Author's response to reviews

Title: Culture, Acculturation and Tobacco Use in Hmong, Khmer, Laotians, and Vietnamese Communities in Minnesota

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Author's response to reviews: see over
May 30, 2014

Dr. Natalie Pafitis
Executive Editor, BMC Public Health

RE: MS 4330763061072564

Dear Dr. Pafitis:

On behalf of my co-authors, I am resubmitting a revised manuscript for publication in *BMC Public Health* entitled, “Culture, Acculturation and Tobacco Use in Hmong, Khmer, Laotians, and Vietnamese Communities in Minnesota.”

We thank the reviewers for the helpful comments and recommendations, which we have tried to address in this revision. We believe that our manuscript is significantly improved as a result, and hope that it is now acceptable for publication in *BMC Public Health*. Below is our point-by-point reply to the comments and recommendations of the referee and a detailed indication of the changes made in the manuscript and where the changes were made.

Please address all correspondence concerning this manuscript to Diana Burgess, Ph.D. (One Veterans Drive; Minneapolis, MN 55419; Phone: 612-467-1591; Fax: 612-467-5699; Diana.Burgess@va.gov).

Thank you for the opportunity to submit our revised manuscript to *BMC Public Health*.

Sincerely,

Diana Burgess, Ph.D.
Associate Professor, Department of Medicine
REVIEWER 1
Reviewer's report
Title: Culture, Acculturation and Tobacco Use among the Hmong, Khmer, Laotians, and Vietnamese Communities in Minnesota
Version: 2
Date: 26 December 2013
Reviewer: Arnab Mukherjea

Reviewer's report:

MAJOR COMPULSORY REVISIONS

1. The BACKGROUND section, although interesting, does not substantiate the extent of the "high rates of tobacco use" by Southeast Asian immigrants and particularly the Hmong, Khmer, Lao, and Vietnamese communities. It would help to know a brief overview of whether the empirical rates mirror those found in the native regions to understand if prevalence is higher, constant, or less among the two groups.

We now provide information about the rates of tobacco use in the different communities and in the native regions of the immigrant groups (p. 3, paragraph 1).

2. Although this point is found later, the TITLE of the manuscript is misleading. By-in-large, the authors are focusing on cigarette smoking, not use of all forms of tobacco.

We now provide clarifying information (see p. 5) showing that the questions in the semi-structured interview guide focused on tobacco use, rather than just on cigarette smoking.

“It should be noted that questions asked broadly about tobacco use, rather than just cigarette smoking, including a question that explicitly asked about “other forms of smoking including cigars, chewing tobacco or betel nuts, and pipes.”

3. More detail is needed about the "some Southeast Asian community leaders had long felt that tobacco use was a serious problem"; that in and of itself does not lend itself to a credible statement of significance. This is essential information given that the authors emphasize a CBPR approach and thus, community members are integral to entire research orientation, including problem definition.

We have revised this section to more accurately reflect how the topic of tobacco use was decided upon (p. 5).

“We adhered to most of the principles of CBPR with two exceptions: the decisions to focus on tobacco and the basic study design (i.e., interviews with community leaders) were driven by the two sponsoring organizations, the Minnesota Partnership for Action Against Tobacco (then MPAAT, now ClearWay MinnesotaSM) and the Center for Prevention at Blue Cross and Blue Shield of Minnesota (BCBSM). The decision to focus on tobacco was based on the funding agencies’ shared missions to work on tobacco control. The decision to interview community leaders was arrived at pragmatically in consultation with the community advisory board because community leaders were seen as experts on the social norms related to tobacco use in their communities and because they were in a position to play a key role in changing these norms and to elevate the importance of tobacco use as a community problem.”
4. *The links between the contextual factors described in the third and fourth paragraphs of the BACKGROUND section does not provide an obvious connection with why they would be related to tobacco use. The third paragraph also does not have any citations.*

We now provide clearer linkages between why the contextual factors would be related to tobacco use (last paragraph on p. 3, continued on p. 4). We also provide citations in the third paragraph.

There are several reasons why the experiences of these Southeast Asian community members might influence tobacco use. First, Khmer, Lao and Vietnamese populations came to Minnesota with tobacco use already well engrained in their cultures, in which the use of tobacco was acceptable [7-9]. Khmer, Lao and Vietnamese people have been using tobacco since the seventeenth century when Portuguese and Dutch traders began distributing it as a gift to promote friendship and as an item to exchange with local goods. Tobacco use spread in Southeast Asia because it was incorporated into daily customs and rituals as social currency, and because of its purported medicinal properties. In the late nineteenth century, Europeans, especially the French colonials, began selling manufactured cigarettes in Southeast Asia and promoting them as a luxury good.[10] Secondly, many people in these three ethnic communities, along with many Hmong, have experienced cumulative stress which is a risk factor for tobacco use.[11] Cumulative stressors include the past trauma of prolonged periods of civil unrest, war, occupation and authoritarian rule and post-migration stress, including unemployment, language difficulties, family conflict and discrimination.[12-15] Third, many Southeast Asian youth who grew up in the U.S. have described their substance use, including tobacco, as stemming from the stress associated with the large intergenerational gap between them and their elders,[16] and the use of tobacco among their friends and family members.[17] [18]

5. *The final paragraph in the BACKGROUND section does not set the stage for the research question. The only allusion is that "community members and policy-makers have called for studies..."; WHY did they call for these? What information would this provide them for the purposes for practice and policy? How this study heed that call? Usually policy makers do not call for studies unless they advance a public health agenda; distilling that would be important to understand why this information is useful for that purpose.*

We have revised the final paragraph to set the stage for the research question, including how this project fits into a broader research and policy agenda.

“To lay the groundwork for developing sound tobacco control policy, researchers and policy-makers have called for studies that examine historical and cultural factors that influence these ethnic groups’ present-day tobacco use norms and practices, with an emphasis on examining community-level factors rather than individual-level factors.[16-18] The present study aimed to produce an in-depth understanding of tobacco use within Minnesota’s Hmong, Khmer, Lao, and Vietnamese populations within the context of the experience of resettlement, immigration and adjustment, in order to inform the development of interventions that would reduce the harms of tobacco in these communities. To this end, we conducted this study using qualitative methods to explore the role of tobacco in Hmong, Khmer, Laotian and Vietnamese cultures in Minnesota.”

6. *An overarching comment: the authors are to be lauded for proposing a CBPR approach. However, more detail and justification needs to be provided about how academics and community-members collaborated to define this research question, create the analytic protocol, analyze data, and arrive at findings that would be disseminated in diverse forms. Otherwise, the authors should consider redefining their research orientation.*

We now provide more detail regarding the CBPR approach (see response to #3 above and text on p 5).
“We chose to use a CBPR approach because the funding agencies did not want researchers to develop intervention strategies that would be imposed on these ethnic populations, but rather to conduct formative research to identify potentially viable and culturally meaningful approaches that would be of interest to these populations.”

“We used a community-based participatory research (CBPR) approach in which community members, representatives from different organizations, and researchers collaborated throughout the research process. In 2002, MPAAT and BCBSM began engaging in dialogue with representatives from the Asian Pacific Tobacco-Free Coalition of Minnesota (APT-FCM), the Southeast Asian Refugee Community Home (SEARCH) and several other local advocacy and social service organizations that serve Southeast Asian communities in Minnesota, along with several university-based researchers. These groups formed the multidisciplinary Diverse Racial Ethnic Groups and Nations (DREGAN) Community Advisory Committee. Representatives from these groups were involved in establishing the research project and all subsequent phases of the research including: defining the research questions; developing the interview guide; identifying, recruiting, and interviewing community leaders; analyzing data; validating and presenting results; and dissemination of the findings. To undertake the study, the Community Advisory Committee designated a research team (the DREGAN team) made up of Hmong, Khmer, Lao, and Vietnamese community members and academic researchers (not of Southeast Asian origin).

“We adhered to most of the principles of CBPR with two exceptions: the decisions to focus on tobacco and the basic study design (i.e., interviews with community leaders) were driven by the two sponsoring organizations, ClearWay Minnesota and the Center for Prevention at Blue Cross and Blue Shield of Minnesota (BCBSM). The decision to focus on tobacco was based on the funding agencies’ shared missions to work on tobacco control. The decision to interview formal and informal community leaders was arrived at pragmatically in consultation with the community advisory board because community leaders were seen as experts on the social norms related to tobacco use in their communities and because they were in a position to play a key role in changing these norms and to elevate the importance of tobacco use as a community problem.”

7. *In the METHODS section, why was it decided that opinion makers were to be sole source of key informant interview data? How were the four "basic" questions arrived upon? This relates to a more refined description of the overall research question.*

We now provide information (on p. 5) about our decision to conduct key informant interviews with formal and informal community leaders (or opinion makers).

“The decision to interview community leaders was arrived at pragmatically in consultation with the community advisory board because community leaders were seen as experts on the social norms related to tobacco use in their communities and because they were in a position to play a key role in changing these norms and to elevate the importance of tobacco use as a community problem.

The DREGAN team developed four overarching questions that guided the study: 1) What were the community leaders’ own feelings, views and beliefs about tobacco use and secondhand smoke? 2) What did the community leaders think members of their ethnic group in Minnesota believed and perceived about tobacco use and secondhand smoke? 3) What patterns of tobacco use and secondhand smoke exposure did the community leaders observe? 4) What did the community leaders makers think might be done to reduce and prevent tobacco use?”
8. The CBPR/qualitative methods section requires major revision. Firstly, how was the interview guide developed? What were the domains of inquiry?

We have extensively revised the Methods section (pp. 5-6) to address the reviewers’ concerns. The section below specifically addresses the interview guide.

“The DREGAN team identified domains of inquiry that would be meaningful for Southeast Asian community members to use in future tobacco control work. These domains included leaders’ own perceptions of tobacco, leaders’ perceptions of community members, leaders’ perceptions of tobacco use patterns, and leaders’ perspectives about prevention. The DREGAN team then developed four overarching questions that guided the study: 1) what were the community leaders’ own feelings, views and beliefs about tobacco use and secondhand smoke? 2) What did the community leaders think members of their ethnic group in Minnesota believed and perceived about tobacco use and secondhand smoke? 3) What patterns of tobacco use and secondhand smoke exposure did the community leaders observe? 4) What did the community leaders makers think might be done to reduce and prevent tobacco use?

To answer these questions, the DREGAN team developed an interview guide and translated it into Hmong, Lao, Khmer, and Vietnamese. Team members with research expertise conducted trainings on interviewing for the Southeast Asian research team members who were fluent in English and their native language. The guide included broad questions about tobacco use, rather than just cigarette smoking, including a question that explicitly asked about “other forms of smoking including cigars, chewing tobacco or betel nuts, and pipes.” The Community Advisory Committee provided input and feedback throughout the process of developing the interview guide.”

9. Was data collection and analysis an iterative process as prescribed by grounded theory? If that is the case, it is likely that the instrument was revised after analysis for purposes of saturation and exploration of disconfirming cases. Similarly, were the participants selected in one sitting or after an initial round of analysis? If this was a linear process of instrument development, data collection, analysis of findings, then the 'grounded theory' claim is not credible.

Although we did revise our interview guide iteratively, we did not use saturation as a means of determining the number of participants to interview. Accordingly, we accept the reviewer’s concern and we have removed the phrase “grounded theory” in describing our data collection and analysis process.

10. *With respect to data analysis specifically in the METHODS section, how many reviewers were involved in each of the "parallel methods"? How many community members were involved? How were discrepancies resolved in theme generation?

We have added information about the data analysis to address the reviewer’s concern (see pp. 6-7). The entire DREGAN team was involved in the parallel methods and discrepancies were resolved by consensus. We have added a piece about the third “member checking” phase of our analysis, involving members of all four communities.

“In the third phase of our analysis, we conducted four separate meetings with members of each of the four communities (which included some interviewers and participants) in which we presented and then extensively discussed our results. This “member-checking” process resulted in clarification and revision of our initial findings, and ensured that our conclusions accurately reflected the experiences and beliefs of the participants.”
11. What was the measure of reliability of coders? How was saturation of themes arrived upon? Were disconfirming cases found and if so, how were they followed up upon iteratively in the data collection process? This information would be absolutely pivotal for me and eventual readers to evaluate the rigor of the methodology employed.

We did not calculate quantitative measures of coder reliability (such as the Kappa statistic). Instead, we reached agreement on our codes through consensus. We interviewed the number of participants based on our a priori decision to interview 15 formal and informal leaders in each of the four communities (8 men and 7 women), rather than by interviewing key informants until thematic saturation was reached. We have added this statement (p, 6):

“Team members then analyzed text segments in each topic document to identify major themes, and to note the degree of variation in views related to these themes. We were sensitive to the amount of variation among participants on a given topic (between and within ethnic groups), and we identified variation as part of our coding, noting disconfirming cases. Specifically, as part of our analysis protocol we examined minority/contrasting views and examined whether there were differences by number of years in the country, smoking status, community, and gender.”

12. *In a similar vein, how were subgroup findings and differences between Subgroups generated in a qualitatively rigorous fashion?

See above.

13. *The first paragraph of the RESULTS & DISCUSSION section seems to confirm my assumption that this paper predominantly explores cigarette smoking and not tobacco use.

We now clarify that this study focused on tobacco use broadly, rather than on cigarette smoking (see response to #2) above.

14. *The specific categories of findings might be better subdivided into patterns found in the native region vs. major differences found after immigration.

We appreciate the reviewer’s suggestion and have, ourselves, considered this presentation of results. However, for ease of comprehension, we decided to maintain the thematic organization, in which we discuss these changes related before and after immigration within each specific theme.

Without clarity regarding the prior points, it is difficult to understand the context of the findings as currently presented. However, they are interesting and seem to be substantiated by the selected quotations. Therefore, these comments are superficial in that they should align with the BACKGROUND and METHODS section concerns.

15. *Throughout the RESULTS & DISCUSSION section, the authors should state whether the majority of respondents agreed with each theme presented; otherwise, it could just be true that one person whose quote is stated reflected that purported theme.

In the Methods section, we have clarified that throughout our coding process we noted the degree of variation in views related to specific themes. (p. 6)
“Team members then analyzed text segments in each topic document to identify major themes, and to note the degree of variation in views related to these themes. We were sensitive to the amount of variation among participants on a given topic (between and within ethnic groups), and we identified variation as part of our coding, noting disconfirming cases. Specifically, as part of our analysis protocol we examined minority/contrasting views and examined whether there were differences by number of years in the country, smoking status, community, and gender.”

We also indicate we have chosen quotes that were highly representative. (p. 7)

“Additionally, in presenting our results, we have chosen quotes that are highly representative of the given theme.”

Throughout the Results section, we have indicated the degree of variation with phrases such as “nearly all of the key informants,” “several Hmong key informants,” “most key informants,” “some key informants,” and “a few key informants.” The use of these qualifiers is a standard practice in reporting the results of qualitative research.

16. *Is they key driver of tobacco use among Hmong due to the civil war in Laos?*

Unfortunately, we cannot answer this question based on our qualitative interviews, as we simply explore respondents’ perceptions and beliefs.

17. Was there no exploration of any other factors, especially in context of immigration? This is where comparative statistics would be helpful in the BACKGROUND section.

We have added comparative statistics about smoking rates in the countries of origin in the background section (see response to #1 above).

18. The CONCLUSION section seems to be a summary of the entire article without placing it in the larger literature. What is the novel information generated? This should be stated explicitly. In essence, the findings seems to boil down to youth & females smoking more than in the native regions whereas those who are older and male may reduce smoking due to changed norms, which does not seem like it expands and/or enhances the body of scientific literature. This section should really articulate the IMPLICATIONS of the findings to prevent and reduce tobacco use among these groups (as presumed by the concern laid out by policy makers in calling for these types of studies).

*The CONCLUSION section should lay out clear directions for future research and specific implications for public health practice and policy. Otherwise, this study simply provides the results of a qualitative CBPR study without any purpose of translation and/or application. The only allusion to this is the last sentence of the section, which is a very generic "programs should address these findings"; provide some comment about how (especially what to do about the tobacco industry).

We have revised the conclusion (now renamed “Discussion”) to address the reviewers concerns. In particular, we have added the following paragraph (p. 20):
“It is important to note that this research project served as an important catalyst for change in Minnesota’s Southeast Asian communities. This research project led community leaders to elevate the problem of tobacco use to an important community problem, which needed to be addressed. A number of key informants and members of the research team from the four communities became advocates for tobacco control. They became key participants in subsequent research projects and community interventions aimed at elevating the use of commercial tobacco as a community problem, shifting social norms related to tobacco use, and motivating current tobacco users to quit. These projects, in which community members were active participants, including the development of tobacco control messages, the integration of community messages into major community activities, and the use of community health workers to address tobacco-related policy and social norms related to tobacco at culturally-specific venues, including multiunit housing, places of worship, ethnic businesses and key community events. These projects incorporated insights from this study including the need to involve family, community, and clan; the need to address smokers’ psychological stress and social isolation, and changing social rituals in order to eliminate the role of commercial tobacco. Thus, this study demonstrates how formative CBPR research examining cultural and historical shifts in tobacco use patterns in ethnic communities can inform the development of tobacco control strategies that will be more effective because they are culturally meaningful in taking account the dimensions of acculturation.”

MINOR ESSENTIAL REVISIONS

19. *Most of the first paragraph in the "...MATERIAL CULTURE" subsection should be in the background, not results*

We have moved this material from the results section to the background section.

20. **In presenting qualitative research, quotes just not end a subsection/section. A wrap up sentence is usually needed to summarize that specific result.**

We have made sure that each set of quotes is accompanied by text that summarizes that specific result. However, in this paper, sometimes the text is before, rather than after the quote. We believe that this is a matter of style.

21. **On page 17, it is claimed that this includes "Southeast Asians of different generations" but it only examines tobacco use among immigrants, which makes that claim false.**

We emphasize that our conclusions are based on the participants’ perceptions of tobacco use among members of their communities, which include multiple generations. In the Discussion section we note the limitations with this approach. We also note that “subsequent research surveyed 1,628 members of the Hmong, Vietnamese, Lao, and Cambodian communities of Minnesota to examine tobacco use more broadly.” Nonetheless, we believe community leaders’ perceptions of tobacco-related problems experienced by individuals of different generations and life stages face is a critical piece in developing culturally appropriate interventions, and ensuring that there is “buy-in” for such interventions.

22. **There are some grammatical errors so a careful proofread of the final version is warranted.**

We have carefully proofread this version of the manuscript. We note, however, that we have deliberately kept the original grammar of the participants, even if it was grammatically incorrect, based on the belief that fixing grammatical mistakes paints an inaccurate portrayal of the participants, and eliminates some important information. We have included this information in the Methods section (p. 6).
DISCRETIONARY REVISIONS

21. Perhaps it might be useful to substantiate why a CBPR and/or qualitative approach was most suited to most comprehensively address the research question. Notwithstanding this recommendation, the principles of CBPR and qualitative methods must be adhered to in alignment with the methods described.

This is a helpful point. As discussed above (in #6 and #8) we have added additional text, describing the ways in which our approach adheres to CBPR research principles.

Level of interest: An article of importance in its field
Quality of written English: Acceptable
Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests: I declare I have no competing interests.

REVIEWER 2
Reviewer's report
Title: Culture, Acculturation and Tobacco Use among the Hmong, Khmer, Laotians, and Vietnamese Communities in Minnesota
Version: 2 Date: 15 April 2014
Reviewer: Sun Kim
Reviewer's report:
Abstract
1. Background: the authors wrote “However, there is scant research on how best to reduce and prevent ....” Thus, it seems that the present study would address the issue. Yet, it is a false proposition and the authors should clearly state here the purpose of the study. In the main text, the authors stated the study aimed to provide community-level factors affecting tobacco-related attitudes, beliefs, and behaviors among Southeast Asians in Minnesota.

We have added additional text, in which situate this project in a broader context, explaining more clearly how this formative work led to initiatives to reduce and prevent harms related to tobacco use.

“We, a team of Hmong, Khmer, Lao, and Vietnamese community members and academic researchers, partnered to undertake a community-based participatory research (CBPR) study using qualitative methods to examine the causes of tobacco use within these four Southeast Asian groups, to set the stage for future projects aimed at preventing and reducing tobacco use. We chose to use a CBPR approach because the funding agencies did not want researchers to develop intervention strategies that would be imposed on these ethnic populations, but rather to conduct formative research to identify potentially viable and culturally meaningful approaches that would be of interest to these populations.” (p. 3)

“The present study aimed to produce an in-depth understanding of tobacco use within Minnesota’s Hmong, Khmer, Lao, and Vietnamese populations within the context of the experience of resettlement, immigration and adjustment, in order to inform the development of interventions that would reduce the harms of tobacco in these communities, in a way that would be acceptable to these communities.” (pp. 4-5)

2. Methods: the authors wrote “Grounded Theory was used to guide data analysis.” The procedures, described in the main text for data collection and analysis, are not congruent with this research method. Furthermore, instead of Grounded Theory, the authors mentioned ethnographic analysis
in the main text. The two research methods are very different. Please indicate clearly and consistently which method was used.

We have removed the statement that grounded theory was used to guide data analysis. (see response to #9 above)

3. Results: Readers who are not familiar with Hmong may wonder how this ethnic subgroup differed from other groups. Stating briefly their tobacco use could be helpful.

We now provide information about how the Hmong differed from other groups (see below) and also provide information about their tobacco use.

It is important to note that the Hmong differed in key ways from the Vietnamese, Khmer, and Laotian populations of refugees and immigrants that were resettled in the U.S. The Hmong an ethnic group that began arriving from Laos as refugees in early 1976 [2]. Their families lived as ethnic minorities, known as “hill tribes,” survived in remote areas for generations by practicing shifting cultivation of food crops and tobacco, raising livestock, and gathering food in the forests [4]. Unlike the other three groups, the Hmong started their lives in Minnesota with low levels of tobacco use. However, since living in Minnesota, more and more Hmong have taken up tobacco use, especially Hmong men and Hmong youth of both genders.[1]

4. “In Minnesota, although elders felt pressure to quit….” Please describe briefly the source of the pressure if it is okay with the word limit in abstract by the journal. Was it referring to perceived social norm in general or perceived family norm or pressure from healthcare workers?

We have revised the sentence to clarify that elders felt “social pressure” to quit.

5. Conclusions: This section seems to lack logically congruence. Authors studied the perceptions of key informants not the perceptions of current smokers. Their perceptions could be different from current smokers’ tobacco-related attitudes, beliefs, and behaviors; hence, I wonder whether findings from the study would have any practical implications for cessation interventions.

This is a helpful point. At several points throughout the paper, we now address our decision to focus on formal and informal community leaders, and point out the strengths and limitations of this approach.

“The decision to interview community leaders was arrived at because these leaders were seen as expert informants on the social norms related to tobacco use in their communities and because they were in a position to play a key role in changing these norms and to elevate the importance of tobacco use as a community problem.” (p. 5)

“There are several limitations to this research. Our findings are derived from in-depth interviews with a stratified purposeful sample of participants who are informal and formal community leaders and thus, they are based on their experiences, perceptions, and opinions. These leaders tended to be somewhat older on average than the general population in their ethnic communities, and by definition they had higher social status than most other community members. Additionally, many of these leaders were not current tobacco users. Thus, while they had a wide perspective based on their many contacts and activities within their communities, their viewpoints do not directly reflect those of smokers and other important segments of these communities. This may have led to comments that reflected more of a shift away from the normative use of tobacco than is the case among smokers and in the community as a whole. However, to the extent that these leaders have a disproportionately large influence on their communities, their perspectives are critical to understanding and shaping tobacco use patterns in these communities.” (p. 19)
Background

6. Page 3, the third sentence of the third paragraph “For many, tobacco use was … in a foreign country.” Please provide reference(s) for the statement.
We have eliminated this statement.

7. Page 3, the first sentence of the last paragraph also needs reference(s).
We have eliminated this statement.

8. Page 4, in the third paragraph starting with “Ethnic Southeast Asian community members…,” the authors stated that the present study aimed to provide community-level factors influencing present-day tobacco use among Southeast Asians. Yet, the study was based on one-on-one interviews and there was not much information about the community where the study was conducted. To have an in-depth understanding of community-level factors, the authors should have provided information on the community such as demographic composition of the residential population, ethnic cultural infrastructure for each ethnic group, and any tobacco control polices such as the clean indoor air policy, excise taxes of cigarettes, etc.
We agree that these are important factors, but consider them beyond the scope of this study. We now note these limitations to the discussion section. (p. 20)

“Additionally, we did not explore the influence of important contextual factors, such as tobacco control policies and demographic composition of the residential population.”

Results and Discussion

9. Page 5, why are Results and Discuss sections combined?
We now separate the Results and Discussion section.

10. Page 5, the first paragraph: among participants, were there any limits for entry age to the United States? To talk about tobacco-related behaviors, knowledge, and norms in their homeland, participants should be immigrants who had some knowledge of the culture by having at least primary education (e.g., elementary school) in their homeland.
There were not limits for entry age to the United States. Our purpose was to gain insight from community leaders. Accordingly, we acknowledge limitations to this approach in the discussion section (p. 20, see response to #8 above).

11. Page 5, the first and second paragraphs: how the interview was conducted, was it audio-taped? Were they transcribed into verbatim scripts? How many single-spaced typed pages of transcripts were collected? Or was the analysis done by listening to the tapes? These processes should be described more thoroughly. If the audiotape was not done, what was the rationale?
We now include additional details in the Methods section where we state that the interviews were audiotaped and transcribed into verbatim scripts.

12. Page 5, the third paragraphs: the authors stated “a standardized framework of ethnographic analysis” and the procedure implemented is different from Grounded Theory that was stated in Abstract.
We now remove reference to Grounded Theory.
13. Please elaborate how discrepancies in coding themes and topics were resolved between or among analyzers and what measures were undertaken to establish the trustworthiness of the findings for qualitative data (e.g., member checking, triangulation of data sources, etc.). This is a helpful point. Please see our response to Reviewer 1, #10 and #11, in which we address these concerns.

14. Page 6, the first paragraph: Please provide demographics of the participants in table. As I expected, all participants were immigrants but still no information was provided as to the age at migration. I think this information should be provided for the credibility of the findings. Furthermore, there were only 3 current smokers and 17 former smokers. Of these smokers, were there any female smokers? Exactly 60% of the participants were never smokers, which is a serious concern for the credibility or validity of the study findings and practical implications. Please provide detailed information about the years of abstinence for former smokers and whether they quit smoking before or after migration to the US.

We now provide a table (Table 1), in which we include demographics, years in the United States, smoking status (broken down by gender), and whether the informant lives with a smoker. As discussed in #5 above, we now provide additional information justifying our decision to restrict our key informants to formal and informal community leaders.

15. Page 8, under the subheading ‘Tobacco, medicine and health’, the authors suddenly threw the concepts “some tobacco key informants” in the second line of this paragraph. Who were they? Were they different from other key informants?

We have revised this so that we refer to “participants,” to avoid confusion.

16. Page 10, the 6th line from bottom of the page “Minnesota, smoking was becoming common youth and women…” I think “among” should be inserted between “common” and “youth and women.”

We have made this revision.

Conclusion

17. Page 14, Conclusion: should it be Discussion?

We have renamed this section “Discussion.”

18. Page 15, the first paragraph: the authors stated that participants in the study informed getting new information from health care professionals, which was not described in Results.

We eliminate this, as it was not described in Results.

19. Pages 16-17, the paragraph on pages from 6 to 7 has a single sentence. The statement “Southeast Asian’s strong focus on the family and community” (the first line on page 7) seems to be out of place. It is read as if the family value of Asian Americans is used by tobacco companies as one of marketing strategies, which does not make a sense. Furthermore, in Results, the marketing strategies were never mentioned. I wonder whether the authors were trying to triangulate the findings with other resources, which is often used in Qualitative Research. If this is so, it should be clearly presented as it is.

We have deleted this paragraph, to avoid confusion.
20. All: I wonder how much the study adds to the existing body of the literature. Much of the information provided is already known. Based on my knowledge, may smokers in Southeast Asia still use roll-your-own cigarettes, betel quid, and/or water-pipe tobacco. Particularly chewing betel quit nuts with tobacco is popular among elder women in this region. There is not much information on how these smoking patterns had changed after living in Minnesota. It is not clear why the authors interviewed key informants instead of real smokers. The findings may have some practical implications in developing tobacco control policies but not much for smoking cessation interventions.

We thank the reviewer for raising these issues. As discussed above, in this revision we now provide additional information that: 1) elucidates the specific contribution our paper makes to the existing literature, 2) explains our rationale for interviewing formal and informal community leaders, and 3) discusses how this formative research informed specific smoking cessation interventions in Minnesota.