverges significantly from its state-based predecessor. Conversely, should the NATS be substantively and technically similar to the ATS, the SAT Module would require only minor modifications to be integrated into CDC's new instrument. In addition, constructs were designed so they may possibly be integrated into other

validated instruments, such as the National Health Interview Survey or Behavioral Risk Factor Surveillance System.

Despite these limitations, the SAT Module fills an important gap in tobacco survey methods among South Asians in the United States. By combining empirical evidence, qualitative data, and theoretical considerations, the culmination of this study protocol is the development of an instrument that has been informed and tested by the community it intends to survey. In order to truly examine the full spectrum of covariates related to culturally-specific tobacco use, behavioral measures must reflect the social context in which these patterns occur. The SAT Module achieves this objective by triangulating multiple sources of data and, most importantly, allowing community members to define the appropriate variables related to the milieu in which these patterns occur.

DISCUSSION & CONCLUSION

To date, this study is the only systematic attempt—using community-based methods— to create an instrument assessing the *true* prevalence of tobacco use among South Asians in the United States. Previous approaches to tobacco surveillance in this population have utilized adaptation of validated instruments or creation of stand-alone surveys with little or no meaningful community input for construct validity. In order to create constructs reflecting use (including cultural equivalents of frequency and dose) of South Asian products as well as the social contexts in which they occur, qualitative methods provide meaningful data to create quantitative measures which accurately capture these patterns. Similar to development of behavioral risk surveys among other minority communities, this study used qualitative methods to develop an instrument reflecting the unique milieu in which South Asian tobacco use is initiated, sustained, and terminated. Not divorcing itself from the value of standardization, this study relied on validated instruments to guide construct development, while taking into account the divergent perspectives expressed by South Asians. In order to ensure that multiple viewpoints were included in instrument development, the study made concerted efforts to secure participants representing diverse demographic backgrounds and distinctions attributable to different ethnic enclaves in the United States.

The themes arising from this study qualitatively confirm quantitative data found locally in the United States and population-based surveys in other countries. Specifically, study findings suggest the frequent use of a large number of culturally-specific products by South Asians in the United States. These products are commonly found in ethnic enclaves and are used differentially by community members based on age, gender, socioeconomic status, generational status, religion, and region of ethnic origin. In addition, there are unique cultural equivalencies, such as for "dose units" and modes of ingestion, that cannot simply be adapted from "Western" validated prompts. Using the correct terminology, verbiage, and units of use are pivotal in surveying accurate prevalence of different forms of South Asian tobacco.

As tobacco use is highly determined by knowledge, attitudes, and beliefs of diverse communities, behavioral risk factor surveys must take into account the various influences that may facilitate or impede usage. Inclusion of relevant covariates will enable researchers to determine relationships between socio-cultural factors and behavioral outcomes. Content analyses found that there are a myriad influences on South Asian tobacco behavior which aren't measured in traditional risk factor surveys. Major findings indicate a relative lack of accurate knowledge about health risks, perception of health benefits, and social and cultural value

ascribed to use of specific products. Qualitative analyses suggest use of certain products serve as symbols of ethnic identity and tradition, facilitate socialization and celebration within a South Asian context, and may be permissible by parents. Inclusion of these contextual factors in survey design is paramount to ensure that meaningful relationships can be extrapolated and measured for strength and directionality.

The primary purpose of tobacco surveillance is to generate population estimates of prevalence and assess the various correlates of tobacco use. Many minority populations in the United States, including South Asians, have a cultural context of tobacco use which diverges significantly from use of cigarettes and Western forms of chew tobacco. As the United States grows increasingly diverse, culturally-specific patterns of use and their various influences must be understood in order for health professionals to create multifaceted intervention strategies. The tobacco industry has identified these social patterns and co-opted cultural characteristics to target their promotional efforts (Muggli et al., 2002). However, behavioral surveillance strategies lag significantly behind, thus not allowing public health approaches to understand and address these social and cultural determinants of tobacco-related disparities. Although instruments have been designed to examine cultural contexts among Latinos and Native Americans, many other minority communities are not surveyed for similar patterns of behavior. Despite being the fastest growing minority population in the United States, a population-based reflection of South Asian tobacco prevalence remains absent. This study provides a community-based, cognitively-tested instrument which is able to generate necessary data upon which public health researchers and practitioners may base tobacco control efforts. As behavioral determinants of South Asian health disparities continue to be elusive, the practical utility of a surveillance tool which may glean information not found in traditional risk factor surveys holds great potential for future research, culturally-appropriate program planning, and targeted policy-level interventions.

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Chapter 3

Examining Organizational Responses to Violence among South Asian American Populations: Implications for Public Health Practice Targeting Understudied Communities

INTRODUCTION

Violence, in its many forms, is being viewed as a major public health concern (Dahlberg & Mercy, 2009). As the field of public health made tremendous strides in reducing the burden of infectious and chronic diseases, rates of interpersonal violence and abusive behaviors rose, reaching startling rates in the 1980s, especially among certain segments of the United States population. Not immune to this pattern are ethnic minority groups, especially as it pertains to domestic, family, and intimate partner violence (Whitaker & Reese, 2007). Among cultural minorities in the United States, researchers and practitioners alike have identified South Asians as a high-risk group for experiencing violence within their community (Yoshihama & Dabby, 2009). Moreover, the forms of abuse and patterns of behavior among this population are unique in their various manifestations, cultural acceptance, and level of willingness of the South Asian American community as a whole to publicly identify and address this health concern. This paper examines the origins and definitions of the problem within the South Asian community, its significance, and organizational responses to addressing the problem among this population in the United States. A logical progression of this inquiry is to evaluate agreement of problem definition and intervention strategies among organizations that aim to address violence among South Asian Americans and, concurrently, assess consistency of organizational responses to the identified problem.

Violence is defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug et al., 2002). Domestic Violence (DV) is characterized by physical (including sexual) and/or emotional (psychological or economic abuse) harm suffered by a person who is a family member of, or residing in the same home as, the offender who caused the harm of injury. Intimate Partner Violence (IPV) is a narrowed definition of domestic violence which describes physical, sexual, or psychological harm by a current or former partner or spouse (Saltzman, 2004). Also within the domain of domestic violence, child abuse/neglect is legally defined (at a minimum) as any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm (U.S. D.H.H.S., 2003). Similarly, elder abuse are "intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm" (Lachs & Pillemer, 2004).

Until the 1970s, issues of violence related to marriage and family were largely perceived to be an individual problem and therefore, not worthy of public response (Abraham, 1995). However, in the mid-1970s, a number of notable changes occurred, which transformed issues of family violence (pertaining to wives, children, and related elders) from an individual issue to a social concern. Stemming from the extension of the social activist movement of the 1960s to

include women and children as oppressed groups as well as the rapid increase of women pursuing higher education in sociology, coupled with a significant growth in family intervention professions, an ideal environment for an organizational response to this issue burgeoned (Straus, 1992). As women became more financially independent and disenchantment grew with the traditional family unit (including divorce becoming more socially accepted), previously tolerated abuses were no longer deemed acceptable. The confluence of these factors culminated in the Battered Women's Movement in the United States, led by feminist scholars and activists (Pagelow, 1992). By increasing public attention and garnering support for protection of victims of violence, the movement focused on creating shelters for women, providing alternative living situations, and the furnishing of resources and support to pursue lives free from violence (Davis, 1987). Concurrently, the Law Enforcement Assistance Administration complemented these efforts by increasing the focus of the criminal justice system on preventing and controlling abusive behavior within domestic settings (Butzer et al., 1996).

The Battered Women's Movement expanded into developing countries, and became especially concerned with institutionalized exploitation and oppression manifesting as culturally-sanctioned forms of violence in those nations. By highlighting normative structures that defined acceptable patterns of behavior in these international communities, feminist scholars and activists simultaneously identified parallel injustices occurring among members of these ethnic communities in the developed world (Abraham, 1995). Consequently, the 1980s saw a rise of organizations that focused on issues of abuse, mainly targeting women, among South Asians in the United States. Although there existed a substantial response to issues of violence within the family by mainstream organizations, the specific concerns of ethnic minorities were excluded by white U.S. feminists (Crenshaw & Weisberg, 1996). Thus, advocates from culturally-diverse populations responded by creating ethnic-specific organizations to target specific issues in their communities. Survivors and advocates have noted that oftentimes, policy definitions of what constitutes violence (and therefore how federal funds are allocated for these purposes) do not take into account specific forms of abuse and control in their communities (Dasgupta, 2000; Yoshihama, 1999). In the current literature, there appears to be an unresolved tension in ascribing the root cause of community violence to functions of "universal" structural inequity or as an extension of cultural normalcy (Sokoloff & Dupont, 2005). Despite ongoing debates about the sociological underpinnings of violent behavior—and various prescriptions on how to eradicate it—ethnic-specific groups targeting violence within the family continue to rise in number and scope throughout the United States.

The South Asian community (individuals with origins in Bangladesh, Bhutan, India, Nepal, Pakistan, Sri Lanka, and throughout other destinations of migration in the Diaspora) is no exception (S.A.A.R.C., 1985). An examination of social service repositories and directories found 25 organizations across the country which exclusively or predominantly serve South Asian Americans and address issues of violence. Almost half of these organizations have existed for over ten years; this number grows when taking into account pan-Asian or non-ethnic (e.g., religious) focused organizations which have large numbers of South Asians within their constituencies. This response to the problem indicates that violence-related issues indeed exist among this population and are being proactively addressed through a variety of mechanisms. Internal data listed by these South Asian programs report that services provided by these organizations are being utilized to capacity, despite major funding constraints. This statistic is even more remarkable considering that South Asians constitute less than one percent of the U.S. population, although they are the second largest Asian subgroup and fastest growing minority

community in the United States, rendering them an important cultural community for health research (A.C.S., 2006).

Despite this tremendous organizational response, there exists a paucity of theoretical and epidemiological research articulating a specific definition of the issue among South Asian communities, assessing the prevalence of the problem, and providing specific programmatic recommendations on how to reduce and eliminate the issue of concern. In the absence of this information, this exploratory study aims to examine the creation of these organizations and the purpose for their existence.

This paper describes a contextual understanding of how groups targeting violence-related issues among South Asians were created and function. To accomplish this objective, the described study used qualitative methods (participant observation, key informant interviews) to examine the relationships between problem definition and both intra- and inter-organizational responses. Organizational leaders, having historical knowledge of the inception of their respective groups and the ability to represent current approaches employed to mitigate the prevalence and consequences of their identified problem, provided meaningful insight regarding the research question. In addition, this study also examined the interaction of these organizations with each other in identifying and participating in potential collaborations to address overlapping issues of concern. This analysis explores consistencies within organizations related to mission, activities, and evaluation while concurrently evaluating alignment across similarly-oriented groups with respect to purpose, function, and indicators of success. Since much of the literature focuses on the theoretical foundation upon which these organizations have come to exist, this study fills an important gap in practice-based approaches targeting violence among South Asian communities in the United States.

The specific research questions governing this study are: a) what was the impetus for these organizations to form?; b) what are their mission statements (including problem statement) and organizational goals?; c) what programs/services do they offer to address their defined issue, and why?; and d) how do they know that their organizational strategies are effective in accomplishing their mission *and* impacting the problem? In addition to examining differences and similarities among each of these dimensions, this study also aims to investigate the *consistency* of organizations with respect to their stated purpose, services and programs offered, and evaluation of activities in meeting organizational and ideological objectives.

BACKGROUND / PREVIOUS RESEARCH

Empirical Data

Much of the limited empirical research available on South Asians is limited to rates of IPV among these specific forms of violence. The percentage of IPV cases in South Asia is far greater than the United States average (25 percent) and is estimated to be between 30 and 47 percent (Abraham, 2000; Heise, et al., 1999). Epidemiological research on IPV among South Asian families in the United States, however, is minimal, with few locally-based quantitative prevalence studies found to date. Using a convenience sample, research in the Greater Boston area (utilizing an adapted Conflict Tactics Scale-2 and acculturation measures tailored to the South Asian population) found that 40 percent of South Asian women reported physical or sexual IPV (Raj & Silverman, 2002). 54 and 36 percent of Nepali women in New York City reported emotional and physical abuse, respectively (Thapi-Oli et al., 2009). A convenience

sample among Pakistanis and Asian Indians in the United States found a rate of 48 percent for lifetime physical abuse experiences (Adam, 2000). The Asian Task Force against Domestic Violence found that 44 percent of South Asians surveyed reported knowing a South Asian woman who has been abused or injured by her partner and 5 percent of respondents knew a man who was being beaten by his partner (Bateman at al., 2009, S.A.P.H.A., 2003). These rates are disproportionately higher than other racial/ethnic groups in the United States; for instance, African-Americans have an IPV prevalence of 29.1 percent and Native Americans & Alaskan Natives reporting 37.5 percent (Tjaden & Thoennes, 2000). Asian/Pacific Islanders, the demographic category in which South Asians are grouped, report an IPV rate of 15.0 percent.

Despite the epidemiological indications of a high prevalence rate, reliable population-based data on the prevalence of violence among South Asian Americans is largely lacking. The population's small size, diverse cultural context, and perception of a "model minority" status have discouraged researchers—especially those who are not of South Asian descent—to take an interest in this minority group (Dasgupta, 2000). Equally important is the disinclination and ambivalence—and perhaps, fear—of the South Asian community-at-large to publicly recognize violence as an issue of concern among its members. These considerations have profound impacts on the ability to collect statistically rigorous and representative data. Notwithstanding these issues, the abundance of anecdotal evidence and media reports have underscored violence as a significant health disparity among South Asian communities in the United States (Dasgupta 2000, Melwani, 1999; Cody, 1999, Lawrence, 1994; Hays, 1993; Melwani, 1993; Dasgupta 1993; Dutt, 1990). Corroborating this assertion is the growth and expansion of domestic organizations which focus on violence-related issues exclusively or predominantly targeting South Asians, as detailed in the literature as well as in this paper (Merchant, 2000; Abraham, 1995; Vaid, 1989). The sum of these observations eliminates any ambiguity that violence—manifested in a variety of ways—is increasingly prevalent among the South Asian American community. Although abuse is an issue of concern among all communities, the unique social placement and cultural milieu in which these instances occur merit critical examination of not only distinctions in manifestations, but also the philosophies and strategies adopted in reducing disproportionate rates and impacts on health among this understudied community.

IPV has serious consequences, for the victim, the perpetrator, and for those who are most directly dependent on the relationship in which it is occurring. However, most injuries and in some cases, causes of mortality, are classified (for instance, by the International Classification of Diseases, or ICD, codes) by direct cause rather than root influence. Respondents who reported IPV in the Boston South Asian study were more likely to have sexual health conditions such as discolored vaginal discharge, burning during urination, and unwanted pregnancies in the current relationship as well as sterilization (Raj et al., 2005). In addition, South Asian victims of IPV are subject to indirect cultural influences, such as economic deprivation, direct verbal and physical abuse from in-laws, including toleration or support of batterers, forced isolation, and domestic servitude (Raj & Silverman, 2003).

There are few data available on the prevalence of child and elder abuse among South Asians in the United States. In the scant research focusing on South Asian child abuse, one study found that 73 percent of participants (which included individuals of Middle Eastern origin) experienced one form of physical abuse before the age of 16 (Maker et al., 2005). Another study found that 79 percent of South Asians were hit regularly by their parents when they were growing up (Yoshioka & Dang, 2000). For elder abuse, no statistics were found reporting prevalence, but epidemiological research from areas of the South Asian Diaspora (e.g., England,

Canada) as well as qualitative studies in the United States suggests that this form of violence is indeed increasing. Victims of any form of family abuse are at higher risk for physical injury and mental illness, depending on the type of violence experienced. Based on cultural norms and values emphasizing loyalty to family and discouraging "airing of dirty laundry" to the community, these individuals are often unsure about mechanisms to escape their abusive situations. In addition, individuals abused as children may be more apt to transmit beliefs condoning violence inter-generationally under the guise of cultural preservation (Maker, et al., 2005).

The literature reviewed found that risk factors for IPV are not necessarily direct causes of IPV, but are large contributing factors instead. Generally speaking, those who are "at-risk" for IPV will not necessarily become involved in violence (Krug et al., 2002). The bulk of IPV risk factors are individual or relationship level factors (e.g. substance abuse, educational or income disparities between partners). The scant IPV research examining community level factors tend to limit their analysis to institutional racism and/or socioeconomic deprivation. Risk factors for child abuse among South Asian Americans included the number of years the victim's parents had lived in the United States and lack of educational attainment by the father; larger social and community factors were absent in the literature.

Similar to other major surveillance systems, the largest crime survey (including violence-related statistics)—the National Crime Victimization Survey—does not disaggregate data by Asian subgroup (N.C.V.S., 2009). Thus, population-based information specific to South Asians is not reported at the national level. The grouping of South Asians into a larger Asian/Pacific Islander demographic can attenuate otherwise large differences of prevalence of IPV (and other measurable indicators), thus mischaracterizing the actual extent of this and other issues in Asian/Pacific Islander subgroups. It should also be noted that the typical methodologies employed in conducting prevalence studies often systematically exclude a significant portion of this population. For instance, random digit telephone interviews are often conducted in English, thus creating an epidemiological bias against those who do not speak fluent English, such as Asian/Pacific Islander immigrant women. This methodology also excludes those who do not have access to landline telephones, such as those ethnic groups occupying lower socioeconomic strata or those in the second-generation, who are increasingly using cellular telephones as their primary mode of communication. The inability or unwillingness of victims to speak candidly—without fear of repercussion from the batterer, other family members, or stigma from the larger South Asian community—often hamper data collection efforts.

Conceptual Studies

Conceptually, researchers have turned to cultural and historical considerations in attempting to describe the uniqueness of violence among South Asians. In many instances, traditions commonly found in the Indian subcontinent are identified as contributing factors, such as widow burning, dowry deaths, and female infanticide (Bush, 1992; Kishwar & Vanita, 1986; Liddle & Joshi, 1986). In extrapolating these patterns to destinations in which South Asians migrate, studies identify cultural characteristics which are preserved in the new dominant society. Such attributes include the social practices of arranged marriages, commitment to stability of the family unit (include deference to husbands/fathers/parents), unconditional reverence to elders (such as paternal in-laws), and gender roles and expectations prescribed by common South Asian religions (Sheehan et al., 2000; Merchant, 2000; Ayuub, 2000). More

recent research suggests that sex-selection technologies may be used to facilitate the preference for male offspring among South Asian immigrants in the United States (Puri, 2006). Although a small amount of studies have sociologically examined the collective ethnic identity of South Asians who have immigrated to or were born in the United States, it remains unclear if "traditional" cultural characteristics are reflective of current perspective and patterns of behavior in South Asia or if they are remnants of normative understandings from the time period in which most South Asians emigrated from the native subcontinent (Bacon, 1999; Janveja, 1990). Nevertheless, researchers, advocates, and survivors emphasize the importance of the immigrant experience in cultural identity maintenance, loss of social supports, intergenerational conflict, financial sustenance, legal status and social stigma on assistance from law enforcement and social service agencies as contributing factors in facilitating (or even enhancing) violence among the South Asian community (Dasgupta, 2000; Purkayastha, 2000). Moreover, lack of knowledge and/or internalized acceptance of abuses as "normal" patterns of behavior permeate many traditional South Asian belief systems (Dasgupta, 1998). These assertions have been reinforced by qualitative studies depicting accounts of victims and descriptions from organizational representatives serving this population (Abraham, 2000; Gill, 2004; Abraham, 1999; Sharma & Gupta, 2006; Dasgupta, 1998).

Only three studies to date were identified that comparatively examine organizations addressing issues of violence within the South Asian community in the United States. The first examined factors leading to the formation of eight organizations in the United States, including geographic focus, scope of services offered, and internal problems impeding organizational stability, collaborative endeavors, and public support (Vaid, 1989). The second study similarly examined the role of eight organizations in addressing marital violence among South Asian Americans and effecting change at multiple levels (Abraham, 1995). This study describes a complex typology of ideologies and various goals and strategies which govern the existence and function of the organizations sampled. The most recent study found explored associations between length of existence, staff characteristics, funding sources, and number and types of services offered by 12 organizations serving South Asian victims of domestic violence (Merchant, 2000). Based on findings emphasizing cultural concordance among organizational representatives and clients, this study concluded that South Asians do indeed have unique needs when intervening on issues of violence.

Although these studies provided in-depth and meaningful information about each individual dimension of inquiry, there has been no systematic analysis of whether these variables are internally consistent among organizational philosophies, purpose, activities, and evaluation strategies. Moreover, although academic discourses and public portrayals imply common philosophical and practical underpinnings which govern the existence and function of these organizations, the degree to which this assertion is, in actuality, valid remains unexamined. In order to generate answers to these questions, the current study relies on the accounts of a diverse subset of organizational representatives to examine these considerations.

THEORETICAL CONSIDERATIONS

Theories attempting to explain violence within the South Asian family unit, predominantly against women, stem from psychological models focusing on individual behaviors, often resulting in inconsistency of patterns of both batterers and victims. Three major

frameworks served as the theoretical context for the current study: the family violence perspective, tenets of feminist theory, and the ethno-gender approach.

The family violence perspective suggests that family abuse arises from personal characteristics of the individuals involved and stressors affecting the family unit. Although external factors (economic hardship, socioeconomic disadvantage, socialization) are taken into account, dysfunction within the family, including violent behaviors, is largely thought to arise from character flaws of its individual members (Kurz, 1989).

Another socio-cultural framework often referenced stems from feminist theory, "which suggests that violence against women emanates from potent socializing messages from families, peer groups, media, the law and other institutions of a sexist society that lead to the acceptance and normalization of gender-based violence" (Campbell et al., 2002). Feminist theorists focus on the global existence and acceptance of violence, which arises out of a normative social structure which defines the heterosexual male as the locus of power, control, and dominance; these patriarchal structures are reinforced in social, economic, political, and legal structures (Sokoloff & Dupont, 2005).

A common critique by cultural theorists of both the family violence and feminist approaches is that these frameworks systematically ignore the experiences of minority communities in a new dominant society, especially those of women (Bograd, 1999; Jagger & Rothenberg, 1993). Sociological examinations of cultural factors which facilitate or legitimize violence among racial/ethnic minority communities are rare in the literature.

One newer framework is the ethno-gender approach, which posits a two-dimensional analytical category for examining domestic (and other forms of) violence among South Asians and other minority communities in the United States (Abraham, 1999). The first dimension, gender, is a socially constructed category which defines and evaluates the roles that each biological sex is expected to represent in concrete settings (Richardson, 1998). Ethnicity is a multi-dimensional category which encompasses cultural differentiation and specificity, as well as a social construct which can be expressed and interpreted differentially in situational contexts. The ethno-gender perspective posits an interaction between the two, and recognizes the duality of subordination based on both gender and ethnicity within a patriarchal social structure. This approach examines the construction of gender relations within a cultural milieu in a new "host" society, and attempts to explain violent behaviors within that context (Merchant, 2000).

Based on this theoretical conceptualization, ethnic-specific frameworks have attempted to describe specific cultural contexts which may explain the patterns of violent behavior among South Asians. For instance, this population fits within the collectivist construct of cultural "syndromes" and thus, the emphasis on promoting the ideal image of social units (family, community, and subgroup) often purposely overlooks this pronounced and historically prevalent feature of South Asian culture (Triandis, 1996). Embedded within this social structure is an honor orientation that emphasizes a hierarchical mode of relations within the family and/or community (Nilchaikovit et al., 1993). Although these normative structures are culturally-framed, they have significant impacts at the individual level. As this orientation is largely patriarchal, elders and males are conferred privileged status, with inherent—and largely unfettered—authority to make decisions and delineate expectations among his subordinates. Deviating from these hierarchical structures implies "improper" expression of individual expectations and often invites ascriptions of disrespect and dishonor among families not adhering to these prescribed roles (Rimonte, 1991). Operationally, this suggests that South Asian victims of violence may choose to not report it or seek treatment in order to avoid conveying disrespect

to authority figures and maintain sanctity of the family name, as well as to not invite negative ascription to this minority community.

Related to these social considerations, there is a large and consistent body of literature which contextualizes violence within this cultural framework (S.A.P.H.A., 2003). Examples of such contextual factors include: 1) many South Asian men see sexual gratification as a right of marriage (Abraham, 1999); 2) assuming the role of being a "traditional" South Asian wife (not questioning the patriarch, not disrupting the "sanctity" of marriage in any way, and maintaining peace within the family unit is aligned with preserving cultural values (Dasgupta & Warrier, 1996); 3) "Saving face" means not bringing shame to the family or community unit, regardless of the nature of abuse, in order to be loyal to the community (Rahim, 2000); and 4) not exacerbating the isolation already felt by South Asian families in leaving behind larger extended family units in the native Indian subcontinent by inviting cultural stigmas ascribed to divorce, shame, or legal proceedings (Abraham, 2000). Other responses to violence in South Asian communities include definitions of family and feminine self-sacrifice based on tenets of major South Asian religions, as well as themes of restorative justice (Goel, 2005). This is exacerbated by the fact that immigrant women are more vulnerable to abuse, due to legal controls and cultural barriers (Raj & Silverman, 2002). In order to be successful in their efforts, organizations addressing violence among South Asians in the United States must include these complex considerations in their creation and strategic planning processes.

Processes related to organizational development adopt many principles from larger frameworks of organizational and systems theories (Katz & Gartner, 1988). The creation of organizations emerges from interactions between agents (e.g. individuals or groups of stakeholders) and the environment (e.g., social concern, no/little existing organizational response). Four major properties govern the creation and emergence of new organizations: intentionality, resources, boundaries, and exchange (McKelvey, 1980). Organizational intentionality is defined as the seeking of information by an agent that can be applied to the goal of creating an organization with a specific mission (Bease, 1981). During the early phases of organizational creation, organizational goals may simply reflect those of the agent or as demanded by the environment; however, as an organization continues its existence as an autonomous entity, it will possess goals that become increasingly distinct from those of the agents or the environment. Resources refer to the human and financial capital required to create the organization; in most cases, the strategic direction and ability to perform certain functions are determined by the ease with which resources are obtained. The barrier conditions (physical and social) between the organization and environment are recognized as the boundary. As organizations exert influences on their environments—which is often reciprocated—the boundary of the organization is defined beyond that of the creating agent. Organizations must also establish the physical, legal, and communicative basis for exchange across their boundaries. The most dynamic of these four properties, exchange, refers to transactions within or across the boundaries of the organization with individuals/groups, the environment, or other organizations. Once initiated, exchange cannot discontinue if the organization is to remain functioning.

As the current study examines organizational responses to violence among South Asian American communities, a conceptual foundation placing the issue in relevant contextual frames enables a theory-informed approach to qualitative data collection and analysis. This study takes these theoretical considerations into account in defining its methodological approach, analysis plan, and discussion of findings, as described in the following sections.

METHODS

As the purpose of this study was to collect contextual data related to the research question and analyze findings for convergent themes and disconfirming cases, the methodology best suited to capture the depth and breadth of relevant information is qualitative inquiry. Qualitative research enables the study of organizational functioning and cultural considerations (among other areas of inquiry) and facilitates the interpretative analysis of findings with respect to describing potential relationships between behaviors and the phenomena of interest (Strauss & Corbin, 1998). Moreover, as this study is exploring an area about which little is known, qualitative methods are the most appropriate to generate findings relevant to its research questions (Stern, 1980). These domains of inquiry include details about thought processes, historical interpretations, and personal philosophies as they relate to defining the issue, understandings of the cause and approaches to addressing it, and articulating the perceived successes of these processes in impacting the problem. Such complex and interrelated themes are not easily captured through quantitative research methods.

This study used three sources of data to generate its findings: organizational documentation, key informant (in-depth) interviews, and participant observations. In-depth interviews were chosen to generate narratives on a key informant's experience and understanding, and search for depth and meaning to study domains (Denzin & Lincoln, 1998). The key informants in this study were selected to gain specific perspectives and interpretations of information (otherwise unavailable) related to the research question, as well as clearly articulate accounts of events from the vantage point of other relevant actors immersed in the culture of interest (Crabtree & Miller, 1999). As a matter of practicality, these key informants provide the needed information in a cost-effective manner. To triangulate data generated by each individual in-depth interview, this study used participant observation methods to assess differences between real and verbal representations and interactions *between* informants to explore the manner in which participants construct their philosophies and organize their cultural context (Crabtree & Miller, 1999). Coupled with other sources of data, the use of multiple qualitative methods in this study generated findings which led to saturation of certain themes while underscoring important differences related to exploring the research question. All study methods were approved for exemption by the Office for Protection of Human Subjects at the University of California, Berkeley. The following sections describe sampling processes, interview and participant observation techniques, and data analysis plans.

Sampling

A list of relevant organizations was created using an exhaustive search of public directories and web-based sources. In order to maximize consistency across potential subjects, the inclusion criteria for the initial list focused on groups who *exclusively* or *predominantly* (e.g. over 75 percent of their target population) served South Asian communities throughout the United States. In other words, organizations who served South Asians by virtue of serving multiple Asian populations or target religious communities (e.g. Islamic) that may have large overlap with South Asian Americans were excluded from the initial list. The reason for developing these boundaries was to ensure that the issues discussed circumscribed South Asian identity, as opposed to other indicators influencing the content of data. In addition, the study explored forums in which these organizations may potentially gather to investigate the

relationships and interactions among one another. For the purposes of this paper, these organizations will henceforth be referred to as South Asian anti-violence organizations, or SAVOs.

This initial list identified 25 SAVOs which met the inclusion criteria. A comprehensive database containing key organization elements was created which included, based on their promotional materials (e.g. websites, brochures, advertisements) their mission statement, geographic constituencies, ethnic populations served, and program activities. Moreover, using public directories and community contacts, key leaders in each SAVO were identified. The definition of "organizational leader" included any individual(s) in a current position of administrative leadership (e.g. executive director, president/chair of Board of Directors, program coordinator) and who had historical knowledge of how their SAVO was formed and had evolved over time. Given limitations of personnel and resources, a subset of the initial SAVO list was purposively selected for key informant interviews. The selection of specific SAVOs for this study were based on ensuring a diverse representation of regions across the United States, urbanicity of location, domains of programs provided, tenure of existence, and population density of South Asians within their affiliated jurisdiction. Organizational leaders were contacted by phone and emails to schedule interviews; all interviews were conducted in-person at either the SAVO's home office or within its city limits. Each semi-structured interview lasted between one to 2.5 hours.

Ultimately, 15 interviews were conducted across the United States, representing 60 percent of the initial roster of identified SAVOs. The selected organizations were located in metropolitan areas in which over 80 percent of the total South Asian American population reside; seven of the ten most densely-populated states were covered in the study, including the top five (S.A.P.H.A., 2003).

In addition, one major conference was identified in which all SAVOs and other similarly-oriented organizations were invited to present unique issues raised among each group and/or geographic vicinity and participate in technical assistance and capacity building activities. This gathering is a biannual event whose overall purpose is to provide a forum for enhanced communication, promotion of leadership, sharing of unique experiences and perspectives, and to foster coalitions among organizations with aligned missions. To investigate the interaction of selected SAVOs amongst one another, the study employed methods of participant observation during this gathering. Representatives from all but one SAVO interviewed in this study were present at the event.

Domains of Inquiry

The study collected general information regarding when, how, and why each organization was formed, target populations which they outreached to and/or served, and makeup of staff, volunteers, and Board of Directors. In order to accomplish this objective, preliminary documents about each organization were collected through their websites and other mechanisms of public access. These materials provided basic information about each organization's mission statement, population served, geographic scope, and the nature of and rationale for services/programs offered.

Analysis of these data sources provided a comprehensive baseline of information for the interview guide. This guide incorporated open-ended questions which explored each of the major domains of inquiry, with accompanying probes to solicit more specific responses. To

assess problem definition, each respondent was asked to identify the specific term and examples of the issue that their organization specifically addressed, as well as unique manifestations of the defined issue among South Asians in the United States. In order to examine organizational function, informants were asked about philosophies governing their approaches, specifics about actual programs/services implemented to address the problem, and criteria used to evaluate activities and organizational success. Demographic information was also collected, including funding sources, number of clients served, and types and scope of collaborations and partnerships. After the first five interviews were completed and transcribed, the content was analyzed, using an iterative process, to determine if relevant themes emerged which addressed the research question. Once this initial analysis was completed, the interview guide was revised (by re-sequencing existing prompts and adding additional questions) to ensure that future interviews investigated emerging issues with sufficient depth to allow analysis for potential saturation or disconfirmation of themes.

Participant observation techniques were used during the major conference in which representatives from South Asian women's organizations and anti-violence groups gathered. Using a framework of theoretical social roles employed in conducting participant observation, this study employed an "observer as participant" technique, which minimizes reactivity of actors, while still allowing collection of "insider" knowledge and opinions through purposive dialogue (Junker, 1960). This method allowed examination of the demographic characteristics of attendees, what types and content of interactions are occurring, the purported and actual reasons for convening, and how both individual and organizational agendas are reflected in dialogue, public presentation, and actions (Goetz & LeCompte, 1984). The data from participant observation was collected using "jottings" during the conference, with specific emphasis being placed on examination of emerging issues found in the five interviews conducted prior to the event. These "jottings" were subsequently converted to formal field notes to represent an expanded and reflective account of the observation period. Data generated from participant observation techniques also enabled a more informed sampling strategy by taking into account organizational characteristics which were not apparent in the initial selection of a subset of identified SAVOs, which was implemented in conducting the remainder of in-depth interviews after the conclusion of the conference.

Data Analysis

Each interview was recorded and transcribed, removing information potentially identifying any given organization and representative, and subsequently uploaded into ATLAS.TI. However, prior to any computer-aided analysis, each transcript was reviewed and analyzed—informed by processes of "immersion/crystallization" undertaken *during* data collection—to develop theoretical memos identifying potential themes (Crabtree & Miller, 1998). Using these initial memos as a guide, all transcripts were analyzed horizontally and were comparatively examined for saturation of themes and discrepant cases across organizations, as well as internal consistency within each interview (Holloway & Wheeler, 2002). Each organizational transcript was considered to be a single analytic unit; they were not differentially "weighted" based on the number of individuals participating in each interview. Given the exploratory nature of this study, the number of potential thematic codes generated from these analyses greatly outnumbered the specific findings relevant to the research question. Final themes for analysis were determined by identifying which ones arose across the vast majority of

transcripts and discussed in sufficient detail for comparative purposes. Each transcript was reexamined, using computer-aided software, to assign thematic codes to relevant text units and identify quotations which reveal the full description of each designated theme. Upon completion of the coding process, the study employed a higher-level analysis to search for alternative interpretations and examine how themes relate to others found in the study. In addition, other sources of data (literature review, organizational documents, field notes) were used to legitimize conclusions or to further examine disconfirming evidence.

FINDINGS

Significant findings from all sources of data are presented within this section. After describing relevant organizational characteristics, major issues found in the study are presented. Specifically, findings are divided into two major sections: Areas of Consistency and Organization Differences. Each of these domains are further subdivided into groupings which illustrate convergent themes across organizations, as well as areas where the study found considerable differences between groups of organizations.

Respondent Characteristics

The organizations selected for key informant interviews were dispersed throughout the United States and were located in both metropolitan cities and suburban areas. Most were located in vicinities that boasted densely-populated South Asian communities. Almost half were located in the western United States, whereas over approximately one third were situated on the East Coast; the remainder were scattered through the Midwest and southern United States. The vast majority self-defined their constituencies to be within the city limits (and surrounding areas) in which they were located; a handful served multiple cities clustered together, while a few aimed to provide statewide services. In terms of length of existence, the time passed since inception ranged from three to over 25 years.

Table 1 presents pertinent organizational characteristics, listed primarily by data collected through key informant interviews. In addition to detailing information related to tenure and impetus for formation, funding, staff, and services, the table also ascribes a conceptual ideology for each organization. Adapted from a typology posited by Abraham, the study uses analyses of qualitative data to determine the appropriate assignment of categories (Abraham, 1995). These ascriptions fall into one of three conceptualizations of organizational ideology: value-oriented, diffused, and unspecified. Value-oriented ideology is defined as an organizational ideology with a set of core values that are explicit and directly correspond to organizational structure, goals, and activities. Diffused ideology emphasizes more dispersed values that loosely form the basis for organizational structure, goals, and activities. Unspecified ideology describes an amorphous set of values that may or may not directly correspond to organizational structure, goals, and activities. Although Abraham provided assigned specific South Asian organizations to one of these categories, results from this study were independently analyzed to arrive at ideological ascriptions for each SAVO included in this research.

All individuals interviewed served in a leadership capacity within the organization with which they were affiliated (e.g. executive directors, founders, members of board of directors, program managers, and service coordinators). Certain organizations chose to have multiple

respondents participate in the study to ensure that both historical and current issues related to organizational mission, philosophy, and programmatic elements were included in this phase of data collection. Almost all organizational representatives were South Asian women, with a relatively equal distribution of first and second generation individuals.

Major Issues

This study revealed a number of major issues related to understanding and reducing violence among South Asian communities in the United States. These major issues are organized into two major domains: Areas of Consistency and Organizational Differences. The research also found emergent themes related to cultural interpretations and acceptance of certain forms of violence, willingness of community members to acknowledge violent behavior, ideologies regarding inclusion of men in participating in anti-violence efforts, and perceived value of collaboration with mainstream and/or ethnic-specific organizations. Although these themes merit further investigation, they are outside the scope of the analysis presented in this paper.

AREAS OF CONSISTENCY

Most of the organizational leaders interviewed were very passionate about their programs and the need for culturally-specific services which address issues of violence among South Asians. There were four major areas of consistency which emerged from the data: (a) impetus for organizational formation; (b) organizational aims and rationale; (c) culturally-specific manifestations of violence; and (d) scope of services offered by the organization.

(a) Impetus for Organizational Formation

With respect to reasons for forming the organization, over half of respondents cited identification of the issue by community members. These concerns came either directly from individuals who conveyed their own experiences with violence, or indirectly through communication with acquaintances or research subjects who knew someone in a situation involving violence. In these circumstances, there were no existing mechanisms to turn to for support. For instance, two respondents cited instances of abuse within their families or by colleagues who knew South Asian victims of violence:

> "They were beginning to get people who were… people would come and say, 'I know this Indian woman' or 'I know this Pakistani woman who is having problems'… Some white person would say to them, at work typically, and say, 'can you help them?' And so, - - - experienced this with professors coming to her who would say that they had an Indian student in their class that was having difficulties and if there was any way she could help her. And - - - had experienced the same thing." (SAVKI02: p. 1)

> "(S)even of us social workers who started with this, we come from large families and we experienced these kinds of abuse, and they go on in a subtle way. And we found that these people don't have a place to go, because it's so personal, and we

> don't talk about it. So the seven of us, we didn't know each other directly. One talked to another, and that to another, and that's how we started, informally. I think whatever we talked out in that first meeting in - - -, we didn't start meeting formally, but got together informally for a year." (SAVKI06: p. 1)

A small fraction of groups were formed out of mainstream media portrayals of major incidents involving South Asians in their jurisdiction. Certain situations involved highly visible South Asian personalities who became victims of violence; others were shocking public displays of abuse, as illustrated by this respondent:

> "Around that time, there were several incidents where too many beatings happened in the late 70s and early 80s. There were a couple of very publicized cases around that time. In one particular case, this woman shot her husband and killed herself. She was an Indian who was either a TV personality or one on the radio. She was quite well- known. That got people very worried… They were few other incidents. There was an incident where there was a taxi driver who publicly set fire to his wife. What was very disturbing was that nobody stopped him. That got people very worried." (SAVKI11: p. 14)

The lack of acknowledgement or strict denial of the existence of the issue by community members was a driving force for about one third of the organizations to form. Moreover, individuals who spoke out against these injustices were perceived to be "home breakers", "divorced lesbians", or other socially stigmatized labels. As demonstrated by this respondent, the active suppression of discussing the issue (and marginalization of individuals who raised it) led to an organized response in addressing violence among South Asian American communities:

> "To go back, there were family members who worked with the - - -, and that got us involved in the issue itself. We started seeing and hearing, in little blips, that there is a need in the community. No one talked about it. In 2001, we did an awareness meeting at the local… it was mainly Indian population, but there were some Bangladeshis and Pakistanis. It involved - - -, who helped facilitate the presentation. One of the remarks we heard from some of the men, actually all of the men that came said that it doesn't happen with us. So we immediately knew that there was a big time denial because we knew there were cases going on. That's when the seed got planted that maybe we can do something right here." (SAVKI04: p. 1)

Interestingly, approximately one third of the respondents indicated that a major reason for formation was to mimic or complement existing, more established and well-known agencies, either in their local vicinity or in other South Asian ethnic enclaves. For instance, two

Table 1

DESCRIPTIVE SUMMARY OF SOUTH ASIAN ANTI-VIOLENCE ORGANIZATIONS INTERVIEWED

REGION OF UNITED STATES	DESCRIPTION OF SETTING	NUMBER OF YEARS IN EXISTENCE (APPROXIMATE)	PRIMARY REASON FOR FORMATION	STAFF COMPOSITION	FUNDING SOURCES	ORGANIZATIONAL IDEOLOGY	ORGANIZATION STRATEGIES
East	Urban	20	Personal experiences	Volunteer	Foundations Individuals	Unspecified	Liaison to existing services Outreach, education & training Emergency assistance
East	Urban	25	Addressing theoretical concerns	Paid & Volunteer	Government Foundations Individuals	Value-oriented	Transitional home Specific services Outreach, education & training
East	Urban	15	Advised by other organization	Paid & Volunteer	Foundations Individuals Academic Institutions	Diffused	Liaison to existing services Emergency assistance Outreach, education & training
East	Urban	20	Addressing theoretical concerns	Paid & Volunteer	Foundations Private Companies Government Individuals	Value-oriented	Specific services Advocacy Outreach, education & training Liaison to existing services
Midwest	Urban	20	Response to community concern	Paid & Volunteer	Government Private Companies Foundations Individuals	Diffused	Shelter Transitional home Specific services Advocacy Outreach, education & training Liaison to existing services Emergency assistance
Midwest	Urban	25	Violence was part of larger approach	Paid & Volunteer	Individuals Professional Associations Foundations	Diffused	Liaison to existing services Specific services Outreach, education & training Emergency assistance
South	Urban	5	Addressing theoretical concerns	Volunteer	Individuals Professional Associations Private Companies	Diffused	Specific services Outreach, education & training Advocacy Transitional home Liaison to existing services
South	Urban	15	Addressing theoretical concerns	Paid & Volunteer	Individuals Foundations	Value-oriented	Specific services Liaison to existing services Outreach, education & training

Table 1 (con't)

DESCRIPTIVE SUMMARY OF SOUTH ASIAN ANTI-VIOLENCE ORGANIZATIONS INTERVIEWED							
REGION OF UNITED STATES	DESCRIPTION OF SETTING	NUMBER OF YEARS IN EXISTENCE (APPROXIMATE)	PRIMARY REASON FOR FORMATION	STAFF COMPOSITION	FUNDING SOURCES	ORGANIZATIONAL IDEOLOGY	ORGANIZATION STRATEGIES
South	Urban	15	Violence was part of larger approach	Paid & Volunteer	Government Foundations Individuals	Unspecified	Specific services Liaison to existing services Outreach, education & training Advocacy
West	Urban	20	Response to community concern	Volunteer	Staff (in-kind & pro-bono) Individuals Offenders (restitution)	Diffused	Specific services Liaison to existing services Emergency assistance
West	Urban & Suburban	5	Advised by other organization	Volunteer	Foundations Membership (dues) Individuals	Unspecified	Liaison to existing services Outreach, education & training
West	Urban	10	Advised by other organization	Paid & Volunteer	Foundation Private Companies Faith-based organizations Government	Value-oriented	Liaison to existing services Specific services Emergency assistance Outreach, education & training
West	Urban	20	Stories of violence in community	Paid & Volunteer	Government Private Companies Foundations Individuals	Value-oriented	Transitional home Liaison to existing services Outreach, education & training Advocacy Specific services Emergency assistance
West	Urban	20	Response to community concern	Paid & Volunteer	Government Foundations Individuals	Diffused	Liaison to existing services Outreach, education & training Specific services Advocacy
West	Urban	20	Modeled after other organizations	Volunteer	Individual Government Private Companies	Unspecified	Liaison to existing services Specific services Transitional home Outreach, education & training

respondents stated that their organizations were formed by hearing about or having their founders work in a South Asian anti-violence organization in another region of the United States:

> "Living in - - -, she had a distinct memory of a woman who had come and stayed with them who was in an abusive situation. I think in her mind, and doing work with - - - and - - -, she said, "wow, it would be great if we had had an organization like this when this woman came to our house." She was aware that there had been issues of domestic violence in - - -, and that there wasn't a resource for this family friend. She had already volunteered with - - - and - - -, so she had seen the impact of their work and done some of this stuff." (SAVKI15: p. 1)

> "Then it took another 12 years for - - - to come up with it. In the meantime, another reason that we came up with this is that all the major cities in New York, New Jersey… San Francisco, Chicago, even - - -, had an organization for domestic violence. Every South Asian community in the major cities was doing this! We knew that - - - could not be immune to this, because we are the - - - largest city. For us, it was easy to look at those cities and say that this was what we needed to do." (SAVKI12: p. 2)

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Respondents cited numerous other explanations for starting such organizations, including increased collaboration with mainstream shelters and programs, having dedicated resources and attention to address this issue within larger South Asian serving groups, and offering an alternative approach to other anti-violence agencies serving South Asians in the same region. These reasons had substantial influences on defining the issue, cause of the "problem", and/or organizational philosophies adopted. For instance, organizations formed as a response to media portrayals tended to adopt a more family harmony approach, whereas groups formed out of social stigmatization may utilize a more justice-oriented ideology. However, the common thread

linking all organizations interviewed was a demonstrable passion for the issue and a commitment to addressing it through social service and community participation.

(b) Organizational Aims and Rationale

For the most part, the mission and goals revolved around providing support to South Asians not found in mainstream organizations (including culturally-appropriate or "unthreatening" services). As community members experienced situations of violence, there were often no programs available that addressed their specific issues and needs. To illustrate, two respondents stated that their aim was focused on integrating program clients into the dominant U.S. culture while not duplicating existing services:

> "Basically, we aim to provide programs that cross sectors of service delivery and supplement the ones already available by mainstream agencies as well as others targeting South Asians. This is what we mean by assuming a collaborative approach to address domestic violence and oppression. We aim to provide or expand services that address the changing needs of the community." (SAVKI01: p. 4)

> "They don't exist or there are limitations in that the person is not eligible to access them. And I'll give you several good examples. 40 percent of our caseload is H-4B visa holders, which means that you are legally permitted to live in this country if you are the spouse of a legal H-1B, which is a visa that allows you to legally work here. H-4 means that you have no legal rights except to reside here. You don't qualify for any kind of assistance or recourse under the law. So we give those individuals services because they don't qualify." (SAVKI02: p. 5)

For those vicinities that had multiple organizations addressing violence among South Asians, almost all adopted a collaborative and complementary approach to each other's services. These organizations articulated activities and initiatives that worked in concert with each other's services and discussed events and projects in which they worked in partnership. However, despite a stated emphasis by most respondents on coalition building, one group maintained a defensive stance when discussing their efforts relative to other agencies in the region:

> "The only people that don't really work well with us are - - -, for whatever reason… They have gotten a grant some time ago in - - - for - - - to partner with us. And - - - said that - - -, and they didn't want to partner with us. But that's kind of stupid, because we are serving the same public, and we are doing a little bit more." (SAVKI03: p. 21)

By and large, however, respondents stressed the need to collaborate with similarly oriented organizations. This was evident by the large representation of South Asian anti-violence organizational leaders attending a major conference, spearheaded by one of the more established

SAVOs. During this meeting, organizational representatives stressed the necessity for coalition building among like-minded groups and disseminating experiences (successes and challenges) related to reducing violence among constituent South Asian American communities.

The mission statements of these organizations reflected an overwhelming attempt to collaboratively fill a void in service delivery. Given the small pool of resources available for addressing violence-related issues, respondents emphasized the value of programs that were not redundant and addressed cultural attributes related to abuse. Although most of these organizational missions did indeed aim to eradicate violence among South Asian communities, oftentimes the scope of programs offered and the criteria used to evaluate organizational success deviated from these governing statements, as described later in the paper.

(c) Culturally-Specific Manifestations of Violence

All respondents largely agreed on the scope and illustrations of unique cultural manifestations of South Asian violence-related issues. Most of these examples revolved around cultural interpretations of what actually constitutes violence and mechanisms of control reinforced by social norms.

Interestingly, a handful of respondents demonstrated inconsistent viewpoints and claimed violence to be endemic among minority populations in the United States, despite initially indicating a need to address culturally-specific attributes of violence:

> "It is an engrained attitude and the really sad part is that when you talk to the Hmong community, the Vietnamese community, the Filipino community, the Chinese community, the Korean community, it's identical! We all like to pretend that no-no-no-no, this is hidden, we need to keep it hidden because it will cause shame. But you talk to any of these communities and it's identical!" (SAVKI02: p. 3)

> "It's happening in every community, and that needs to be reiterated. When you were asking me specifically about low-income women, how did I start that? I said that it happens everywhere; however, that's who we work hand-in-hand the most. It's our philosophy to say that it happens everywhere and to make sure we keep saying that and that's it not specific to South Asians even, or a specific religion, or anything like that. Our community education always emphasizes that." (SAVKI09: p. 4)

However, despite these exceptions, all respondents cited violence-related issues specific to South Asians in the United States. The description of these abuses—largely consistent with the literature—fell into four categories: (a) withholding of resources; (b) immigration-related abuses; (c) misalignment of legal and cultural definitions of violent behavior; and (c) normative values, beliefs, and expectations within a South Asian context.

Withholding of resources

One such form of abuse was the client's lack of access to financial resources. This victimization occurred irrespective of whether it was the perpetrator or victim who generated

income. This manifestation of culturally-specific violence prohibited the victim from pursuing reasonable personal objectives or exerting any independence, as illustrated by this respondent:

> "It's usually financial control. I have clients who are working women, they are financially independent themselves, but they don't have control over the money that they earn. I was just talking to a client last week who was saying that even when she takes trips to India, her husband will take away all her credit cards, and will send her there with $100 for her entire trip. She's not allowed to make any purchases in India, she's not allowed to buy gifts for her parents. So it's that financial control." (SAVKI10: p. 8)

Immigration-related abuses

Given the unique patterns of South Asian immigration, almost all respondents referred to abuses related to withholding or falsification of documents indicating legal status in the United States. By not having access to materials verifying her identity or legal authority to participate in mainstream institutions, the victim is unable to pursue any recourse to situations of violence and this furthers her dependency on the perpetrator. One respondent described the consequences of this form of social control:

> "On an H-4 visa, the woman can do nothing. She can't work, study, open a bank account. She can't even get a social security number. She can't even drive unless she has a letter from her husband. And what abuser is going to give you a letter? So, these are state-sanctioned abuse tools. And then like you said, a man has a green card but doesn't sponsor the wife for a green card." (SAVKI05: p. 4)

The study found another mechanism of misuse of the legal system by perpetrators, commonly referred to as transnational abandonment. Although not all organizations necessarily dealt with specific cases of it, almost all respondents made reference to this phenomenon as a unique and emerging issue of concern among South Asian communities. Transnational abandonment refers to the practice and consequences of cross-continental abandonment of the victim. This abuse allows the perpetrator to engage in activities which facilitate his takeover of community property without objection and legal accountability to his intimate partner and/or family (e.g. through ex-parte divorce). It may also enable him to pursue other relationships more "convenient" for his life circumstances and romantic pursuits. Two respondents described the various forms of this phenomenon and its consequences for the victim:

> "As mentioned earlier, we see a lot of violence as it pertains to immigration. This includes withholding immigration papers, or threatening immigration status with divorce or falsification of documents. More recently, we've seen abandonment become a bigger issue, where the victim is left here while the spouse returns to South Asia, with or without her child. There are also situations where the spouse

may 'return' the wife to South Asia, which causes elements of social stigma and blame upon the woman. Oftentimes, these men have mistresses in other parts of the world. The internet has facilitated or enhanced the ability of these forms of violence to become more and more common among South Asians." (SAVKI01: p. 4)

"Abandonment is defined in several ways… It's typically a South Asian man who lives in the US and marries a woman from South Asia. He might bring her here, live with her for a few years. Then he'll take her back, often on the pretext of a vacation, and leave her behind. And vanishes. He's untraceable. Meanwhile, some of the most horrific things that happen are that he divorces her here, ex parte. So, he can live happily here, divorced, and do whatever else he wants. She often doesn't even know that she's been divorced." (SAVKI05: p. 10)

Misalignment of legal and cultural definitions of violent behavior

In addition to taking advantage of the legal system, almost half of respondents also highlighted misalignment with legal and cultural interpretations of acceptable forms of maintaining discipline with the family. One respondent illustrated how socially-accepted forms of punishment may actually result in abuse, especially toward children:

"There's also the legal issues. We're talking about people not being aware, that is also true for child abuse. The rules here are very defined. And they don't realize that in the schools, they'll inquire about anything abusive. Oftentimes, parents get in trouble because they slap the child and somebody at the school finds out and reports it. A child says, 'my father hit me' and then the father gets reported to Child Protective Services!" (SAVKI06: p. 12)

Reciprocally, mainstream institutions in the United States (e.g. law enforcement, judicial system, social service agencies) may not be able to identify cultural dynamics which result in abusive outcomes, due to certain perceptions and assumptions. By not being able to identify the social hierarchy among South Asians which facilitate abusive situations, mainstream interventionists may revert to more convenient means of assessing violence among this population, as demonstrated by this respondent:

"First of all, big culturally-specific thing is that in-laws are often present in the house. In-law abuse is part of the whole patriarchal structure. Patriarchy doesn't consist just of a man oppressing a woman. Patriarchy consists of man, and all the men and women who support him… and a lot of women support this patriarchy because that's the status quo and they see an advantage in that. So, women with sons will definitely support patriarchy. That's why the mother-in-law… and I'm sure you have far more knowledge of this than me… but this is just our

perspective on this. In-law abuse is often not recognized or understood in the United States. If a woman calls 911 in the middle of the night; cops arrive. They sometimes talk to the nice elderly man in the house, who might know English, and they determine that everything is fine! She's just having a little neurotic fit, so let's get out of here. Or they might look at the gentle old woman sitting in the corner, and think, 'well, let me arrest the husband, who's clearly the aggressor; I can see that.' But let me leave the wife behind with that nice old woman there." (SAVKI05: p. 9)

Normative values, beliefs, and expectations within a South Asian context

More than half of respondents cited normative values, beliefs, and expectations within a South Asian context as a determinant of violence-related outcomes; they were very candid about providing illustrative cases of each of these aspects. For instance, one cited unconditional reverence to certain family members, such as elders or males, as a common influence on abusive behavior:

"It's more so in the older generation-my generation or older-that will say that I must respect my husband no matter what. He is the breadwinner. He's an incarnation of God. You don't see that in the younger generation. The way we were raised in India and how we saw our parents interacting, we have imbibed that and we bring that to our relationships. So some of that is unique. You will not see that in the mainstream culture. The theory of *karma*. If I get a beating, then I must have done something bad! Or even our scriptures, our sayings! 'The drum, a beast, and a woman are to all be beaten.' This is a popular saying. There is a Punjabi song that goes, 'my beloved, he loves me a lot and sometimes, as part of my loving, he takes a whip and beats me up.' That's a folk song sung by women in Punjab! That tells you that violence is accepted there! Not only accepted, but women are told that it's OK if your husband beats you! You must have done something bad! The first thing a mother will ask a girl in India, if she tells on her husband, she is going to say, 'what did you do?' Not 'how dare he beat you!' I think in those respects, there are some very unique things and the knowledge of culture becomes VERY important." (SAVKI11: p. 25)

Compounding this issue was the commonly-held belief that preserving the marital and family units is paramount, irrespective of the internal disharmony that may be present. As an example, one respondent cited a common response to claims of abuse by victims:

"I've heard the family pressure issue in other communities as well, in terms of 'give it one more try.' In the South Asian community, I think it's coupled with the fact that 'you have to give it one more try. There's nothing else you can do. Marriage is the end of the line.' The way we raise women in South Asian communities, marriage really is the end of the line; it's the end all. If that fails,

> especially if you have children, the idea of getting married again is non-existent. It's really a lifetime of loneliness, and what if you lose your children? Then you are really completely alone, if he gets them in the divorce process. So the pressure to make it work is, I feel, even more. Even though in other communities it's there to try again, for us, there's really no other option." (SAVKI08: p. 9)

One respondent also pointed out that the lack of acknowledgement of culturally-stigmatized conditions also lead to social ostracization of community members diagnosed by or afflicted with these issues:

> "The denial of mental illness is extremely prevalent in the South Asian community. The stigma that is attached with mental health, such as depression; it is something that we just don't want to address. Our clients, when we tell them that you are depressed and you need help after our psychiatrist has evaluated them and referred them to a local mental health clinic, the clients refused to go. 'Nothing is wrong with me.' They may be crying 20 out of 24 hours but they still not accept that it is depression, that this is not normal or dysfunctional." (SAVKI06: p. 13)

Almost all respondents agreed that South Asians did experience unique forms of violence that were not included in mainstream definitions. Based on these manifestations, organizations demonstrated a commonality of approaches to intervene upon the type and severity of violent activity, as discussed below.

(d) Scope of Services offered by the Organization

This study found that the majority of these organizations began as a referral service to connect affected community members to services and programs that may aid them in their specific circumstances. Depending on the length of existence, longer tenured organizations were able to expand their programmatic offerings to encompass both direct and indirect services. More established organizations operated shelters or transitional homes for South Asians victims of abuse. These and others in more intermediate stages of development implemented a number of programs designed to address a diverse array of situations. Newly-formed organizations largely focused on capacity building and serving as a liaison between community members and existing services.

More immediate services included hotlines/helplines, crisis interventions, individual counseling and therapy, translation/interpretation services and accompaniments, direct financial/emergency assistance, medical care, and legal aid. Longer-term activities included comprehensive case management, support groups, language and professional development workshops, navigation of mainstream structures (transportation, social services, and public entitlements/benefits) and assistance with attainment of legal status. Less than a third of organizations interviewed participated in providing technical assistance for other anti-violence (culturally-specific and mainstream) organizations as well as conducted legislative and policy advocacy. Almost all respondents emphasized that their organizations incorporated some form

of community education or awareness, whether it be in the form of publicity and activism at cultural events of value, use of ethnic media or dissemination of newsletters and web-based information, seminars at faith- and/or community-based organizations, training of mainstream public agencies (police, judges/lawyers, child protective services, social workers) or informal gatherings to discuss issues of violence within the South Asian community.

A couple of organizations were particularly insistent in specifying that those providing such services to South Asians should provide them without compensation. These respondents stated that volunteering time and effort increased organizational sustainability and implied that doing so enhanced the "purity" of the motive in providing these social services:

> "The strength we see among us is that all of us who are Board Members or volunteers working for this particular cause, we have no self-interests or motives. Whenever we do any event that requires payment, we always buy our own tickets. We never take any - - - money. This is how we sustain ourselves." (SAVKI06: p. 20)

> "Not one person in our whole organization, meaning - - -, gets paid… even for their gas. It's commitment and I think it's better… I've never heard of any organization… who has done this." (SAVKI03: p. 5)

Despite the varied stages of organization development and differential offering of services, all organizational representatives demonstrated a willingness to refer to and collaborate with most other agencies to ensure that their target population's needs were being met. This was clearly evident during the conference in which almost all organizations committed to ending violence among South Asian communities in the United States were present. During this gathering, attendees shared promising practices, solicited input regarding unique challenges in their self-defined jurisdictions, and explored directions where these organizations can work collaboratively across the nation to achieve their common goal. The study found that established organizations were willing to share their history and development process to those in earlier stages of identity formation and strategic planning. In addition, all conference attendees proactively addressed emerging issues of concern, such as transnational abandonment and human trafficking and were keen to forge alliances with organizations doing similar work in the South Asian subcontinent. This overwhelming response demonstrates an overarching philosophy of collaboration and elucidated the numerous levels of similarities that these organizations maintain.

However, the study found a significant number of differences between these organizations. In addition, there were a number of discrepancies reported by respondents regarding various aspects of their respective organizations. Below, the study findings discuss domains in which these organizations differed dramatically from each other and were inconsistent with other aspects of their interviews.

ORGANIZATIONAL DIFFERENCES

This study found a significant number of differences pertaining to certain aspects of organizational purpose or function. The study illustrates a large diversity of opinions or thoughts regarding specific issues; the following will be discussed in length: (a) defining "the issue" (and its causes) that organizations addressed; (b) organizational philosophy and impacts on interactions with clients[1]; and (c) defining and measuring success.

(a) Defining "the issue"

The issue that these organizations addressed was defined in four major ways: (a) specific terms for the problem and its causes; (b) the problem as a function of cultural norms; and c) manifestations of larger social inequities. The fashion in which the issue was framed had considerable influence on the perceived causes of the problem as well as defining the programmatic frameworks within which it was addressed, as discussed below.

Specific terms for the problem

About one third of representatives interviewed stated a specific problem, oftentimes associated with cultural attributes. Some claimed it to be any form of violence that occurs within the shared space of individuals living together, not simply those who are married. This was not limited solely to actions perpetrated by a single person, but any individual acting on behalf of him/her, as illustrated by this respondent:

> "Violence is violence whether it's intimate partner violence between the spouses, between the mother-in-law and the daughter-in-law as family violence… If it's between a mother-in-law and daughter-in-law, people categorize it as family violence, and not as spousal abuse. However, the spouse has neglected to protect their spouse and allowed that situation, so family dynamics are involved. If it's two gay people and it's intimate partner violence, then yes, of course, it's called that… Domestic violence, people generalize, is only between the spouses. No. Domestic violence is any violence that happens in the house." (SAVKI06: p. 4)

Others used more expansive definitions to include abuses that may not involve intimate partners. For instance, these two respondents felt that the issue was based on violent situations which may occur within a family unit, which can be expanded to extended family, domestic partnerships (usually involving same-sex couples), and/or child abuse:

> "That can mean anything from husband/wife issues to those involving in-laws. To the same degree, it can be a mother-in-law who is being abusive or it could be siblings who are being abusive. It could be two partners living together or a

[1] Many organizations emphasized that the term "client" was not appropriate in defining the population that they served. However, for the purposes of this paper, "client" will be used to consistently identify those seeking or using services, programs, and other forms of assistance provided by SAVOs interviewed.

> Lesbian/Gay/Bisexual/Transgender couple, so there's a whole gamut when we talk about domestic violence. It's individuals living in the same household; it's not just limited to intimate partner violence." (SAVKI15: p. 4)

> "We use 'family violence' or 'domestic violence'. We do see types of intimate partner violence, but we don't tend to use that term, because we do work on other issues. We do work on child abuse, child sexual abuse, for instance, which doesn't usually get covered in 'intimate partner violence'. Issues of sexual assault, actually, don't even get covered in 'family violence'. Sexual assault, human trafficking... that's why we use the broader brush stroke of 'violence'. And if we narrow it down, yes, the majority of our clients are domestic violence victims. In either married relationships or dating or fiancée… more of those traditional relationships. You have to keep in mind that we do work with trafficking victims or sexual assault cases or child abuse. That's why we prefer to use the broader terms." (SAVKI08: p. 6)

Interestingly, although the common denominator connecting these organizations was addressing forms of abuse, a couple of organizations shied away from explicit terms in their problem definitions. By utilizing such "loaded" terminology, these organizations felt that community members experiencing abuse would be reluctant in using program services, due to negative cultural connotations and mainstream remedies. For instance, the following respondent offered a less threatening alternative:

> "We call it family discord. We hesitate to use the word 'domestic violence' because the Western model of domestic violence really doesn't suit us as well as a more family-oriented model of negotiating discord. We've always called it 'family discord'." (SAVKI14: p. 4)

Some of these organizations were able to articulate a specific term for the issue, but upon further discussion, lacked clarity about what specific forms of violence that term entailed. For instance, two respondents were initially insistent that the issue their organizations addressed was any form of violence against South Asian women, but made later references to oppression and other forms of social injustice:

> "So the problem as we define it is violence against women. It is definitely violence against women and not restricted to domestic violence. Domestic violence is just one manifestation of violence against women. So that's how we define the problem. How you describe violence against women… Well, there's a huge spectrum, going from sex-selective abortion and female infanticide to oppression and malnutrition of the girl child. Just the 'unwantedness' of the girl child… So, any kind of oppression. What a lot of people call oppression, we call

> violence. It really encompasses all of that, going onto sexual assault, domestic violence, abuse of older women." (SAVKI05: p. 4)

> "I know all these terms, 'family violence', 'domestic violence', and others, even in the mainstream, they are using them interchangeably. The way we say it and do things is about violence against women and children. It happens to be domestic violence that comes to us, but on the periphery, if there are things like genocide and other forms of oppression towards women, we feel like we need to address it and make it part of our work. It all comes under the big umbrella of violence against women and children. It's just one aspect of that." (SAVKI12: p. 3)

Conversely, one organization was very hesitant to use such large-scale terms, as they may not reflect the specificity of the issue that was being targeted:

> "I would say that 'oppression' is a very loaded term. Oppression against women is a very big area. We're just focusing on one part of that. I don't know if it's oppression? Oppression may not be the right word, in my opinion." (SAVKI13: p. 4)

A few organizations chose to purposely use certain problem definitions because of their ambiguity or interchangeability with other terms commonplace in the anti-violence movement. Two respondents illustrated how use of certain terminology would allow them to incorporate a variety of target issues:

> "I still like the term 'domestic violence' because it can address… it's an umbrella. It can be oppression, and the other issues of intimate partners and family members are under that umbrella." (SAVKI13: p. 3)

> "We also use 'family (or) sexual violence', we also use 'domestic violence'. It just depends. We use them interchangeably." (SAVKI15: p. 5)

<u>Problem as a function of cultural norms</u>

Another third of the organizations squarely defined the issue to be a function of cultural norms, religious expectations, and other mechanisms of social control. The various forms of abuse common in South Asian American communities were perceived extensions of larger structures of inequity embedded in normative cultural characteristics. One respondent clearly articulated how various forms of violence manifested themselves from a cultural context:

"Then we have cultural violence, which is sanctioned and encouraged by cultural mores. Some examples include the dowry, the preference for sons, the expectation of the woman's role, the expectation from religion. We've had clients that are from orthodox communities. Not just one orthodox community, but a couple of them, where they've been excommunicated or threatened by the temple or the *masjid* or the *gurduwara*, if they complain. This to me is religious violence, when you control or manipulate somebody through the context of this familial violence… This is the next type of violence, the extended family violence, which is not prevalent in the mainstream. Extended family violence is where the mother-in-law, father-in-law, sister-in-law, brother-in-law can be involved in emotional, physical, mental, and psychological abuse whether they are living in that same family house or not. They could be living in a joint family or orchestrate it from a long distance, which is the immigrant piece of it." (SAVKI02: p. 16)

Manifestations of larger social issues

The remaining third of respondents framed the issue in more theoretical abstractions, encompassing larger concepts of power, control, and equity (without direct associations with cultural norms). Some of these organizations emphasized the role of universal patriarchal structures and their influences on preserving "tradition". This was especially true for cultural minorities in a new dominant society, as illustrated by the following respondents:

"(T)he roots of violence against women don't lie in a few criminals. The roots lie in patriarchy! And everyone around us, all of us as a community, even those of us who work with - - -, everyone has some role to play in upholding that patriarchal system. We all do it in various ways in our lives." (SAVKI05: p. 15)

"I think that essentially we are trying to address a patriarchal issue. There is a hierarchy. There are two issues here. One is the patriarchy issue. The second issue is the one of cultural mores… Let me address the cultural issues first. Cultural issues are led by these issues where family business is family business. It's the job of the woman to keep the marriage going. There are all these cultural expectations and norms. They put the responsibility on one person, which is the woman in this situation. Then you have the patriarchy, which defines that the dominant partner is always the man. You have an unequal situation where when there is partner violence… and I'm going to talk about heterosexual violence first. When there is heterosexual violence, we find that typically… and I/we have male clients, by the way, but they are only 3 percent of our work; at any given time we have about two male clients, but have 100 female clients… but typically what we find is that the violence is perpetrated by the person who is control, which is the man. It's perpetrated on the person who is supposed to hold the cultural mores for the family… The number two issue is that when you come to a new place, you give up all your social networks, all your familial networks, all of your support structure. This is not to say that there is no violence in the home countries. But,

> you have no mechanisms to deal with that violence here that you could have used in the home country. That is really the societal problem of how to deal with a rigid system where people are justified or excused to do certain things… But, for us, violence falls in several categories. Number one, we talk about heterosexual relationships where it's what the mainstream considers the cycle of violence. A lot of times, that honeymoon phase is missing. It goes from walking on eggshells to 'boom!' For us, that is what we consider to be partner violence. This partner violence is driven by power and control." (SAVKI02: p. 14)

Remarkably, none of the respondents cited any epidemiological data to support their definition(s) of violence-related issues among the South Asian American communities. As almost all organizations were formed in response to anecdotal "evidence", they had significant latitude in defining the issue. This flexibility facilitated their interpretations of why the problem existed in the first place, and what the appropriate philosophies were to address and eradicate it within the South Asian American community.

The study found a range of responses in each organization's interpretation of the cause of their identified problem. Approximately a third of respondents reported that their issue was a function of cultural norms and inequitable social structures perpetuated through generations, while others claimed them to be a repercussion of a "model minority" ascription placed on the South Asian community within the mainstream United States. Over half of respondents claimed that these issues arose out of an unwillingness to disrupt the hierarchical family structure and reverence for authority figures immensely valued among South Asians, yet a small fraction placed fault on a lack of community acknowledgement of socially unjust behaviors among individuals of their own ethnic identity.

Based on the wide range of issue definition, organizational approaches to addressing the problem were equally as diverse. For instance, organizations with more narrow definitions tended to use terms such as "intervention", "education", and "development" to describe their activities, whereas those with larger socially-oriented perspectives commonly claimed that their approaches used philosophies of "empowerment" and "independence". Despite these associations, the actual objectives and programs offered by these organizations may or may not align with the issue (and their perceived causes) which they address.

(b) Organizational Philosophy and Impacts on Interactions with Clients

Similar to issue definition, the organizational philosophies and mission statements informing program planning and service delivery encompassed a broad spectrum. These philosophies fell into two major categories: (a) principled frameworks; and (b) culturally-specific approaches.

Principled frameworks

Over one third of organizations interviewed utilized a more principled framework of human rights or social justice to direct their activities. These organizations tended to incorporate more rigid expectations from those who sought their assistance. These prerequisites often limited the client population which they served. For instance, one respondent stated that their organization required specific legal mechanisms prohibiting contact with their perpetrators.

> "… (W)e do require a restraining order for people who we are going to help. They have to be serious… We cannot have anyone here who doesn't have a restraining order. Let's say somebody calls and says, 'well, you know I'm having a lot of problems.' Well, have you done anything for this problem? They'll say, 'what can I do?'" (SAVKI03: pp. 33-34)

Others respondents indicated those seeking their organization's services can only access them as a last resort:

> "We make sure that she doesn't have other options, because then she'll just be going back and forth between her brother, who lives ten miles away, and this place." (SAVKI05: p. 7)

Less than a third of organizations placed conditions on clients related to the types of abuse experienced. For example:

> "The second condition is that you have to make a decision-not a commitment-to us that you want to move out of the life of violence and as a part of that, you need to tell us a plan… Unless they show us a plan-and we will work with them and suggest a plan-they cannot come into - - -, because we want that - - -, they are moving to phase two, which still may be crisis-driven, but they are not in an immediate crisis of domestic violence where there is an episode today and it calms down tomorrow. We don't want that kind of back and forth thing, though it does sometimes wind up happening. The third phase is that we want them to go to a life of independence. But that life of independence will be in the mainstream. They have to tell us a plan to be able to come into - - -; there's case management that occurs on a weekly basis for those who are further along in the spectrum, twice a week for clients who are not the far along in the spectrum of being independent, and daily for clients who are crisis-driven. We have a - - - coordinator who does the case management. There are certain requirements… If you come into - - -, and have experienced any sort of violence, you are required to do ten sessions of therapy. We have a therapist who works with them. We pay for that, but the clients have to pay for part of it. This is all driven towards independence in the mainstream." (SAVKI02: p. 10)

<u>Culturally-specific approaches</u>

Almost two thirds of organizations interviewed adopted a more fluid and culturally-specific approach to their interactions with South Asians seeking their assistance. Most of these respondents stressed the autonomy of their clients in providing them choices (rather than dictating) to make decisions best suited for their specific situations. By allowing these

individuals to choose options more aligned with their other social priorities, it facilitated the empowerment process and enhanced their own agency to leave or mitigate the consequences of their abusive environments. One respondent detailed this approach:

> "But it's so engrained when you are in a controlling relationship that there's nothing that's up to you. So we start from day one saying, 'it's whatever YOU want. I can provide you the information or the large spectrum of services we offer. I can tell you how long the divorce process takes, the different immigration options that are available to you. But in the end, it's YOUR decision.' Clients will always call and ask for our opinion, 'tell me what you think.' And I respond with, 'tell what YOU think!' It's constantly taking it back to them and asking what they want. By giving them the best information that we have… they're the ones in the situation, so they know what's going to work for them… it starts there and builds up from that." (SAVKI08: p. 13)

Some of these organizations emphasized replicating social units or characteristics found commonly among South Asian cultures in order to address the abusive situation without creating other forms of distress. One respondent detailed specific aspects of preserving important cultural structures:

> "More importantly, we utilize a sister-to-sister or family-based model, which provide choices to community members who are potential or actual victims of violence. Our goal is to replicate the extended family environment found in communities in South Asia and to minimize the isolation of escaping victimization in a new dominant society." (SAVKI01: p. 2)

Similarly, some specifically did not disparage the pursuit of preserving cultural norms valued by South Asians in the United States, recognizing that maintenance of these structures are important for identity among minority populations. However, these respondents stressed that basic knowledge about protecting one's self or their dependents in a new society is pivotal to avoiding or escaping violent situations, as exemplified by this respondent:

> "We're not saying to anyone, 'don't have an arranged marriage' or 'don't marry people from abroad', we're saying to do due diligence. Do not send your children off to the wilderness without knowing something about where they are going. Know what the legal status is. It's very practical when we go there. For me, if I go to somebody and say 'you can't do this', nobody is going to listen to me. If I present to them an issue and present very practical solutions and let them make an informed decision, then that is what we're trying to address." (SAVKI02: p. 14)

Related to this point, a couple of these organizations emphasized that many of the violence-related behaviors transpiring in South Asian communities can be defined as illegal. However, these respondents also stressed that their services don't necessarily entail legal remedies and instead, facilitate solutions that are acceptable in a cultural context, as illustrated by this individual:

> "We encourage them. But most of our women from our community don't want to bring charges against their husband. They are always afraid that their visa might be in jeopardy if the husband gets in trouble, so they don't like to bring any charges. We only recommend what's good for them and they make their own decisions. We never tell them what to do, we just give them options. And that's hard because sometimes women who are in that situation don't make the right decision. But we don't abandon them." (SAVKI07: p. 7)

Organizations involving more static philosophies (largely compromised of more established groups) tended to employ more prescriptive services in that they had more prerequisite requirements and/or maintained stricter standards of accountability for clients to receive assistance. These groups (approximately half of the study population) also tended to adopt problem definitions from sources outside of community input (although some level of feedback was always incorporated). The remaining organizations—adopting more context-driven definitions—tended to have more flexible policies for community member participation. Interestingly, most of the more recently-formed groups wanted to model their approaches after longer tenured ones, based on their visibility and reputation within the professional anti-violence community. However, funding seemed to be the larger barrier for developing organizations to adopt a more formal infrastructure with defined policies and procedures, as well as deliver specific services.

(c) Definitions of Success

The wide spectrum of problem definitions (and potential causes), organizational philosophies, and flexibility of community access to services also had impacts on how these groups determined success. All respondents indicated an organizational mission commensurate with addressing a broad issue of concern, usually related to violence, among South Asian communities. Statements articulating "empowerment", "integration", "support", "safety", "sensitive" as well as elements of raising or promoting awareness or community outreach were found in almost all organizational missions. Over one third of organizations described more magnanimous goals in eradicating (or ending) all forms of violence, exploitation, and/or oppression within South Asian communities.

However, most of those interviewed indicated no formal plan to evaluate if and how their organizations met the goals outlined in their mission statements. Of the more than half which collected quantitative data, their statistics largely consisted of call volume, number of cases in progress or completed, and clients seen in a variety of service capacities. Such measures were imposed by funding agencies providing support to these organizations. None of the organizational leaders interviewed indicated that they had any formal means of following up with clients to determine how many achieved success, based on their own organization's mission

statement. The study found five major categories of success: (a) resolution of client cases; (b) reciprocal contributions from clients to the organizations; (c) organizational sustainability, development, and expansion; (d) organizational longevity and reputation; and (e) changing policies and practices of mainstream institutions.

Resolution of client cases

Many organizations based such assessments on subjective accounts of clients who made the effort to keep in contact. Organizations often cited successful resolution of clients' cases, as stated by this respondent:

> "There was a resolution of a certain issue that we came to terms with them. It was because we were at it and kept at it hard. And this was because there was a language barrier with this client and she kept getting walked all over on. We just stayed and stayed with it. We brought it to a lawyer, to the court, to CPS… And we stayed our course… I don't want to say what course! (Laughing). But we ended up succeeding! It has been close to two years, but we succeeded. As there's been others. We had a transnational abandonment case. One particular one… at that time, I did not realize that that was what it was, but it was! And we succeeded." (SAVKI04: p. 7)

Similarly, a couple of respondents cited clients moving past the situations which caused them to contact their organizations, illustrating their successful ability to integrate and be successful within mainstream society:

> "Clients are remarried, very happy, settling down, and/or are working, becoming professionals. What could be more gratifying?" (SAVKI06: p. 23)

Almost one third of respondents felt proud of the fact that they simply existed, based on positive feedback received by clients. These successes may not necessarily be related to accomplishing their organizational objectives, but rather an acknowledgement of kinship and contributions to minority community members looking for social support and assistance. Two respondents detailed their interpretations of such successes:

> "The fact that we are here and are able to entertain this cause for people, that in and of itself, I feel, is a tremendous service. Many of the clients say to us that we are like an extended family. Those who don't have much of a support system here, even those who do have one but they are not helping, they look at us like a family, but a family that doesn't interfere and tell them what to do. I have a feeling that we provide a very crucial service. Knowing that we are here and that they can do about different options, even if they don't do anything about it. Just to be able to pick up the phone and call is something that is very crucial which we are doing." (SAVKI12: p. 22)

> "When a case is closed and a client's problem is solved. A divorce is done. She gets what she asked for. Everything is settled down. She has a nice job. No more worrying. She looks forward. When the client says, 'thank you for your help', we feel better! I don't know if it's a success or if she will continue or start a new relationship, we don't know! Ono more thing; I don't know if you consider this a success, but our satisfaction level grows when we know we are serving our community who need help, especially because they are in a new situation, a new country. There are a lot of limitations they are facing in the United States. They get the help because we understand the culture, the language. We assume we are making some sort of contribution. Since 2001, we've served over 1200 women and children through - - - programs, so we know we are filling a need." (SAVKI08: p. 21)

Reciprocal contributions from clients to the organizations

For a small fraction of the study population, definitions of client-based successes were based on direct or indirect contributions to the organization's function, objectives, or sustainability. These assertions were usually made by relative newcomers to the anti-violence movement. For instance, some respondents cited financial reciprocation by former clients:

> "And these are the women we were talking about previously, the ones who still send a check… They have seen it, and became a victim, and then begin to support the cause." (SAVKI03: p. 28)

Similarly, approximately 25 percent of respondents indicated that their success was tied to how many former clients return to provide personnel support or programmatic assistance for their organizations. Having participation from these affected community members indicated an active attempt to facilitate support to others facing similar situations, as indicated by the following representatives:

> "Also, when we see support group members, when we see them start their own projects. They say, 'I want to volunteer or contribute so that these other women (new support group members), they are not suffering.' That makes us feel that some sort of impact has happened." (SAVKI08: p. 21)

> "We've had so many people volunteer for us, who are coming back as volunteers. People are showing interest and passion to join." (SAVKI10: p. 34)

Within this subset of respondents, some indicated that their successes were based on how clients helped them meet their own organizational objectives, *irrespective* of the success of the client him/herself.

> "How we measure success in the transitional house is that we go through the list of goals for the clients with us and we ask if they've accomplished them. So, even though they may leave unhappy with us, because they don't want to leave, it's the next transition; for us, it's how many of the goals did we match. Was it 100 percent? 50 percent? For us, that is what determines success." (SAVKI02: p. 10)

Organizational sustainability, development, and expansion

Remarkably, much of the discussion surrounding organizational successes did not involve the client. Over 75 percent of those interviewed, including individuals representing almost all of the more established organizations, indicated that their primary successes revolved around organizational development and/or expansion, as well as greater influence and recognition in their professional networks. More than half cited an increase in their organization budget, as detailed by these respondents:

> "Definitely one success is, organizationally, when we started out, our budget was $1,200 the year I joined - - -. Now it's $300,000 and 90 percent of it is privately raised. This is the same community supporting us who said that we were interfering in their matters, in family matters, shaming the community… that we were a bunch of divorced lesbians who wanted to interfere. I think, organizationally, that's been an amazing success." (SAVKI02: p. 27)

Related to increased revenue, respondents also cited fundraising efforts by other parties as an indicator of their organizational success. These activities demonstrated that other institutions recognized the value of their existence and efforts to eradicate violence among South Asian Americans. One respondent emphasized the importance of such recognition:

> "The support, not just the money, but support in terms of people willing to do fundraisers for us, that really speaks to it. We've had the - - - pick us, after researching all the South Asian non-profits. They do their annual shindig and performance, and they put our banner up and they gave us all the money they raised that night. That speaks to that we are doing work that is appreciated." (SAVKI02: p. 27)

Organizational longevity and reputation

Pioneering organizations in the South Asian anti-violence movement often deemed their successes as a function of the longevity and reputation of their organizations. Representing half of the study population, these groups were notably prideful of being the first ones to respond to their identified issue in an organized fashion. As the length of existence increased, respondents cited positive repercussions of their tenure as an indicator of their organization success:

> "We're 20 years old, in 2009, and that in and of itself is amazing. Another thing that's happened, in 2001 we had, in terms of tracking calls, 200-someodd calls. Last year, we had 727! We don't believe the increase is due to an increasing in violence, it's an increase in people knowing about our existence. I think those are some of our big successes." (SAVKI09: p. 10)

> "- - - is known not only known as a DV agency for South Asians or immigrant populations in - - -, but throughout the - - -. Our successes are that whenever another South Asian DV agency has started, we have been their consultants. We have done on-site and phone consultations, shared our programs with them… We have come to be known as THE DV organization." (SAVKI11: p. 28)

Other respondents referred to programmatic growth and development of internal infrastructure and processes, in alignment with their philosophy, as their primary success as an organization. For example, one respondent emphasized the importance of having solidified their foundation without compromising organizational values:

> "I think - - - has grown into a really solid program. I would say that of all our programs. We've always had excellent programs. The ideas behind them have always been great. As an organization, we've stabilized and solidified our programs. Everything is now well-documented. The next person who walks in as a staff member doesn't have to reinvent the wheel. We've got processes in place. We also underwent a big strategic planning process in 2003 and moved from a complete non-hierarchical system where we had three staff members who came and did their own thing. There was no one really watching out for the organization or running the organization. We've now become larger and with respect to that increase in our work, programs, and policy efforts, we now have a little bit of structure. The philosophy is still non-hierarchical." (SAVKI05: p. 16)

<u>Changing policies and practices of mainstream institutions</u>

Other references to successes not directly related to clients include the impact of organizational activities in changing the policies and practices of mainstream institutions as they pertain to interactions with violence within the South Asian community. Having the ability to influence social service and other welfare-oriented agencies to include nuances specific to South Asians increased awareness and heightened sensitivity to this population. Interestingly, this respondent remarked that these successes were related to reference to their organization, and not necessarily related to interacting with situations involving South Asian perpetrators and victims:

> "I would also talk about the successes with the mainstream. There is a much greater sensitivity with police departments; now I'm specifically speaking about -

> - - County and maybe - - - County to some degree, although - - - County is a very tough nut. But definitely in - - - County, when the police are called to a South Asian house, they talk about (us)." (SAVKI02: p. 28)

One may logically assume that expansion and enhancement of organizational infrastructure and activities would translate into improved programmatic offerings which, in turn, would result in more positive outcomes for a larger proportion of clients. However, almost all organizations articulated creation of additional services or newer programs without systematic evaluation of existing ones. Some did not feel the need for formal evaluation plans. Many respondents indicated that newer funding streams, provision of certain programs by more recognized anti-violence programs, and/or academic-based recommendations were the foundation of initiating certain types of efforts. Although all organizational representatives interviewed for this stressed a community-based component of their respective entities, less than a third actually implemented a systematic feedback loop in practice.

In summary, recurring themes largely revolved around issue definition, organizational philosophy, and measures of success. These differences play a significant role in the approaches that each organization employs to address its identified problem and evaluate if they are successful in accomplishing their stated objectives. In the absence of epidemiological data and prescribed programmatic strategies, these findings provide critical insight in how SAVOs formulate their organizational strategies and assess their impact in reducing the prevalence and burden of violence among South Asian American communities. Analysis of key themes will be presented in the following section.

DISCUSSION

This study explores the various influences on how South Asian anti-violence organizations in the United States define their target issue, conceptualize their organizational philosophies, design approaches to addressing their defined problem, evaluate their programmatic activities, and determine success. The findings, based on interviews with key organizational leaders, provide an intimate and familiar perspective on the creation, purpose, and function of their affiliated organizations. The analysis focuses on examining areas of agreement and divergence among organizations interviewed, while also evaluating consistencies among individual groups in their organizational mission, approaches, programs/services, and evaluations. In the absence of more systematic program planning frameworks targeting violence among South Asians, this study offers important insights into why an abundance of these organizations have formed, what issue(s) they are targeting, and the rationale for implementing their respective programs. In addition, this study also provides unique information regarding the intra- and inter-organizational consistency of approaches employed relative to mission statements and identification and causes of the issue addressed.

Study findings reinforced specific issues and patterns presented in the literature. Consistent themes include the existence of violence among South Asian communities (and their social, cultural, and historical influences), the necessity for dedicated organizations providing culturally-appropriate services, and characteristics of the dominant society which may impede successful resolution of abusive situations. This study also found that, in an environment of increasingly limited resources, these organizations are enthusiastically willing to engage in

collaborative activities, provide technical assistance, share successes and failures, and participate in agenda setting with one another. Although many of these groups exist to provide services not found in mainstream structures, there exists a heavy emphasis across organizations to work with social service agencies, law enforcement, and judicial system (among other key stakeholders) to ensure awareness and sensitivity to unique issue that arise in situations of violence among South Asian Americans. As evident in the annual conference of South Asian Women's Organizations, these organizations are also willing to collectively advocate for policy-level changes which incorporate culturally-specific considerations in their drafting and passage.

Given the lack of large-scale population studies which definitively support a disproportionate burden of certain forms of violence among South Asian Americans, the study found that many of these organizations—especially the more established ones—were formed as a response to personal experiences or knowledge of community incidents involving violence. More recently developed organizations often followed the approach and service delivery models of the pioneering groups. Organizations existing for less than five years cited the program plans of three major SAVOs who happened to be the oldest ones in existence. The problem definition (and perceived causes) of all of these organizations were often based on those identified by these pioneering groups and modified slightly to incorporate concerns specific to their constituent populations. For instance, although transnational abandonment is becoming an emergent issue of concern, not all organizations had clients who had experienced this form of abuse. Interestingly, most organizations still included this in the scope of their programmatic offerings, despite not having any knowledge of its actual existence within their client populations. If this pattern of problem definition (based on anecdotal "evidence" or prescribed by more established SAVOs) holds true for other identified issues, these groups may not be addressing violence-related concerns specific to their communities. For instance, second-generation individuals are becoming a larger proportion of the South Asian population and thus, violence related to immigration status or perceived mechanisms of control in the native subcontinent may not be as relevant as other violence-related issues. Some organizations alluded to dating violence and abuses related to substance use becoming more common among South Asians. Perhaps more formal means of needs assessment at the local level would identify more contextually-appropriate targets for organizational intervention.

The study also found a significant conflict among SAVOs about which philosophy was more appropriate to address violence within South Asian American communities. Those who relied on more anecdotal or personal experiences tended to adopt more principled and theoretically-informed approaches. For example, respondents representing more established groups cited patriarchy and other structures of inequity in their service delivery models and consequently, aimed to target larger issues of oppression and facilitate the empowerment of clients through their programs. For these groups, interventions often ignored the role of males (as the usual perpetrator population) and focused on the individual development of clients without necessarily taking into account culturally-valued notions of family harmony and socially-accepted behaviors, such as reverence to elders/parents and the expectations placed upon men as the "head" of the family unit. Moreover, these SAVOs were more likely to place certain restrictions on their clients as a condition of participating in their programs (e.g. securing a restraining order, commitment to certain developmental goals, partial payment for specific services); these prerequisites seem contrary to the notion of escaping cultural mechanisms of control. Interestingly, these organizations also indicated that their clients often return to violent situations multiple times before successfully resolving their specific situations.

On the other philosophical continuum, many organizations emphasized the need to minimally disrupt culturally-valued beliefs and expectations. These SAVOs often attempted to reframe their problem definitions within "non-threatening" domains, such as successfully raising children (by adopting more "healthy" behaviors for youth to model) or maximizing economic security through skill development and education. This recontextualization was also evident during the technical assistance conference, where presenters offered different social contexts in which issues of violence could be framed.

However, these organizations often had significant problems in ensuring that their identified problems were indeed addressed, as community members often focused on concerns not relating directly to violence. The study found a notable observation in both groups: behaviors and attitudes ascribed to culture appeared to be static interpretations. Moreover, these attributes were often based on an understanding of South Asian identity and behaviors specific to a certain time period in the native Indian subcontinent. Certain respondents were cognizant of this (mis)interpretation of culture and remarked that during visits to South Asia and/or in talking to community members, these assumptions were often challenged and sometimes deemed invalid. For instance, the assertion that females were victimized due to adherence to "traditional" cultural processes (e.g. arranged marriage) or passive participation in spousal and family relations may be steeped in stereotypes or personal experiences and thus may not be as applicable to the current behavioral patterns of South Asians in the United States. As the demographic profile of South Asians continues to shift and other forms of marital union and family development becomes more common, SAVOs may want to monitor these patterns to ensure that their programs are addressing actual and more-relevant forms of violence, as opposed to issues more common in a different time frame and/or geographic vicinity.

With respect of organizational development and function, a crucial finding was the inconsistency between the mission of these groups and how they determined success. Remarkably, mechanisms of systematic evaluation were notably absent among all SAVOs interviewed. Most respondents cited indicators completely unrelated to case resolution and/or client satisfaction. Instead, SAVOs were keen to report increases in organizational revenue and/or sustainability, greater visibility and positive recognition within the anti-violence movement, and participation by former clients (and other community members) in their program planning as measures of organizational success. For those groups who indeed underwent programmatic expansions, service additions were often based on funder priorities and/or modeled after other groups who offered specific remedies, as opposed to a direct response to community concerns. Although all SAVOs stressed the importance of making programs relevant to their constituent communities, the feedback loop informing program planning was often non-existent. Organizations reporting client-based evaluations based their successes on a self-selected sample of individuals who actively chose to report on their progress and resolution of specific circumstances. On one end, this may demonstrate an increase in self-efficacy for those who report positive outcomes and provide reciprocal contributions to aiding organizations. On the other hand, clients who may not have successfully escaped their situations of abuse may not be acknowledged by SAVOs as there was no systematic mechanism of monitoring or follow up with these individuals.

From a program planning perspective, these issues are pivotal in determining if existing programs are indeed effective and service additions are appropriate and relevant for violence-related issues among South Asian Americans. Especially for newer groups who model their service delivery after more established SAVOs, common approaches must be evaluated to

determine actual impact and effectiveness. For instance, one respondent representing a more established SAVO admitted that their organization was suffering from "mission drift" and that adoption of (non-existent) measurable outcomes may indeed shed light on the perceived effectiveness of established philosophies and programs. All SAVOs may benefit in re-examining the source and rationale of their existing organizational mission and evaluating whether their processes/outcomes actually accomplish the objectives laid forth by their governing philosophy (both conceptually and empirically). Failure to measure successes commensurate with organizational aims may lead to continuing/adding programs which lack impact and ultimately, do not contribute to successful reduction of the problem, as defined by each organization. More emphasis on client follow-up and barriers to escaping abusive situations may provide valuable information in defining more contextually-relevant issues of concern, refining service delivery and incorporating other stakeholders not traditionally included in the administration of SAVOs, such as men and second-generation community members.

Finally, all organizations emphasized the importance of community outreach and raising awareness as a means of making these issues less "hidden" and mobilizing change in cultural norms. Interestingly, there was an equally high representation of frustration about not being able to influence certain cultural institutions (e.g. cultural groups, faith-based institutions, ethnic health associations). As much of the South Asian American population is ascribed the label of "model minority" by the mainstream society, community members may internalize this depiction and distance themselves from characteristics dispelling that notion. As issues of violence are publicly stigmatized by South Asian Americans, confronting the existence of these manifestations seems to be difficult and, in some cases, vehemently denied. As such, organizations which aim to draw more attention to these injustices may elicit negative and visceral reactions, as found in this study. As SAVOs attempt to secure more community engagement, strategies which overcome this apprehension need to be devised in a manner consistent with South Asian attitudes and beliefs yet not minimizing the severity of violence and their impacts on this minority population. More detailed descriptions regarding issues of community mobilization and engagement are reported elsewhere.

LIMITATIONS

As this research was conducted as part of a degree requirement for a doctoral program, it was largely limited by the lack of human resources, time, and funding necessary to conduct a study of this magnitude. As a result of these circumstances, the depth of contextual information may have been limited by the ability to only conduct one interview with each organization. As this research was exploratory in nature, there were no prescribed "variables" that the study sought to test or validate. Given the volume of meaningful data collected, one key observation was the existence of more cases than interviews, necessitating significant follow up to adequately achieve saturation of themes. As a result, the study identified many future directions for in-depth research that provides a more comprehensive description of the complex influences pertaining to the study's research questions. Similarly, due to the inductive nature of qualitative inquiry, the initial interview guide was revised to enable saturation of initial themes and explore emerging and unforeseen concepts. Consequently, organizations interviewed prior to the revision were not surveyed again for relevant domains of inquiry found in the initial analysis. This study also based its conclusions solely on the accounts of organizational representatives; perspectives from

clients and other community members may have provided more opportunity for triangulation of data.

Despite these limitations, this study is the first to contextually examine and compare organizational approaches to addressing violence among South Asian communities in the United States. With a focus on analyzing both intra- and inter-organizational consistency, findings from this research elucidate the complex relationships between problem definition, organizational philosophy and activities, and evaluation activities. In addition, this study critically examines the intersection between theoretical premises and practical application in order to provide a systematic analysis of organizational approaches largely governing the movement to eradicate all forms of violence among South Asians in the United States.

CONCLUSION

Ethnic-specific organizations provide a valuable service to community members who are unable to seek assistance and avail of resources available in mainstream institutions. South Asian Americans who have experienced violence are no exception. By addressing distinct forms of abuse having social and cultural origins, SAVOs play a pivotal role in providing culturally-sensitive programs, offer a safe haven for individuals to escape victimization, and endow affected community members with the support needed to overcome their specific circumstances. The findings from this study confirm that violence is indeed a major health concern among this minority community and manifests in physical, emotional, sexual, political, economic, and cultural expressions. In addition, given the social stigma associated with acknowledging the existence of violence-related behaviors, SAVOs play an integral role by transforming the issue from an individual, private problem to a public and social concern. The increasing number of SAVOs around the United States, coupled with the significant expansion of more established organizations, demonstrates that the organizational response to violence is gaining momentum in addressing a significant issue of concern. Moreover, the emphasis espoused by these organizations on building coalitions and setting a collaborative anti-violence agenda underscores the potential that these groups have to create social change. As a whole, SAVOs attempt to employ strategies that mitigate and reduce violence at multiple levels.

This study found that there are considerable areas of agreement among SAVOs interviewed. Organizational representatives largely agreed on the impetus for forming their SAVOs, aims and rationale, culturally-specific manifestations of violence, and the types of services offered. These similarities indicate that there is consistency in forming an organizational response to accounts of violence by South Asian victims, providing services that are not available through mainstream institutions, and addressing forms of abuse that are distinctly prevalent among this minority population. In addition, these organizations are keen on engaging in collaborative agenda-setting, as demonstrated by the activities and dialogue surrounding shared experiences and collective recommendations generated at the biennial gathering of SAVO representatives. These areas of consistency indicate a shared commitment that permeates the structure and function of each of these organizations.

However, despite these commonalities, there exist significant differences among these organizations. This study found that SAVOs have diverse and distinct interpretations of the specific problem they are addressing, the philosophical premises on which organizational activities are implemented, and the criteria utilized to measure success. By maintaining divergent stances on key elements of program planning and evaluation, the ability of SAVOs to

collectively articulate and galvanize around a core set of principles and applications become largely attenuated. In the absence of a consistent body of theory-driven and evidence-based recommendations for addressing violence among South Asian Americans, it is increasingly important that social movements initiated by organizational response share an agreed-upon problem definition and common philosophical base from which to frame their approaches.

In addition to inter-organizational variance, there were also significant intra-group discrepancies that were found in this study. The most common illustration of this difference was the disconnect between a given organization's mission statement, the perceived causes of their identified problem, and the measures used to evaluate success. For many organizations, evaluative criteria were often divorced from the objectives that they hoped to accomplish. From the perspective of organizational sustainability and enhancement of program delivery, these considerations are essential in demonstrating internal consistency, effectiveness, and impact to a diverse audience of stakeholders. Ensuring that program activities and services contribute directly to an organization's stated mission demonstrates that there is a relationship between organizational interventions and mitigation of the defined issue. The study findings indicate that SAVOs may want to consider a vertical alignment of their mission statement, purported causes of the problem, programmatic elements, and outcome evaluation. Without this internal consistency, it will be difficult to assess whether or not the movement initiated by SAVOs are indeed impacting the rate of violence among South Asian communities in the United States.

In the current discourse on eliminating health disparities, the existence and influence of SAVOs are paramount to addressing the disproportionate burden of violence among South Asian American populations. The findings from this study are meant in no way to diminish the significant accomplishments and impact that SAVOs have had on reducing the prevalence and severity of violence-related consequences among South Asians in the United States. Rather, the purpose of this study to highlight areas where SAVOs may improve their individual impacts on their defined issues and moreover, their collective approaches are aligned to maximize their potential as a true social movement.

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Chapter 3

A Critical Examination of Culturally-Informed and Community-Based Approaches in Understanding and Addressing South Asian Health Disparities in the United States: Future Directions for Public Health Research and Practice among Understudied and Emerging Populations

OVERVIEW

By definition, the field of public health focuses on preventing disease and promoting health and wellness among populations. As opposed to clinical treatment of individual illness, public health encompasses a broad range of philosophical and theoretical premises, with dynamic emphases on prevention, political action, and scientific evidence to guide research and practice (Turnock, 2007). With an interdisciplinary approach, the field has achieved great successes through sanitation, vaccinations, workplace and motor vehicle safety, and family planning, among many others; these efforts have resulted in a longer lifespan and quality of life for many throughout the United States and globally (C.D.C., 1999). In contemporary times, public health has identified social and structural conditions as its focal targets, as illustrated by the Institute of Medicine's characterization of the field's mission as "fulfilling society's interest in assuring conditions in which people can be healthy" (I.O.M., 1988). This definition shifted the emphasis from individually-oriented interventions to effecting social and structural conditions which facilitate or impede the pursuit of optimal health for all populations.

By extension, much of the current discourse in public health revolves around the examination of empirical existence of disparities in health indicators and outcomes across different populations (Adler & Stewart, 2010). These disparities have been reported among numerous social and demographic variables, such as socioeconomic status, gender, sexual orientation, race/ethnicity, and immigrant status, among many others. In the past 20 years, research in the field of health disparities has surged, partly in response to the persistence and growth of disparities despite advancements in medical care and prevention initiatives. Originally thought to be a consequence of differences in economic advantage and access to health care, evidence has demonstrated that disparities persist even when adjusting for age, income, income, and severity of conditions (Smedley at al, 2003). Thus, much of the current health research has been immersed in examining the actual causes of disparities, with a prime focus on racial and ethnic minority populations. As the biological basis of race has been largely discredited as a primary contributor, the field of public health is in a perpetual pursuit in trying to conclude upon the true contribution and relationship of race/ethnicity to health-related differences. As a result, countless research methodologies, practical approaches, and theoretical conceptualizations have been offered and defended as an attempt to reconcile the gap in knowledge of the relationship between racial/ethnic background and disparities in health (Braveman, 2006). Progressive disciplines have emphasized that the persistent existence and growth of health disparities violates core principles of social justice and human rights (Whitehead, 1992; Mann, 1996). In addition, numerous institutions have arisen throughout the United States, all with a common commitment to understanding and eliminating health disparities among racial and ethnic minority populations. While theoretical, methodological, and organizational approaches grow in number and

sophistication, disparities among racial/ethnic minority populations continue to increase, suggesting a lack of alignment between theory, research, practice, and impact.

Those most concerned with health disparities are the populations who actually experience and are impacted by their existence and severity. While the increasing complexity of academic discourses serve a meaningful purpose, a commensurate advancement in impacting disproportionate burdens of disease and risk-factors is largely lacking. For instance, it is questionable that any significant progress has been made on the Healthy People 2010's objective to eliminate health disparities, despite its articulation one decade earlier. As such, health professionals must be able to devise novel mechanisms to comprehensively and effectively stunt the widening of disparities between diverse racial and ethnic communities.

As a response, the formulation of contemporary paradigms has been largely influenced by those who have experienced firsthand the social reality and consequences of health disparities: the affected communities themselves. Termed "community engagement", this philosophy emphasizes the role of working with and through groups distinguishing themselves from others by some affiliation (C.D.C./A.T.S.D.R., 1997, I.O.M, 1995). The notion of "community" is a fluid and dynamic construct and, as such, cannot be summarized succinctly and comprehensively. At the very least, they can be characterized by individuals who either are defined or define themselves to be part of a group united by a common characteristic. In addition, an individual may be considered part of multiple communities and differentially assign him/herself depending on time and place. Recognizing the value of community engagement in improving the health of minority populations, the field of public health has conceptualized a number of frameworks that build from this foundation. For research and practice specifically, there is a relative consensus around a number of principles that encompass the philosophy of community engagement. Most saliently, these include the understanding that: 1) health behaviors are often defined by cultural characteristics; 2) community engagement must address multiple levels of the social environment, many of which can be identified by community members to be impediments or promoters of health; and 3) individuals tend to participate in endeavors when they feel a sense of community, the issues addressed are relevant to them, and their involvement and participation is invited, worth their time, and supported throughout the process. By extension, these principles can expand to more formal efforts for community empowerment, coalition building, and civic advocacy. These considerations have dramatic impacts in elucidating the complex factors and influences that contribute to minority health disparities and identifying mechanisms to reduce their prevalence and severity.

With these considerations in mind, the primary objective of this paper is to describe the adequacy of selected frameworks in addressing the underserved health concerns of the South Asian population in the United States. As this minority community has been aggregated into an "Asian" demographic category, unique concerns facing this and other population subgroups are often attenuated relative to the entire Asian population. The Asian ethnic identifier is an artificial category insofar that it encompasses groups representing over 50 countries, more than 100 languages, and a multitude of other diverse social, cultural, and demographic characteristics. Inherent to its definition, the field of health disparities research and practice must distill the distinct determinants of health for each subgroup to appropriately address specific inequities. In this regard, the South Asian population is especially unique with respect to its existence and growth in the United States, placement in the racial hierarchy, and assumptions of advantage in health-related indicators and prospects. To elucidate this contextual analysis, this paper will begin with a description of selected contemporary frameworks in the field of minority health and

health disparities, with an emphasis on culturally-oriented and community-based applications to research and practice. This will be followed by a presentation of unique social and cultural characteristics of South Asians in the United States associated with pertinent indicators of community health. Based on the findings of two complementary health studies conducted among South Asian Americans, a critical analysis of these frameworks will be offered, relative to the overall objective of improving minority health and eliminating health disparities. The paper will conclude with a commentary on the future implications for the field of public health, as well as recommendations for health professionals to consider when working with understudied and emerging communities, such as the South Asian population in the United States.

SELECTED MINORITY-ORIENTED HEALTH FRAMEWORKS

Considerable effort has been placed on the conceptualization of frameworks that illuminate diverse contexts in which racial/ethnic health disparities may occur. As minority populations in the United States have unique social and cultural characteristics—often sustained in ethnic enclaves having large concentrations of individuals from similar cultural backgrounds—novel approaches have been proposed to include such specificities. This section summarizes three contemporary frameworks, largely selected for their emphasis on cultural attributes and community involvement. It merits noting that the selected approaches—cultural adaptation, cultural competency, and community-based participatory research—are fundamentally different in their respective emphases. Cultural adaptation largely focuses on adapting measures and surveys, whereas cultural competence focuses on the appropriateness and sensitivity to programs and practices. Community-based participatory research emphasizes the mobilization and active engagement of affected populations in all aspects of the research and practice process. However, principles from each maintain large overlaps in philosophy and application with the others. Moreover, these approaches have strong interactional relationships, as the formulation and application of each are largely influenced by implementations of the other. For instance, culturally-oriented activities often identify domains for which community-based input is needed for nuanced research and/or practice. Reciprocally, community participation may highlight pertinent cultural contexts which need to be incorporated into targeted public health strategies. Although other public health models may also hold relevance, the ones presented in this paper have been utilized most frequently for both research and practice focusing on minority populations in the United States.

Cultural Adaptation

Approaches to improving public health have emphasized philosophies that espouse scientific rigor, broad applicability, and sustainability. For health research specifically, this entails a commitment to standardization of assessment and evaluation procedures, resulting in comparability of measures across different populations and periods of time (Guillemin et al., 1993). Health practitioners often implement efficacious approaches with fidelity in hopes that they will produce the same successes found in randomized trials (Castro et al., 2004). This commitment to "universal equivalence" has culminated in a tension with modalities that emphasize understanding and responding to the local needs of a culturally-concordant group. The latter has often been criticized for not having a broader impact due to the specific tailoring of a given approach to a specific ethnic community. This tension is pervasive throughout the

field and, while inequities in health indicators grow for many racial/ethnic groups, debate continues as to which imperative holds more rigor and value for public health.

One theoretical response to these competing priorities has been termed "cultural adaptation" (or "cross-cultural adaptation") (Ringwalt et al., 2004, Kumpfer et al., 2002; Guillemin et al., 1993). This approach aims to remedy "top-down" strategies put forth by scientific experts—through the vehicles of validated research methodologies and efficacy-driven program planning—by adapting components to distinct attributes of a specific cultural group. Most of these efforts have focused on linguistic translations (Secherst et al., 1974; Brislin et al., 1973; Brislin, 1970; Hunt et al., 1991; Narroll et al., 1970). For research specifically, emphasis has been placed on equivalencies related to semantics, idioms, and experiences, while preserving content validity of the original assessment criteria (Hunt, 1986; Flaherty et al., 1988). In addition to linguistic adaptation, programmatic adaptations involve modification of program content or delivery to ensure that original program components are presented, albeit with changes to channel and/or location of delivery (Castro et al., 2004). In concert with these approaches, recommendations have been put forward to expand the scope of research and practice models to include conceptual equivalency and take into account considerations of "affective-motivational" characteristics. Conceptual equivalence refers to a valid representation of a given concept measured or addressed by members of the target culture. For instance, a survey prompt or program activity might be semantically identical but hold completely different meanings conceptually in a different cultural context. Building off of this principle, "affective-motivational" adaptation calls for program-based modifications which avoid conflicts or reactance with the norms, beliefs, and values of a given cultural group (Castro et al., 2001). Health researchers have called for an incorporation of these deeply-rooted contexts when considering culturally-relevant modifications (Skaff et al., 2002).

Despite prescriptions for context-driven public health approaches encompassing racial/ethnic minority populations, the large preponderance of validated methods and evidence-based programs emphasize replication and fidelity as a cornerstone of scientifically-rigorous research, practice, and evaluation. In other words, deviations from the original modality should be avoided or, if needed, modifications should be minimal and absolutely necessary to achieve the desired outcome. Oftentimes, funding agencies make decisions on provision of resources based on compliance with a standardized protocol, despite their lack of alignment with significant social and cultural attributes of targeted minority populations. At one end, standardization does provide comparability of indicators and evaluation of outcomes. On the other hand, since most of these models have been developed in predominantly English-speaking, Anglo-Saxon environments, cultural specificities related to health and illness may be deemphasized or not incorporated altogether (Zborowasky, 1952; Kleinman et al., 1978; Helman, 1990)

Cultural Competence

Recognizing the mismatches that present themselves between public health endeavors and culturally diverse groups, a more recent framework of "cultural competence" has been proposed as a more adequate philosophy to address racial and ethnic health disparities. As opposed to an adaptive framework, which largely posits that cultural considerations serve as secondary to the validity and efficacy of health initiatives, culturally-competent approaches put the onus on incorporating cultural dynamics as a primary focal point on health practitioners

themselves (Tervalon & Murray-Garcia, 1997). In other words, a culturally-competent health system is one that acknowledges and incorporates the dynamic role of culture to meet the needs of racial and ethnic populations (Betancourt et al., 2003). The field of cultural competence recognizes the complex interactions of cultural characteristics within a new dominant social structure, all of which have direct influences on the health of minority populations in the United States (Green et al., 2002). As the framework of cultural competence puts racial and ethnic considerations as a high priority for public health strategies, this movement has become a primary component of the national agenda to eliminate health disparities (Brach & Fraser, 2000). It should be noted that, although tenets of this framework are applicable to research methodologies, most culturally-competent efforts are targeted towards health programs and service delivery.

Despite the acknowledgement the root causes of health disparities fall outside the clinical realm, culturally-competent strategies often focus their efforts on the health care delivery system (Betancourt et al., 2005). Most cultural competency research has focused on socio-cultural barriers *within* the health care system and proposed remedies at the organizational, structural, and clinical levels (Betancourt et al., 2003). The techniques most often presented in the literature include interpretation services, recruitment and retention of minority staff, clinical and administrative training, coordination with traditional healers, use of community health workers, culturally competent health promotion, incorporation of family and community members, immersion into another culture, and administrative and organizational accommodations (Brach & Fraser, 2000). However, these strategies emphasize the improvement of the health care delivery system, be it in the form of increased access to quality care, ease of navigating administrative bureaucracies, or enhanced patient-provider communication and clinical encounters. Moreover, the overarching aim of adhering to criteria of administrative and clinical success largely remains the highest priority, despite the heavy emphasis on acknowledgement and respect for cultural diversity (Paasche-Orlow, 2004).

On a practical level, measures of what constitutes culturally competent practice are varied and inconsistent (Kumas-Tan et al., 2007). Evaluative criteria often embed problematic assumptions about the definition and process of cultural competence and often measure success based on the actions of the provider or health care system. In addition to issues of reliability and validity, many major assessment instruments have been purported to oversimplify the field of cultural competence and assume a singular, static conceptualization of minority culture relative to the dominant society (Betancourt, 2003; Nunez, 2000). Moreover, the linkages between culturally-competent activities and reduction of racial and ethnic health disparities are weak, if not absent (Brach & Fraser, 2000). Much of the public health literature focuses on theoretical associations and potential of cultural competent health care systems to impact disproportionate outcomes plaguing cultural minority populations. However, the most glaring gap in the discourse on cultural competence is the lack of focus on minority communities and conditions outside of the health care system, despite recognition that the social determinants of health are perhaps the largest contributors to health disparities.

Community-based Participatory Research

A framework which weds academic and professional expertise with cultural context is the paradigm of "community-based participatory research", or CBPR. As an orientation to research, CBPR maintains a fundamental commitment to a cooperative process which emphasizes

community members as key contributors to the field of public health, involving systems development, local capacity building, and empowering participants to take control over their lives (Israel et al., 1998). CBPR also places heavy accents on issues of trust, power, dialogue, and collaborative inquiry as a mechanism to improve community health and eliminate health disparities (Minkler & Wallerstein, 2003). By mobilizing community members to participate in issue definition, intervention design, and evaluation, CBPR espouses a co-learning process which empowers affected populations to take ownership and action upon their own health prospects. This orientation also recognizes that communities, as units of identity, have the potential to describe meaningful aspects of their social realities, identify assets and prioritize concerns, articulate historical and structural impediments, and offer contextual insight regarding relevant mechanisms to assess and intervene upon health disparities impacting their own racial/ethnic populations. It is surmised that authentic community participation reduces dependency on the health care system, optimizes cultural tailoring of health research and programs, facilitates social change, and empowers individuals from similar social contexts to engage in pursuing optimal health (Israel et al., 1998; Jewkes & Murcott, 1998; Scott, 1990).

Most CBPR-oriented activities have taken place among communities of color (Green & Mercer, 2001). Rooted in historical origins of implementation in developing countries, the value placed on involvement of oppressed communities in the examination and solutions to health and social problems is a defining principle of CBPR (Yeich & Levine, 1992). In the United States, the definition of oppression concentrates on those who do not experience the reality and privilege conferred to the normative dominant group: Caucasians (Lee et al., 1998). Sociological examination of Caucasian Americans suggests that this "reference" group does not tend to identify their ethnicity as a defining component of their identity or actions (Omi, 2000). Furthermore, belonging to a group defined as Caucasian, male, and upper/middle class is seen to have a procurement of entrenched, unearned privileges, often defined as "White privilege" (Lee et al., 1998). In turn, those not included in this dominant class are seen as members of subordinate communities who are victims of repressive power structures. As a key illustration, the racialized hierarchy found in the United States provides differential access to opportunities to education, employment, living conditions that contribute to health and illness. For those communities who don't express social realities which include racial oppression, CBPR acknowledges the potential existence of internalized racism where community reflections are self-censored to conform to an ideal normative judgment (Jones, 2000). CBPR notes that community members represent their realities through public discourse and hidden transcripts; it is the latter which this orientation aims to unravel for the purposes of research and practice (Scott, 1985). This "culture of science" is seen to be an expression of deference and subordination, illuminating explicit and subtle differentials in power and respect. Concurrently, minority populations may also shed a positive light on their social realities to break stereotypes and not challenge the status quo governing their existence, including relationships with researchers examining their health prospects. The orientation of CBPR is inherently rooted in a social justice framework which aims to amplify community experience, examine power dynamics, and enable a candid and complete account of "lived" realities which provide meaningful entry points for researchers and practitioners to impact racial and ethnic health disparities.

UNIQUE CONSIDERATIONS FOR SOUTH ASIAN AMERICAN HEALTH PROSPECTS

South Asians—individuals with origins in Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka—hold a unique position within the diverse United States population. This section details relevant characteristics and issues pertaining to the existence and growth of this minority population. Moreover, findings from two specific studies will be presented to illuminate the impact of these social, cultural, and demographic factors on the field of public health's ability to examine and intervene upon community health disparities. As a part of a doctoral dissertation, these two studies were purposely conducted to highlight special considerations in undertaking public health approaches among South Asians in the United States. Details about both of these studies are presented in Chapter 2 and 3 of this dissertation. However, both these studies focused on empirical disparities existing among South Asian populations in the United States: tobacco-related disease (e.g., cardiovascular disease, site-specific cancers) and specific forms of violence. To elucidate considerations pertaining to public health research, one of these two studies—hereafter referred to as the "tobacco study"—focuses on the creation of a South Asian tobacco instrument, using qualitative and community-based methods, to measure the true prevalence and associated cultural contexts of tobacco use among this minority population. The other study—hereafter referred to the "violence study"—examines intra- and inter-organizational philosophies and approaches utilized across the United States which aim to reduce the burden of violence among South Asians; this research illustrates the complexity of designing and implementing practice-based initiatives among this community. It merits mentioning that this analysis focused on specific forms of abuse—such as domestic violence (DV), intimate partner violence (IPV), and family violence—identified in the literature and by organizational representatives; other forms of violence (e.g., gang violence, hate crimes) were not examined in the study. Although these two qualitative studies had distinct objectives, an abbreviated meta-synthesis found persistent, higher-level themes which are discussed in context of characteristics and issues relevant to South Asian American health.

South Asian Immigration into the United States & Impact of the "Model Minority" Label

To understand the social position of South Asians in the United States requires a comprehension of the factors leading to immigration and growth of this minority population. With the exception of a small proportion of individuals who emigrated from South Asia in the late 1800s, the vast bulk of immigration occurred after 1965, when racial quotas were abolished for certain population groups and emphasized preferences for certain skilled labor and professional classes (Waters & Ueda, 2007; S.A.P.H.A., 2003). As a result, over 85,000 scientists, doctors, and engineers migrated to the United States between 1966 and 1977 (Prashad, 2000). As the majority of South Asia was at, one time or another, subject to British colonialization, the system of higher education remaining in the Indian subcontinent was conducive to producing professionals able to succeed in a "Western"-oriented culture, as most immigrants were proficient in English and able to navigate educational and employment institutions in the United States (Bhattacharya & Schoppelrey, 2004). These post-1965 immigrants, based on their educational and professional pedigrees, demonstrated remarkable success in various socioeconomic indicators. To illustrate, South Asians maintain median household incomes and educational attainment levels well above averages found in the general

United States population. Based on this tremendous success, South Asians were deemed a "model minority" within the dominant society and cited as an exemplar for other minority groups to attain similar socioeconomic milestones (Tayyub, 2001). This pattern also was seen to be illustrative of the "healthy migrant effect", which posits that only a select group of individuals with the necessary resources, knowledge, and motivation are able to *voluntarily* migrate to a new dominant society (Anderson et al., 2004). By extension, these self-selected groups are assumed to have highly-favorable health profiles, compared to the general population in the new dominant society (Flores & Brotanek, 2005). This wave of immigration culminated with the family reunification provisions added to the 1965 Immigration and Naturalization Act, which allowed spouses and relatives of the initial immigrants to enter the United States (Hondagneu-Sotelo, 2003).

However, a subsequent wave of immigration began in the late 1980s and early 1990s, where expansion of the information technology and computer science industries resulted in a large influx of South Asians entering the country on skilled-personnel or student visas (Hondagneu-Sotelo, 2003). The demographic profile of these more recent migrants reflects a distinct contrast from their earlier arriving counterparts (Bhattcharya & Schoppelrey, 2004). For example, many of these individuals assumed blue-collar employment, working as taxi drivers, convenience store employees, line workers, motel clerks, gas station attendants, and other roles in the service sector. Representation in these capacities has seemingly increased with the failure of the dot-com industry in the early 2000s and the economic downturn during the latter half of the decade. As such, South Asians arriving during this wave of immigration represented less professional and educational standing and more socioeconomic disadvantage (S.A.P.H.A., 2003). These two distinct periods of migration have resulted in a bimodal distribution of social and demographic characteristics, indicating a high level of success at one pole with tremendous disadvantage on the other end of the distribution (Families U.S.A., 2002; Brown et al., 2000; U.S. Census, 2000; U.S. Census, 1990). Most population-based surveys do not have the statistical power to conclusively determine the socio-demographic profile of South Asians born in the United States, as second-plus generation individuals comprise a small proportion of the overall South Asian American population. However, the extreme economic and educational success of a subset of the South Asian population has resulted in a persistent "model minority" label ascribed to the entire population.

Cultural Preservation and Social Identity

This characterization of South Asian success cannot solely be attributed to the mainstream United States population. In fact, the "model minority" label has been internalized by a large proportion of the South Asian population (Zia, 2001; Asher 2002). This is evidenced by extremely high expectations of academic and professional success as well as public celebrations of significant accolades by prominent members of the community in ethnic media and by culturally-specific organizations. In addition, many ethnic institutions representing South Asian perspectives in many facets of American life are keen to credit their "model minority" status on cultural values and priorities (Min, 2006). In order to perpetuate this perceived success, these structures promote ethnic solidarity and preservation of socio-cultural norms. Within the lens of segmented assimilation theory, South Asians are seen to pursue a mechanism of social incorporation which is characterized by "rapid economic advancement with deliberate preservation of the immigrant community's values and tight solidarity" (Portes & Zhou, 1993).

This can be seen in the development and growth of heavily-populated ethnic enclaves throughout the United States, which concentrate on social, cultural, and religious attributes endemic to the South Asian region. This assimilatory pathway may also be supported by low rates of naturalized citizenship by South Asian immigrants, as community members may ascribe successes to cultural attributes as opposed to participation in mainstream institutions and structures. In other words, preservation of socio-cultural normative structures—including identity, values, beliefs, and behaviors—may be seen as determinants of the perceived outcomes associated with a "model minority" moniker.

Although the term "South Asian" has been used unilaterally through this paper to identify minority communities with origins from the subcontinent, discussion of this ethnic identifier deserves some clarity. The origin of the label "South Asian" has its roots and sustenance in academic discourses and media portrayals in reference to this ethnic group (Brown, 1964; Salam, 2005). The extent to which this categorization has been adopted by community members themselves is more questionable. Much has been written about the emergence of a common South Asian identity—irrespective of national, regional, religious, or linguistic origins—binding together the children of immigrants through shared experiences, commonality and community (Maira, 2002; Prashad, 2000). In other words, the "South Asian" category only makes sense in context of the racialized, classist, and generational hierarchy found in the United States (Finn, 2008; Bijlani, 2005; Salam, 2005; Purkayastha, 2005). Mobilizing around a pan-ethnic South Asian identity has been assumed to be a response to contradictory patterns of historical and contemporary discrimination and the exotic and "model minority" attribution (Srikanth, 2003; Wildman, 2001). For immigrants, however, self-defined membership in this socially-constructed category may be more problematic. Given the divergent loyalties maintained by South Asian immigrants—largely based on religion and/or caste, national origin, or political ideology—members of this ethnic community may primarily identify along these lines rather than a unified yet artificial regional category (Rao, 2003). Moreover, successes of the members of any South Asian subgroup are often shared by the entire community, whereas negative attention is commonly ascribed to a narrow subset of the population (Prasad, 1999). This assumption of situational identity has considerable influence on values, beliefs, and behaviors expressed by a subset or majority of South Asian Americans, depending on time, place, and context.

Implications for South Asian Health

These considerations have significant implications for South Asian health. As many community health disparities are largely preventable and can be explained by social and behavioral patterns, understanding the theoretical underpinnings and specific influences of cultural contexts is imperative for research and practice. Four overarching themes arose from both studies which confirm this assertion: (1) lack of acknowledgement of risky or stigmatized behaviors; (2) cultural values and norms supersede health and social consequences; (3) cultural freeze; and (4) perceived value of prevention for health promotion. These findings will be discussed at length in the following section in context of cultural features known to be associated with South Asian communities.

Lack of acknowledgement of risky or stigmatized behaviors

The first key finding from the meta-synthesis of both health studies was the lack of acknowledgement of risky or stigmatized behavior by members of the South Asian population.

Qualitative data from the violence study repeatedly indicated that the community-at-large did not readily admit that specific forms of abuse, such as domestic violence, were prevalent in their community (Chapter 3). This is not a surprising finding, as socially-stigmatized behaviors are often underreported and denied in both minority and mainstream populations. However, when empirical data and documented experiences were presented to South Asians—via community gatherings, cultural events, and ethnic media—to raise awareness about the issue, the response was predominantly that of persistent denial. In cases of rare acknowledgement, reactions were largely adversarial in nature. Content analyses found that the majority of dismay and outrage about violent behaviors among South Asians was not pointed at perpetrators, but rather the practitioners and advocates who were committed to eliminating abuse among the South Asian community. Study participants repeatedly cited that victims who made concerted efforts to escape their abusive situations—through legal means, divorce proceedings, refuge in shelters, resource or support seeking, or public revelations—were seen as not adhering to collectivist values of prioritizing family before the individual, maintaining culturally-valued hierarchies and means of discipline, and keeping private matters outside of the public sphere; such attributes are often viewed internally as drivers of South Asian success. These individuals (as well as their individual and organizational supports) are often socially ostracized from their families/communities and unsuccessfully able to reintegrate into South Asian cultural environments; these outcomes are usually in addition to financial losses and inability to secure sustainable means of employment and suitable living conditions. As a result, community members are often hesitant to report abusive episodes, publicly support victims, or advocate for social change for fear of marginalization from the larger South Asian community. In certain cases, some survivors maintain that the long-term social consequences are more severe than specific forms of abuse suffered. This rationale has also been found in other research of South Asian violence (Robertson & Oulton, 2008).

Similarly, findings from the tobacco study indicated a general reluctance to acknowledge community uses of any forms of tobacco (Chapter 2). Study respondents seemed to associate tobacco use with lack of education and lower socioeconomic status. This finding is consistent with other population-based surveys which report a low prevalence of cigarette smoking and use of other "Western" products (McCarthy, 2002). However, the study found that there was indeed common use of culturally-specific products containing tobacco by all segments of the South Asian community. When probed about use of such items, respondents often conveyed doubt or surprise about the tobacco content and denied or minimized knowledge of health risks or consequences associated with use. Determinants of culturally-specific product use were hardly associated with addiction or lower social class status, with a few exceptions. In one research site, no participants were found who were willing to publicly acknowledge consumption of *any* form of tobacco—"Western" or indigenous—although they expressed knowledge of other community members who partook in more hidden forms. By and large, participants in three ethnic enclaves were hesitant to report use of explicit tobacco products by the community-at-large, despite admission that certain culturally-specific products were readily available in South Asian commercial outlets and cultural venues.

Both studies indicate a concerted effort by community members to preserve the positive image ascribed to South Asians in the United States. By denying the existence of risky health behaviors or socially-stigmatized conduct, South Asians are able to deflect any potentially negative characterizations which may draw attention away from otherwise affirmative portrayals. However, in instances where tobacco-related and abusive behaviors were acknowledged,

findings from both studies indicated an interesting pattern. Respondents were more keen to attribute the existence of these patterns of behavior to South Asian subgroups in which they did not claim membership. For example, tobacco study participants reported use of certain products for groups with shared characteristics of religion, socioeconomic status, and national origin, with whom they were largely unaffiliated. To a lesser extent, data from the violence study indicated that certain segments of the South Asian population were more apt to describe abusive behaviors by communities subscribing to a different faith. Both studies also found differential ascriptions of behavioral prevalence based on gender, generational status, and, for immigrants, length of time in the United States.

These findings suggest that the "model minority" label externally ascribed to this minority population has been internalized by a large proportion of the South Asian community. Study participants represented a readiness to largely deny the existence of these behaviors or, in instances of admission, mitigate their severity or consequences. In addition, a consistent pattern of situational identity was also apparent, insofar that respondents were more likely to indicate that tobacco-related behaviors or patterns of abuse were ascribed to South Asian subgroups representing variables of identity not associated with their own. The complex notion of identity seems to be significantly related to the existence and rationalization of social and behavioral determinants of health outcomes, as evidenced by other overarching thematic findings.

Cultural beliefs and norms supersede health and social consequences

Both qualitative studies relied on accounts of community members as primary sources of data, triangulated with other relevant research. Inclusion criteria for participation in the tobacco study were self-identification as an individual of South Asian descent and use (current or prior) of one or more culturally-specific tobacco product (Chapter 2). For the violence study, respondents were required to serve in a leadership capacity with an organization that focuses on addressing violence exclusively or predominantly among South Asian populations in the United States (Chapter 3). As a result of these requirements for participation, both studies were able to generate in-depth and meaningful data from respondents who had firsthand knowledge about cultural contexts in which these behaviors occur. Despite indications of denial or external ascriptions about both domains of research inquiry, study participants were able to represent perspectives of South Asians who had been directly involved with these health-related issues. Thus, overarching findings could be reasonably considered as reflective of values, beliefs, and attitudes associated with direct engagement in tobacco- and violence-related patterns of behavior.

Based on these considerations, one associated finding from the meta-synthesis process was the role of cultural norms with respect to both the use of culturally-specific tobacco products and existence of violence among South Asian communities. For instance, content analyses from the tobacco study indicate that community members of diverse South Asian backgrounds place a high value of use of indigenous tobacco products as a mechanism to preserve ethnic identity, participate in cultural traditions and ceremonies, and socialize with other members of the community (Chapter 2). In addition, many participants expressed an inaccurate or incomplete knowledge of health risks among community members associated with product use. Moreover, there was large agreement that use of culturally-specific products actually confer health benefits. However, most respondents agreed that, in spite of comprehension of health consequences, the use of these products for maintenance of social identity and cultural expressions were of high value, especially as a means of distinguishing South Asians from other minority populations. In other words, culturally-specific tobacco products had important social purposes which largely

superseded knowledge and/or fear of adverse health consequences. Findings from this study confirm results found in other research (Bode, 2006; Nunez-de la Mora et al., 2007; Khawaja et al., 2006; Glenn et al., 2009).

Similarly, findings from the violence study indicated that strict adherence to roles and expectations of the South Asian family structure were key drivers of violence within the community (Chapter 3). In general, one of the key cultural features among South Asian populations is a collectivist orientation, which differs dramatically from the notion of individualism found in the United States. Characteristics of this cultural profile are highly applicable to South Asian families, which include strong allegiances to parents and extended family, deference to elders and males, and prescribed roles of subordination for wives and children (Ahmed & Lemkau, 2000; Lee & Zane, 1998). Educational and professional successes are seen by community members as a direct result of this discipline-oriented family structure. In contrast, lack of alignment with patriarchal hierarchies is seen as contributing to juvenile delinquency, substance abuse, poor academic performance, and other negative perceptions of assimilation into the dominant culture. To perhaps maintain components of a "model minority" stature, study findings indicate that various manifestations of abusive behaviors—physical, emotional, sexual, financial, political, and social—arise as a mechanism to resist processes of acculturation and preserve cultural structures associated with community success. These mechanisms of social control are maintained and enforced in spite of legal ramifications, health consequences, financial loss, and damage to professional reputation. Moreover, study findings indicate that victims often accept these conditions as a function of normative cultural standards and seek help only when the extent of abuse reaches unbearable levels of psychological and physical effects. As a result, many health and social consequences for individuals and families remain unfettered so that South Asian communities may retain a distinct cultural identity. These preserved patterns of behavior are often defined by beliefs and norms associated with success.

The two studies emphasize the maintenance of culturally-valued behaviors even in recognition of potentially adverse outcomes. Adherence to collectivist values and resistance to Westernization has been demonstrated in other research (Robertson & Oulton, 2008; Choudhry et al., 2002). Meta-analyses of data from the tobacco and violence studies also suggest that these social patterns are reinforced by formal and informal community structures. For instance, South Asians are often reluctant to intervene—publicly or privately—on at-risk or unjust activities as it conveys disrespect for autonomy. In parallel, South Asians also hesitate to draw any negative attention by publicly acknowledging behaviors that may detract from their highly-reputed status. Seemingly, emphasis is placed on maintaining culturally-defining features when balanced against significantly adverse health and social consequences related to preserving these attributes. These considerations may have broader implications in their potential for extrapolation to other social and behavioral determinants of disparities and inequity among this population.

Cultural freeze

In South Asia, a significant and interrelated public health and human rights agenda has burgeoned, targeting at-risk behaviors and emphasizing social justice for disenfranchised individuals and communities. For instance, tobacco control activities have resulted in massive health education campaigns, targeted efforts toward industry regulation, and creation of strategies which aim to reduce initiation and support cessation of South Asian tobacco product consumption (Reddy & Gupta, 2004; Gupta, 1994). With respect to violence, both policy-level

and community-based interventions have been initiated, focusing on patriarchal structures, prescribed social roles and expectations, and collective empowerment to end specific forms of abuse, such as family violence, against disadvantaged segments of South Asian society (Mehta, 2004). Although much more progress is needed to demonstrate a significant impact, the discourse on both these health-related issues is notable and has the potential for large-scale social change.

Despite the recognition of and efforts to intervene upon health and social inequities in the native subcontinent, parallel levels of acknowledgement have not taken hold among South Asians in the United States. Although public health and social service agencies have attempted to address racial and ethnic disparities domestically, the South Asian community-at-large has expressed denial of socially-stigmatized issues or reluctance to identify culturally-valued behavioral patterns as causes for concern. In addition to data presented earlier in this paper, findings from both studies indicate a common origin of values and beliefs related to tobacco- and violence-related disparities (Chapters 2 & 3). Respondents indicated that much of the South Asian American context governing culturally-preserved perspectives are actually based on static understandings of tradition remnants from historical experiences and interpretations. In other words, South Asian immigrants base their claims of cultural values on normative beliefs and attitudes commonplace in the native subcontinent at the time of migration. Moreover, these features are transmitted to subsequent generations without representing contemporary shifts in traditions and beliefs occurring in the region of ethnic origin. Findings from these studies are consistent with social constructions of culture—as defined by a static and stable set of beliefs, thought, traditions, values, and possessions by ethnic minority communities—often conceptualized as "cultural freeze" (Vo & Bonus, 2002; Warrier, 2002). Cultural freeze also refers to the maintenance and rigidity of traditions and perspectives as a means to explain and justify certain patterns of social behavior (Dabby, 2007). These scenarios are common among immigrant and minority communities who are struggling to maintain a social identity which is distinct from the dominant society (Robertson et al., 2007). Interestingly, many of these "preserved" cultural features are often unrepresentative of social perspectives and patterns currently present in South Asia (Sokoloff, 2008). Meta-analyses from both studies confirm the theoretical premise of cultural freeze, as it pertains to rationalization of culturally-specific tobacco use and abusive behavior among South Asians in the United States.

Perceived Value of Prevention for Health Promotion

In the available research on South Asian health belief systems, much of the emphasis is placed on traditional approaches to treatment, such as through the religious medical systems of *unani tibbi* (Muslim) and *ayurveda* (Hindu) (Themstrom, 1994). Through these lenses, determinants of poor health and disease are largely attributed to "root causes" of forces and imbalance outside of the body, such as spiritual vulnerability or accumulation of faults from past lives (e.g., *karma*) (Bhungalia et al., 2006). Although the role of prevention in traditional health systems is emphasized, it often entails intervening at levels outside of medical, behavioral, or structural spheres. For instance, in order to return the body to a balanced state, meditation, yoga, and herbal remedies are often prescribed. Behavioral changes are often employed in response to acute illness and ceased when symptoms and/or pain subside. Chronic conditions are often seen as predetermined outcomes, either due to a genetic predispositions or a function of religious or spiritual consequences. Emphasis on behavioral modification or improved social conditions is largely absent as a means of pursuing optimal health.

Findings from both studies support the notion that behaviors and social conditions are often overlooked as a means of impacting disparate health indices among this population. Results from the tobacco study indicate a more explicit articulation of this mentality. As illustrated earlier, the social value ascribed to culturally-specific products supersedes fear of health consequences associated with use. Respondents indicated that, although many community members are aware of health risks, the prospect of any immediate health effects seem remote. This sentiment is bolstered by common perception of health benefits and incomplete knowledge about adverse outcomes associated with product use by a large proportion of the South Asian community. As with many other chronic conditions, behaviors have significant influences on the onset and progression of disease. Findings from the tobacco study indicate that heightened awareness or increased knowledge may have minimal impacts of modifying consumption patterns, due to the cultural contexts that govern use and frequency (Chapter 2).

As opposed to overt explanations found in the tobacco study, the violence study found a subtle and complementary philosophy regarding the role of prevention in reducing abuse among South Asian Americans (Chapter 3). Organizations targeting specific forms of violence (e.g., DV, IPV, family violence) among South Asian communities astutely identified the multifaceted and complex determinants of abusive behavior within this population. Respondents also stressed the need to intervene upon patriarchal systems, power imbalances, normative roles for women and children, and other root causes of violence among South Asian communities. Outside of delaying the severity and frequency of episodes, the study found that abused South Asians had little or no ability to adopt a preventive approach, largely due to involuntary victimization at the hands of perpetrator(s). Participants indicated that certain subsets of the South Asian population—such as men, immigrants, and elders—were perceived as more likely to partake in oppressive behaviors, largely due to culturally-framed expectations and norms defining social norms and expressions. Based on a prevention-oriented framework, a logical direction for intervention might entail the targeting of potential perpetrators *prior to* engagement in offending behaviors; this approach has demonstrated success among communities highly impacted by violence, including in India (Berkowitz, 2004; Haysim, 2006). When such a strategy was inquired about as a possible mechanism to reduce violence among South Asians in the United States, however, the overwhelming reaction was dismissive in nature. Most organizations emphasized the necessity of dismantling cultural structures which conferred prioritized stature to certain subgroups; however, these same groups often were unwilling to engage in discourse with these potential subjugators to illuminate and address social inequities leading to violence. As such, respondents reported that much of their activity was reactive, requiring individuals to have already have experienced violence before intervention efforts could begin. Thus, from an institutional perspective, the operationalization of prevention-based philosophies seems to be largely lacking.

As prevention is the cornerstone of public health, understanding individual, organizational, and social influences which facilitate or impede such approaches is pivotal for health promotion and eliminating health disparities. This is especially important for outcomes that can be successfully avoided or limited in severity if preventive approaches were employed on multiple levels and early on. For instance, tobacco-related diseases (e.g., cardiovascular disease, cancer) often have delayed onset or latent symptoms, and at the time of diagnosis, treatment has little efficacy in achieving the outcome that would have occurred without use. Similarly, the culmination of violent behavior is often a result of multiple socializing experiences which have been sustained over generations. For the elimination of health disparities among

South Asian Americans, the role of practical prevention strategies is paramount but seemingly absent based on these two studies.

In summary, this section details unique considerations for South Asian health prospects in context of this population's history of immigration, formation of social identity and preservation of cultural attributes, and implications for community health. The latter segment uses two illustrative studies to highlight patterns and processes relevant to public health research and practice. The following section critically examines these findings with respect to the selected minority-oriented health frameworks presented in this paper.

ANALYSIS

In the initial sections of this paper, three contemporary public health frameworks are presented. These models were selected largely on the basis of their stated objectives to understand and address health disparities among racial and ethnic minorities. The purpose of this analysis is not to question the intentions of these frameworks nor is it to critique their applicability and documented successes among specific minority populations. Rather, this section aims to evaluate the congruency between theoretical premises and practical applications in reducing health disparities among the South Asian community in the United States. The unique cultural profile and social position of South Asians within the racially-hierarchical milieu found in the United States may have significant implications on the adequacy of these paradigms to effectively reduce the prevalence and severity of community health inequities. As such, the analyses presented below will explore the alignment of conceptual foundations with practical considerations and, to the greatest extent possible, suggest revisioning of specific models when disharmonies are asserted.

Cultural Adaptation

Principles of cultural adaptation aim to modify standard protocols of research and practice to meet the needs of diverse populations. Specific activities include linguistic and cultural adjustments to validated methods and evidence-based strategies, which attempt to align efficacious public health approaches with unique cultural attributes of minority populations. For assessment measures, knowledge and belief systems, and behavioral patterns which are comparable to those observed among the dominant social environment, this framework can yield great benefits in accurately understanding and addressing racial and ethnic health disparities.

However, for the communities in which cultural contexts of knowledge, values, beliefs, and behaviors differ dramatically from the host society, the "top-down" approach of cultural adaptation may net inaccurate and irrelevant information and impact. This assertion is supported by findings from both the tobacco and violence studies. For instance, since most tobacco surveillance in the United States concentrates on assessing prevalence and frequency of smoking behavior, research among populations which largely consume tobacco in alternative forms— such as South Asians— often yield marginally meaningful information regarding the true impact of tobacco on these communities. In addition to divergent product definitions and modes of ingestion, the cultural contexts in which these behaviors occur are largely missed by "adapted" instruments. As an illustration, determinants of South Asian tobacco use seem to be associated with cultural identity and social cohesion, as opposed to addiction-related and knowledge-based factors. Although the latter measures have merit, most validated instruments don't assess the

cultural contexts in which these behaviors are initiated and sustained. Understanding these social influences holds high value for establishing the true extent of the problem and highlighting areas for intervention.

Similarly, many theory-driven and evidence-based program strategies often presume a logical commonality of outcomes when exposed to certain resources, knowledge, support, and incentivization. Moreover, these approaches may also assume comparable agency of the individual actors who are exposed to a specific intervention. Similar to cultural adaptation of research modalities, program plans are often modified to accommodate language, appropriateness of venue, and generic assumptions of cultural characteristics. However, these practical strategies don't take into account unique cultural contexts within a larger dominant society and often assume that understandings from other minority communities might be extrapolated. This is increasing true for most Asian subgroups, which fall under the umbrella of an artificial pan-ethnic category. In the case of family and domestic violence among South Asian Americans, culturally-adapted intervention approaches don't take into consideration the impact of "model minority" ascription, collectivist orientation, and unanticipated social consequences of active attempts to escape abusive situations. This assertion is no way precludes the violation of basic human rights caused by family and community violence; rather, it is meant to critique the successful adaptability of mainstream interventions to a racial/ethnic minority assuming a unique social position and expressions of cultural priorities.

Cultural adaptation holds great potential for translation and modification of research and practice strategies for diverse communities. However, this value is only applicable when social and behavioral contexts are similar to those assumed in the original public health modality. As such, for South Asians and other understudied populations, a "bottom-up" conceptualization of targeted public health approaches may yield larger impacts. These approaches may have similar value for understanding and addressing the cultural contexts governing dietary behavior, physical activity, substance abuse, and other patterns associated with community health disparities. Such contextually-driven formulations will not only increase the validity of research and programmatic effectiveness, but might also contribute to narrowing the social divide that often persists between researchers and ethnically-diverse communities who are pursuing common outcomes for optimal health.

Cultural Competence

As opposed to cultural adaptation, the philosophies of cultural competence embrace a "bottom-up" approach. This is evident by its governing principles of acknowledgement and respect for racial/ethnic differences as well as alterations within the field to embrace diverse cultural values and perspectives. The onus for incorporating meaningful cultural contexts is put on the profession of public health, in contrast to requiring cultural minorities to adapt to vocational priorities.

Cultural competency largely focuses on the practice of public health, although certain elements are equally relevant to research methodologies. In addition, much research has examined the role of intra-cultural diversity and the implications of using broad generalizations to simplify understandings of culture. Another critique is the insinuation of "competency" as a distinct endpoint in mastery of finite knowledge. As opposed to the notion of "cultural humility", cultural competency has been faulted for not taking into account the dynamic nature

of culture and the effect of structural power imbalances on racial and ethnic minority populations (Tervalon & Murray-Garcia, 1998).

Notwithstanding these considerations, another less studied phenomenon bears relevance. Oftentimes, public health is seen as an objective and scientific discipline, minimally subject to ideological influences. In fact, the health professions themselves are a culture in their own right, bound by their fundamental commitment and associated approaches to disease prevention and health promotion. This is evident in the governing mantra of "do no harm" embedded in the ethics of health and medical practice (Ashcroft et al., 2007). As such, the field of public health has a vested interest in producing outcomes that legitimize its existence and social value. For health disparities specifically, these evaluative criteria are often based on indicators of risk and prevalence among racial and ethnic minorities. Thus, the stated priorities of public health and culturally-framed pursuits may come into conflict, often resulting in an uneasy philosophical tension.

This dilemma is illustrated clearly by findings from the violence study. Most respondents articulated a deep philosophical commitment to eradicating violence within South Asian communities and implementing culturally-competent approaches to achieve this goal. In fact, culturally-competent services provide recourse for abusive situations that fall outside of traditional definitions of physical, sexual, and emotional violence. However, analyses found differing degrees of accommodation for cultural priorities. At one extreme, pursuit of absolutist principles of social equity governed programmatic activities; on the other, escape from abusive situations is adequate even while leaving intact situations where cultural patterns of behaviors are preserved (including hierarchical structures). However, qualitative accounts from the violence study also indicate marginal attention paid to cultural priorities which may not entail a complete extraction from social environments which facilitate violent behavior. In fact, content analyses found that a large proportion of community members don't follow-up after initial contact nor completely fulfill programmatic requirements largely due to honoring cultural expectations. As a consequence, these individuals do not have their specific needs met even though provided services may have indeed met the test of culturally competent principles. To a lesser extent, findings from the tobacco study also illustrate this pattern. Although this study focused on creating a research instrument, content analyses indicate that reducing or ceasing the use of culturally-specific tobacco—in spite of health consequences—may not be a high priority for community members. Thus, future intervention efforts incorporating culturally-competent principles may not result in outcomes sought after by the field of public health.

In the field of minority health, the notion of cultural competence is held in extremely high regard as a means to address racial and ethnic health disparities (Paasche-Orlow, 2004). Public health approaches infused with culturally-competent principles appear to be universally accepted as positive, due to their worthy intentions and active efforts to heighten consciousness of cultural impacts on health inequities. However, little attention is paid to conflicts that arise when principles of cultural competence do not align with the fundamental objectives of public health. In essence, these tenets are conditional in that they may only be fully implemented when the final outcomes are satisfactory from a disciplinary perspective. For many racial and ethnic minorities, the priorities of the institution of health and medicine are secondary to issues of social identity and cultural preservation. These considerations are evident in relevant findings from the tobacco and violence study. In order for the cultural competence framework to accommodate these disconnects, it must resolve the tension between fundamentalism and multiculturalism. Therefore, cultural competence must not only define a principled approach, but also articulate

the characteristics of professionals who are able to address difficult issues in alignment with their own personal values and convictions. The field may benefit from acknowledging that not all health professionals are suitably-equipped to grapple with these dilemmas and that institutional priorities may not always align with cultural expectations. In light of these considerations, researchers and practitioners must critically evaluate whether they have the capacity to provide purely culturally-competent services and programs. In absence of this intuition, the field of minority health must define other avenues to improve health—with or without a universal commitment to cultural sensitivity—in alignment with a public health and social justice philosophy, without fear of judgment or prejudice.

Community-based Participatory Research (CBPR)

Culture, as a construct, is in no way innate or static, and is subject to ongoing redefinition under dynamic social and political conditions. Both cultural adaptation and cultural competence presume, perhaps unintentionally, that cultural characteristics may be reduced to a summary list of descriptors, knowledge, beliefs, and behaviors. To definitively articulate a singular and universally-accepted definition of any particular culture is impossible. However, incorporating cultural patterns in a meaningful and authentic fashion does indeed hold value in informing the enterprise of public health. In order to truly have a relevant understanding of complex cultural features, health professionals must distill such nuances from individuals and communities who actually experience these social realities. CBPR provides such an avenue. Although the term "research" is embedded in the label, this orientation emphasizes participation of community members in every aspect of the public health process, from problem definition to research methods to program evaluation. Sincere efforts to incorporate community input allows health professionals to glean important social and cultural considerations in creating appropriate research protocols and implementing effective programs. Moreover, CBPR also places a heavy emphasis on dismantling structures of oppression and the dynamics of power inequity. To understand all sources of multiple hierarchies with a given cultural, representative community members are able to provide information which reflects the context of time and place. In addition, they are able to glean how these sources of imbalance contribute to health disparities among and within the population.

Many of the challenges—and to a lesser extent, critiques—of engaging in CBPR have been presented in academic literature (Minkler, 2004; Cornwall & Jewkes, 1995; Lovell, 2007). Much of this discussion has revolved around the divergent priorities of the public health enterprise and those of minority communities who exhibit disproportionate indices of poor health. The CBPR orientation often assumes that community members will engage in the process of research and action when provided an equitable influence in problem identification, data collection, interpretation and analysis, ownership of results, and responsibility for action. It also presumes that community inequities, in health and otherwise, are a function of oppressive structures. Based on the purported benefits of community-led health endeavors, those who are mobilized to actively participate in defining and addressing their own health concerns—with the necessary technical assistance, resources, and influence on decision-making—are assumed to want to continue on a sustained trajectory of action. Moreover, this process of empowerment will also allow disadvantaged populations to challenge current and future sources of oppression. Inherent inequity in resources and power are emphasized when community priorities and

normative structures don't align with those of the research and practice agenda, as defined by the field of public health.

These dilemmas were clearly delineated in the tobacco and violence research. Although these two studies didn't, by definition, follow a purely CBPR approach, they shed unique and pivotal insights that have not been commonly discussed in the health literature. Both studies emphasize the crucial relevance of situational identity discussed earlier in this paper. The most pertinent challenge to assumptions of CBPR is the notion that all minority communities—even those at high risk for certain health disparities or social injustices—consider themselves to be victims of structural and institutional oppression. Findings from the violence study indicated that abused South Asians did not often want to seek violence-related services due to their association with other minority populations who don't have the same ascription of heightened value placed on their ethnic community. As a corollary, many community members were hesitant to recognize or support organizations which focused on violence among South Asian populations, largely due to the denial of this issue within the community-at-large and marginalized status of those who supported these "fringe" endeavors. To a lesser extent, the tobacco study confirmed these patterns. The commercial co-optation of culturally-specific tobacco products, coupled with a lack of priority on reducing use, seem to indicate that South Asians don't view related health disparities as a consequence of oppression. In fact, much of the value ascribed to use symbolizes ethnic and cultural pride. Thus, these expressions of social differentiation from more traditionally-demarcated disenfranchised minority populations may be contrary to certain assumptions on which CBPR is founded. More directly, certain communities may be more apt to purposely deny, disregard, or recontextualize health or social concerns as a mechanism to preserve a favorable status and draw a more profound distinction between themselves and more publicly-recognized disadvantaged groups. Thus, embarking on a public health or social justice agenda which aligns priorities among groups with different social positions—and commensurate impressions of those higher or lower in the racial hierarchy—may be difficult given a specific community's ability or willingness to coalesce with dissimilar characteristics. Seemingly, even the most rigorous CBPR-oriented health endeavor may have little ability to change these deeply-rooted community perspectives.

Related to the reported virtues of CBPR, findings from both studies highlight an important yet understudied consideration. Although the term "community" is embedded in the title, CBPR often focuses on communities that are purported to be distinct, well-bounded, monolithic, and integrated (Schwartz, 1981). Although acknowledged that communities share multiple axes of difference and power relations, the success of CBPR nevertheless depends on focusing on a group bounded by at least one common dimension. The expression of situational community identity complicates this notion. Both the tobacco and violence studies illustrate that, when stigmatized behaviors and issues are indeed acknowledged within a socially-constructed variable of commonality, there is an ability to intentionally fragment a given "community" into identity groups that draw boundaries between those that engage in adverse patterns. When ethnic communities, such as South Asians, are able to distinguish themselves by characteristics that separate themselves from "others" that are perceived to be more at-risk or disadvantaged, the ability for a cohesive and consistent "voice" is limited and situational. As such, the application of CBPR among such communities might never be able to truly capture or address health and social inequities which might be better understood through a more distant lens. As CBPR can only depend on community perspectives as articulated by a subset of the population, this orientation will always be subject to the dilemma of the situational expression of

priorities by the innate agendas of community leaders and representatives. Oftentimes, those who are most marginalized and at-risk are hardly represented among these spokespersons (Kaseje et al., 1987; Morley et al., 1983). In fact, by taking an active role in supporting "outsider" groups within the same ethnic population, these individuals may alienate themselves from the community-at-large if they choose to highlight culturally-valued influences on health inequities or criticize the dominant status-quo that confers it a favorable status. In the case of South Asians, the intentional expression of situational identity provides a complicated context for which principles of CBPR may not be adequate to address.

Similar to cultural competence, CBPR and its focus on community participation is almost universally seen as a means to increase the relevance and efficiency of public health initiatives to reduce community disparities. Notwithstanding its noted successes, CBPR is also founded on basic assumptions—often embedded in ideological value—which may not be appropriate nor adequate for improving the health of all minority populations. The presumption of oppression, ability or willingness to define common concerns, and perceived value placed on community engagement or priority on health may not be valid for all communities. Findings from both the tobacco and violence studies illustrate the complexity of community participation with respect to forwarding specific public health priorities. With its own philosophical premises, CBPR may actually be more consistent with its own values in acknowledging its lack of adequacy for different cultural contexts. At the very least, CBPR must be humble in recognizing that its assumptions do not and cannot capture the tremendous complexity of "culture" and that the enterprise of public health will often be in conflict with community prioritization of health equity and social justice. To this end, the inherent value placed on community-based approaches must be critically appraised for universal relevance and, in cases of inadequacy, the role of more appropriate mechanisms must be identified and encouraged.

FUTURE DIRECTIONS AND CONCLUSION

Public health frameworks emphasizing the importance of cultural features and community participation have highly virtuous intentions for addressing and eliminating racial health disparities. More pragmatically, the incorporation of knowledge, values, beliefs, and behaviors specific to culturally-diverse communities—in research design, program planning, and policy interventions—provides a meaningful and necessary mechanism to understand the complex influences which shape differential distributions of health indicators. These nuances may not be wholly identifiable through traditional protocols, which often relegate the role of culturally-diverse community members to study subjects or program recipients. The selected frameworks presented in this paper have achieved considerable success in making public health endeavors more relevant to diverse populations and, in many cases, have mobilized specific communities to engage and take ownership of their own health prospects. Reciprocally, contemporary approaches in public health have developed a keen appreciation for the pivotal roles that cultural and community play in elucidating key determinants of adverse outcomes; this is exemplified by the proliferation of academic curricula, research studies, and practice-based endeavors adopting these frameworks. Although empirical associations between these approaches and improved minority health outcomes remain scarce, researchers and practitioners alike have overwhelmingly recognized their potential to reduce racial and ethnic health disparities (Stevenson, 2007; Betancourt et al., 2005, Castro et al., 2004).

Notably, these frameworks also maintain paradigmatic assumptions which may impede realization of their noble intentions. As part of the larger institution of public health, these conceptualizations often simplify, albeit necessarily, the notion of "culture" and "community" as singular, static entities. Moreover, with the presupposition that structures of oppression and inequity govern the existence of minority health disparities, these frameworks maintain that realization and mobilization around institutional injustices will result in an alignment with the field's overarching objectives. As illustrated in these studies, these assumptions often prove to be reductionistic, or even invalid, for certain communities which don't squarely fit within these models. For instance, the aggregation of South Asians and other subgroups into an artificial racial/ethnic designation diminishes the ability to define the role of culture or community for these populations. In addition, the mythical "model minority" label attenuates the ability of communities falling within this label to realize—willingly, in many cases—the role of oppression in their own health prospects. By extension, the ability to socially differentiate from marginalized populations, including from one's own ethnic group, result in complex and dynamic influences on health not easily resolved by culturally-specific and/or community-based health approaches. Even in light of adverse health impacts, the favorable social position ascribed to South Asians often influence the preservation of normative cultural structures. Thus, it is often the maintenance and expression of cultural attributes and community values themselves which are directly determinant of inequitable health indices in certain populations. Disparities in such communities, therefore, may necessitate an approach which challenge the core of cultural and community realities to improve population health. These dilemmas are not easily resolved, but require a balanced and critical assessment of utility of the universal value of community-oriented or culturally-sensitive to all facets of minority health promotion.

Much attention has been paid to the theoretical and practical processes which may be employed to understand and address racial and ethnic health disparities. However, there is a relative paucity of research examining the impact of the demographic characteristics of health professionals themselves. In an ideal setting, the background of the health researcher or practitioner would have no relationship with the field of public health's commitment and approach to creating conditions which facilitate optimal health for all communities. In reality, the demographic composition of leadership in the health professions, especially among non-clinical professionals, is largely overrepresented by members of the dominant society (Misra et al., 2009; Sullivan Commission, 2004). As a result, divergences in health objectives, cultural considerations, and community priorities remain emphasized, even in the context of progressive public health frameworks. Instead of surmising how to bridge these gaps conceptually, the field of public health might be well served to place more emphasis on developing health professionals from diverse backgrounds who are able to more acutely realize and address contextual overlaps and discrepancies. In the case of South Asians, those born in the United States seem to indicate a more cohesive perspective to address health prospects of the entire community. These individuals may have considerable influence in cultural spheres as well as among dominant institutional structures. As such, mobilizing this subset of the South Asian population, to critically examine and advocate for internal social change, may reap more tangible benefits for health and social equity. Concurrently, second-generation South Asians may also have the ability to navigate dominant structures and exert influence on health-related institutions to ensure that disparities are acknowledged and addressed, if and *especially when* they are not emphasized by communities themselves.

For public health specifically, increased representation in leadership capacities—in research, practice, policy, or other decision-making environments—will enable the creation of targeted strategies which take into account unique social and cultural contexts. Reciprocally, such individuals, by virtue of advanced training, will also understand and be accountable for the disciplinary objectives of public health. In light of anticipated tensions and conflicts, a representative health workforce would be in an ideal position to evaluate and employ strategies which promote public health. In many cases, these approaches may fall outside the prescriptions of culturally-sensitive or community-oriented frameworks. However, lived experiences, as a member of the community whose health prospects are being addressed, may shed pivotal insight into integrated health strategies and help temper extreme ideological applications (be it professional or cultural). Higher representation of understudied population groups in the health professions—such as South Asians[*]—will also ensure that cultural simplification is mitigated and that dynamic community priorities are evaluated relative to the theoretical and practical objectives of the field.

Culturally-appropriate and community-based mechanisms have been of tremendous value in highlighting the complex influences on racial and ethnic health disparities. These frameworks have provided a voice to community members and representation of diverse cultural perspectives within the public health enterprise. Based on their noble intentions, these philosophies have garnered significant accolades within the field of public health, with an emphasis on reducing racial and ethnic health disparities. In undertaking a nuanced assessment of applicability to the South Asian community, this paper sheds light on the appropriateness of universally adopting such approaches among all culturally-diverse populations. As illustrated in findings from two highlighted studies, the definitions of and interactions between "culture" and "community" are highly complex notions which shift over time, place, and social context. This critical commentary is not meant to devalue the important contributions of these approaches. Rather, this analysis calls for an expansion of frameworks which take into account understudied and emergent minority group dynamics, as well as the consideration of alternative mechanisms to improve the health of these populations. Although there is no panacea solution which will address every possible scenario, less ideological and more flexible models of public health might elucidate more context-driven and practical means to understand and address the social determinants of health. An institutional priority on a more representative composition of public health professionals, coupled with active engagement of individuals who can dually navigate culturally-specific environments and dominant structures, would help bridge the disconnect between the field and the populations it serves. As the institution of public health itself is a culture, it must recognize that it has its own "community" values and, as such, be humble to acknowledging that its priorities may indeed be a form of oppression in the rigid application of any given paradigm.

[*]A superficial assessment of the composition of South Asians in the health professions may indicate that this population is overrepresented. In reality, South Asians—Asian Indians and Pakistanis, in particular—are indeed overrepresented in the *medical* profession (A.A.P.I., 2007, Castillo-Page, 2006). However, all Asian subgroups, including South Asians, are largely underrepresented in the public health workforce, such as among community health workers and health service researchers (Trinh-Shervin et al., 2009).

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Chapter 5

Conclusion

DISSERTATION PURPOSE AND CONTEXT

The overarching objective of this dissertation has been to: 1) examine multilevel (e.g., social, cultural, organizational, behavioral) influences on understanding and addressing disparities of tobacco-related disease and violence among South Asians in the United States; 2) elucidate considerations for conducting health disparities research and/or implementing targeted intervention strategies among South Asian American communities; and 3) assess the ability of culturally-oriented and/or community-based minority health frameworks to adequately identify and impact the health and well-being of South Asian populations in the United States.

In order to place it in context of the field of public health—and minority health, in particular—this dissertation describes issues related to identity and categorization among South Asians in the United States, perceived social position among a racialized hierarchy, and impacts of dynamic cultural features on health disparities among this minority population. As South Asians are usually aggregated within a larger Asian demographic category, disproportionate indices of health among this community are largely unexamined. In addition, the mythical "model minority" label ascribed to South Asians often deems this population unworthy of attention from public health professionals, as they are assumed to have resources and control over their own health prospects. From the relatively scant information available about specific disparities, most research focuses on biological etiology or examines social and behavioral determinants based on "Western" concepts and constructs. Research modalities—especially surveillance systems—often fail to take into account cultural contexts of knowledge and behavior pivotal to measuring the entirety of determinants on minority health disparities (Michaud et al., 2001; Greene & Watkins, 1998). Health programs and practices targeting minority populations often aim for fidelity to "evidence-based" approaches—deemed to be effective in the mainstream or other diverse communities—without critically examining the cultural applicability of intervention assumptions, processes, or outcomes (Bent-Goodley, 2007). Contemporary frameworks guiding minority health research and practice maintain inherent ideological assumptions and biases which impact universal applicability; this is despite their well-intentioned commitment to incorporate cultural attributes and community participation in all aspects of the public health enterprise (Johnson & Munch, 2009; Paasche-Orlow, 2004; Cornwall & Jewkes, 1995).

With these contextual considerations in mind, this dissertation uses two defined disparities to examine issues pertaining to public health research and practice, respectively, among the South Asian community in the United States. Meta-synthesis of findings from both studies is used to critically assess culturally-oriented and community-based frameworks for relevance and applicability to the South Asian population in the United States. In the form of three papers, this dissertation underscores the necessity of a revisioning of public health paradigms to ensure an inclusive approach to eliminating racial and ethnic health disparities.

SUMMARY OF DISSERTATION STUDIES

Details about the rationale, methods, and findings from the three aforementioned studies can be found in the earlier chapters of this dissertation. However, pertinent aspects of each are summarized in this section.

This purpose of the first study in this dissertation has been to highlight unique aspects of conducting behavioral survey research among South Asians. In order to do so, this study utilizes qualitative methods to explore the cultural context of tobacco behavior within this population. Focus groups—separated by gender, generational status, and length of time in the United States—were conducted in three ethnic enclaves comprised of distinct compositions of South Asians. Findings from this research indicate that there are culturally-specific patterns of use related to product type, modes of ingestion, and units of dosage. In addition, this study also found unique behavioral determinants related to level of knowledge and perception of risks/benefits associated with use. Most importantly, the differential use of tobacco products specific to South Asia are largely tied to cultural contexts, such as identity formation and preservation, expression of tradition and celebration, and socialization with community members. Content analyses were used to create a South Asian Tobacco (SAT) Module, designed to supplement the Adult Tobacco Survey validated by the Centers for Disease Control and Prevention (CDC). Focus groups were also utilized to perform cognitive testing of survey prompts which, triangulated with relevant input from other instruments, were refined to create the final version of the SAT Module. A key methodological finding was that "top-down" approaches to survey adaptation are not conducive to creating an instrument which accurately capture unique social and cultural contexts related to behavior. In the case of tobacco use, formative research generated contextual information which was used to create culturally-relevant constructs and measures.

The second dissertation study aimed to investigate the formulation of an organization response to violence among South Asian Americans. To accomplish this objective, this study utilizes qualitative methods to examine how anti-violence organizations focusing exclusively or predominantly on South Asians in the United States (SAVOs) define their issues of concern and philosophical orientation, design their programmatic strategies and activities, and devise criteria for evaluating success. Key informants consist of organizational leaders representing a diverse and large (60 percent) segment of SAVOs across the United States. The study found that within specific organizations, there were considerable intra-organizational similarities and differences. Similarities were found among: (a) impetus for organizational formation; (b) organizational aims and rationale; (c) culturally-specific manifestations of violence; and (d) scope of services offered by the organization. Domains of analysis with significant divergences include (a) defining "the issue" (and its causes) that organizations addressed; (b) organizational philosophy and impacts on interactions with clients; and (c) defining and measuring success. In addition, intra-organizational inconsistencies were found with respect to problem definition, governing philosophy and values, strategies employed, and impact assessment. In the absence of "evidence-based" prescriptions, this study elucidates key processes in how organizations addressing stigmatized issues evolve, function, and evaluate themselves with respect to addressing their chosen issue. Moreover, in the case of specific forms of abuse, this study also illustrates how ethnic communities may not identify or acknowledge—perhaps purposely—certain cultural attributes that should elicit a cause for concern.

The purpose of the final dissertation study has been to critically examine contemporary public health frameworks in light of common themes generated from the previous two studies. As this dissertation focuses on addressing South Asian health disparities, three highly-lauded frameworks are selected for analysis: "cultural adaptation", "cultural competence", and "community-based participatory research". The principles and assumptions of each are presented, including their purported impact on understanding and impacting racial and ethnic health disparities. Based on relevant findings from the tobacco and violence studies, these frameworks are assessed for adequacy in addressing South Asian health concerns. The analysis found that many of the core assumptions and objectives governing these frameworks are inappropriate to effect disparities impacting the South Asian population. Pertinent conclusions from the meta-synthesis process include (a) communities don't necessarily identify social problems having adverse impacts on health, despite potentially having knowledge of their existence; (b) expression of situational identity among ethnic communities confounds ability to define issues of "common" concern; (c) communities who are ascribed a privileged status may internalize this attribution and, as a consequence, be wary of inviting shame or stigma upon themselves; (d) acknowledgement and respect for cultural attributes don't necessarily align with pursuit of community health and well-being; (e) preservation of cultural norms and values are not necessarily reflective of current patterns exhibited in the region of origin. These findings have significant implications for the applicability of culturally-oriented and community-based frameworks in identifying and addressing disparities among the South Asian population in the United States. The complexity of ethnic identity maintenance, coupled with a "model minority" characterization, may result in conflicts with the ideological assumptions held by contemporary minority health frameworks.

RELEVANCE TO SOUTH ASIAN HEALTH

Findings from the qualitative studies elucidate unique considerations in health surveillance and intervention design targeting tobacco-related disease and stigmatized conditions among South Asians. These aspects may also be extrapolated to other preventable diseases and/or stigmatized conditions among the South Asian community.

For instance, there is a significant cultural value ascribed to South Asian dietary patterns which may preclude risks imparted to disparities in cardiovascular disease and diabetes (Rankin & Bhopal, 2001). Validated surveillance systems may inadequate to accurately assess risks associated with dietary quality, frequency and timing, and other behavioral aspects. Similar corollaries may be relevant for alcohol use, physical activity, and sexual behavior (Morjaria & Orford, 2002; Sriskantharajah & Kai, 2007; Fisher et al., 2003). It is imperative that modalities of health research accurately capture cultural contexts of behaviors in order to generate accurate estimations and delineate potential areas of intervention, be it at the individual, community, or policy level.

In terms of stigmatized conditions, South Asians exhibit a propensity to deny the existence of issues relating to mental illness, reproductive health, and substance abuse, among others (Burr, 2002; Trollope-Kumar, 2001; Bhattacharya, 2002). For purposes of program planning, this lack of acknowledgement may have considerable impacts on the design of targeted intervention strategies. Moreover, the potential conflict between cultural belief systems and conventional approaches in addressing stigmatized conditions may have significant consequences for effective practice-based approaches. In the absence of "evidence-based"

frameworks, health professionals must be able to design and execute intervention strategies which take into account cultural patterns not readily identified by community members. Organizations must also ensure that their missions, governing philosophies, program plans, and evaluative criteria are consistent with each other and with respect to impacting the issue of concern. For collaborative endeavors, participating organizations must also examine the degree of institutional alignment to avoid false assumptions and maximize the efficacy of mutual activities and common agenda building.

For emerging disparities among the South Asian communities, prescribed minority health frameworks must be revisioned or expanded to ensure that unique cultural contexts are acknowledged and addressed. Although ideological premises may have well-intentioned objectives, the practical utility of value-laden models is only as efficacious as the magnitude of impact on *all* racial and ethnic populations. As such, contemporary and future paradigms must take into account the existence of minority groups that don't categorically fit within an oppression-oriented social hierarchy. In order to truly impact health disparities among South Asian populations, it is pivotal that minority health frameworks posit mechanisms to address the unique cultural contexts and structural barriers influencing community health disparities. To do this successful, the field of minority health must not only address the conceptual presumptions and processes related to impacting health inequities, but also characteristics of professionals and organizations best-suited to understand and address social determinants of adverse indicators and outcomes. Assuming that the background and experience of the change agent is irrelevant is an utopian premise and is largely divorced from the realities of integrating community and professional priorities.

BROADER IMPLICATIONS FOR MINORITY HEALTH

The conclusions generated by this dissertation are not relevant solely for South Asian communities. As stated repeatedly, the aggregation of Asians into one superficial "variable" masks significant disparities in health and social prospects of each distinct subgroup. As such, other Asian populations may be subject to the consequences of the "model minority" fallacy and undergo the same processes of identity formation and maintaining differentiation from both the dominant society and traditionally-demarcated disenfranchised populations. The assumption that all minority groups are monolithically juxtaposed against the privileged mainstream group is a false notion. In order for *all* racial and ethnic groups to pursue optimal health, the expansion and revision of frameworks need to take into account populations that don't fall within the lowest rung of social position. Although idealistic in denial, tension between minority populations is rampant and has had significant consequences for health parity and pursuit of socially just conditions among affected populations.

As the United States becomes increasingly diverse, small and understudied populations will continue to grow in number and size. For instance, communities identified as Middle Eastern have yet to be classified within currently existing racial and ethnic categorizations. Nevertheless, these also maintain unique cultural features and social positions in the United States. Other small populations, such as Pacific Islanders and Native Americans, have been recognized as distinct cultural communities, but the health and well-being of these groups are often subject to the same issues highlighted in this dissertation. In order to address health prospects of existing and emerging understudied populations, the considerations and recommendations proposed in this dissertation may have high relevance and practical utility. If

the field of public health is to adequately reduce disparities and improve health outcomes among *all* populations, research and practice modalities must take into account the unique cultural contexts and social realities governing determinants of community health. In the absence of context-driven models, the field of public health is subject to the same criticisms that it places upon the status quo. As arguably one of the most important fields emphasizing equity and justice for all, the field must be humble to recognizing its own biases and ensuring that these presumptions are adequately addressed in light of the tremendous cultural diversity that currently exists and will continue to permeate the social fabric in the United States.

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Appendices

APPENDIX A: ADULT TOBACCO SURVEY
CENTERS FOR DISEASE CONTROL & PREVENTION (C.D.C.)

Appendix A contains the most current public Adult Tobacco Survey published and validated by the Centers for Disease Control & Prevention. As with other minority-oriented Adult Tobacco Surveys, the C.D.C.'s instrument was used as the foundational basis for the sectional and phrasing structures utilized in the South Asian Tobacco Module.

APPENDIX B: SOUTH ASIAN TOBACCO (S.A.T.) MODULE, version 2.0

Appendix B contains the most current version of the S.A.T. Module, formulated by input from community members representing diverse segments of the South Asian population in the United States. Although the C.D.C.'s Adult Tobacco Survey was referenced for structure, the substantive components of the S.A.T. Module are based on content analyses of qualitative data generated in this dissertation's tobacco study (Chapter 2). In addition, S.A.T. Module survey prompts were cognitively tested by community members for clarity and cultural-appropriateness. This instrument has purposely not been integrated in the C.D.C's Adult Tobacco Survey as the C.D.C. is currently adopting a new national surveillance system for tobacco surveillance. As such, if the National Adult Tobacco Survey is unavailable for the foreseeable future, this S.A.T. is currently ready for formal pilot testing and subsequent implementation in the field.

APPENDIX A

ADULT TOBACCO SURVEY; CENTERS FOR DISEASE CONTROL & PREVENTION

Recommended Adult Tobacco Survey Questions, Version 1.3

June 5, 2003

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Approximate Length:

Screener: 17 items

Recommended for all states:

49 items (CURRENT SMOKERS);

39 items (NEVER SMOKERS)

Recommended for specific pursposes:

118 potential questions (CURRENT SMOKERS)

64 potential questions (NEVER SMOKERS)

QUESTIONS RECOMMENDED FOR ALL STATES

SCREENER

S1. HELLO, My name is ____(name)____.

I'm calling for the _(health department)_.

We're gathering information on the health of _____(state)_____ residents.

Your phone number has been chosen randomly, and I'd like to ask some questions about health and tobacco.

S1a. Do not read:

Completed introduction.

1. Yes → **Skip to S2**
2. No

S1b. Do not read:

Number of sentences completed in introduction (0-3).

0-3. → **Assign disposition code**
7. Don't know/Not sure

S2. Is this _(phone number)_?

Do not read:
1. Yes
2. No (**Read**: Thank you very much, but I seem to have dialed the wrong number. It's possible that your number may be called at a later time.) → **Assign disposition code**
7. Don't know/Not sure (Ask to speak to someone else)
9. Refused (Including hang-up)

S3. Is this a private residence?

Do not read:
1. Yes
2. No (**Read**: Thank you very much, but we are only interviewing private residences.) → **Assign disposition code**
7. Don't know/Not sure (Ask to speak to someone else)
9. Refused (Including hang-up)

S4. I need to randomly select one adult who lives in your household to be interviewed. How many members of your household, including yourself, are 18 years of age or older?

Do not read:
1-76. Number of adults **If >1 → Skip to S9**
77. Don't know/Not sure (Ask to speak to someone else)
99. Refused (Including hang-up) → **Assign disposition code**

S5. Are you the adult?

Do not read:
1. Yes (**Read**: Then you are the person I need to speak with.)
2. No. → **Skip to S7**
7. Don't know/Not sure (Ask to speak to someone else)
9. Refused (Including hang-up) → **Assign disposition code**

S6. Are you male or female? (Ask only if necessary)

Do not read:
1. Male → **Skip to S14 [CATI programmer: Enter 1 for S9 and 0 for S10]**
2. Female → **Skip to S14 [CATI programmer: Enter 0 for S9 and 1 for S10]**
7. Don't know/Not sure → **Assign disposition code**
9. Refused (Including hang-up) → **Assign disposition code**

S7. Is the adult a man or a woman?

Do not read:
1. A man **[CATI programmer: Enter 1 for S9 and 0 for S10]**
2. A woman **[CATI programmer: Enter 0 for S9 and 1 for S10]**
7. Don't know/Not sure (Ask to speak to someone else)
9. Refused (Including hang-up) → **Assign disposition code**

S8. May I speak with **[**fill in **him/her** from previous question**]**?

Do not read:
1. Yes → **Skip to S13**
2. No (Try to schedule an appointment)
7. Don't know/Not sure (Ask to speak to someone else)
9. Refused (Including hang-up) → **Assign disposition code**

S9. How many of these adults are men?

Do not read:
1-76. Number of men
77. Don't know/Not sure (Ask to speak to someone else)
99. Refused (Including hang-up) → **Assign disposition code**

S10. How many are women?

Do not read:
1-76. Number of women
77. Don't know/Not sure (Ask to speak to someone else)
99. Refused (Including hang-up) → **Assign disposition code**

S11. The person in your household that I need to speak with is the (State age rank and gender of selected respondent) .

[CATI Programmer: Enter code for selected respondent.]
101. Oldest male
102. Second oldest male
103. Third oldest male
…
199. Ninety-ninth oldest male

201. Oldest female
202. Second oldest female
203. Third oldest female
…
299. Ninety-ninth oldest female

S12. **(Do not read.)** Is the selected respondent on the phone?

1. Yes (**Read**: Then you are the person I need to speak with) → **Skip to S14**)
2. No.
7. Don't know/Not sure (Ask to speak to someone else)
9. Refused (Including hang-up) → **Assign disposition code**

S13. . HELLO, My name is ____(name)____.

I'm calling for the _(health department)_.

We're gathering information on the health of _____(state)_____ residents.

Your phone number has been chosen randomly, and I'd like to ask some questions about health and tobacco.

S13a. Do not read:

Completed introduction.

1. Yes → **Skip to S14**
2. No

S13b. Do not read:

Number of sentences completed in introduction (0-3).

0-3. Yes → **Assign disposition code**
7. Don't know/Not sure → **Assign disposition code**

Confidentiality statement: S14. I won't ask for your name, address, or other personal information that can identify you.

You don't have to answer any question you don't want to, and you can end the interview at any time.

The interview takes only about ___ minutes and any information you give me will be confidential.

If you have any questions about this survey, I will provide a telephone number for you to call to get more information.

S14a. Do not read:

Completed confidentiality statement.

1. Yes → **Skip to Q1**
2. No → **Assign disposition code**

S14b. Do not read:

Number of sentences completed in confidentiality statement.(0-3).

0-3. Yes → **Assign disposition code**
7. Don't know/Not sure → **Assign disposition code**

SECTION 1: GENERAL HEALTH

1. Would you say that in general your health is:

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS; State ATS]

Utility: This item provides an easy opening to the survey and can prove a useful covariate in analysis. This is a Healthy People 2010 overarching quality of life measure.

SECTION 2: TOBACCO USE

2. Have you smoked at least 100 cigarettes in your entire life?

1. Yes
2. No → **Skip to Q14**

Do not read these responses

7. Don't know/Not sure → **Skip to Q14**
9. Refused → **Skip to Q14**

[BRFSS; State ATS]

Utility: Used in conjunction with Q3, this is a standard question used to assess smoking status (current smoker, former smoker, never smoker). In order to define what proportion of smokers have quit it is necessary to define established smokers. An established smoker is defined as a person who has smoked 100 cigarettes or more.

3. Do you now smoke cigarettes everyday, some days, or not at all?

1. Everyday
2. Some days → **Skip to Q5**
3. Not at all → **Skip to Q8**

Do not read this response

9. Refused → **Skip to Q14**

[BRFSS; State ATS]

Utility: This is the standard question to assess smoking status. As progress towards cessation occurs, smokers may shift from every day to some day smoking. Shifts in the proportion of smokers who are someday smokers may be an indicator of program effect. Reducing tobacco use by adults is a Healthy People 2010 objective.

4. On the average, about how many cigarettes a day do you now smoke?

1-180 Number of cigarettes → **Skip to Q7**
(Note to interviewer: 1 pack=20 cigarettes. Verify 61 or more cigarettes.)
666 Less than one cigarette a day → **Skip to Q7**

Do not read these responses

777 Don't know/Not sure → **Skip to Q7**
999 Refused →**Skip to Q7**

[BRFSS, State ATS]

Utility: Questions 4-6 provide the information needed to calculate consumption. Changes in consumption are often detectable before changes in smoking prevalence. In addition, the number of cigarettes smoked per day, together with question 7, provides an indicator of level of addiction to nicotine.

5. During the past 30 days, on how many days did you smoke cigarettes?

0-30. Number of Days
[If Q5 = 0 →**Skip to Q7]**

Do not read these responses

77. Don't know/Not sure → **Skip to Q7**
99. Refused → **Skip to Q7**

[YTS, State ATS]

Utility: Questions 4-6 provide the information needed to calculate consumption. Changes in consumption are often detectable before changes in smoking prevalence.

6. On the average, on days when you smoked during the past 30 days, about how many cigarettes did you smoke a day?

1-180. Number of cigarettes____
(Note to interviewer: 1 pack=20 cigarettes. Verify 61 or more cigarettes.)
666. Less than one cigarette a day

Do not read these responses

777. Don't know/Not sure
999. Refused

[BRFSS; State ATS]

Utility: Questions 4-6 provide the information needed to calculate consumption. Changes in consumption are often detectable before changes in smoking prevalence.

7. How soon after you wake up do you have your first cigarette?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: This question provides an indicator of addiction to nicotine when used with Q4.

Ask if FORMER SMOKER [Core Q2 = 1 "yes" and Q3 = "Not at all"]

8. About how long has it been since you last smoked cigarettes regularly?

1. Within the past month (≤ 1 month ago)
2. Within the past 3 months (>1 month but ≤ 3 months ago)
3. Within the past 6 months (>3 months but ≤ 6 months ago)
4. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)

[If Q8 = 1 - 5: Skip to Q10]

6. Within the past 10 years (>5 years but ≤ 10 years ago)
7. Over 10 years ago

77. Don't know/Not sure
99. Refused

[If Q8 = 6 -99: Skip to Q14]

Do not read these responses

[BRFSS]

Utility: This question provides the information needed to assign relative risk to estimate smoking attributable morbidity and mortality.

SECTION 3: CESSATION

QUIT ATTEMPTS

Ask Q9 – Q11 of CURRENT SMOKERS [Q3 = 1 "Every day" or 2 "Some days"]

9. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

1. Yes
2. No → **Skip to Q12**

Do not read these responses

7. Don't know/Not sure → **Skip to Q12**
9. Refused → **Skip to Q12**

[BRFSS]

Utility: Most smokers make several quit attempts before successfully quitting. An increase in the number of people who have stopped smoking for one day or longer in the past year may be an indicator of program effect. In addition, this question identifies persons who have tried to quit, who may be an important group to characterize and target with cessation activities. Increased smoking cessation attempts is a Healthy People 2010 objective.

METHODS OF QUITTING

Ask Q10 - Q11 of:
(1) CURRENT SMOKERS who made a quit attempt in the past year (Q9 = 1 "yes") or
(2) FORMER SMOKERS who quit in last 5 years (Q8 = 1 - 5)

10. [**FORMER SMOKERS**:] When you quit smoking…
[**CURRENT SMOKERS**:] The last time you tried to quit smoking,

did you use the nicotine patch, nicotine gum, or any other medication to help you quit?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

11. [**FORMER SMOKERS**:]: When you quit smoking …
[**CURRENT SMOKERS**:] The last time you tried to quit smoking,

did you use any other assistance such as classes or counseling?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: Even though the number of effective pharmacotherapies available has increased, most people continue to try to quit without assistance. It is important to monitor whether use of these products, or of other types of assistance is changing over time.

Comment: For those who would like more detail on methods used, these questions can be used as screeners and follow up questions can be added (see optional section 3). It is important to note, however, that the number of persons reporting the use of any particular modality will be small, making changes over time difficult to detect.

STAGES OF CHANGE FOR QUITTING

Ask Q12 – Q13 of CURRENT SMOKERS only

12. Are you seriously considering stopping smoking within the next six months?

1. Yes
2. No → **Skip to Q14**

Do not read these responses

7. Don't know/Not sure → **Skip to Q14**
9. Refused → **Skip to Q14**

[2003 CPS, State ATS]

13. Are you planning to stop smoking within the next 30 days?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[CPS; State ATS]

Utility: Questions 9, 12 and 13 can be combined to determine the readiness for change (i.e., stage of change) for current smokers. This can be valuable for detecting population level changes that precede cessation over time:

- ***Precontemplation stage**: Smokers who are not considering stopping smoking in the next 6 months (Q12="no").*
- ***Contemplation stage**: Smokers who are seriously considering quitting in the next 6 months (Q12="yes").*
- ***Preparation stage:** Smokers who plan to quit in the next 30 days and have had a quit attempt in the past 12 months (if they did not have a quit attempt they are in the contemplation stage) (Q12="yes", Q13="yes", Q9="yes").*

PHYSICIAN AND HEALTH PROFESSIONAL ADVICE

Ask Q14 of all respondents

14. In the past 12 months, have you seen a doctor, nurse, or other health professional to get any kind of care for yourself?

1. Yes
2. No → **Skip to Q18**

Do not read these responses

7. Don't know/Not sure → **Skip to Q18**
9. Refused → **Skip to Q18**

[BFRSS]

Utility: This question establishes the denominator for subsequent questions.

Comment: Other providers, including nurses, dentists, and other health care professionals, may play a role in cessation. If programs target these health professionals or organizations that are associated with these health professionals, then additional similar questions can be added for specific professionals.

Ask Q 15 of current smokers [Q3="every day" or "some days"] who had seen a health professional in the past 12 months [Q14=1]

15. During the past 12 months, did any doctor, nurse, or other health professional advise you to not smoke?

1. Yes → **Skip to Q17**
2. No

Do not read these responses

7. Don't know → **Skip to Q18**
9. Refused → **Skip to Q18**

[BRFSS; State ATS]

Utility: This series of questions provides a means of evaluating the implementation of the Clinical Practice Guidelines (AHRQ).

Ask Q16 {of never smokers [Q2=2], of former smokers [Q3=3], of smokers who were not advised to quit [Q15=2], and of respondents with unknown smoking status [Q2=7,9 or Q3=9]} who had seen a health professional in the past 12 months [Q14=1]

16. During the past 12 months, did any doctor, nurse, or other health professional ask if you smoke?

1. Yes → **Skip to Q18**
2. No → **Skip to Q 18**

Do not read these responses

7. Don't know/Not sure → **Skip to Q18**
9. Refused → **Skip to Q18**

Utility: This series of questions provides a means of evaluating the implementation of the Clinical Practice Guidelines (AHRQ).

17. In the past 12 months, when a doctor, nurse, or other health professional advised you to quit smoking, did they also do any of the following?
[CPS]

17a. READ**:**

Prescribe or recommend a patch, nicotine gum, nasal spray, an inhaler, or pills such as Zyban?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[CPS]

17b. READ**:**

Suggest that you set a specific date to stop smoking?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[CPS]

17c. READ:

Suggest that you use a smoking cessation class, program, quit line, or counseling?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[CPS]

17d. READ:

Provide you with booklets, videos, or other materials to help you quit smoking on your own?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[CPS]

Utility: This question provides a means of evaluating the implementation of the Clinical Practice Guidelines (AHRQ).

SECTION 4: SECOND-HAND SMOKE

Ask if number of adults in household (screener) >1

18. Not including yourself, how many of the adults who live in your household smoke cigarettes, cigars or pipes?

0-76. Number of adults

77 Don't know/Not sure
99 Refused

Utility: This information is used to interpret information about home rules and home exposure.

19. During the past 7 days, that is since [DATEFILL}, on how many days did anyone smoke cigarettes, cigars, or pipes anywhere inside your home?

0-7. Number of days

77. Don't know/Not sure
99. Refused

[modified NHIS]

Utility: This question measures whether there was exposure to environmental tobacco smoke at home in the last week Information on exposure complements information about rules in the home (next question). Rules may not be fully implemented or followed, and people may not always accurately report rules. Reducing the proportion of nonsmokers exposed to environmental tobacco smoke is a Healthy People 2010 objective.

20. Which statement best describes the rules about smoking inside your home? Do not include decks, garages, or porches.

READ:
1. Smoking is not allowed anywhere inside your home
2. Smoking is allowed in some places or at some times
3. Smoking is allowed anywhere inside the home

Do not read these responses

7. Don't know/Not sure
9. Refused

[modified BFRSS]

Utility: Rules in the home provide information about whether the home is a supportive environment for preventing initiation among co-inhabitants, quitting smoking, and eliminating environmental tobacco smoke exposure. Changes in rules in the home may lead to increased cessation attempts and permanently quitting. Changes in rules may also reflect shifting social norms.

WORKPLACE POLICY AND EXPOSURE

I am now going to ask you about some questions about workplace policies on smoking.

21. My first question is about your employment status. I am going to read a l of alternatives to you. Please choose the first that applies. Are you currently…

1. A student **and** employed for wages part-time or full-time?
2. A student? → **Skip to Q26**
3. Employed for wages part-time or full-time?
4. Self-employed?
5. Out of work for more than 1 year? → **Skip to Q26**
6. Out of work for less than 1 year? → **Skip to Q26**
7. A homemaker? → **Skip to Q26**
8. Retired?, or → **Skip to Q26**
9. Unable to work? → **Skip to Q26**

Do not read these responses

77. Don't know → **Skip to Q26**
99. Refused → **Skip to Q26**

[BRFSS]

Utility: This question is needed to determine the denominator for the following questio about workplace policies.

22. While working at your job, are you indoors most of the time?

1. Yes
2. No → **Skip to Q26**

Do not read these responses

7. Don't know/Not sure → **Skip to Q26**
9. Refused → **Skip to Q26**

[BRFSS; State ATS]

Utility: The purpose of this question is to determine who should be asked the following questions about workplace policies.

23. As far as you know, in the past seven days, that is since [DATE FILL],

has anyone smoked in your work area?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[modified NHIS]

Utility: Smoke free workplaces reduce exposure to ETS, and have also been shown to decrease consumption among smokers. This item assesses actual exposure in the workplace. Information on exposure complements information about workplace policies because policies may not be fully implemented or enforced and persons may not always accurately report policy.

24. Which of the following best describes your place of work's official smoking policy for work areas?

1. Not allowed in any work areas
2. Allowed in some work areas
3. Allowed in all work areas or

or

4. No official policy

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS; State ATS]

Utility: Smoke free workplaces reduce exposure to ETS, and have also been shown to decrease consumption among smokers. In addition, increases in smoke free workplaces reflect changes in social norms.

Comment: Smoke free workplaces are those where smoking is not allowed in any common areas or in any work areas, or is allowed only in enclosed, separately ventilated areas.

25. Which of the following best describes your place of work's official smoking policy for indoor public or common areas, such as lobbies, rest rooms, and lunchrooms?

READ:

1. Not allowed in any public areas
2. Allowed in some public areas
3. Allowed in all public areas

or

4. No official policy

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

26. In indoor work areas, do you think smoking should be allowed in all areas, some areas or not at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: This question provides information on the level of support for smoke free indoor work areas that may be useful for businesses, unions, or other groups seeking to prohibit smoking indoors.

EXPOSURE IN A CAR

27. In the past seven days, that is since [DATE FILL], have you been in a car with someone who was smoking?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: After the home, the car is another environment in which exposure to second hand smoke can be limited by rules, and increases in the prevalence of such rules reflect changes in social norms.

ATTITUDES ABOUT CLEAN INDOOR AIR RULES

28. In the indoor dining area of restaurants, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Clean indoor air rules in restaurants reinforce the social norm that smoking is not permitted. Public support for this type of restriction can be used to support the adoption of voluntary policies.

29. In indoor shopping malls, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Clean indoor air rules in restaurants reinforce the social norm that smoking is not permitted. Public support for this type of restriction can be used to support the adoption of voluntary policies.

SECTION 5: RISK PERCEPTION AND SOCIAL INFLUENCES

RISK PERCEPTION

Ask all respondents

I am going to read a statement. I want you to tell me whether you strongly agree, agree, disagree, or strongly disagree with this statement.

30. If a person has smoked a pack of cigarettes a day for more than 20 years, there is little health benefit to quitting smoking.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

[1993 COMMIT EVALUATION SURVEY]

Utility: Recognition of the health benefits of cessation may be an important determinant of quit attempts, and an early indicator of the effects of health education efforts.

Now I am going to ask about smoke from other people's cigarettes.

31. Do you think that breathing smoke from other people's cigarettes is:
READ 1-4

1. Very harmful to one's health
2. Somewhat harmful to one's health
3. Not very harmful to one's health
4. Not harmful at all to one's health

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: The perception that environmental tobacco smoke is harmful can be an important factor for gauging public support for tobacco control efforts. This question also can be an indicator of the effects of ETS education efforts.

32. Would you say that breathing smoke from other people's cigarettes causes:

RANDOMIZE ORDER:

(**CATI Programmer**: The order in which Q32a – Q32e are asked should be randomized for each respondent. The specific order in which these questions are asked to each respondent should be recorded in columns 310-314 of the data file, as noted in the accompanying data layout.)

[1987 NHIS]

32a.

Lung cancer in adults

1. Yes
2. No

Do not read these responses

7. Don’t know/Not sure
9. Refused

[1987 NHIS]

32b.

Heart disease in adults

1. Yes
2. No

Do not read these responses

7. Don’t know/Not sure
9. Refused

[1987 NHIS]

32c.

Colon cancer in adults

1. Yes
2. No

Do not read these responses

7. Don’t know/Not sure
9. Refused

[1987 NHIS]

32d.

Respiratory problems in children

1. Yes
2. No

Do not read these responses

7. Don’t know/Not sure
9. Refused

[1987 NHIS]

32e.

Sudden infant death syndrome

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[1987 NHIS]

Utility: The perception that environmental tobacco smoke is harmful can be an important factor for gauging public support for tobacco control. These items can gauge the level of public understanding of the effects of ETS. Colon cancer was included in this series as an indicator for "over-reporting" in order to estimate the possible magnitude of overreporting.

SECTION 6: DEMOGRAPHIC ITEMS

33. What is your age?

18-99. Age in years (99=99+)

Do not read these responses

7. Don't know/Not sure
9. Refused

34a. How many children aged 17 or younger live in your household?

0-15 Number of children (15=15+)

9 Refused

34b. What are the ages of the children from oldest to youngest?

34b.1.

101-136	Age of oldest child in months
201-217	Age of oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.2.

101-136	Age of second oldest child in months
201-217	Age of second oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.3.

101-136	Age of third oldest child in months
201-217	Age of third oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.4.

101-136	Age of fourth oldest child in months
201-217	Age of fourth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.5.

101-136	Age of fifth oldest child in months
201-217	Age of fifth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.6.

101-136	Age of sixth oldest child in months
201-217	Age of sixth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.7.

101-136	Age of seventh oldest child in months
201-217	Age of seventh oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.8.

101-136	Age of eighth oldest child in months
201-217	Age of eighth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.9.

101-136	Age of ninth oldest child in months
201-217	Age of ninth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.10.

101-136	Age of tenth oldest child in months
201-217	Age of tenth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**..

34b.11.

101-136	Age of eleventh oldest child in months
201-217	Age of eleventh oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.12.

101-136	Age of twelfth oldest child in months
201-217	Age of twelfth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.13.

101-136	Age of thirteenth oldest child in months
201-217	Age of thirteenth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.14.

101-136	Age of fourteenth oldest child in months
201-217	Age of fourteenth oldest child in years
777	Don't know/Not sure
999	Refused

If no more children, then → **Skip to Q35**.

34b.15.

101-136	Age of fifteenth oldest child in months
201-217	Age of fifteenth oldest child in years
777	Don't know/Not sure
999	Refused

Utility: This variable can be used to estimate the number of children in specific age groups who live with a smoker

35. Are you Hispanic or Latino?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

36. Which one or more of the following would you say is your race?

READ:

Mark all **that apply**

1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Other Pacific Islander
5. American Indian, Alaska Native

or

6. Other **[specify:]** _____

Do not read these responses

7. Don't know/Not sure
9. Refused

If more than one response to Q36, (or Q36 = 6, 7, or 9) continue to Q37. Otherwise, Skip to Q38.

37. Which one of these groups would you say **best** represents your race?

READ:

1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Other Pacific Islander
5. American Indian, Alaska Native
   or
6. Other **[specify:] _____**

Do not read these responses

7. Don't know/Not sure
9. Refused

38. Are you:

READ:

1. Married
2. Divorced
3. Widowed
4. Separated
5. Never married or
6. A member of an unmarried couple

Do not read this response

9. Refused

39. What is the highest level of school you completed or the highest degree you received?

Read Only if Necessary

1. Never attended school or only attended kindergarten
2. Grades 1 through 8 (Elementary)
3. Grades 9 through 11 (Some high school)
4. Grade 12 (High school graduate)
5. GED
6. Some College, no degree
7. AA, Technical/vocational
8. AA, Academic
9. BA,BS (college graduate)
10. Some graduate or professional school
11. Graduate or professional degree

Do not read these responses

77 Don't know
99 Refused

[modified NHIS]

Comment: This education question provides more detail than the equivalent BRFSS question. Combining answer options 5-7 creates the BRFSS category "College 1 year to 3 years (some college or technical school)" but allows for looking separately at these groups, if desired. Similarly, combining answer options 3 and 4 creates the BRFSS category "grade 12 or GED (High school graduate)"

40. Is your annual household income from all sources:

READ AS APPROPRIATE

0 4	Less than $25,000 ($20,000 to less than $25,000)	**If "no," ask 05; if "yes," ask 03**
0 3	Less than $20,000 ($15,000 to less than $20,000)	**If "no," code 04; if "yes," ask 02**
0 2	Less than $15,000 ($10,000 to less than $15,000)	**If "no," code 03; if "yes," ask 01**
0 1	Less than $10,000	**If "no," code 02**
0 5	Less than $35,000 ($25,000 to less than $35,000)	**If "no," ask 06**
0 6	Less than $50,000 ($35,000 to less than $50,000)	**If "no," ask 07**
0 7	Less than $75,000 ($50,000 to less than $75,000)	**If "no," code 08**
0 8	$75,000 or more	
Do not read these responses		
7 7	Don't know/Not sure	
9 9	Refused	

41. Indicate gender of respondent. **Ask only if necessary**

1. male
2. female

REQUIRED FOR WEIGHTING

42. Do you have more than one telephone number in your household? Do not include cell phones or numbers that are only used by a computer or fax machine.

1. Yes
2. No → **Skip to CLOSING**

Do not read these responses

7. Don't know/Not sure → **Skip to CLOSING**
9. Refused → **Skip to CLOSING**

43. How many of these are residential numbers?

0-6. Number of residential telephone numbers **(**6=6 or more)

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: These two questions provide information that states can use to appropriately adjust sample weights in order to account for the increased probability of selection in the sample when households have more than one residential telephone line.

QUESTIONS RECOMMENDED FOR SPECIFIC PURPOSES

SECTION A: DEMOGRAPHIC ITEMS

A.1 What county do you live in?

NNN County FIPS code

Do not read these responses

777. Don't know/Not sure
999. Refused

CATI Programmer: The response categories above indicate that county FIPS codes should be put on the data file to indicate county of residence If respondents know the county that they live in, they will, of course, respond with the name of the county. There are a variety of ways that the county FIPS code can be determined. If a state has no more than 10-12 counties, the interviewer may be able to enter the FIPS code from a list of county names and FIPS codes that appears on the screen for this question. If a state has too many counties to make this work well, it is best to have the interviewer just enter whatever the respondent says. Then, at the end of the survey, display the text typed and have the interviewer look up (on a paper list) the name and enter the appropriate number. Asking the interviewer to enter a code from a list while the respondent is on the phone can cause the respondent to break off the

interview if the interviewer takes too long or the interviewer to commit an error if the interviewer hurries too much.

Utility: Because mapping of telephone exchanges to counties is approximate, programs that will be implementing interventions at the county level may be interested in collecting county level information.

A.2 Are you currently enrolled in a graduate or professional school, a 4 year college, a 2 year college, a technical or vocational school, or a GED program?

1. Graduate or professional school
2. 4 year college
3. 2 year college
4. Technical or vocational school
5. GED program
6. Other
7. Not enrolled

Do not read these responses

77. Don't know
99. Refused

Utility: This questions allows for identifying persons who are currently college students (the education question in the demographics section does not allow for that). College students have experienced increases in smoking rates in recent years. Thus there may be a need to focus specific programmatic interventions on this population group. Because students enrolled in 4 year colleges are different from other types of students, the question allows for collecting this additional information.

A.3 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This information is useful for investigating the role of third-party coverage on participation in smoking cessation programs and for developing interventions and policies on coverage of cessation for the uninsured.

Comment: The Agency for Health Care Policy and Research (AHCPR) has recommended that smoking cessation treatments be provided as paid services and providers be reimbursed for delivering effective smoking cessation interventions.

Ask A.4a if Male, (Ask A.4b if Female)

A.4a Do you think of yourself as . . .

1. Heterosexual or straight (attracted to women)
2. Homosexual or gay (attracted to men)
3. Bisexual (attracted to men and women)
4. Something else
5. Not sure

Do not read these responses

7. Don't know/Not sure
9. Refused

[NHANES]

Utility: Persons who are gay, lesbian, or bisexual may have higher rates of smoking.

Comment: It is important to note that only a small percent of respondents will self-identify as gay, lesbian, or bisexual. Therefore, small numbers will limit the ability to generate precise estimates of smoking prevalence in this population. Aggregating data from multiple years will enhance the ability to provide accurate estimates.

Ask A4b, if Female:

A.4b Do you think of yourself as . . .

1. Heterosexual or straight (attracted to men)
2. Homosexual or lesbian (attracted to women)
3. Bisexual (attracted to men and women)
4. Something else
5. Not sure

Do not read these responses

7. Don't know/Not sure
9. Refused

[NHANES]

The following questions are about health problems or impairments you may have.

A.5 Are you limited in any way in any activities because of physical, mental, or emotional problems?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

Utility: Persons with disabilities may have higher rates of smoking. The information from this question can be used to target interventions for populations with specific needs.

Comment: It is important to note that only a small percent of respondents will be identified as disabled. Therefore, small numbers will limit the ability to generate precise estimates of smoking prevalence in this population. Aggregating data from multiple years will enhance the ability to provide accurate estimates.

A.6 Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? Include occasional use or use in certain circumstances.

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

SECTION B: TOBACCO USE

SMOKING INITIATION IN YOUNG ADULTS : ASK IF AGE 18-29

B.1 During the past 30 days, on how many days did you smoke cigarettes?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

[YTS, State ATS]

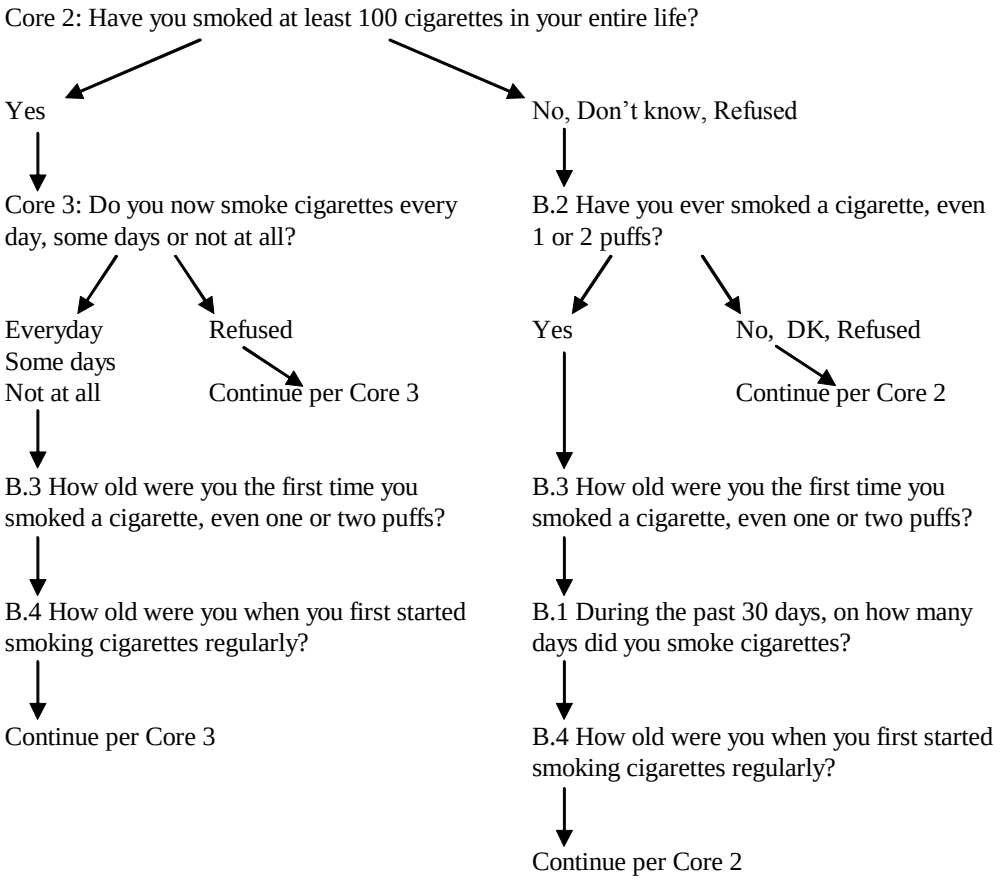
Utility: Persons 18-29 have experienced increasing rates of smoking in recent years. The standard adult smoking definition screens out persons who have smoked fewer than 100 cigarettes, and may be systematically screening out young adults who are

initiating and have not yet smoked 100 cigarettes. Adding this question provides the opportunity to estimate prevalence using the youth definition for persons in the 18-29 age group.

Current smokers among 18-29, using youth definition:

Everyday smokers 18-29 (Core 3)
+ those smoking ≥1 day in the past 30 days (some day [Core 3] and recent initiators [B.1])
All respondents 18-29

Comments: When incorporating questions to assess smoking using the youth definition, we recommend using the order described below. This figure also shows where questions about age at initiation (B.3, B.4) can be inserted.



B.2 Have you ever smoked a cigarette, even 1 or 2 puffs?

1. Yes
2. No

Do not read these

responses

7. Don't know
9. Refused

[BRFSS]

Utility: This question, together with B.3 and B.4 can be used to estimate the number of young persons who initiate smoking and become regular smokers each year.
Comment: If included, this question should be inserted as described in the flow chart above. Questions B.2-B.4 should only be asked of adults 18-29 years old because information on age at initiation is less useful from a programmatic point of view for older persons.

B.3 How old were you the first time you smoked a cigarette, even one or two puffs?

1-29. Number of years

Do not read these responses

77. Don't know/Not sure
99. Refused

[BRFSS; State ATS]

Utility: This question, together with B.2 and B.4 can be used to estimate the number of young persons who initiate smoking and become regular smokers each year.

Increasing the average age of first use of tobacco products by adolescents and young adults is a Healthy People 2010 objective.

B.4 How old were you when you first started smoking cigarettes regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

[BRFSS, State ATS]
Utility: This question, together with B.2 and B.3 can be used to estimate the number of young persons who initiate smoking and become regular smokers each year.
Increasing the average age of first use of tobacco products by adolescents and young adults is a Healthy People 2010 objective.

SMOKING PATTERNS

B.5 Have you ever smoked cigarettes every day?

1. Yes
2. No

Do not read these responses

7. Don't know
9. Refused

[NHIS]

Utility: This question provides a way to indirectly collect longitudinal information through a cross sectional survey. As some day smoking becomes more common, it may be helpful to track whether some day smokers are initiating smokers that have not yet become daily smokers or former daily smokers.

B.6 Around this time last year, were you smoking cigarettes every day, some days, or not at all?

1. Every day
2. Some days
3. Not at all

Do not read these responses

7. Don't know/ Not sure
9. Refused

[CPS]

Utility: Smoking status in the prior year indicates whether smoking status has changed.

BRAND USE

Ask of CURRENT SMOKERS only.
Former smokers SKIP to next section

The next few questions are about the cigarette brand you usually smoke now.

B.6a Do you happen to have one of your cigarette packs handy?

1. Yes
2. No → **Skip to B.7**

Do not read this response

9. Refused → **Skip to B.7**

B.6b Please take a look at it. On its side, you will find a number, called a UPC code, which has vertical lines above it. Please tell me this number.

NNNNNNNNNNNN. UPC Number

99 Undetermined UPC

Continue to read

The number I have is NNNNNNNNNNNN. Is that correct?

Utility: The UPC code identifies the brand and type of cigarette smoked (e.g. Marlboro Ultra light 100). Information on brand smoked provides a self-reported estimate of a brand's market share.

Comment: Matching results to a coded database is necessary in order to analyze the data. This will be facilitated by OSH. Similar, but less precise information can be collected by asking questions B.7 through B.10. States should consider using the UPC code if they wish to collect this level of detail. If the UPC method is included in the survey, follow up questions that don't require having a pack of cigarettes handy (B7-B10) must also be included in the survey.

B.6c At the end of the string of numbers there is a space and one single number. Can you tell me what that single number is?

N. Single UPC Digit

99. Undetermined UPC

Utility: The single number at the end is called the verification digit. It is used to validate the UPC code. Invalid codes resulting from errors in reading or in recording can be excluded from analysis.

Ask B.7-10 if B.6A = NO or B.6B or B.6C are not complete

B.7 What brand of cigarettes do you smoke most often?

(Do not read response categories, code only one)

1. Benson & Hedges
2. Camel
3. Carlton
4. Generic
5. Kent
6. Kool
7. Marlboro
8. Merit
9. More
10. Newport
11. Pall Mall
12. Salem
13. Virginia Slims
14. Winston
15. Lucky Strike
16. Other (specify)
77. Don't know
99. Refused

[State ATS]

B.8. Do you usually smoke menthol cigarettes?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[Modfied NHIS]

Utility: Information on type of cigarettes smoked may enable the tracking of changes in industry marketing strategies.

B.9. Do you usually smoke a discount, or generic, brand?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: In areas where taxes have increased, change in purchasing behaviors may be observed.

B.10 Do you usually smoke regular, light, or ultra light cigarettes?

1. Regular
2. Light
3. Ultra light

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: Many smokers of Lights or Ultra Lights mistakenly believe they are smoking a less harmful cigarette. This question allows for identifying smokers of Lights and Ultra Lights and can be used in conjunction with optional questions regarding beliefs about light cigarettes (E4). This information can help states develop interventions that focus on persons who smoke Lights.

PURCHASE PATTERNS

B.8a Do you usually buy cigarettes by the pack or the carton?

1. By the pack
2. By the carton → **Skip to B.8c**

Do not read these responses

7. Don't know → **Skip to next section**
9. Refused → **Skip to next section**

Utility: Cigarette purchases by the carton tend to increase when there is a price increase.

[If B.8a = "By the pack"]:
B.8b How much do you usually pay for a pack of cigarettes?

NNNN Amount usually paid for a pack of cigarettes (in cents, 2 implied decimals)
7777 Don't know/Not sure
9999 Refused

[If B.8a = "By the carton"]:
B.8c How much do you usually pay for a carton of cigarettes?

NNNN Amount usually paid for a carton of cigarettes (in cents, 2 implied decimals)

7777 Don't know
9999 Refused

In the last 12 months have you ever bought cigarettes…

B.9a. READ:

In a neighboring state?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.9b. READ:

On an Indian reservation?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.9c. READ:

On the Internet**?**

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This question provides information that complements state revenue data.

OTHER TOBACCO PRODUCTS

Smokeless Tobacco Use

B.10a Have you ever used or tried any smokeless tobacco products such as chewing tobacco or snuff?

1. Yes
2. No → Skip to B.11a

Do not read these responses

7. Don't know/Not sure → Skip to B.11a
9. Refused

[BRFSS]

Utility: Questions B.10a and b assess the use of smokeless tobacco. Smokeless tobacco is the second most commonly used form of tobacco after cigarettes, but its use varies substantially by region.

B.10b Do you currently use chewing tobacco or snuff every day, some days, or not at all?

1. Every day
2. Some days
3. Not at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

Cigar Use

B.11a Have you ever smoked a cigar, even one or two puffs?

1. Yes
2. No → Skip to QB.12a

Do not read these responses

7. Don't know/Not sure → Skip to QB.12a
9. Refused

[BRFSS]

B.11b Do you now smoke cigars every day, some days, or not at all?

1. Every day
2. Some days
3. Not at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

Utility: Questions B.11 to B.14 focus on other tobacco products. These items follow the same two item series for each type of tobacco product

Pipe Use

B.12a Have you ever smoked tobacco in a pipe, even one or two puffs?

1. Yes
2. No → Skip to QB.13a

Do not read these responses

7. Don't know/Not sure → Skip to QB.13a
9. Refused

[BRFSS]

B.12b Do you now smoke a pipe every day, some days, or not at all?

. 1. Every day
2. Some days
3. Not at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

Bidi Use

B.13a A bidi is a flavored cigarette from India. Have you ever smoked a bidi, even one or two puffs?

1. Yes
2. No → Skip to B.14a

Do not read these responses

7. Don't know/Not sure → Skip to B.14a
9. Refused

[BRFSS]

B.13b Do you now smoke bidis every day, some days, or not at all?

1. Every day
2. Some days
3. Not at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

Kretek Use

B.14a Have you ever smoked kreteks or clove cigarettes, even one or two puffs?

1. Yes
2. No → Skip to B.15a
7. Don't know/Not sure → Skip to B.15a

Do not read these responses

9. Refused

[BRFSS]

B.14b Do you now smoke kreteks or clove cigarettes every day, some days, or not at all?

1. Every day
2. Some days
3. Not at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[BRFSS]

New Tobacco Products

B.15a. Tobacco companies have recently introduced new products that are not cigarettes but look like them. These don't burn tobacco, but just heat up, and are claimed to have fewer harmful chemicals. These have names like Accord or Eclipse. Have you ever heard of one of these products?

1. Yes
2. No → Skip to next section

Do not read these responses

7. Don't know/Not sure → Skip to next section
9. Refused → Skip to next section

Utility: This question provides a means of monitoring the awareness of new products.

B.15b Have you tried one of these products?

1. Yes
2. No → Skip to next section

Do not read these responses

7. Don't know/Not sure → Skip to next section
9. Refused → Skip to next section

Now I'm going to read to you a list of these products. Please tell me which ones you have tried. Have you tried…

B.15c1. [Name of first product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c2. [Name of second product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c3. [Name of third product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c4. [Name of fourth product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c5. [Name of fifth product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c6. [Name of sixth product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c7. [Name of seventh product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c8. [Name of eigth product]

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

B.15c9. Some other similar product?

1. Yes (Specify: _____)
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: These questions provide a means of monitoring the use of new products.

INTENTION TO SMOKE

Ask B.16 if age = 18 - 29 FORMER SMOKER or NEVER SMOKER

B.16 Do you think you will smoke a cigarette anytime during the next year?

1. Definitely yes
2. Probably yes
3. Probably not
4. Definitely not

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: The perceived degree of likelihood of smoking in the next year may indicate a person's intention to begin smoking.

SECTION C: CESSATION

Q **C.1-C.3 CURRENT SMOKERS Only. Ask before Q9 if used.**

C.1 Have you ever stopped smoking for a day or longer because you were trying to quit smoking?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[CPS]

Utility: Smokers who have never tried to quit are "hard core" smokers. It may be useful to monitor their prevalence as a proportion of all smokers over time.

INTEREST IN QUITTING

C.2 CURRENT SMOKERS Only

C.2. Do you ever expect to quit smoking?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[state ATS]

Utility: This item can be used to identify confirmed ("hard core") smokers, and can be inserted in the core for those who answer "no" to "Are you seriously considering stopping smoking within the next 6 months?"

C.3 If you decided to give up smoking altogether, how likely do you think you would be to succeed?

1. Very likely
2. Somewhat likely
3. Somewhat unlikely
4. Very unlikely

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This measure of self-efficacy of smoking is a strong predictor of cessation and might be influenced by campaign efforts to encourage cessation.

METHODS OF QUITTING

Ask C.4a if CURRENT SMOKER or FORMER SMOKER who quit within last 12 months

C.4a In the past 12 months, have you seen a dentist?

1. Yes →
2. No → Skip to next section (QC.7)

Do not read these responses

7. Don't know/Not sure → Skip to next section or QC.7
9. Refused → Skip to next section or QC.7

Utility: Dentists may play an important role in smoking cessation counseling .

Ask C.4b if current smoker

C.4b In the past 12 months, did a dentist advise you to quit smoking?

1. Yes → Skip to next section or QC.7
2. No

Do not read these responses

7. Don't know/Not sure → Skip to next section or QC.7
9. Refused → Skip to next section or QC.7

[CPS]

Utility: This question measures whether dentists provided cessation advice to patients in the last year.

Ask C.4c if "no" to C4b or if non smoker

C.4c In the past 12 months, did a dentist ask if you smoked?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This question measures whether dentists provided cessation advice to patients in the last year.

HEALTH CARE PROVIDER INTERVENTION

Ask if Q10: *"The last time you tried to quit smoking, did you use the nicotine patch, nicotine gum, or any other medication to help you quit?"* = **'yes"**

C.5 Did you use…

C.5a.
nicotine gum?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.5b.
a nicotine patch?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.5c.
a nicotine nasal spray?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.5d.
a nicotine lozenge?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.5e. (Formerly C.5d.)
an inhaler?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.5f. (formerly C.5e.)
Buproprion, Wellbutrin, or Zyban?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.5g.
Other? Specify:_____)

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Ask if Q11 *"The last time you tried to quit smoking, did you use any other assistance such as classes or counseling?"* **= 'yes."**

C.6. Did you use…

C.6a.
a stop smoking clinic or class?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.6b.
a telephone quit line?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.6c.
one-on-one counseling from a doctor or nurse?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.6d.
self help material, books or videos?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.6e.
acupuncture?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.6f.
hypnosis?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

C.6g.
Did you use anything else to help you quit?

1. Yes (Specify _____)
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This questions provides more specific information on the types of medication or other methods persons used during the last quit attempt.

C7. [**CURRENT SMOKERS**:] Are you aware of assistance that might be available to help you quit smoking, such as telephone quitlines, local health clinic services, and ?.

1. Yes
2. No

7. Don't know/Not sure
9. Refused

Utility: Awareness of smoking cessation resources increases the likelihood that smokers will make quit attempts. Information on the reach of interventions enables states to assess and improve the delivery of available resources

C.8 Have you ever used a nicotine skin patch, gum, inhaler, or nasal spray?

1. Yes → Skip to next section
2. No

Do not read these responses

7. Don't know → Skip to next section
9. Refused → Skip to next section

Utility: This question identifies those who have never tried nicotine replacement and serves as a screener for the following question.

CURRENT SMOKERS Only

C.9 has been deleted

Ask C.10 if respondent has children <18 and if saw a health professional in the past 12 months:

C.10 During the past 12 months, did any doctor, nurse, or other health professional ask if you smoke around your children?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

Utility: This series of questions provides a means of evaluating the implementation of the Clinical Practice Guidelines of the Agency for healthcare Research and Quality (AHRQ).

Ask C.11 if employed for wages

C.11 Within the past 12 months, has your employer offered any stop smoking program or any other help to employees who want to quit smoking?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Work site cessation programs provide a supportive environment for those persons seeking to quit smoking and have been shown to be effective in increasing quit attempts and the likelihood of permanently quitting.

SECTION D: ENVIRONMENTAL TOBACCO SMOKE

WORKPLACE SMOKING

Ask D.1 if employed for wages or self-employed, otherwise skip to next section

D.1 Do more than 50 people work for you/your employer? (Number employed in entire company, not local branch or office)

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: The existence of smoke free policies varies by company size, and state laws governing smoke free policies vary depending on the state.

Comment: It may be useful to adapt this question to the smoke free policies in each state.

D.2 Would you prefer a stronger workplace smoking policy, a weaker workplace smoking policy, or no change [in your current policy]?

1. Prefer stronger policy
2. Prefer weaker policy, or
3. Prefer no change

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Answers to this question may be useful for obtaining support for more stringent policies.

ATTITUDES REGARDING CLEAN INDOOR AIR POLICIES

D.3 In public buildings, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: QD.3 to D.6. provide information on attitudes towards restrictions on exposure to second hand smoke, a measure of social norms. Questions about the workplace and restaurants are included in the core. Programmatic focus and activities will influence whether other environments need to be included in the survey.

D.4 In bars and cocktail lounges, do you think smoking should be allowed in all areas, some areas or not at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

D.5 In day care centers, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

D.6 In indoor sporting events and concerts, do you think that smoking should be allowed in all areas, some areas, or not allowed at all?

1. Allowed in all areas
2. Allowed in some areas
3. Not allowed at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

BEHAVIOR REGARDING CLEAN INDOOR AIR

D.7 About how often do you eat out at a restaurant? Would you say: more than once per week, about once a week, about once or twice a month, less than once a month, or never?

1. More than once per week
2. About once a week
3. About once or twice a month
4. Less than once a month
5. Never

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: This question provides information on the frequency in which people go to restaurants, needed to interpret answers to D8 and D9.

D.8 In the past year, did you <u>not go to a restaurant</u> because you knew

smoking was permitted?

1. Yes
2. No

Do not read these responses

7. Don't know/not sure
9. Refused

[State ATS]

Utility: Questions D7,8, and 10 help assess whether the introduction of smoke free restaurants would result in a loss of business.

D.9 In the past year, did you <u>not go to a restaurant</u> because you knew smoking was not permitted?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Questions D7,8, and 9 help assess whether the introduction of smoke free restaurants would result in a loss of business.

D.10 Some cities and towns are considering laws that would make restaurants smokefree; that is eliminating all tobacco smoke from restaurants. Would you support such a law in your community?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: This question gauges the level of support for smoke free restaurant policies.

D.11 If there were a total ban on smoking in restaurants, would you eat out more, less, or would it make no difference?

1. More
2. Less
3. No difference

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Questions D7,8, and 11 help assess whether the introduction of smoke free restaurants would result in a loss of business.

D.12 If someone were smoking near you in the nonsmoking area of a restaurant, would you ask them to stop?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This question measures people's perceived self-efficacy in enforcing smoke free restaurants. Such changes are expected to result from changes in social norms.

D.13 In the past 12 months, have you ever asked a stranger not to smoke around you so you wouldn't have to breathe their smoke?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: This question measures people's self-efficacy in enforcing smoke free places in the last year. Such changes are expected to result from changes in social norms.

SECTION E: HEALTH AND SOCIAL INFLUENCES

E.1 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe smoking cigarettes is a cause of this condition.

[Modified 1987 NHIS]

E.1a.
Heart attack

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

E.1b.
Colon cancer

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

E.1c.
Stroke

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

E.1d.
Low-birth weight

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

E.1e.
Lung cancer

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

E.1f.
Impotence

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This question assesses knowledge of the health effects of tobacco use. While there is widespread recognition of the effects on lung cancer, effects on heart attack and stroke are not a widely recognized, and knowledge of effects on low birth weight and impotence are not well known. Colon cancer is included so that all items in the list are not positive; hence, a positive response on this item would be an indication of the extent of misunderstanding of health effects.

COMORBIDITY

E.2 I am going to read a list of medical conditions that many people have. After each one, please tell me if you have ever been told by a doctor or other health professional that you have that condition.

E.2a.
Asthma, bronchitis, or emphysema

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

E.2b.
Diabetes

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

E.2c.
Heart disease

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: This question, in conjunction with information on medical advice, allows analysts to investigate whether persons who are at especially high risk of adverse outcomes related to smoking are being advised to quit. This information might be particularly relevant to a program that was targeting a particular risk group (e.g., diabetics.).

Note: Because, in general less than half of the persons with these conditions are smokers, small numbers will constrain the ability of study in an individual state to develop precise estimates. However, aggregating data from several waves of data collection or from adjacent states may provide a way to increase the power of analyses.

RISK PERCEPTION

I'm going to read you a series of statements. After I finish, please tell me whether you strongly agree, agree, disagree, or strongly disagree with the statement.

E.3 Smoking is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

Do not read these responses

8. Don't know/Not sure
9. Refused

[State ATS]

Utility: Nonsmokers may not recognize the addictive nature of tobacco, and there are often important differences in this perception by race/ethnicity.

E.4 Smoking light cigarettes is safer than smoking regular cigarettes

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: Many smokers believe that Light and Ultra light cigarettes are safer that regular cigarettes and this perception could be a deterrent to cessation. Changes in beliefs about the safety of light cigarettes may be useful in planning and monitoring the effects of public education directed at this misperception.

E.5 Smoking by a pregnant woman may harm the baby.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

Do not read these responses

7. Don't know/Not sure
9. Refused

[NHIS]

Utility: Recognition of the danger of tobacco use during pregnancy can be an important motivation toward cessation. This information can be useful in states that are planning education programs to address smoking during pregnancy.

SOCIAL INFLUENCES

E.6 Ask of 18-29 year olds only

E.6 How many of your friends use any tobacco products? Would you say:

1 None
2. A few
3. Less than half
4. About half
5. Most or all

Do not read these responses

7. Don't know/Not sure
Refused

[State ATS]

Utility: Smoking by friends is often an important predictor of the uptake of tobacco, and an important reinforcement for continued tobacco use. Inclusion of this item can help in analysis to control for the influence of peer tobacco use, in order to provide more sensitive detection of program effects.

E.7 Ask of NEVER SMOKERS and FORMER SMOKERS

E.7 People close to me would be upset if I smoked.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Information about the perceptions of others is an important factor in preventing the initiation of smoking and in reinforcing the maintenance of cessation. Programs may increase their efficacy by promoting a social climate that discourages smoking.

E.8 for CURRENT SMOKERS only

E.8 People close to me are upset at my smoking.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Information about the perceptions of others is an important factor in motivating successful cessation attempts. Programs may increase their efficacy by promoting a social climate that discourages smoking.

E.9- E.10 Ask for CURRENT SMOKERS WHO ARE PARENTS of Children Ages 5 - 17

E.9 My children are upset about my smoking.

1. Strongly agree
2. Agree
3. Disagree
5. Strongly disagree

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Children can be a powerful influence on successful cessation attempts by their parents. One of the effects of public education about smoking may be an increase in the proportion of children who encourage their parents to quit.

E.10 Have your children talked with you about stopping smoking?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: One potential indicator of the effects of a public education on reinforcing factors, may be a change in the number of parents who report that their children ask them to stop smoking.

SECTION F: POLICY ISSUES

YOUTH ISSUES

F.1 How important is it that communities keep stores from selling tobacco products to teenagers. Would you say it is:

1. Very important
2. Somewhat important
3. Not very important
4. Not important at all

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Easy access to tobacco both enables tobacco use while restriction of access can provide an important cue that smoking is socially unappealing. Adult support of minor's access laws is an important contributor to enforcement of minor access laws.

F.2. (Replaces former F3) How strongly do you agree or disagree with the following statement:

Tobacco use by adults should not be allowed on school grounds or at any school events.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Use of tobacco by adults can model the acceptability of tobacco use. This is particularly true in the case when these models are respected adults such as teachers or family members who attend school events. Support for restrictions in this area can help to discourage the modeling to tobacco use.

F.3 (Replaces former QF.4) How strongly do you agree or disagree with the following statement:

Storeowners should be required to have a license to sell tobacco products, similar to alcohol, so that teens can't buy tobacco products.

1. Strongly Agree
2. Agree
3. Disagree
4. Strongly Disagree

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: The requirement for licenses to sell tobacco provides an additional threat of sanction for selling tobacco to minors. In communities that are considering ordinances in this area, support for licensure can be an indicator of community support for tobacco control.

F.4. (Formerly F.2) Over the past 12 months, did you ever buy or give someone under the age of 18 cigarettes, chewing tobacco, or any other tobacco products?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Even when retail access to tobacco is restricted, adolescents can often obtain tobacco from social sources. Furnishing tobacco to teenagers can also reinforce the acceptance of tobacco use. Hence, changes in the willingness of adults to provide tobacco to teenagers may be an indicator of changes in social norms. This item may be particularly useful in surveys of 18 - 29 year olds, since they are a common source of tobacco for teenagers.

Comment: In those states where purchasing cigarettes for minors is illegal, this question should not be added.

SPONSORSHIP AND MARKETING

F.5 Do you think tobacco companies should be allowed to include coupons in cigarette packs that can be used to obtain promotional items that may be appealing to teenagers, such as hats, tee shirts, jackets or caps?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: The use of pro-tobacco gear by youth is a strongly associated with subsequent uptake of tobacco. Use of this gear can also increase advertising of tobacco products. Support for restrictions of this marketing practice can be a useful indicator of community support for rigorous tobacco control.

F.6 Do you think sponsorship of sporting events or concerts by tobacco companies should be allowed?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

Utility: The sponsorship of sporting events by tobacco companies not only provides additional advertising of tobacco products, but it can also foster the association of tobacco use with physical fitness and excitement. Support for restrictions in this area can therefore be a good indicator of the effects of education efforts on public support for tobacco control

F.7 Some tobacco companies make promotional items like clothing, hats, bags, or other things with their brand on it. Do you have a piece of clothing or other item that has a tobacco brand or logo on it?

1. Yes
2. No

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: The use of promotional items is strongly associated with actual tobacco use and openness to the use of tobacco. This item may be particularly useful as an indicator of educational effects on the acceptance of tobacco by 18 - 29 year olds

.

TAXATION

F.8a. How much additional tax on a pack of cigarettes would you be willing to support if some or all the money raised was used to support tobacco control programs?

1. More than two dollars a pack
2. Two dollars a pack
3. One dollar a pack
4. Fifty to nine-nine cents a pack
5. Less than fifty cents a pack
6. No tax increase

Do not read these responses

7. Don't know/Not sure
9. Refused

Utility: Tax increases have a strong association with lower initiation of tobacco use and with lower levels of tobacco use. Willingness to financially support programs associated with tobacco control is a key indicator of the social acceptability of tobacco that might be influenced by education efforts.

SECTION G: PARENTAL INVOLVEMENT

SCREENING/ELIGIBILITY

If no children ages 5-17 (Q37), then, section ENDS here.

Now, I want you to think of the child in your household who is nearest to the age of 10.

(If children are equidistant in age (e.g., 9 and 11), select the older.)

G.1 What is the age of the child nearest to age 10?

5-17 Age of child nearest to age 10

Utility: This item starts a series of questions regarding parental communication about tobacco use among preadolescents. This age is selected because it is just prior to the age at which youth are likely to begin to smoke cigarettes and is an age during which parental influence is often comparatively high, vis-à-vis peers. If an education effort were focusing of a parental communication with a different age group, this age group could be selected.

G.2 Is that child a boy or a girl?

1. Male
2. Female

Utility: This item is included, because parental communication can often vary by gender.

G.3 What is your relationship to that child?

Ask only if necessary

1. Father or stepfather
2. Mother or stepmother
3. Brother
4. Sister
5. Grandmother
6. Grandfather
7. Other relative
8. Unrelated to child

Utility: This item completes the series of items needed to know which child is the focus of the parental communication.

PARENT-CHILD COMMUNICATION

During the last 6 months, how many times have you:

G.4 Talked to your child about what he/she can or cannot do when it comes to tobacco?

1. Never
2. Once
3. Twice
4. Three or more times

Do not read these responses

7. Don't know/Not sure
9. Refused

[Modified Bauman 2000]

Utility: This item is the first of two measures of communication about tobacco use in prospective studies of adolescents.

G.5 Told your child he/she cannot use tobacco?

1. Never
2. Once
3. Twice
4. Three or more times

Do not read these responses

7. Don't know/Not sure
9. Refused

[Modified Bauman 2000]

Utility: These two items were found to be measures of communication about tobacco use in prospective studies of adolescents. They are indicators of communication of disapproval.

CHILD'S SMOKING STATUS

G.6 Do you think your child smokes?

1. I <u>am certain</u> that my child does <u>not</u> smoke
2. I don't <u>think</u> that my child smokes
3. I <u>don't know</u> if my child smokes or not
4. I <u>suspect</u> that my child smokes
5. I <u>am certain</u> that my child smokes

9. Refused

[Modified Clark 1999]

Utility: Parental awareness of their child's smoking status will help in the interpretation of the results of these questions. We caution, that teenagers will often smoke in settings where a parent is unaware of their smoking, so this item should not be used to generate prevalence estimates of smoking. Rather, this item is intended as a variable for use in analysis to characterize difference between parents who are certain that their child does not smoke, parents who are certain that their child does smoke, and the middle groups of parents who are more uncertain about their child's smoking status.

DISAPPROVAL

G.7 How much would you like it or dislike it if you found your child smoking cigarettes now? Would you…….

1. Like it a lot
2. Like it some
3. Neither like it nor dislike it
4. Dislike it some
5. Dislike it a lot

Do not read these responses

7. Don't know/Not sure
9. Refused

[Modified Bauman 2000]

Utility: Parental disapproval of smoking can often help to prevent the initiation of tobacco use and influence cessation attempts. This item helps to monitor the effect of educational efforts directed at parents in increasing the disapproval of tobacco use.

MONITORING

Ask H.8 – (Q25) if child is between the ages of 12 and 17.

G.8 Does your child have to be home by a certain time on **school nights?**

1. Yes
2. No
3. Never away from home on school nights

Do not read these responses

7. Don't know/Not sure
9. Refused

[Modified Bauman 2000]

G.9 Does your child have to be home by a certain time on **weekend nights?**

1. Yes
2. No
3. Never away from home on weekend nights

Do not read these responses

7. Don't know/Not sure
Refused

[Modified Bauman 2000]

Utility: These two items help to provide an indicator of parental monitoring of their children. In general, increased monitoring is associated with lower tobacco use. A number of public education campaigns encourage more effective parental monitoring of the behavior of their children.

SECTION H: MEDIA EXPOSURE

MEDIA EXPOSURE

H.1. deleted.

H.2 During the past 7 days, how many commercials have you seen on TV about NOT smoking cigarettes?

0. None
1. One
2. Two or three
3. Four to six
4. Seven or more

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Recall of exposure to anti-smoking ads can be an indicator of campaign exposure. The use of this general item is helpful because if can help to characterize level of exposure to the broad range of state and national media-based anti-tobacco education campaigns

H.3 During the past 7 days, how many commercials have you heard on radio about NOT smoking cigarettes?

0. None
1. One
2. Two or three
3. Four to six
4. Seven or more

Do not read these responses

7. Don't know/Not sure
9. Refused

[State ATS]

Utility: Recall of exposure to anti-smoking ads can be an indicator of campaign exposure. Radio is often a relatively low-cost method of campaign dissemination that can be targeted to specific audiences. Radio use is also a frequent source of media use among 18 - 29 year olds. This information can help to characterize level of exposure to the broad range of state and national media-based anti-tobacco education campaigns

H.4 During the past 7 days, how many messages have you seen on billboards about NOT smoking cigarettes?

0. None
1. One
2. Two or three
3. Four to six
4. Seven or more

Do not read these responses

7. Don't know/not sure
9. Refused

[State ATS]

Utility: Billboards are often an important cue to action for a number of public education campaigns. This information on recall of exposure to anti-smoking ads on billboards can be an indicator of campaign exposure in campaigns that make use of outdoor advertising.

CONFIRMED AWARENESS OF SPECIFIC ADS

H.5. to H.10. deleted.

SECTION I: CLOSING

I1. That's my last question. Everyone's answers will be combined to give us information about tobacco in this state. Thank you very much for your time and cooperation.

Note: States should modify the closing statement to fit their exact requirements. After the last question has been asked for a respondent who has completed the interview, the interviewer should be brought to a screen where s/he thanks the respondent for his or her cooperation. After this screen, additional tasks—such as having the interviewer enter his or her id number or having the interviewer re-enter county name in order to perform a look-up of county FIPS code—may be performed.

Interviewer: Please answer

I2. In what language was the interview conducted? If more than one, indicate the predominant language used.

1. English
2. Spanish
3. As specified in data layout sent to State and CDC
. As specified in data layout sent to State and CDC
. As specified in data layout sent to State and CDC
. As specified in data layout sent to State and CDC
99. As specified in data layout sent to State and CDC

APPENDIX I: CHANGES FROM VERSION OF DECEMBER 12, 2002

This appendix indicates the changes to the May 9, 2003 version of the ATS questionnaire, from the previous version, dated December 12, 2002. Minor changes were made to several questions. A few questions were re-worked or, in some cases, deleted. Below are descriptions, first, of the general types of changes that were made and, secondly, of the types of changes made to individual questions. Although many questions were changed (in minor ways), the intent of this revision was to tweak the existing questionnaire rather than to make an extensive overhaul of it.

Changes Not Individually Listed:

The screener was turned into survey questions.

Formatting changes were made regarding skip patterns.

Common Changes Individually Listed:

Response codes were changed or clarified.

Multiple part questions were separated into their component parts.

"No opinion/Don't know" value categories changed to "Don't know/Not sure."

(Usually) Minor word changes were made to questions.

Changes to Specific Questions:

4,5,6. Coding change.

8. Coding change

11,14,16,17. Word change.

17a-17d. Separated question into component parts.

18,19. Coding change

28,29,30,31. "No opinion/Don't know" value categories changed to "Don't know/Not sure."

32a-32e. Separated question into component parts.

34a-34b.15. Word and coding changes. Now ask for the ages of each child individually.

39. Coding change.

A.1. Coding change.

A.2. Word and coding changes.

B.1,B.2,B.3,B.6a,B.6b,B.6c,B.7. Coding change.

B.8,B.9,B.10. Word and coding changes.

B.8a,B.8b,B.8c. Coding change.

B.9a,B.9b,B.9c. Separated question into component parts and coding change.

B.11a, B.12a,B.13a,B.14a. Changed skip.

B.15c1-B.15c9. Separated question into component parts.

C.4a. Changed skip.

C.5,C.6. Separated question into component parts.

Old C.9. Deleted.

C.10. Word change.

D.2,D.3,D.4,D.5,D.6. "No opinion/Don't know" value categories changed to "Don't know/Not sure."

D.13. Word change.

E.1,E.2. Separated question into component parts and coding change.

E.3,E.4,E.5,E.7,E.9,F.1,F.2,F.3. "No opinion/Don't know" value categories changed to "Don't know/Not sure."

F.2,F.3,F.4. Questions re-ordered.

F.5. Word and coding change.

F.6. Coding change.

F.7. "No opinion/Don't know" value categories changed to "Don't know/Not sure."

F.8a. Word and coding change.

Old F.8b,F.8c. Deleted.

G.3,G.9. Change in value description.

Old H.1, H.5-H.10. Deleted.

APPENDIX II: CHANGES FROM VERSION OF MAY 9, 2003

This appendix indicates the changes to the June 5, 2003 version of the ATS questionnaire (1.3), from the previous version (1.2), dated May 9, 2003.

Titles and section headings were changed to more accurately convey the actual use of the questions. A few minor typographical errors were corrected.

Changes to Specific Questions:

S1,S13. The order in which the interviewer states name and organization for which s/he is called was reversed.

16. Changed skip pattern to include all respondents with unknown smoking status.

34a. Set the value for Refused to 9 (from 8).

34b.1. Added range for Age of oldest child in years.

B.6b. Added confirmation of UPC code, which was inadvertently dropped in the previous version.

I2. Added question specifying language in which interview was predominantly conducted.

Appendix B

SOUTH ASIAN TOBACCO (SAT) MODULE

SOUTH ASIAN TOBACCO MODULE

Arnab Mukherjea
School of Public Health; University of California, Berkeley

VERSION 2.0
June 23, 2010

Page and prompt numbers in reference to CDC Adult Tobacco Survey (June 5, 2003)*

NOT TO BE INTEGRATED WITH VALIDATED SURVEYS
OR
USED FOR INDEPENDENT SURVEILLANCE
UNTIL
FORMAL PILOT TESTING IS COMPLETED

* Certain survey prompts are remain identical to those in CDC's Adult Tobacco Survey and are presented here for reference and use for independent surveillance.

CORE QUESTIONNAIRE ADDITIONS & MODIFICATIONS

SECTION 6: DEMOGRAPHIC ITEMS
(page 25)

35. Are you Hispanic or Latino?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

36. Which one or more of the following would you say is your race?

1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Other Pacific Islander
5. American Indian, Alaska Native

or

6. Other [specify:] _____

7. Don't know/Not sure
9. Refused

36A. Do you consider yourself South Asian (an individual with origins in Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and/or Sri Lanka)?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

36B. Which of the following would you say is your country of origin?

[CHECK ALL THAT APPLY]

1. Bangladesh
2. Bhutan
3. India
4. Maldives
5. Nepal
6. Pakistan
7. Sri Lanka
8. Other [specify]: _____

777. Don't know/Not sure
999. Refused

[IF 36B HAS MORE THAN ONE RESPONSE, CONTINUE TO 36C]

36C. Which of the following would you say ***best*** represents your country of origin?

1. Bangladesh
2. Bhutan
3. India
4. Maldives
5. Nepal
6. Pakistan
7. Sri Lanka
8. Other [specify]: _____

777. Don't know/Not sure
999. Refused

36D. Is English your first language?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

36E. Do you use a language other than English as your primary language with South Asian friends or family members?

1. Yes
2. No → Skip to 36G

7. Don't know/Not sure
9. Refused

36F. Which language do you speak most often?

1. Assamese
2. Balochi / Baluchi
3. Bengali / Bangla
4. Bhojpuri
5. Bodo / Boro
6. Chhattisgarhi
7. Dzongkha
8. Dhivehi / Divehi
9. English
10. Gujarati
11. Hindi
12. Kashmiri
13. Kannada
14. Khasi
15. Kokborok
16. Konkani
17. Maithili
18. Malayalam
19. Manipuri / Meiteilon
20. Marathi
21. Mizo
22. Nepali
23. Oriya / Odiya
24. Pahari
25. Parsi
26. Pashto / Pathani
27. Punjabi
28. Santali
29. Saraiki / Siraiki
30. Sindhi
31. Sinhalese
32. Tamil
33. Telegu
34. Urdu
35. Other: _____

777. Don’t know/Not sure
999. Refused

36G. Which one of the following best describes the religion you practice?

1. Agnosticism
2. Atheism
3. Bahai / Zoroastrian
4. Buddhism
5. Christianity
6. Hinduism
7. Islam
8. Jainism
9. Judaism
10. Sikhism
11. Other religion
12. No religion

777. Don’t know/Not sure
999. Refused

"RECOMMENDED" QUESTIONNAIRE ADDITIONS & MODIFICATIONS

SECTION A: DEMOGRAPHIC ITEMS
(page 28)

A.0.5 Were you born in the United States?

1. Yes → Skip to A.0.8
2. No

7. Don't know/Not sure
9. Refused

A.0.6 How long have you lived in the United States?

1. 0 – 5 years
2. 5 – 10 years
3. 10 – 15 years
4. Over 15 years

7. Don't know/Not sure
9. Refused

A.0.7 When you lived in South Asia, did you live most of the time in a village, town, or big city?

1. Village
2. Town
3. Big City

7. Don't know/Not sure
9. Refused

A.0.8 Were either of your parents born in the United States?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

SECTION B: TOBACCO USE
(page 31)

Other Tobacco Products

Smokeless Tobacco Use
(page 38)

***Paan* is a betel leaf, in which many ingredients are mixed (areca-nut/*supari*, tobacco, lime/*chunna*, and other spices), which is sealed with lime paste/*catechu*. The sealed *paan* is also known as a quid. Another term for *paan* is *bulath vita* or *sara vita*.**

B.10.0a Have you ever used or tried *paan*?

1. Yes
2. No → Skip to B.10.1a

7. Don't know/Not sure → Skip to B.10.1a
9. Refused

B.10.0b At what age did you first use *paan*?

0-99. Age in years

77. Don't know/Not sure
99. Refused

B.10.0c Do you chew *paan* everyday, some days, or not at all?

1. Everyday
2. Some days → Skip to B.10.0f
3. Not at all → Skip to B.10.0k

9. Refused

B.10.0d How old were you when you first started using *paan* regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

B.10.0e How soon after you wake up do you have your first *paan*?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

7. Don't know/Not sure
10. Refused

B.10.0f On the average, about how many *paan (*quid) a day do you now chew?

1-180 Number of *paan* (quid)
666 Less than one *paan* (quid) a day

777 Don't know/Not sure
999 Refused

B.10.0g During the past 30 days, on how many days did you use *paan*?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

B.10.0h During the past 12 months, have you stopped using *paan* for one day or longer because you were trying to quit?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

B.10.0i Are you seriously considering stopping using *paan* within the next six months?

1. Yes
2. No → Skip to B.10.1a

7. Don't know/Not sure → Skip to B.10.1a
9. Refused → Skip to B.10.1a

B.10.0j Are you planning to stop using *paan* within the next 30 days?

3. Yes
4. No

7. Don't know/Not sure
9. Refused

B.10.0k About how long has it been since you last used *paan* regularly?

5. Within the past month (≤ 1 month ago)
6. Within the past 3 months (>1 month but ≤ 3 months ago)
7. Within the past 6 months (>3 months but ≤ 6 months ago)
8. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)
6. Within the past 10 years (>5 years but ≤ 10 years ago)
8. Over 10 years ago

77. Don't know/Not sure
100. Refused

Paan Masala* comes in a packet or tin and has all the ingredients that a *paan* has, without the leaf. Common names for *paan masala* include *Paan Parag.

B.10.1a Have you ever used or tried *paan masala*?

1. Yes
2. No → Skip to B.10.2a

7. Don't know/Not sure → Skip to B.10.2a
9. Refused

B.10.1b At what age did you first use *paan masala*?

0-99. Age in years

77. Don't know/Not sure
99. Refused

B.10.1c Do you chew *paan masala* everyday, some days, or not at all?

1. Everyday
2. Some days → Skip to B.10.1f
3. Not at all → Skip to B.10.1k

7. Don't know/Not sure
9. Refused

B.10.1d How old were you when you first started using *paan masala* regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

B.10.1e How soon after you wake up do you use *paan masala*?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

7. Don't know/Not sure
9. Refused

B.10.1f When you use *paan masala*, do you use it in packets or by pinches or teaspoons from a tin?

1. Packets
2. Pinches or teaspoons

7. Don't know/Not sure
9. Refused

B.10.1g On the average, about how many packets OR pinches/teaspoons of *paan masala* a day do you now chew?

1-180 Number of *paan masala* packets OR pinches/teaspoons
666 Less than one *paan masala* packet OR pinches/teaspoons a day

777 Don't know/Not sure
999 Refused

B.10.1g During the past 30 days, on how many days did you use *paan masala*?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

B.10.1h During the past 12 months, have you stopped using *paan masala* for one day or longer because you were trying to quit?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

B.10.0i Are you seriously considering stopping using *paan masala* within the next six months?

1. Yes
2. No → Skip to B.10.2a

7. Don't know/Not sure → Skip to B.10.2a
9. Refused → Skip to B.10.2a

B.10.0j Are you planning to stop using *paan masala* within the next 30 days?

5. Yes
6. No

7. Don't know/Not sure
9. Refused

B.10.0k About how long has it been since you last used *paan masala* regularly?

1. Within the past month (< 1 month ago)
2. Within the past 3 months (>1 month but ≤ 3 months ago)
3. Within the past 6 months (>3 months but ≤ 6 months ago)
4. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)
6. Within the past 10 years (>5 years but ≤ 10 years ago)
7. Over 10 years ago

77. Don't know/Not sure
99. Refused

***Guthka* comes is a flavored mixture of areca nut/*supari*, catechu, and tobacco and comes in small packets. A common brand of *guthka* is Manikchand.**

B.10.2a Have you ever used or tried *guthka*?

1. Yes
2. No → Skip to B.10.3a

7. Don't know/Not sure → Skip to B.10.3a
9. Refused

B.10.2b At what age did you first use *guthka*?

0-99. Age in years

77. Don't know/Not sure
99. Refused

B.10.2c Do you chew *guthka* everyday, some days, or not at all?

1. Everyday
2. Some days → Skip to B.10.2f
3. Not at all → Skip to B.10.2k

9. Refused

B.10.2d How old were you when you first started using *guthka* regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

B.10.2e How soon after you wake up do you use *guthka*?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

7. Don't know/Not sure
9. Refused

B.10.2f On the average, about how many packets of *guthka* a day do you now chew?

1-180 Number of *guthka* packets
666 Less than one *guthka* packet a day

777 Don't know/Not sure
999 Refused

B.10.2g During the past 30 days, on how many days did you use *guthka*?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

B.10.2h During the past 12 months, have you stopped using *guthka* for one day or longer because you were trying to quit?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

B.10.2i Are you seriously considering stopping using *guthka* within the next six months?

1. Yes
2. No → Skip to B.10.3a

7. Don't know/Not sure → Skip to B.10.3a
9. Refused → Skip to B.10.3a

B.10.2j Are you planning to stop using *guthka* within the next 30 days?

1. Yes → Skip to B.10.3a
2. No → Skip to B.10.3a

7. Don't know/Not sure → Skip to B.10.3a
9. Refused → Skip to B.10.3a

B.10.2k About how long has it been since you last used *guthka* regularly?

1. Within the past month (< 1 month ago)
2. Within the past 3 months (>1 month but ≤ 3 months ago)
3. Within the past 6 months (>3 months but ≤ 6 months ago)
4. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)
6. Within the past 10 years (>5 years but ≤ 10 years ago)
7. Over 10 years ago

77. Don't know/Not sure
99. Refused

***Zarda* is processed tobacco, which has been dried and shaved into flakes. <u>This *zarda* is NOT referring to sweet rice dessert.</u> Common names for *zarda* include Baba Zarda and Gopal Zarda.**

B.10.3a Have you ever used or tried *zarda*?

1. Yes
2. No → Skip to B.10.4a

7. Don't know/Not sure → Skip to B.10.4a
9. Refused

B.10.3b At what age did you first use *zarda*?

0-99. Age in years

77. Don't know/Not sure
99. Refused

B.10.3c Do you chew *zarda* everyday, some days, or not at all?

1. Everyday
2. Some days → Skip to B.10.3f
3. Not at all → Skip to B.10.3k

9. Refused

B.10.3d How old were you when you first started using *zarda* regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

B.10.3e How soon after you wake up do you use *zarda*?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

77. Don't know/Not sure
99. Refused

B.10.3f On the average, about how many pinches (or tablespoons) of *zarda* a day do you now chew?

1-180 Number of *zarda* pinches
666 Less than one *zarda* pinches a day

777 Don't know/Not sure
999 Refused

B.10.3g During the past 30 days, on how many days did you use *zarda*?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

B.10.3h During the past 12 months, have you stopped using *zarda* for one day or longer because you were trying to quit?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

B.10.3i Are you seriously considering stopping using *zarda* within the next six months?

1. Yes
2. No → Skip to B.10.4a

7. Don't know/Not sure → Skip to B.10.4a
9. Refused → Skip to B.10.4a

B.10.3j Are you planning to stop using *zarda* within the next 30 days?

1. Yes → Skip to B.10.4a
2. No → Skip to B.10.4a

7. Don't know/Not sure → Skip to B.10.4a
9. Refused → Skip to B.10.4a

B.10.3k About how long has it been since you last used *zarda* regularly?

1. Within the past month (< 1 month ago)
2. Within the past 3 months (>1 month but ≤ 3 months ago)
3. Within the past 6 months (>3 months but ≤ 6 months ago)
4. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)
6. Within the past 10 years (>5 years but ≤ 10 years ago)
7. Over 10 years ago

77. Don't know/Not sure
99. Refused

***Niswar* or Indian snuff is a mixture of tobacco and spices which are rolled up in balls. *Niswar* or Indian snuff is also known as *naswar* or *nass*.**

B.10.4a Have you ever used (chewed or sniff) *niswar* or Indian snuff?

1. Yes
2. No → Skip to B.10a

7. Don't know/Not sure → Skip to B.10a
9. Refused

B.10.4b At what age did you first use *niswar* or Indian snuff?

0-99. Age in years

77. Don't know/Not sure
99. Refused

B.10.4c Do you use *niswar* or Indian snuff everyday, some days, or not at all?

1. Everyday
2. Some days → Skip to B.10.4f
3. Not at all → Skip to B.10.4k

9. Refused

B.10.4d How old were you when you first started using *niswar* or Indian snuff regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

B.10.4e How soon after you wake up do you use *niswar* or Indian snuff?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

77. Don't know/Not sure
99. Refused

B.10.4f On the average, about how many pinches of *niswar* a day do you now sniff or chew?

1-180 Number of *niswar* pinches
666 Less than one *niswar* pinches a day

777 Don't know/Not sure
999 Refused

B.10.4g During the past 30 days, on how many days did you use *niswar*?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

B.10.4h During the past 12 months, have you stopped using *niswar* or Indian snuff for one day or longer because you were trying to quit?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

B.10.4i Are you seriously considering stopping using *niswar* or Indian snuff within the next six months?

1. Yes
2. No → Skip to B.10a

7. Don't know/Not sure → Skip to B.10a
9. Refused → Skip to B.10a

B.10.4j Are you planning to stop using *niswar* or Indian snuff within the next 30 days?

1. Yes → Skip to B.10a
2. No → Skip to B.10a

7. Don't know/Not sure → Skip to B.10a
9. Refused → Skip to B.10a

B.10.4k About how long has it been since you last used *niswar* or Indian snuff regularly?

1. Within the past month (< 1 month ago)
2. Within the past 3 months (>1 month but ≤ 3 months ago)
3. Within the past 6 months (>3 months but ≤ 6 months ago)
4. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)
6. Within the past 10 years (>5 years but ≤ 10 years ago)
7. Over 10 years ago

77. Don't know/Not sure
99. Refused

B.10a Have you ever used or tried any smokeless tobacco products such as chewing tobacco or snuff?

1. Yes
2. No → Skip to B.11a

7. Don't know/Not sure → Skip to B.11a
9. Refused

B.10b Do you currently use chewing tobacco or snuff every day, some days, or not at all?

1. Every day
2. Some days
3. Not at all

7. Don't know/Not sure
9. Refused

Bidi Use
(page 40)

B.13a A *bidi* is a flavored cigarette from India. Have you ever smoked a *bidi*, even one or two puffs?

1. Yes
2. No → Skip to B.14a

7. Don't know/Not sure → Skip to B.14a
9. Refused

B.13b At what age did you first smoke a *bidi*, even one or two puffs?

0-99. Age in years

77. Don't know/Not sure
99. Refused

B.13c Do you now smoke *bidis* every day, some days, or not at all?

1. Every day
2. Some days → Skip to B.13.0f
3. Not at all → Skip to B.13.0k

7. Don't know/Not sure
9. Refused

B.13d How old were you when you first started smoking *bidis* regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

B.13e How soon after you wake up do you smoke your first *bidi*?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

77. Don't know/Not sure
99. Refused

B.13f On the average, about how many *bidis* a day do you now smoke?

1-180 Number of *bidis*
666 Less than one *bidi*

777 Don't know/Not sure
999 Refused

B.13g During the past 30 days, on how many days did you smoke *bidis*?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

B.13h During the past 12 months, have you stopped smoking *bidis* for one day or longer because you were trying to quit?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

B.13i Are you seriously considering stopping smoking *bidis* within the next six months?

1. Yes
2. No → Skip to B.13.0a

7. Don't know/Not sure → Skip to B.13.0a
9. Refused → Skip to B.13.0a

B.13j Are you planning to stop smoking *bidis* within the next 30 days?

1. Yes → Skip to B.13.0a
2. No → Skip to B.13.0a

7. Don't know/Not sure → Skip to B.13.0a
9. Refused → Skip to B.13.0a

B.13k About how long has it been since you last smoked *bidis* regularly?

1. Within the past month (< 1 month ago)
2. Within the past 3 months (>1 month but ≤ 3 months ago)
3. Within the past 6 months (>3 months but ≤ 6 months ago)
4. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)
6. Within the past 10 years (>5 years but ≤ 10 years ago)
7. Over 10 years ago

77. Don't know/Not sure
99. Refused

Hookah (Waterpipe) Use
(added)

B.13.0a A *hookah* is a waterpipe, used in South Asian countries, through which a flavored mixture or *shisha* is smoked. Have you ever smoked *hookah* (even one or two puffs)?

1. Yes → Skip to B.13.0b
2. No

7. Don't know/Not sure
9. Refused

B.13.0b At what age did you first smoke *hookah* (even one or two puffs)?

0-99. Age in years

77. Don't know/Not sure
99. Refused

B.13.0c Do you now smoke *hookah* every day, some days, or not at all?

1. Every day
2. Some days → Skip to B.13.0f
3. Not at all → Skip to B.13.0k

7. Don't know/Not sure
9. Refused

B.13.0d How old were you when you first started smoking *hookah* regularly?

1-29. Number of years

77. Don't know/Not sure
99. Refused

B.13.0e How soon after you wake up do you smoke your first *hookah*?

1. Within 5 minutes
2. 6-30 minutes
3. 31-60 minutes
4. After 60 minutes

77. Don't know/Not sure
99. Refused

B.13.0f On the average, about how many *hookahs* a day do you now smoke?

1-180 Number of *hookahs* or *shishas*
666 Less than one *hookah* or *shisha*

777 Don't know/Not sure
999 Refused

B.13.0g During the past 30 days, on how many days did you smoke *hookah*?

0-30. Number of Days

77. Don't know/Not sure
99. Refused

B.13.0h During the past 12 months, have you stopped smoking *hookah* for one day or longer because you were trying to quit?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

B.13.0i Are you seriously considering stopping smoking *hookah* within the next six months?

1. Yes
2. No → Skip to next section

7. Don't know/Not sure → Skip to next section
9. Refused → Skip to next section

B.13.0j Are you planning to stop smoking *hookah* within the next 30 days?

1. Yes → Skip to next section
2. No → Skip to next section

7. Don't know/Not sure → Skip to next section
9. Refused → Skip to next section

B.13k About how long has it been since you last smoked *hookah* or *shisha* regularly?

1. Within the past month (< 1 month ago)
2. Within the past 3 months (>1 month but ≤ 3 months ago)
3. Within the past 6 months (>3 months but ≤ 6 months ago)
4. Within the past year (>6 months but ≤ 1 year ago)
5. Within the past 5 years (>1 year but ≤ 5 years ago)
6. Within the past 10 years (>5 years but ≤ 10 years ago)
7. Over 10 years ago

77. Don't know/Not sure
99. Refused

SECTION E: HEALTH AND SOCIAL INFLUENCES
(page 56)

E.1 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe smoking cigarettes is a cause of this condition, even if you don't currently use or have never used this product.

E.1a.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1b.

Colon cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1c.

Stroke

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1d.

Low-birth weight

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1e.

Lung cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1f.

Impotence

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1g.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.1 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe smoking *bidis* is a cause of this condition, even if you don't currently use or have never used this product.

E.1.1a.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.1b.

Colon cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.1c.

Stroke

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.1d.

Low-birth weight

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.1e.

Lung cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.1f.

Impotence

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.1g.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.2 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe smoking *hookah* is a cause of this condition, even if you don't currently use or have never used this product.

E.1.2a.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.2b.

Colon cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E. 1.2c.

Stroke

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E. 1.2d.

Low-birth weight

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E. 1.2e.

Lung cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E. 1.2f.

Impotence

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E. 1.2g.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.5 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe using *paan* is a cause of this condition, even if you don't currently use or have never used this product.

E.1.5a.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.5b.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.5c.

Stomach cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.5d.

Stroke

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.5e.

Tooth decay

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.5f Nasal cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.6 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe using *paan masala* is a cause of this condition, even if you don't currently use or have never used this product.

E.1.6a.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.6b.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.6c.

Stomach cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.6d.

Stroke

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.6e.

Tooth decay

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.6f Nasal cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.7 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe using *guthka* is a cause of this condition, even if you don't currently use or have never used this product.

E.1.7a.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.7b.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.7c.

Stomach cancer

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.1.7d.

Stroke

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.1.7e.

Tooth decay

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.1.7f Nasal cancer

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.1.8 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe using *zarda* is a cause of this condition, even if you don't currently use or have never used this product.

E.1.8a.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.8b.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.8c.

Stomach cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.8d.

Stroke

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.8e.

Tooth decay

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.8f Nasal cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.9 I'm going to read a list of medical conditions. After I read each one, I want you to tell me whether you believe using *niswar* is a cause of this condition, even if you don't currently use or have never used this product.

E.1.9a.

Oral cancer (gums, tongue, mouth, throat)

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.9b.

Heart attack

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.1.9c.

Stomach cancer

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.1.9d.

Stroke

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.1.9e.

Tooth decay

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.1.9f Nasal cancer

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

Comorbidity
(page 57)

E.2 I am going to read a list of medical conditions that many people have. After each one, please tell me if you have ever been told by a doctor or other health professional that you have that condition.

E.2a.

Asthma, bronchitis, or emphysema

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.2b.

Diabetes

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.2c.

Heart disease

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.2d.

Lung cancer

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.2e.

Any disease of the mouth (gum disease, oral cancer, tooth decay, oral discoloration)

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.2f.

High blood pressure

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

Risk Perception
(page 58)

E.3 Smoking cigarettes or *bidis* is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7 .Don't know/Not sure
9. Refused

E.3.1 Smoking *hookah/shisha* is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

E.3.5 Using *paan* is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

E.3.6 Using *paan masala* is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

E.3.7 Using *guthka* is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

E.3.8 Using *zarda* is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

E.3.9 Using *niswar* is physically addictive

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree

7. Don't know/Not sure
9. Refused

Perceived Benefits

E.3.2 I'm going to read a list of benefits. After I read each one, I want you to tell me whether you believe using *paan* results in any of these benefits.

E.3.2a.

Mouth freshener

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.2b.

Increased alertness

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.2c.

To help digest after a meal

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.2d.

Physical strength

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.2e.

Improved memory

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.2f.

Cleans teeth or mouth

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.2g Relaxation or stress relief

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.2h Lose weight

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.2i To help me go to the bathroom

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.2j I need to have something in my mouth

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.3 I'm going to read a list of benefits. After I read each one, I want you to tell me whether you believe using *paan masala* results in any of these benefits.

E.3.3a.

Mouth freshener

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.3b.

Increased alertness

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.3c.

To help digest after a meal

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.3d.

Physical strength

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.3e.

Improved memory

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.3f.

Cleans teeth or mouth

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.3g Relaxation or stress relief

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.3h Lose weight

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.3i To help me go to the bathroom

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.3j I need to have something in my mouth

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.4 I'm going to read a list of benefits. After I read each one, I want you to tell me whether you believe using *guthka* results in any of these benefits.

E.3.4a.

Mouth freshener

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.4b.

Increased alertness

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.4c.

To help digest after a meal

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.4d.

Physical strength

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.4e.

Improved memory

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.4f.

Cleans teeth or mouth

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.4g Relaxation or stress relief

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.4h Lose weight

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.4i To help me go to the bathroom

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.4j I need to have something in my mouth

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.5 I'm going to read a list of benefits. After I read each one, I want you to tell me whether you believe using *zarda* results in any of these benefits.

E.3.5a.

Mouth freshener

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.5b.

Increased alertness

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.5c.

To help digest after a meal

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.5d.

Physical strength

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.5e.

Improved memory

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.5f.

Cleans teeth or mouth

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.5g Relaxation or stress relief

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.5h Lose weight

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.5i To help me go to the bathroom

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.5j I need to have something in my mouth

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6 I'm going to read a list of benefits. After I read each one, I want you to tell me whether you believe using *niswar* results in any of these benefits.

E.3.6a.

Mouth freshener

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6b.

Increased alertness

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6c.

To help digest after a meal

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.6d.

Physical strength

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.6e.

Improved memory

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.6f.

Cleans teeth or mouth

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.6g Relaxation or stress relief

1. Yes
2. No

7. Don’t know/Not sure
9. Refused

E.3.6h Lose weight

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6i To help me go to the bathroom

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6j I need to have something in my mouth

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6.1 I'm going to read a list of benefits. After I read each one, I want you to tell me whether you believe smoking *hookah* results in any of these benefits.

E.3.6.1a Relaxation or stress relief

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6.1b Less harmful or safe alternative to cigarettes or *bidis*

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6.1c Sleeping aid

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6.1d Less addictive than cigarettes or *bidis*

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6.1e To help digest after a meal

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6.1f Mouth freshener

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.3.6.1g To help me go to the bathroom

1. Yes
2. No

7. Don't know/Not sure
9. Refused

Reasons for Use

E.3.7 Please let me know how important the following reasons are for you to use *paan* in the past or currently.

E.3.7a.

It helps me identify or puts me in touch with my South Asian background

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.7b.

Social or cultural celebration

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.7c.

Spending time with friends and/or family

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.7d.

It is customary at traditional South Asian events or gatherings

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.7e.

I like the taste

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.7f.

Alternative to other chewed or smoked products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.8 Please let me know how important the following reasons are for you to use *paan masala* in the past or currently.

E.3.8a.

It helps me identify or puts me in touch with my South Asian background

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.8b.

Social or cultural celebration

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.8c.

Spending time with friends and/or family

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.8d.

It is customary at traditional South Asian events or gatherings

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.8e.

I like the taste

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.8f.

Alternative to other chewed or smoked products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.9 Please let me know how important the following reasons are for you to use *guthka* in the past or currently.

E.3.9a.

It helps me identify or puts me in touch with my South Asian background

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.9b.

Social or cultural celebration

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.9c.

Spending time with friends and/or family

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.9d.

It is customary at traditional South Asian events or gatherings

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.9e.

I like the taste

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.9f.

Alternative to other chewed or smoked products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.10 Please let me know how important the following reasons are for you to use *zarda* in the past or currently.

E.3.10b.

It helps me identify or puts me in touch with my South Asian background

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.10b.

Social or cultural celebration

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.10c.

Spending time with friends and/or family

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.10d.

It is customary at traditional South Asian events or gatherings

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.10e.

I like the taste

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.10f.

Alternative to other chewed or smoked products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.11 Please let me know how important the following reasons are for you to use *niswar* in the past or currently.

E.3.11a.

It helps me identify or puts me in touch with my South Asian background

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.11b.

Social or cultural celebration

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.11c.

Spending time with friends and/or family

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.11d.

It is customary at traditional South Asian events or gatherings

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.11e.

I like the taste

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.11f.

Alternative to other chewed or smoked products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12 Please let me know how important the following reasons are for you to smoke *hookah* in the past or currently.

E.3.12a.

It helps me identify or puts me in touch with my South Asian background

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12b.

Social or cultural celebration

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12c.

Spending time with friends and/or family

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12d.

It is customary at traditional South Asian events or gatherings

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12e.

I like the taste

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12f.

Alternative to other chewed or smoked products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12 Please let me know how important the following reasons are for you to stop using *paan* in the past or currently.

E.3.12a.

Not socially acceptable in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12b.

Lack of availability in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12c.

Cost of products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12d.

Health concerns

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12e.

My friends and family don't like it

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12f.

Don't want family members or friends to use products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12g.

My religion prohibits or discourages it

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12h.

Using it makes other South Asians think I am of a lower class

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12i Addiction

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12i Impact on my appearance

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12j Don’t like it anymore

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12k Prefer to use another product

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12l Impairs my ability to function or perform tasks

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12m Because my friends and family don't use it themselves

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13 Please let me know how important the following reasons are for you to stop using *paan masala* in the past or currently.

E.3.13a.

Not socially acceptable in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13b.

Lack of availability in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13c.

Cost of products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13d.

Health concerns

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.13e.

My friends and family don’t like it

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.13f.

Don’t want family members or friends to use products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.13g.

My religion prohibits or discourages it

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.13h.

Using it makes other South Asians think I am of a lower class

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13i Addiction

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13j Impact on my appearance

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13k Don't like it anymore

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13l Prefer to use another product

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13m Impairs my ability to function or perform tasks

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.13n Because my friends and family don't use it themselves

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14 Please let me know how important the following reasons are for you to stop using *guthka* in the past or currently.

E.3.14a.

Not socially acceptable in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14b.

Lack of availability in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14c.

Cost of products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.14d.

Health concerns

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.14e.

My friends and family don’t like it

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.14f.

Don’t want family members or friends to use products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.14g.

My religion prohibits or discourages it

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14h.

Using it makes other South Asians think I am of a lower class

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14i Addiction

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14j Impact on my appearance

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14k Don't like it anymore

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14l Prefer to use another product

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14m Impairs my ability to function or perform tasks

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.14n Because my friends and family don't use it themselves

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.15 Please let me know how important the following reasons are for you to stop using *zarda* in the past or currently.

E.3.15a.

Not socially acceptable in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.15b.

Lack of availability in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15c.

Cost of products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15d.

Health concerns

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15e.

My friends and family don’t like it

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15f.

Don’t want family members or friends to use products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15g.

My religion prohibits or discourages it

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15h.

Using it makes other South Asians think I am of a lower class

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15i Addiction

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15j Impact on my appearance

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15k Don’t like it anymore

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15l Prefer to use another product

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15m Impairs my ability to function or perform tasks

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.15n Because my friends and family don’t use it themselves

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.16 Please let me know how important the following reasons are for you to stop using *niswar* in the past or currently.

E.3.16a.

Not socially acceptable in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.16b.

Lack of availability in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.16c.

Cost of products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.16d.

Health concerns

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.16e.

My friends and family don't like it

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.16f.

Don't want family members or friends to use products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.16g.

My religion prohibits or discourages it

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.16h.

Using it makes other South Asians think I am of a lower class

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.12i Addiction

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12i Impact on my appearance

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12j Don’t like it anymore

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12k Prefer to use another product

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12l Impairs my ability to function or perform tasks

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.12m Because my friends and family don't use it themselves

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.17 Please let me know how important the following reasons are for you to stop using *hookah* in the past or currently.

E.3.17a.

Not socially acceptable in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.17b.

Lack of availability in the United States

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.17c.

Cost of products

1. Very Important
2. Slightly Important
3. Not at all

7. Don't know/Not sure
9. Refused

E.3.17d.

Health concerns

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17e.

My friends and family don’t like it

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17f.

Don’t want family members or friends to use products

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17g.

My religion prohibits or discourages it

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17h.

Using it makes other South Asians think I am of a lower class

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17i Addiction

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17j Impact on my appearance

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17k Don’t like it anymore

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17l Prefer to use another product

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17m Impairs my ability to function or perform tasks

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

E.3.17n Because my friends and family don’t use it themselves

1. Very Important
2. Slightly Important
3. Not at all

7. Don’t know/Not sure
9. Refused

Social Influences
(page 58)

E.6 How many of your friends smoke cigarettes or *bidis*? Would you say:

1 None
2. A few
3. Less than half
4. About half
5. Most or all

7. Don't know/Not sure
9. Refused

E.6.1 How many of your friends or family members smoke *hookah*? Would you say:

1 None
2. A few
3. Less than half
4. About half
5. Most or all

7. Don't know/Not sure
9. Refused

E.6.2 How many of your friends or family members use *paan, paan masala, guthka, zarda, or niswar*? Would you say:

1 None
2. A few
3. Less than half
4. About half
5. Most or all

7. Don't know/Not sure
9. Refused

E.6.3 Do you think it is acceptable to smoke cigarettes OR *bidis* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.3a Do you think it is acceptable to smoke cigarettes OR *bidis* during cultural events?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.4 Do you think it is acceptable to smoke *hookah* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.4a Do you think it is acceptable to smoke *hookah* during cultural events?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5 Do you think it is acceptable to use *paan* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5a Do you think it is acceptable to use *paan* during cultural events?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5b Do you think it is acceptable to use *paan masala* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5c Do you think it is acceptable to use *paan masala* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5d Do you think it is acceptable to use *paan masala* during cultural events?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5e Do you think it is acceptable to use *guthka* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5f Do you think it is acceptable to use *guthka* during cultural events?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5g Do you think it is acceptable to use *zarda* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5h Do you think it is acceptable to use *zarda* during cultural events?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5i Do you think it is acceptable to use *niswar* when you are with other members of the South Asian community?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

E.6.5j Do you think it is acceptable to use *niswar* during cultural events?

1. Yes
2. No

7. Don't know/Not sure
9. Refused

SECTION G: PARENTAL INVOLVEMENT
(page 65)

Parent-Child Communication
(page 66)

During the last 6 months, how many times have you:

G.4.0 Allowed your child to use *paan*?

1. Never
2. Once
3. Twice
4. Three or more times

7. Don't know/Not sure
9. Refused

G.4.01 Allowed your child to use *paan masala*?

1. Never
2. Once
3. Twice
4. Three or more times

7. Don't know/Not sure
9. Refused

G.4.02 Allowed your child to use *guthka*?

1. Never
2. Once
3. Twice
4. Three or more times

7. Don't know/Not sure
9. Refused

G.4.03 Allowed your child to use *zarda*?

1. Never
2. Once
3. Twice
4. Three or more times

7. Don't know/Not sure
9. Refused

G.4.04 Allowed your child to use *niswar*?

1. Never
2. Once
3. Twice
4. Three or more times

7. Don't know/Not sure
9. Refused

G.4.0 Allowed your child to use *hookah*?

1. Never
2. Once
3. Twice
4. Three or more times

7. Don't know/Not sure
9. Refused

G.4 Talked to your child about what he/she can or cannot do when it comes to tobacco?

1. Never
2. Once
3. Twice
4. Three or more times

7. Don't know/Not sure
9. Refused