Mobilizing merchants and healthcare providers to reduce tobacco use in South Asian communities in Southern California

Final Evaluation Report

2006- 2008

CHAI tobacco control program

Project Director: Hamid Khan
South Asian Network
18173 S. Pioneer Blvd suite I
Artesia, California 90701
Phone: (562) 403-0488
Fax: (562) 403-0487
E-mail: hamid@southasiannetwork.org


Report Submitted: July 22nd, 2008

Made possible by funds received from the California Department of Public health, Tobacco control section under contract # 05-45978, contract term: 10/01/2005 - 06/30/2008

Abstract

California’s STAKE Act prohibits tobacco retailers from selling tobacco products to youth under the age of 18. Many retailers in California’s South Asian communities (Bangladeshi, Indian, Pakistani, Nepali, Sri Lankan and many others) are not aware that this law also prohibits the sale of such South Asian smokeless tobacco products as Gutka, paan masala and Zarda. The CX Assessment revealed that there is insufficient data available on the extent of compliance with posting the STAKE Act age of sale warning sign among South Asian businesses.

The CX Assessment showed that widespread tobacco cessation programs that address the culturally-specific needs of South Asian tobacco users are non-existent and that there is a need for improved screening protocols by health care providers to combat South Asian tobacco use.

South Asian Network’s (SAN) CHAI Tobacco Control program developed two major objectives with the goal of reducing the availability of tobacco products to minors and to promote tobacco cessation services for South Asians in Southern California.

Objective 1: By June 30, 2008 90% of South Asian convenience stores, grocery stores, mini marts and neighborhood stores within the Artesia/Cerritos, Los Angeles/South Bay, Anaheim/Garden Grove, and San Fernando Valley communities will be in compliance with posting STAKE Act age-of-sale warning signs. Indicator: 3.1.2

Objective 2: By June 30, 2008 two clinics serving South Asians will adopt and implement a Tobacco User Identification System (TUI) as part of the improved screening protocols to increase referrals to the Community Health Action Initiative (CHAI) cessation services by at least 50% of baseline. Indicator: 4.1.1 and 4.2.2

For Objective 1- (SAN) a social organization serving the South Asian community, has taken the lead in helping tobacco retailers in South Asian communities comply with this law. Using in-language posters, community workshops, merchant surveys, unannounced store visits and health education directed to the merchants, South Asian Network field workers sought to mobilize retailers in South Asian communities to comply more fully with the STAKE Act. In particular, they sought to have merchants post signage indicating that youthful looking persons must have government identification showing that they are 18 or older in order to purchase tobacco products and signage indicating the state’s 800-5ask4ID number that patrons can use if they witness store staff not checking the identification of youthful persons. Method: A pre-post uncontrolled design was used to evaluate the impact of a tobacco control health education effort targeted to the subset of 68 merchants who were non-compliant with the State’s STAKE Act. Stores were identified from phone book listings and from walking the streets in neighborhoods where clusters of South Asians were known to live. At baseline, information was obtained both by self-report survey of the merchants and by independent observation of signage in the store. Follow-up occurred nearly 6 months later, consisting of independent observation of signage in the store. Separate pre-post surveys were administered to persons attending community workshops designed to increase community awareness of the importance of local stores complying with the State’s STAKE Act. Main results: Nearly 30 percent of merchants at baseline were not aware that state law required tobacco retailers to post both an 800 number for
patrons to call if they witnessed the store selling tobacco products to minors and signage that warns patrons that they will be asked for proof of age if they look possibly underage. At follow-up nearly six months later, 100% of the merchants knew what state law required. Consistent with the improved knowledge of the law, compliance of the law also improved. At baseline only 43% of stores featured the required 800-5ask4ID number; at follow-up nearly six months later, the percent of compliant stores was 82%. On the downside, 28% of the stores [N=8] that were initially compliant and therefore did not receive education about the STAKE Act, were NOT compliant with the STAKE Act at follow-up assessment. **Conclusions and recommendations:** The South Asian Network’s merchant tobacco use prevention education program was effective in increasing knowledge and increasing merchants’ compliance with the STAKE Act. The intervention might have been even more effective if education about the STAKE Act had been provided to merchants whose stores appeared to be already complying with state law instead of being limited only to merchants at non-compliant stores. Getting merchants to agree to publicize their store’s compliance with the STAKE Act also appears to increase compliance at 6 months follow-up.

**For objective 2-** Most adults see a primary care physician at least once a year. If primary care providers used each visit to identify the patients who were tobacco dependent and to encourage them to quit, the decline in adult tobacco prevalence would accelerate. Many tobacco-dependent South Asians would still fail to be reached because they use non-traditional tobacco products unfamiliar to primary care providers. The South Asian Network identified eight medical clinics serving areas with significant concentrations of South Asians in the Los Angeles / Orange County area. South Asian health educators arranged 1-hour trainings for primary care providers to highlight federally recommended strategies for identifying and treating tobacco-dependent patients and to apprise primary care providers of the major south Asian-specific tobacco products such as Gutka, paan masala and Zarda. **Methods:** Eight administrators of medical clinics selected because they served areas where South Asians clustered were surveyed about their receptivity to partnering with the South Asian Network to promote tobacco control. A pre-post uncontrolled design was then used to evaluate the impact of a 1-hour training program on 16 health care providers from two of the targeted clinics. The training program focused on how to use a federally-recommended system to identify and counsel patients who are tobacco-dependent and how to conduct culturally appropriate interventions involving tobacco-dependent South Asian patients. **Main results:** Two of eight clinics signed memoranda of understanding with the South Asian Network for their primary care providers to get tobacco control training from SAN and to refer patients to SAN’s CHAI smoking cessation program. Sixteen primary care providers participated in 1-hour trainings on promoting tobacco control in medical settings. On most measures, respondents reported significant increases in knowledge and motivation as a result of participating in SAN’s training session. **Conclusions and recommendations:** Patience and persistence are needed to get busy medical clinics to sign memoranda of understanding, to get them to permit the professional staff to participate in tobacco control training, and to get them to refer patients to culturally appropriate smoking cessation services.
Mobilizing merchants and healthcare providers to reduce tobacco use in South Asian communities

Final evaluation report

Project Description

Background:

According to the CX Assessment, there is insufficient data available on the extent of compliance with posting the STAKE Act age of sale warning signs among South Asian businesses. There are many alternative, culturally specific tobacco products used by South Asians that are easily available to youths in convenience stores, grocery stores, mini marts and neighborhood stores generally owned and run by South Asians. Some of these products include tobacco-containing paan, guthka, zarda, supari etc. which are easily available in stores which carry South Asian products. While there is little data publicly available on the proportion of local businesses that are posting the STAKE Act signs in their stores, focus group data with South Asians revealed that an increasing number of South Asian youth are acquiring and engaging in use of various, alternative tobacco products. These youth are particularly likely to come from Bangladesh. Local South Asian merchants need to be educated about the STAKE Act so that they are aware that these laws apply to all tobacco products, not just cigarettes. Furthermore, data on South Asian businesses must be collected and evaluated in an effort to measure compliance with the posting of the STAKE Act age-of-sale warning signs. Since the enactment of the STAKE Act, there have been many merchant education and evaluation efforts conducted throughout the State of California to assess retailer compliance with this law. However none of the campaigns or evaluations have specifically targeted merchants selling South Asian-specific tobacco products. Local South Asian merchants need to receive culturally and linguistically appropriate education about the STAKE Act to ensure on-going compliance. This is also a step to mobilize community members around policy adoption and implementation.

The CX Assessments showed that there is a need for culturally and linguistically appropriate cessation services. Community members and outreach workers reported that tobacco users are not comfortable accessing existing services due to language barriers and a lack of awareness of available cessation services. In addition, Outreach Workers from the Community Health Action Initiative (CHAI) reported the appreciation that many of their clients expressed in receiving culturally and linguistically appropriate health services. CHAI is the first comprehensive, culturally/linguistically appropriate program focused on adoption of healthy lifestyles through promotion of chronic disease prevention and healthcare access for underserved South Asians in
Southern California. While it also provides support to clients who are trying to stop tobacco use, outreach workers feel that increasing awareness of the program and building bridges with existing evidence-based/informed cessation programs is vital to supporting more clients and to providing more access points for clients in their efforts to be rid of their addiction. There is also a need for improved tobacco use screening protocols by health care providers serving South Asian patients.

**Objective 1:** By June 30, 2008 90% of South Asian convenience stores, grocery stores, mini marts and neighborhood stores within the Artesia/Cerritos, Los Angeles/South Bay, Anaheim/Garden Grove, and San Fernando Valley communities will be in compliance with posting STAKE Act age-of-sale warning signs.

**Objective 2:** By June 30, 2008 two clinics serving South Asians will adopt and implement a Tobacco User Identification System (TUI) as part of the improved screening protocols to increase referrals to the Community Health Action Initiative (CHAI) cessation services by at least 50% of baseline.

**Intervention:** In 1994, the Stop Tobacco Access to Kids Enforcement (STAKE) Act was added to the State Business and Professions code. The California Department of Health Services: Tobacco Control and Prevention Division website (available at: http://www.lapublichealth.org/tob/legislation.htm), highlights the act requirements as follows: “(1) the California Department of Health Services (CDHS) to enforce the laws prohibiting youth sales, (2) tobacco retailers to check the identification of anyone appearing to be underage, (3) tobacco retailers to post warning signs at potential points of sale that include a toll-free number (1-800-5ASK-4-ID) to report underage sales, and (4) tobacco wholesalers to provide CDHS with a list of all tobacco retailers that they supply. The law was amended in 1996 to prohibit tobacco vending machines from all businesses except those holding a valid on-site sale liquor license, and they were required to keep machines at least 15 feet from the business entrance. The law also required the CDHS, Food and Drug Branch to conduct on-site compliance checks.”

To meet the objective of 90% of South Asian convenience stores, grocery stores, mini marts and neighborhood stores within the Artesia/Cerritos, Los Angeles/South Bay, Anaheim/Garden Grove, and San Fernando Valley communities will be in compliance with posting STAKE Act age-of-sale warning signs, a Store Merchant Campaign Consultant (SMCC) with specific multi-lingual language skills (Hindi, Urdu, Punjabi) was recruited in Spring of 2006 to oversee the pre-post test and intervention activities for each of the stores. The following activities were implemented:

In the beginning of the project period task force members consisting of 8-10 members from the community and various organizations were recruited. Several meetings and collaboration with organizations were key in carrying out our intervention activities successfully. These included:

**Distribution of Information Kits:** After baseline data is collected, Information Kits were assembled and distributed to all 100 Stores. Information kits included information on the STAKE Act & other tobacco control laws that pertain to the retail environment. A copy of the 1-800-5-
ASK4ID sticker was also included from TECC. In addition, culturally appropriate materials such as fact sheets and posters on tobacco use created by South Asian Network were included (i.e. information on paan use, gutkha, zarda, bidis, statistics, etc.)

Posters in English, Urdu, Hindi, and Bangla were developed. The posters were culturally appropriate with information about STAKE act and its applicability to products used among South Asians. To have a greater impact, the poster contained visual images of tobacco commonly used in the South Asian community (i.e. English cigarettes, bidis, paan, gutkha, zarda, pan masala, tambaku etc.) Throughout the intervention activities, it was emphasized that tobacco is more than simply English cigarettes and chewing tobacco; it also includes the culturally specific forms of tobacco greatly used by South Asians. Based on Focus Group data, we learned that many people in the community do not think that these South Asian tobacco products are subject to the same rules and regulations as English cigarettes. We attempted to add more emphasis on compliance than on education because compliance rather than education appears to have more impact on teen smoking rates (Stead & Lancaster, 2005). However, education was needed to ensure that merchants regard South Asian tobacco products with the same seriousness as English cigarettes. This includes understanding the products, the health consequences, and legal responsibilities and consequences of non-compliance.

For the Stores that were compliant during baseline assessment, personalized letters with completed checklists were sent with their Information Kits. The purpose of sending compliant Store merchants Information Kits and letters was to ensure on-going compliance. Some Store Merchants may be compliant without realizing it (i.e. the sticker with the toll-free number (1-800-5ASK-4-ID) to report underage sales may have been placed on the register by the previous owner). Stores that were not compliant at baseline assessments were eligible for the intervention where owners/staff received personal visits and retailer instruction/education provided in-language. Languages included Hindi/Urdu and Bangla. Based on observational assessments, SMCCs noted what specific changes needed to be made and will communicate these changes to merchants and/or employees in-language as well. The purpose of the visits was to have specific changes pointed out to the merchants and explained so that they understand how to be compliant with STAKE Act requirements. A 15-20 minute training was also given to store merchants to review the checklist used to assess the site as well as review the recommended protocols such as checking IDs and posting the STAKE Act signage and stickers.

In addition to addressing commercial sources of tobacco use, trainings were developed and delivered to address social sources as well. Harrison et. al (2005) and Rigotti et. al (1997) point out that tobacco retailer education and law enforcement efforts alone are not enough, because youth tend to replace the lost commercial sources with social sources such as friends and/or relatives. Therefore, efforts to prevent youth from having access to tobacco products must include social sources as well as commercial sources.

To address this, Outreach Workers (not the SMCCs) in year 2 of the project delivered the trainings/presentations to South Asian youth, families, community members and other potential social sources of tobacco. They delivered trainings to the Los Angeles Taxi Workers Alliance (LATWA) and a South Asian Lesbian, Bisexual, Gay, Transgender, Questioning, Intersexual (LBGTQI) organization (Satrang) in an effort to approach South Asian groups with high rates of
tobacco use. Presentations stressed the importance of preventing youth access to tobacco and were delivered in English and in Hindi, Urdu, and/or Bangla, when appropriate. To properly prepare Outreach Workers to deliver the trainings/presentations to community members, a training of the trainers (TOT) was developed and delivered to the Outreach Workers by the program coordinator.

To meet our second objective: By June 30, 2008 two clinics serving South Asians will adopt and implement a Tobacco User Identification System (TUI) as part of the improved screening protocols to increase referrals to the Community Health Action Initiative (CHAI) cessation services by at least 50% of baseline.

Given CHAI's focus on providing culturally competent cessation services to South Asians, this objective focused on CHAI's current provider network to improve their capacity to incorporate counseling for South Asian tobacco users using the "5 As" (Ask, Advise, Assess, Assist, and Arrange) as well as to institutionalize a proven systems for improving screening of patients for tobacco use among South Asian and to make referrals, when appropriate, to cessation resources. Our role (with help from community partners) included the provision of tools, processes, staff trainings and materials that help towards establishment of these systems. To accomplish the objective, the following intervention activities were carried out.

In Year 1 of the project the eight clinics that are currently part of the CHAI provider network in Los Angeles who serve a high volume of South Asian patients were contacted to assess their willingness to participate, to integrate a provider reminder system to screen patients for tobacco use and to refer them to agencies that can offer culturally and linguistically appropriate services to their clinic. This system aimed to establish and improve the cessation counseling offered to their South Asian patients during visits and through follow-up support. The clinics identified to participate in the intervention redrafted the current Memorandum of Understanding (MOUs) they had with CHAI. The MOU previously stated that clinics would provide culturally and linguistically appropriate care that is free or low cost to clients referred by CHAI and to work with CHAI to help patients who need further care navigate through the health system. Redrafting the MOUs was the first step for the clinics to voluntarily adopt and implement a policy to improve screening protocols for South Asians and refer them to appropriate cessation services. Signing the MOU with the clinic had been very difficult and challenging due to the lack of time for the providers to conduct special screenings for South Asian clients. Our staff at SAN constantly met with the providers and directors of the clinic to overcome this challenge. It took a while until the clinics finally signed the MOU and agreed to participate in the training. The clinics signed the MOU in the second year of the project. The referral system for the clinics was recommended by NCI based on the "5 A's" and adopted by AzTEPP (Arizona Tobacco Education and Prevention Program) into a health care provider and lay outreach worker training program/curriculum. Staff at the clinic will use the “5 A’s” algorithm (i.e., ask, advise, assess, assist and arrange), an evidence-based approach to identify tobacco users and inform them about culturally and linguistically appropriate cessation services available through CHAI. The purpose of providers and CHAI outreach workers using the 5 A’s was to increase the number of access points to cessation services for South Asians and to promote higher quit attempt rates.
The two clinics received a Provider Toolkit, adapted from the California Tobacco Control Alliance, which consisted of patient screening forms, chart stickers, statistical and cultural information related to South Asian tobacco usage, and cessation materials. In addition to the materials in the Toolkit, posters with images of various forms of culturally-specific tobacco products, mostly smokeless, such as bidis, paan and supari, zarda, gutka, paan parag, paan masala and snuff were distributed to the clinics. CHAI's contact information was also included on the poster. Curriculum Consultants developed a curriculum to be used in on-site trainings at the two clinics. The curriculum consultant provided education on South Asian tobacco use and products, a review of the tools in the Provider Toolkit, and on strategies to implement a culturally competent system to track tobacco use among patients and on how to refer them to cessation support services. The curriculum, “Delivering Culturally Relevant Tobacco Cessation Services" was developed and delivered to clinics by curriculum consultants and program coordinator. After the two clinics had undergone the training, letters were sent to the clinics to encourage maintenance of the updated policies and practices.

**Evaluation method, data collection, and results**

Baseline and follow-up data collected by South Asian Network, of Merchant Tobacco Education effort conducted by staff from the South Asian Network: March 2, 2008

The purpose of the baseline survey of South Asian-serving merchants was to determine if they sold tobacco products and if yes, then to determine if they were aware of the state law, the STAKE Act, that barred tobacco retailers from selling tobacco products to any person under the age of 18.

**Sample:** South Asian Network consultants canvassed shopping areas around Artesia for South Asian-serving convenience stores, grocery stores, mini marts and neighborhood stores, to determine whether they sold any tobacco-containing products. A survey was administered to an owner or manager of the store to determine if they were aware of California’s STAKE Act and if their store complied with the provisions of the STAKE Act. Sixty-eight (n = 68) stores were located and surveyed in Orange and Los Angeles counties. Most of the stores were grocery or grocery + liquor stores (71.2%); a quarter were liquor stores (24.2%) and three stores were convenience stores (4.5%).

The list of tobacco-containing products included: cigarettes, cigars, gutka, paan masala, Zarda / suti, bidis, Khaini, Epco / toothpaste / gul, Kimam.

Most of the South Asian-serving stores surveyed (92.6%) reported selling at least one tobacco-containing product. The range of tobacco-containing products varied by venue, with less than 3% selling the full range. Most stores carried two (29.4%), three (29.4%) or four (13.2%) different tobacco-containing products.

The STAKE Act created a new statewide enforcement program to take regulating action against businesses that illegally sell tobacco to minors. Authority for enforcement and responsibility for
implementation of the program was delegated to the Department of Health Services, Food & Drug Branch (FDB). The Act required DHS to:

- implement an enforcement program to reduce the illegal sale of tobacco products to minors and to conduct sting operations using 15 and 16 year old minors granted immunity;
- operate a toll-free number for the public to report illegal tobacco sales to minors;
- assure that tobacco retailers post warning signs which include the toll-free number to report violations;
- assure clerks check the identification of youthful-appearing persons prior to a sale;
- assess civil penalties ranging from $200 to $6,000 against the store owner for violations; and
- comply with the Congressionally-mandated SYNAR Amendment and
- prepare an annual report regarding enforcement activities and their effectiveness for the federal government, the California legislature, and California’s governor.

The SAN consultant conducting surveillance of South Asian-serving stores examined compliance with two specific features of the STAKE Act:

- 1) signage indicating that tobacco products could not be sold to persons under the age of 18;
- 2) the requirement that tobacco retailers post warning signs which include the toll-free number to report violations.

A survey of all stores showed poor compliance with the requirement that signage warn consumers that it is illegal to sell tobacco products to minors (19.1%). Compliance was better with respect to the requirement of posting an 800 number that patrons could use to report store non-compliance with state law (42.6%). Neither form of compliance was related to the size of the store, as reflected by the number of cash registers it had (range = 1-4 cash registers), nor to the type of store (e.g., grocery versus liquor store versus convenience store). Compliance with signage warning consumers that it is illegal to sell tobacco products to minors was unrelated to the number of tobacco-containing products for sale, but compliance with posting an 800 number was positively related to the number of tobacco-containing products for sale (OR = 1.52, 95% CI: 1.04, 2.21). Compliance with posting an 800 number was more common in stores that sold cigarettes, than in stores that did not (OR = 8.2, 95% CI: 2.3, 28.9).

Most of the owners/managers queried said that they had heard about California state laws designed to discourage youth from using tobacco (97%). Most said that they supported laws barring the sale of tobacco products to minors (89.7%). Perhaps because of the high prevalence of support, support for the STAKE Act was unrelated to compliance with its provisions. When queried specifically about the STAKE Act specifically, however, a majority of respondents reported either not knowing about the law (33.3%) or not being sure about its provisions (23.5%).
Most said that they were aware that government-sponsored undercover purchases were made by underage youth in order to catch merchants who were willing to break state law by selling tobacco products to minors (73.1%). This knowledge was unrelated to compliance with the STAKE Act. Almost all said that they were aware that merchants would pay fines to the government if they were discovered to be selling tobacco products to children (97%).

When asked about several possible influences on youth initiation of smoking, the respondents cited peer influence, parental influence and media influences as having larger impact than youth access to tobacco products (see Table 1). Despite this fact, respondents were nearly unanimous (98.5%) in agreeing that “tobacco retailers can play an important role in protecting our children from tobacco addiction and its serious health consequences.” There was also consensus (93.8%) that “cutting off the supply of tobacco products to youth reduces the number who smoke and who get disease.”

<table>
<thead>
<tr>
<th>Table 1. Baseline merchant views about probable influences on youth initiation of smoking.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How large an influence are the following, in your opinion, for causing a child or teenager to start smoking?</strong></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Easily accessible tobacco products.</td>
</tr>
<tr>
<td>Peer influence</td>
</tr>
<tr>
<td>Tobacco advertising and promotion</td>
</tr>
<tr>
<td>Parental smoking or other parental tobacco use</td>
</tr>
<tr>
<td>The use of tobacco products in movies and television</td>
</tr>
<tr>
<td>The price of tobacco products</td>
</tr>
</tbody>
</table>
Respondents agreed that merchants who don’t know English may make it hard for them to understand the California law about selling tobacco products to minors (65.1%).

Most respondents agreed that all use of tobacco products, including Desi tobacco products, contribute to avoidable disease. Ninety-seven percent agreed that nicotine was very addictive, particularly in persons who begin tobacco use early in life. Ninety percent agreed that smokeless tobacco products raise risk of cancer of the mouth. Eighty-five percent said that they were aware that more than one third of oral cancers in India were attributable to tobacco use. Eighty-seven percent recognized that tobacco use was the single greatest cause of preventable death in the U.S.

In summary, the foregoing suggests that merchants understand the importance of preventing youth from purchasing tobacco products and generally support government efforts to ensure that tobacco retailers not sell tobacco products to persons under the age of 18 but this support does not automatically translate into compliance with the particulars of California’s STAKE Act. Compliance with posting the 800 number was significantly higher in stores that sell cigarettes compared to stores that do not sell cigarettes but do sell other tobacco-containing products. These results suggest that an education campaign focusing on the sale of tobacco-containing Desi products is needed to improve retailer compliance with the STAKE act when selling non-cigarette tobacco products.

Follow-up results: Year 2

Health education was provided to the owners / managers of 47 stores that did not comply with state law concern STAKE Act signage at baseline. No education about the importance and requirements of the STAKE Act was provided to the owners / managers of stores that were already complying with state law, on the presumption that their compliance reflected both understanding of the law and a commitment to abide by it. In two instances, the quality of the health education was impaired by interruptions such that the owner/ manager probably did not receive all of the information. For all other merchants, SAN field staff reported a high quality of education. Field workers revisited the 67 stores (one store from the 68 baseline stores was closed) an average of 170 days after the health education to determine if the stores that had not been compliant were now compliant.

At the level of increased knowledge, the health education appeared to have an impact. Nearly thirty percent of merchants at baseline were not aware that state law required tobacco retailers to post both an 800 number for patrons to call if they witnessed the store selling tobacco products to minors and signage that warns patrons that they will be asked for proof of age if they look
possibly underage. At follow-up nearly six months later, 100% of the merchants knew what state law required. Consistent with the improved knowledge of the law, compliance of the law also improved. At baseline only 43% of stores featured the required 800-5ask4ID number; at follow-up nearly six months later, the percent of compliant stores was 82%. The compliance would have been higher except for the fact that 28% of the stores [N=8] that were initially compliant and therefore did not receive education about the STAKE Act were NOT compliant with the STAKE Act at follow-up assessment. The owner of one of the stores that remained compliant at both baseline and follow-up ruefully reported getting fined by the state for non-compliance in the interim period, so the non-compliance rate could have been higher still. He admitted that he might have benefited from the health education about the STAKE Act that SAN was providing only to the stores that were initially noncompliant. These results suggest that tobacco control activists cannot assume that stores that are compliant today will be compliant tomorrow. Stores that appear to be in compliance can still benefit from refresher education about the importance of complying with the STAKE Act.

During the nearly six months between initial assessment and follow-up observation the number of stores selling cigarettes increased from 27% of stores to 36% of stores. Part of the increased compliance with the STAKE Act could be attributed to this increase in the number of stores selling cigarettes because at baseline those stores carrying cigarettes were significantly more likely to comply with the STAKE Act. The increase in compliance with the STAKE Act during the study period was far greater among stores NOT selling cigarettes, however (from 30% to 79%), compared to stores that did sell cigarettes (from 78% to 88%). The good news is that all eight (100%) of the stores that started selling cigarettes during the study period became compliant with the STAKE Act after not being compliant at baseline. The cautionary news is that 19% of the stores that sold cigarettes at both baseline and follow-up had been compliant at baseline (and therefore did not appear to need education about the STAKE Act) but were no longer compliant at follow-up. Ownership of these stores remained the same during the study period, so the change in compliance cannot be attributed to new ownership. This suggests the need to monitor continuously those stores with a history of selling cigarettes and suggests that there is potential benefit in periodic re-education about the importance of stores complying with the STAKE Act.

Most of the South Asian-serving stores surveyed (91.2%) continued to sell at least one tobacco-containing product. The range of tobacco-containing products varied from 0 products to six different tobacco-containing products, with less than 2% selling the full range. Most stores carried two (25%), three (32.4%) or four (22.1%) different tobacco-containing products. Despite considerable variability in the choice of tobacco products at each store from baseline to follow-up, the aggregate availability of tobacco products was remarkably constant. If a store sold any tobacco product, it was most likely to be gutka or paan masala (91% of stores). Zarda was sold by half (50%) of the stores. Cigarettes were sold at 36% of the stores. All remaining tobacco-containing products were sold at less than 14% of the stores.
Following the provision of education about the importance and requirements of complying with the state’s STAKE Act, the SAN outreach worker asked the merchant whether it would be okay to highlight his store’s experience with respect to coming into compliance with the STAKE Act in the South Asian Network’s CHAI newsletter. Nearly half (47%) agreed to have their experience featured in SAN’s CHAI newsletter. Of course, there was no way that SAN was going to feature all of these stores but it was thought that a public commitment to compliance with the STAKE Act would strengthen their compliance. As expected, agreement to have their experience featured in SAN’s newsletter was associated with 100% subsequent compliance to the requirement to post the 800-5ask4ID number, which was significantly higher than the 83% compliance by those who refused.

More detailed comparisons of merchants’ beliefs and attitudes generally but not always showed improvement compared to baseline. Beliefs endorsed by 100% of the merchants surveyed included: agreed that various types of tobacco use were related to cancer, agreed that tobacco use was the single most important contributor to preventable death in the U.S. had heard about the STAKE Act, had heard about undercover buys (“sting” operations) to catch non-compliant tobacco retailers, and had heard of a tobacco retailer being fined for non-compliance. By contrast, at baseline only 33% of the merchants had heard about the STAKE Act and on all the other questions, the level of agreement ranged from 73% to 97%, never 100%.

When queried about particular stipulations of the STAKE Act, respondents still indicated less than total knowledge, but still an improvement over baseline. At follow-up none of the merchants made the mistake of saying that neither clerk nor owner could be fined (4% at baseline) or that the clerk alone could be fined (13% at baseline) but 63% erroneously said that only the owner could be fined when, in fact, both clerk and owner can be fined for violating the STAKE Act. When queried about the application of the STAKE Act to Desi products, namely products of South Asian origin, all but one respondent at follow-up agreed that the STAKE Act applied to such products, in contrast to 30% at baseline who had said that they were not aware that Desi products were subject to the state prohibition on sales to minors.

Merchants’ beliefs about the probable major influences on why youth take up tobacco use registered some changes relative to baseline and not always in beneficial directions. Curiously, for those merchants with information at both baseline and follow-up, they said at follow-up that tobacco product availability was a lesser influence for causing youth smoking than they had said at baseline (t(43) = - 3.8, p = .0005). Whereas 68% had said at baseline that tobacco product availability as an influence was “a lot” or “some” (versus “a little” or “none”), at follow-up nearly 6 months later only 25% rated tobacco product availability that high as an influence on youth tobacco use. The merchants were less likely to blame tobacco advertising and promotion as causes of youth smoking at follow-up compared to baseline (t(43) = - 4.8, p < .0000). Instead they were more likely at follow-up to blame youth tobacco use on parental tobacco use (t(43) =
2.5, p = .01). They also discounted the influence of tobacco product prices on youth tobacco use at the follow-up assessment compared to their baseline assessment (t(42) = -5.0, p < .0000). The beliefs that didn’t change from baseline to follow-up were the merchants’ beliefs about the large influence that peer tobacco use has on youth tobacco use and the influence of tobacco product placement in movies.

Despite shifts in merchants’ beliefs that favor tobacco industry positions, there was no shift in their support for state laws that prohibit the sale of tobacco products to minors. At baseline 91% of merchants were “very supportive” of such laws; at follow-up 93% were “very supportive.” Nor did these beliefs undermine their unanimous agreement that cutting off the supply of tobacco products to youth would reduce the number who became addicted and would thereby reduce their risk of tobacco-related disease. These store owners / managers were even unanimously in agreement that tobacco retailers can play an important role in protecting our children from tobacco addiction and its serious health consequences by strongly complying with the law such as checking ID’s of customers while selling any tobacco products (including desi tobacco products) and not selling them to children under the age of 18.

Community workshops

SAN field staff conducted 17 community workshops throughout their home base area of Artesia as well as one workshop in Los Angeles, to spread the word about the important benefits to the community of decreased community tolerance of tobacco use. These workshops took place in different venues, including: offices (n=5), restaurants (n=4), in outside venues (n=2), and at homes, apartments, and grocery stores (n=2 each). These took place at the rate of several a month, from the middle of September, 2007 through the middle of April, 2008. The ethnicity of the primary audience varied by workshop, including Indians, Pakistanis, Bangladeshis and Nepalese. The language used for the presentation varied correspondingly, including Hindi, Urdu, Bangla and Nepalese. The average size of the audience for each workshop was 5 persons, for a total of 85 people who attended. These people were asked to complete a two-question pretest marked with an arbitrary identifying number before listening to the tobacco control presentation. After the presentation they were asked to complete the two-question posttest questionnaire marked with the same arbitrary identifying number associated with the pretest questions.

The results of comparing pretest to posttest questions indicated that at pretest only 39% of respondents knew that tobacco retailers had to check the identification of youthful-appearing persons to make sure that they were over 18 before selling them paan, Gutka, Khaini, etc. By posttest this proportion had increased to 68%, a significant increase. At pretest only 12% of respondents knew that the STAKE Act was a state law prohibiting the sale of tobacco products to minors; 6% thought it was a law mandating a tax on tobacco products and 82% simply had not heard about it. At posttest, 99% correctly identified the nature of the STAKE Act, representing as great a change in knowledge as has been recorded in health education efforts.SAN’s health
education outreach efforts in the form of community workshops presented in a large variety of venues have been successful in raising community awareness of the nature and importance of California’s STAKE Act

In summary, the South Asian Network’s merchant tobacco use prevention education program was effective in increasing knowledge and increasing merchants’ compliance with the STAKE Act. The intervention might have been even more effective if education about the STAKE Act had been provided to merchants whose stores appeared to be already complying with state law instead of being limited only to merchants at non-compliant stores.

**Objective 2:** By June 30, 2008 two clinics serving South Asians will adopt and implement a Tobacco User Identification System (TUI) as part of the improved screening protocols to increase referrals to the Community Health Action Initiative (CHAI) cessation services by at least 50% of baseline

Eight community clinics were approached about participating in SAN’s clinic tobacco control intervention in the fall of 2007. These eight were located in areas known to be near significant concentrations of South Asians, including: Anaheim, Gardena, Long Beach, Los Alamitos, Los Angeles, Redondo Beach, and Wilmington. The position of the person who provided the requested information about the clinic’s services for South Asians was a manager (n = 4), medical assistant (n = 2) or staff physician (n = 1).

For all clinics, South Asians were a minority group, representing between 1% and 25% of their patient population with a median of 5%. Adults (as opposed to children) comprised between 50% and 100% of the patient population, with a mean of 74%.

With respect to the provision of tobacco control services, 88% of the clinics said that they offered some kind of smoking cessation services to all patients. 75% specifically reported that smoking cessation counseling was offered. None of them offered group smoking cessation classes, however. Half of them indicated offering nicotine replacement or other smoking cessation drugs. One clinic indicated that it offered acupuncture treatment as a treatment for nicotine dependency. For only two of these clinics was the claim made that their cessation services were culturally tailored for South Asians although a third could claim that their cessation services were culturally tailored for Asians more generally. Three quarters of the clinics said that they referred tobacco using patients wanting assistance to help them quit their habit to outside agencies. For the clinics that made outside referrals, 50% of them said that the outside cessation programs were culturally tailored for South Asians. None of them said that they referred South Asian patients to SAN’s CHAI smoking cessation program, probably because most providers were not aware of SAN’s program. For two of the clinics this failure to take advantage of SAN’s smoking cessation program was subsequently corrected.

The clinics were queried as to whether their health system would benefit from implementation of the Public Health Service Smoking Guidelines, including the use of “Tobacco as a vital sign /
User identification system” at their site. None of them indicated that this system was already currently implemented at their site. Three clinics said yes, two others said no, one was not sure and two clinics did not answer the question. Of those who said yes, all said that they were ready to implement the system within the next six months. Two of these subsequently signed a memorandum of understanding with SAN to have SAN assist their facilities in implementing their tobacco user identification system and to provide cessation services to patients identified and referred by the participating clinic. These two clinics were the Asian Pacific Health Care Venture clinic in Los Angeles (APHCV) and St. Nazarene Medical Clinic in Long Beach. Sixteen providers working at these two clinics were subsequently trained to use the PHS tobacco user identification system.

**Clinic health provider training**

Physicians and nurse practitioners from the two participating clinics attended a 1-hour training session during the lunch hour. The training for one clinic took place in November, 2007; for the other clinic, it took place in early December, 2007. Pretest information was collected before the training event; posttest information was collected at the end of the training event.

Two SAN staff members, armed with handouts, reviewed system strategies outlined by Public Health services guidelines that hospitals/clinics can use to promote tobacco use cessation among tobacco-dependent adults. The first recommended step is to implement a Tobacco-user Identification System (TUIS) in every clinic.

- Implementing clinic systems designed to increase the assessment and documentation of tobacco use markedly increases the rate clinicians intervene with their patients who smoke. Including tobacco status as a vital sign increases the probability that tobacco use is consistently assessed and documented.
- Having a clinic system in place to identify smokers also results in higher rates of smoking cessation.

**Strategies for implementation:**

*Office system change:* Expanding the Vital Signs to include tobacco use or implement an alternative universal identification.

*Responsible staff:* Nurse, medical assistant, receptionist, or other individual already responsible for measuring the vital signs. These staff must be instructed regarding the importance of this activity and serve as non-smoking role models.

*Frequency of utilization:* Every visit for every patient suspected of tobacco use regardless of the reason that brought the individual to the clinic. Repeated assessment is not necessary for adults known to have never used tobacco or not used tobacco for many years, and for whom this information is clearly documented in the medical record.
System implementation steps: Prepare progress note or computer record to include tobacco use along with the traditional vital signs for every patient visit. A vital sign stamp also can be used. Alternatives to the vital sign stamp are to place tobacco-use status stickers on all patient charts or to indicate smoking status using computer reminder systems.

The two clinics received one hour training on South Asian tobacco use habits, myths and the importance of screening South Asian patients for tobacco use. Included in the training packet were the Provider Toolkit, adapted from the California Tobacco Control Alliance, which consisted of patient screening forms, chart stickers, statistical and cultural information related to South Asian tobacco usage, and cessation materials and screening forms. In addition to the materials in the Toolkit, posters with images of various forms of culturally-specific tobacco products, mostly smokeless, such as paan and supari, zarda, gutka, paan parag, paan masala, and snuff were distributed to the clinics. CHAI's contact information was also included on the poster. Pre- and post-tests were also administered during the training session.

The respondents from the two clinics did not differ substantively, by clinic, on baseline measures of motivation or ability to help tobacco-dependent patients. The data from all sixteen providers who participated in the two clinic trainings were therefore combined into a single sample for comprehensive assessment of the impact of the training on provider knowledge and motivation.

On most measures, respondents reported significant increases in knowledge and motivation as a result of participating in SAN’s training session. With respect to knowledge of South Asian-specific tobacco products, most baseline respondents (81%) said that their knowledge was “low.” At the end of the training, most respondents (94%) said that their knowledge was “high” or “medium.” Respondents reported significantly greater ability to provide culturally appropriate smoking cessation as a consequence of the training. Most (60%) had rated their ability to provide culturally appropriate smoking cessation as “low” at baseline. On the posttest administered after the training had been completed, 100% of the respondents rated their ability as “high” or “medium.” Most (73%) rated their ability to refer South Asian patients to culturally appropriate smoking cessation services as “low” at baseline in contrast to 73% at posttest who rated this same ability as now “high.” Provider motivation to address tobacco dependence was already high at baseline (63%) but still increased significantly by posttest, to 88% who rated their motivation as “high.” At baseline a quarter of the providers rated as “low” or “moderate” the importance of having clinicians being actively involved in getting patients to quit their tobacco use. By the time of the posttest, there was near-unanimity (94%) that such importance was “high.” The one issue on which a non-significant increase was noted was the proportion of providers who supported the use of a tobacco user identification system in patient records. The change was from 69% whose baseline support was “high” compared to 88% whose support was “high” at posttest. The greatest improvement in knowledge was obtained for provider awareness of SAN’s CHAI smoking cessation program for South Asians. At pretest, only one provider (6%) indicated knowing about SAN’s CHAI smoking cessation program. By posttest, 94% indicated knowing about SAN’s CHAI smoking cessation program.
An additional seven questions were asked at posttest, specific to evaluating the perceived usefulness of various features of the training program. In general, respondent ratings of various features of the training program were high. They are summarized in Figure 1. Ratings were particularly high for the quality of the health education materials provided to participants as well as for the content of the training program. Ratings were also high for the training skills of the team of presenters, for the length of the program, for the degree to which the training program actively engaged the audience, and for its overall usefulness.

![Figure 1. Rating of usefulness, from least (1) to highest (5)](image)

Finally, respondents were asked two questions about whether conditions at their respective clinics made it easy or difficult to implement the suggestions made at the clinic. Overwhelmingly (88%), the respondents saw no difficulty emanating from their respective clinics that would impede their implementing the Surgeon General recommendations. In fact, three respondents (19%) said that there were features of their clinic that facilitated implementing the Surgeon General recommendations.

Overall, the sixteen trainees’ ratings consistently indicated a beneficial impact of the 1-hour noon-time training program on their knowledge and motivation to assist their South Asian patients in quitting their dependency on tobacco.

**Summary:** SAN ’s Community Health Action Initiative (CHAI) Tobacco Control program was a new ground-breaking project that we launched and introduced to our community. Over this
period the CHAI Tobacco Control project has accomplished great work in the South Asian community. Some of our achievements and accomplishments have created new pathways for changing community tobacco-related norms, have challenged community stakeholders to comply with current State laws/policies regarding tobacco control and filled the knowledge gap about the trends in use of culturally specific South Asian tobacco products and the serious health consequences of using such products over a lifetime.

The South Asian Network (SAN) partnered with community clinics in an effort to address culturally specific needs of South Asian tobacco users and provide culturally appropriate care. SAN provided two major clinics in the community with training on specific needs/use of tobacco products among South Asians and how to implement a culturally appropriate Tobacco User identification system to improve their screening protocol for identifying South Asian clients who smoked or used tobacco. These clinics signed a memorandum of understanding with SAN and agreed to institutionalize in their facility a policy to screen South Asian patients with respect to current tobacco use and, if appropriate, to refer the smokers to appropriate cessation services in the community. This experience has increased our capacity to partner with other clinics in other regions serving South Asian communities to institutionalize practices that increase the likelihood that smokers will get repeated opportunities and assistance to quit their tobacco use habit. Through our community education outreach and intervention activities, SAN has been educating retailers serving its community about the need for compliance with the STAKE Act, especially the provision of checking ID to reduce availability of tobacco products to underage minors in order to protect their health.

These efforts have clearly improved awareness among healthcare staff and community retailers about the contributions that they can make to reducing the health burden of tobacco use. There is more work to be done, unfortunately, to further increase awareness and have all community stakeholders more actively involved in efforts to minimize tobacco use among South Asians. These initial two years of support from the state have increased SAN’s capacity to mobilize our community to take important new steps to reduce the burden of tobacco use on our members. We have forged new alliances with groups such as the American Cancer Society and anticipate forging even more new alliances with groups such as S.A.F.E. in our continuing efforts to change retailer behaviors and health professional behaviors in ways that will ultimately reduce our community members’ risk of tobacco-related disease.

**Conclusion:** Patience and persistence are needed to get busy medical clinics to sign memoranda of understanding, to get them to permit the professional staff to participate in tobacco control training, and to get them to refer patients to culturally appropriate smoking cessation services. The South Asian Network’s merchant tobacco use prevention education program was effective in increasing knowledge and increasing merchants’ compliance with the STAKE Act. The intervention might have been even more effective if education about the STAKE Act had been provided to merchants whose stores appeared to be already complying with state law instead of being limited only to merchants at non-compliant stores. Getting merchants to agree to publicize their store’s compliance with the STAKE Act also appears to increase compliance at 6 months follow-up.
**Recommendations:** Given the necessity for information about South Asian tobacco products and use patterns, the following are recommendations for policy makers, public health professionals, and clinicians to effectively reduce or prevent the use of tobacco in this population

- Separate collection of data for South Asian ethnic groups (along with others) from the larger Asian and Pacific Islander (API) demographic category.
- Research targeted toward understanding the scope of tobacco products used by South Asians as well as the value and stigma ascribed to use of various products by South Asian subgroups (such as gender, region of origin, generational status, era of migration and level of acculturation).
- Policy research about which manufacturers produce South Asian tobacco products internationally, the mechanisms by which these tobacco items enter the U.S., and potential targeting of South Asians in tobacco marketing efforts.
- Culturally appropriate surveillance of tobacco use, related health behaviors, and pertinent health outcomes at the statewide and national level for South Asians.
- Design and implementation of community-driven and targeted intervention strategies geared toward reducing the prevalence of tobacco-related diseases and establishment of culturally-appropriate methods to curb tobacco use in South Asian subgroups.

**References:**


2 South Asian Network’s Tobacco policy brief. 2003

3 California Department of Health Services.