Implementing a Community Readiness Approach to Tobacco Control

Implementing A Community Readiness Approach to Tobacco Control

is a compilation of case studies highlighting how five regional coalitions or networks from across the continental U.S. and Hawai`i took up the challenge of reducing tobacco use in their local Asian American and Pacific Islander (AAPI) communities using a community capacity building approach. By sharing their experiences, accomplishments and challenges, we hope others will learn new ideas and fresh strategies to apply within their own communities.

Table of Contents

INTRODUCTION

In 1995, the landscape for tobacco control among Asian American and Pacific Islander (AAPI) communities looked very different than today. Although tobacco industry targeting was rampant and tobacco use prevalence was high among certain communities, tobacco was a low priority with most AAPI communities and no national AAPI tobacco control movement existed. With a few notable exceptions, like California, AAPI communities had little in place in terms of research, infrastructure, programs or policies to respond to tobacco's deadly threat, and no national network existed to coordinate efforts. At the same time, there was little inclusion or understanding of AAPIs within mainstream tobacco control efforts.

It was in this environment that Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) was born. Using strategies of network development, leadership training, education, advocacy/policy, and capacity building for over ten years, APPEAL has forged a national network of over 500 organizations working towards healthy, tobacco-free AAPI communities. Since being founded, APPEAL has worked to:

APICAT youth advocate against tobacco use.

- inform communities, mainstream organizations and policy makers about the significant impact of tobacco on AAPI communities
- build capacity of communities to mobilize against tobacco by developing educational materials and providing technical assistance and training (TAT)
- build leadership among adults and youth from the AAPI community and other communities of color to empower them to lead tobacco control efforts in their own communities
- counter the tobacco industry's targeted marketing of AAPI communities
- collaborate with organizations and leaders to advocate for the needs of AAPI communities in eliminating tobacco related disparities

A key challenge in initiating tobacco control activities within AAPI communities is that they are extremely diverse and vary in capacity to do tobacco control work. Some have never tried to address tobacco use before, even if they've been actively addressing other issues. Other communities have been working in tobacco control for quite some time. Furthermore, the diversity in terms of ethnicity, language, immigration history, religion, socioeconomic status, age, geography, and cultural norms regarding tobacco makes assessing community readiness levels even more important.

To help address these challenges, APPEAL created a tool called the Community Stages of Readiness Model to assist communities in assessing where they stand in regards to tobacco control and in developing plans for addressing their unique needs.

� The APPEAL Community Stages of Readiness Model

APPEAL's Community Stages of Readiness Model[1] provides a framework through which tobacco control areas can be assessed for diverse AAPI communities. Each of these areas fall under a 4-pronged, comprehensive approach that includes: (1) **research and data dissemination**, (2) **infrastructure building**, (3) **programs**, and (4) **policy change**. For the broad strategy of infrastructure building, for example, communities consider where they stand in terms of having tobacco competent organizations and staffing available, the inclusion of AAPI tobacco issues in mainstream coalitions, and leadership development. See Appendix A for a full listing of sub-categories for a comprehensive approach to tobacco control.

The Community Readiness Model proposes that tobacco control work is best accomplished using methods tailored to a region's specific assets, needs, and readiness to address tobacco use as a health and social justice issue. APPEAL adapted concepts from the Transtheoretical Model[2] to identify benchmarks of community capacity building along a continuum of five stages:

1. **Pre-contemplation:** A community or coalition has not seriously thought about addressing an area of tobacco control

2. **Contemplation:** A community has thought about taking action, but has not developed plans to work in an area of tobacco control

3. **Preparation:** A community has thought about taking action and is developing plans to work in an area of tobacco control

4. **Action:** A community has taken action in an area of tobacco control

5. **Maintenance:** A community has been taking action in an area of tobacco control for an extended period of time and has developed a plan for sustaining its efforts

As part of the assessment process, users of the Community Readiness Model explore efforts made or not made in each tobacco control area as well as consider relevant contextual factors before placing themselves in one of the five stages listed above. See Table 1 for an example of the five possible stages for placement in the second-hand smoke category.

Table 1: Definitions of the Five Stages for Secondhand Smoke Programs

Secondhand Smoke (SHS) Programs	
Pre-contemplation	Communities have not thought about addressing SHS issues.
Contemplation	Communities start to think about addressing SHS. They gather data on smokers in households and public places.
Preparation	Communities outreach and begin to develop appropriate strategies to address SHS in the community.
Action	Communities implement SHS educational campaigns and promote the campaign through ethnic and mainstream media.
Maintenance	Communities launch new SHS campaigns and establish a tracking system to monitor the program. New individuals, families and businesses are involved in campaigns.

[1] Lew R, Tanjasiri SP, Kagawa-Singer M, Yu JH. Using a stages of readiness model to address community capacity on tobacco control in the Asian American and Pacific Islander community. Asian American and Pacific Islander Journal of Health. 2001 Winter-Spring; 9(1): 66-73.

[2] Prochaska JO, DiClemente CC. Stages and process of self-change in smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology. 1983; 51: 390-395.

❈ The Community Readiness Model in Action

In 2000, APPEAL invited five regional partners (organizations or networks representing broader communities) at varying stages of readiness to work on tobacco control capacity building within their regions. Partners were selected due to their shared ability to engage AAPIs communities within their respective regions, geographical diverseness, and varying experiences with issues of tobacco control.

The five partners and their stages of community readiness were:

Regional Partner	Region	Regional Tobacco Control Readiness Stage (self-assessed)
Asian Services in Action, Inc. (ASIA)	Ohio	Pre-Contemplation / Contemplation
Charles B. Wang Community Health Center (CBWCHC)	New York City	Contemplation
Washington Asian Pacific Islander Families Against Tobacco (WAPIFASA)	Washington State (Greater Seattle-King County Area)	Preparation
Papa Ola Lōkahi (POL) and Coalition for a Tobacco-Free Hawai'i (CFTFH)*	Hawai'i	Contemplation (Native Hawaiian Population) Action (General Population)
Asian & Pacific Islander American Health Forum (APIAHF)	California	Maintenance

* In the second year of the project, Papa Ola Lokahi (POL) became APPEAL's regional partner in Hawaii, focused primarily on the health of Native Hawaiians. CFTFH was APPEAL's regional partner in year 1 of the project and focused primarily on the general population of Hawaii.

APPEAL introduced the Community Stages of Readiness Model with each partner and worked with them to assess their region's readiness in a number of areas important to tobacco control work. These areas included research and data, infrastructure issues, specific programs, and policies. Partners then used their assessments to create annual work plans aimed at promoting growth within prioritized areas.

❈ Community Results

Over the course of five years, all of APPEAL's Regional Partners successfully increased the capacity of their coalition or network to do tobacco control work. Specific successes included coalition or network building, the securing of additional funding, the launching or expansion of program or policy efforts, and enhanced expertise as technical assistance providers.

The Community Stages of Readiness Model served as a practical tool for identifying resources and gaps, prioritizing efforts, developing plans, and evaluating progress. Overall, the Community Readiness Model worked best when approached with flexibility and when used in dialogue with other groups in their region

and APPEAL. Using the Model over time allowed Partners to track efforts as they expanded or shrunk to new geographic regions or in comprehensiveness. It also illuminated the impact of larger community or state issues (such as the passing of laws, the allocation of funding, and so on) on their specific efforts and the region's readiness as a whole.

✳ Benefits of Using the Community Readiness Model

Using a community readiness approach can help you think through your community's assets and needs that either support or hinder tobacco control work. It also allows you to consider these factors on a level broader than just one organization or program and to think comprehensively across multiple approaches. Practically speaking, this information can then help inform planned action in terms of a strategic plan to build readiness. Reassessment of community readiness later on in the process provides important feedback on progress and next steps as well.

In the sections that follow, APPEAL's five regional partners will share their stories of how they used a community readiness approach in their tobacco control work. It will provide concrete examples of how they used APPEAL's Community Stages of Readiness Model to assess local AAPI communities on tobacco readiness and develop strategic regional action plans for developing local tobacco control capacity.

Through the experiences of others, readers will learn how APPEAL's Community Stages of Readiness Model can be used:

- As an assessment and strategic planning tool
- As a process evaluation tool to chart progress or challenges over time
- To determine areas of technical assistance and training that might best support different tobacco control efforts.

For additional assistance applying the Community Readiness Model to your community, please contact APPEAL at appeal@aapcho.org or 510 272-9536.

Regional Partners Kenny Kwong (CBWCHC) and Cheryl Owens (ASIA, Inc.) share their strategies for implementing the Community Readiness Model.

Ohio

Starting Readiness Stage: Pre-Contemplation/Contemplation

Ending Readiness Stage: Action

Geographic Area: Ohio (primarily Columbus, Cleveland, Cincinnati, Akron, and Dayton)

Regional Partner: Asian Services in Action, Inc. (ASIA)

AAYAT youth raise public awareness about the dangers of tobacco use.

Asian Services in Action, Inc. (ASIA) is a community resource center providing information to and services for Asian Americans in Ohio. From 2000-2005, ASIA used the APPEAL Community Stages of Readiness Model as a planning and assessment tool to understanding the issues associated with tobacco control work in the Asian American and Pacific Islander (AAPI) community. During those five years, the AAPI communities in Ohio moved from the Pre-Contemplation/Contemplation stage to the Action stage. For ASIA, the combination of availability of funding, data, and well implemented programs contributed to the expansion of programs in other areas that the agency was not initially capable of undertaking. ASIA was able to focus particularly on mobilizing AAPI youth, positioning the AAPI community in the right place for funding and resources, and collecting and disseminating data on Asian American tobacco use.

✳ Baseline Assessment

Ohio is home to more than 132,000 Asian American and Pacific Islanders (AAPI). The defined region of tobacco control work began in Cleveland and Akron whose AAPI population numbered over 25,000 and 8,000 respectively. When tobacco settlement funding from the state was successfully obtained, the tobacco control work expanded to three additional regions in the state: Cincinnati, Columbus and Dayton with AAPIs numbering 13,602, 32,784 and 7,341 respectively within those cities and their surrounding suburbs.

Ohio's AAPI youth mobilize against tobacco at the 2004 AAYAT (Asian American Youth Against Tobacco) Youth Leadership Summit.

The growth rate of the number of AAPIs increased nearly 48% from 1990-2000. However, in Cleveland the rate of increase has been cited as high as 67%. Chinese, Japanese, Korean, Vietnamese, and Filipino are the largest subgroups, but Laotian, Cambodian and Hmong communities are also represented. These Asian American communities are not only diverse in terms of nationalities, but also in language, English proficiency, education, socioeconomic background, acculturation levels, religion, and immigration patterns.

When tobacco control work was first considered in 2000, an assessment using the APPEAL Community Stages of Readiness Model placed the region in **pre-contemplation** and **contemplation**. A breakdown of the staging of each category was as follows:

- **Research and Data (Contemplation):** Except for a few research studies conducted through a local state university, very little to nothing was being done in Ohio AAPI communities in regards to tobacco control.

- **Infrastructure (Contemplation):** AAPI communities were not aware and indifferent to health promotional efforts and tobacco use prevention.

- **Programs (Contemplation):** Mainstream efforts failed to reach out to AAPI communities by developing and implementing programs that lacked cultural and linguistic relevance. The AAPI's needs to address tobacco remained invisible and unmet.

- **Policy (Pre-Contemplation):** Clean indoor air and youth access policies were not established or enforced; many in the AAPI community were in violation of selling cigarettes to minors and were reluctant to enforce no tobacco use in business and public places.

✿ APPLICATION OF THE COMMUNITY READINESS MODEL

Overall, the APPEAL Community Stages of Readiness Model served as a very useful tool to help educate the community and ASIA's staff about the elements and processes of tobacco work that are also applicable to other health issues. To be effective as a program of change, the program needed to have a critical understanding of the elements of the Community Readiness Model.

AAYAT advocates participate in the 1200 campaign in Washington, DC.

ASIA's executive director and program staff utilized the Community Readiness Model to discuss staging for the organization and to identify key areas of focus. The Community Readiness Model was reviewed on a semi-annual basis and enabled staff to evaluate movement in the various stages of readiness. As an evaluation tool, the Community Readiness Model helped them assess readiness levels on multiple areas of tobacco control. For example, when funding became available, the tobacco control efforts expanded to tobacco control areas on the Community Readiness Model that were not initially identified as priority areas. This occurred because priority areas, such as youth mobilization enabled accessing of funds for new areas, such as youth cessation.

Through the assessment process, staff also discussed the various factors that contributed to changes within the Community Readiness Model; in addition to funding, factors included staffing, collaboration with other agencies and environmental factors. The Community Readiness Model enabled ASIA to engage in a qualitative evaluation of the programs and helped to supplement quantitative data collection and analysis.

DETERMINATION OF PRIORITY AREAS

The priority areas ASIA chose to work on were:

- **Funding Resources** (Contemplation)
- **Local AAPI Coalitions** (Contemplation)
- **Youth Mobilization** (Contemplation)
- **Tobacco Use and Data Collection** (Contemplation)

All the areas were assessed to be in the **contemplation** stage, meaning that there was some consideration of the issues, but no definitive steps toward action.

ASIA's staging of their priority areas were based on the following factors:

- The community resources that can support tobacco control activities
- The agency programs and network that can support tobacco control activities
- The current opportunities available for tobacco control work to build capacity and program track record
- The positioning of the organization to compete for tobacco settlement funding to expand and sustain tobacco work

For ASIA, adequate funding was critical to starting its tobacco control programs. Starting the programs meant having the support to build the infrastructure for competent staff that must attend mainstream coalition meetings; engage local AAPI community leaders; link with priority population groups; mobilize youth to develop tobacco control leadership; and organize and form Asian coalitions.

✳ Key Outcomes

Overall Movement along the Community Readiness Model

From 2000-2005, ASIA's targeted priority areas moved from **Contemplation to Action** in all the priority areas, as well as additional areas not initially identified, such as "Clean Indoor Air" and "Youth Cessation" (see table 2).

Table 2: Staging of ASIA's Priority Areas from 2001-2005

	Research & Data	Infrastructure		Programs		Policy
	Data Collection	Funding Resources	AAPI Coalitions	Youth Mobilization	Cessation	Clean Indoor Air
Pre-contemplation						2001
Contemplation	2001		2001		2001, 2003	
Preparation		2001		2001		
Action	2002-2005	2002-2003, 2005	2002-2005	2002-2004	2004-2005	2003-2005
Maintenance				2005		

⟶ = *direction of movement along the Community Readiness Model*

ASIA can lay claim to many accomplishments in its tobacco efforts. Among them are the following:

Funding Resources: Funding from the Ohio Tobacco Use Prevention and Control Foundation remains the main source of support for the tobacco control efforts in the Asian communities. A positive track record helps to be considered for future funding to sustain the expansion of existing programs.

ASIA was successful in positioning itself well for resources and funding and accessing linkages to support its tobacco control work. When the opportunity for involvement in the tobacco control leadership program availed itself through APPEAL, ASIA's executive director participated, learned the fundamentals and the successes of other AAPI tobacco control programs, and developed a network for technical assistance and collaboration. Some of the major outcomes from involvement in the APPEAL leadership program included:

- Tobacco control funding from the Ohio Department of Health. This enabled ASIA to become prepared when the state tobacco settlement funding became available.

- ASIA's successful application for funding from the Ohio Tobacco Use Prevention and Control Foundation (the main source for distribution of Master Settlement Agreement monies) enabled the expansion of the tobacco control work into five major cities in Ohio.

- The positive program track record that ASIA built resulted in gaining advocacy from the state commission on minority health to secure Robert Wood Johnson Foundation funding to address Clean Indoor Air for communities of color in Cleveland. This last and most recent source of support allowed the tobacco control effort to focus on policy change.

Research and Data: In four years, ASIA conducted over 1,070 adult and 369 youth surveys in Northeast Ohio and 1,600 adult and 1,364 youth surveys statewide to assess the tobacco use prevalence in Ohio's AAPI communities. The surveys were translated for adult administration and targeted eight Asian nationalities. The

data disaggregated by ethnicity showed prevalence rates for smoking and secondhand smoke exposure that were significantly higher for certain Asian groups than the national averages. The statewide youth survey report noted that smoking prevalence was highest among Cambodian (40%), Laotian (32%), Hmong (29%) and Korean (23%).

The massive "Data Collection" and the dissemination of its results increased the visibility of the needs in the Asian communities for tobacco control and other related health issues, as well as increased access to resources, collaboration with mainstream coalitions and linkages with other communities of color.

Youth Mobilization: A historical progression of ASIA, Inc.'s work in Ohio demonstrates its growth in engaging AAPI communities in the area of tobacco control.

- In 1997, ASIA engaged the Asian Teen Board comprised of five AAPI youth to create a tobacco control project for the community. The project resulted in a multi-lingual calendar with "no smoking" messages drawn by AAPI youth.

- In 1998, ASIA was granted funding to develop Asian Youth Against Tobacco (AYAT), a coalition of AAPI youth in Northeast Ohio.

- In 2002, this pilot project was then expanded statewide and became Asian American Youth Against Tobacco (AAYAT) through funding from the Ohio Tobacco Use Prevention and Control Foundation.

- To date, AAYAT has reached over 200 AAPI youth in leadership and advocacy development and conducted over 40 projects throughout the state. AAYAT's projects include smoke-free dining events, tobacco-free fashion shows, adult and youth presentations and support of local clean indoor air campaigns.

*AAYAT youth rally against tobacco by taking part in a **stand** youth campaign.*

- In 2004, AAYAT's success was given national recognition by the Campaign for Tobacco-Free Kids as the Youth Advocate of the Year Award in the group category. The Youth Mobilization program's national recognition by the Campaign for Tobacco-Free Kids qualifies it as a best practice that can be replicated in other regions of the country for Asian and other immigrant communities. This has lead to the development of a training kit that enables agencies to utilize AAYAT's model as a template.

Cessation and Clean Indoor Air Policy: Through their successes with data collection and youth mobilization, ASIA has been able to expand its reach into the areas of cessation and policy work — two areas which were not initially identified as priority areas, but became areas of focus. As a sub-grantee of the Greater Cleveland Health Improvement Service Council (GCHSC), ASIA has initiated cessation programs for the Southeast Asian and Chinese youth and adults in Northeast Ohio. Originally at the Contemplation level in the area of cessation, ASIA found it helpful to seek TAT through APPEAL's network from other community based organizations that were already working on cessation in their communities.

Through collaborating with other communities of color, ASIA was also able to expand into the area of clean indoor air policy change. Initial funding through the Special Opportunities Grant by the Robert Wood Johnson Foundation (RWJF) enabled ASIA to provide outreach to the AAPI community in Cleveland in collaboration with the African American, Hispanic and Native American communities. This pilot project led to continued funding to sustain the outreach effort among the minority communities of greater Cleveland.

✳ Lessons Learned

ASIA has found that key successes translate to increased interaction with mainstream organizations, many of which are limited in their cultural sensitivity to communities of color. Such a situation often results in communication that hampers effective collaborations.

Although funding has been provided on a meaningful level and work has progressed, there is a realization that in order to conduct tobacco control programs adequately, each targeted region needs to be supported with full time staff. Limited funding cannot provide this and therefore restricts the comprehensiveness of programs in certain regions targeted.

The Community Readiness Model is an extremely useful tool to understanding the phenomenon of change with health issues. Unless some level of understanding of the processes and issues entailed occurs prior to committing to tobacco work, the likelihood of commitment and success are limited. Passion for a cause must be balanced by the reality of the circumstances at hand. The Community Readiness Model with its comprehensive assessment model has the ability to help achieve this balance.

New York City

Starting Readiness Stage: Contemplation

Ending Readiness Stage: Action

Geographic Area: New York City, NY

Regional Partner: Charles B. Wang Community Health Center (CBWCHC)

A GUIDE TO QUIT SMOKING

戒 煙 指 南

Quit Smoking Guide developed for Chinese communities.

For more than 30 years, the **Charles B. Wang Community Health Center (CBWCHC)** has been a leader in providing high-quality, affordable, culturally competent health-care to the Asian American community in New York City. They promote the health of the community through innovative, award winning health education and advocacy programs, and by recruiting and training bilingual health care providers. CBWCHC was also instrumental in the formation of the New York AAPI Tobacco Control Network, a coalition of community-based agencies, community advocates and leaders, and health care organizations who work to increase awareness and capacity to address tobacco issues impacting AAPI communities.

During the five years of using the APPEAL Community Stages of Readiness Model, the Asian American and Pacific Islander (AAPI) community in the New York City region progressed from the Contemplation to the Action stage. In 2001, the Community Readiness Model was an especially important tool for the recently formed New York AAPI Tobacco Control Network. The Community Readiness Model provided a framework for planning and prioritizing the Network's tobacco control efforts and also highlighted the importance of developing its infrastructure. Although challenges existed in accessing funding and resources, the Network was able to move forward in addressing cessation, advocating for clean indoor air policies, and developing collaboration and competency to address tobacco in the AAPI community.

� Baseline Assessment

According to the 2000 U.S. Census, the AAPI population represented almost 10% of the city's eight million people in NYC. This diverse group increased by more than 54% in ten years, an increase that far outpaced

the 9.4% growth of the general population in NYC during the same period. With a population of 361,531 that has grown approximately 51% between 1990 and 2000 (US Census Bureau), Chinese Americans are the largest Asian American ethnic group in NYC. They are followed by the Asian Indian population at 170,899, Filipino population at 54,993 and Pakistani population at 24,099.

When CBWCHC began its work five years ago, they assessed the AAPI community overall at the **Contemplation** stage of readiness and the breakdown of the four tobacco control areas were as follows:

- **Research and Data (Contemplation):** Very little data were available on AAPIs in regards to tobacco use in the community. Capacity building was needed on how to utilize existing data and resources. The community was only beginning to think about strategies to collect data in order to strengthen their programs.

- **Infrastructure (Contemplation):** The community had not yet developed strategies for obtaining resources and funding and was only beginning to develop plans for expanding community capacity and awareness on tobacco issues.

- **Program (Contemplation/Preparation):** The community had only begun planning for work in youth mobilization and had started thinking about cessation program for AAPIs and how to incorporate tobacco with other community programs.

- **Policy (Contemplation):** The community was only beginning to focus on issues such as clean indoor air and youth access to tobacco.

At the time, the New York Coalition for a Smoke Free City (of which CBWCHC is a member) was focused on reducing the impact of secondhand smoke in the community, reducing youth access to cigarettes, and advocating with the NY City Council to ban smoking in workplaces such as restaurants and bars. Even though all three focus areas affected AAPIs, CBWCHC was one of the few coalition members who repre-

CBWCHC advocates for tobacco-free NYC communities at the Strike Back Against Tobacco event featuring Jackie Chan.

sented the AAPI community. The AAPI population was growing rapidly and CBWCHC saw the need to organize the AAPI groups around tobacco control, both as its own coalition and as liaison with the mainstream coalition.

In 2001, CBWCHC led the development of the New York Asian American and Pacific Islander (AAPI) Tobacco Control Network (Network) to represent the AAPI population in the five boroughs of metropolitan New York City: Brooklyn, Bronx, Manhattan, Queens, and Staten Island. The Network's purpose would be to: 1) collaborate and network among community-based agencies, community advocates and leaders, and health care organizations to increase awareness about tobacco issues impacting AAPI communities; 2) prioritize tobacco as an agenda in the AAPI community; and 3) increase regional capacity and cultural competency in addressing tobacco control activities in NYC.

✳ Application of the Community Readiness Model

From the beginning, the APPEAL Community Stages of Readiness Model provided the New York AAPI Tobacco Control Network with a framework that was helpful in terms of planning and prioritizing the areas to work on. This was especially useful since the Network had recently formed with the goal to increase the community's capacity regarding tobacco issues. Movement in one area of the Model (policy, programs, research and infrastructure) was also found to have an effect on movement in another tobacco control area.

Yet before the Network could implement a plan to improve the community's capacity and to mobilize individuals to address tobacco cessation and prevention, the Community Readiness Model helped members understand the importance of developing the Network's infrastructure first. Initially, the Network held meetings to assess community-based resources and current tobacco control activities to help them prioritize. These meetings provided an excellent opportunity not only for prioritizing issues, but also for identifying resources and services in addressing gaps. The Network also worked together to identify opportunities for inter-agency collaboration to pursue funding to address tobacco.

Regional Partners Kenny Kwong and Amy Shek from CBWCHC.

Determination of Priority Areas

Several concerns were discussed at the first New York AAPI Tobacco Control Network meeting: identifying educational materials on tobacco; youth development/involvement in tobacco control activities; smoking cessation activities; and strengthening the communication between community-based organizations and local, city, and state agencies to improve access to the resources they offer. During this initial discussion and staging of its region, the Network identified the following three priority areas:

Infrastructure Development, particularly coalition building (Contemplation): The Network prioritized building the infrastructure and capacity of the coalition because it was necessary to first strengthen its own capacity, knowledge and leadership before successfully mobilizing the community on tobacco control. A challenge faced by the Network was the lack of time and resources to implement tobacco control activities among its Network members and the community perception of tobacco as less of a priority compared to other health issues. The Network provided the potential of pooling resources and knowledge and strengthening their

own individual efforts through collaboration to implement tobacco control activities and apply for funding from state agency and/or private foundations.

Cessation (Contemplation): Since many Network members were actively engaged in smoking cessation and prevention activities, the members felt it would be helpful to develop a clearinghouse of culturally relevant materials to distribute to the community and to also tailor cessation programs to meet the diverse needs of NY's AAPI community. This was especially important since New York City and State were in the process of passing clean indoor air policies, and if the policies were successfully implemented, the need for culturally appropriate prevention and cessation services would also increase.

Clean Indoor Air Policy (Preparation): Initially, very few Network members were working on policy issues. However, the mainstream efforts to implement clean indoor air policies and the political climate of the city and state led to the Network's focus on clean indoor air policy work within AAPI communities.

� KEY OUTCOMES

OVERALL MOVEMENT ALONG THE COMMUNITY READINESS MODEL

From 2001-2005, New York region's targeted priority areas moved from **Contemplation to Action** stage (see table 3).

Table 3: Staging of CBWCHC's Priority Areas from 2001-2005

	Research & Data	Infrastructure	Programs	Policy
	Utilization of Data	Coalition Building	Cessation	Clean Indoor Air
Pre-contemplation				
Contemplation	2001	2001	2001	
Preparation	2002		2002	2001
Action	2003-2005	2002-2005	2003-2005	2003-2004
Maintenance				2005

⟶ = *direction of movement along the Community Readiness Model*

Since its formation in 2001, the Network has taken up major initiatives to address tobacco in policy, research, and programs. The Network has established a secure base that has built linkages and allowed the Network to understand the expertise, skills and knowledge that each has to offer; thus increasing their competency in addressing tobacco.

Infrastructure Development (Coalition Building): In 2002, the Network was able to increase community involvement and to build the region's capacity to mobilize on tobacco control issues by hosting its First Regional Conference on Tobacco Control for Asian & Pacific Islanders in NY. The conference was attended

by nearly 100 representatives of tobacco control programs and organizations, who learned and shared information regarding tobacco control initiatives, policies, advocacy, effective interventions and programs, and data and research in the Asian American population.

The Network was also able to improve communication and collaboration between the AAPI community and mainstream coalition groups. Regional and New York State organizations were invited to serve as members of the Network. This helped to foster relationships that increased community involvement and informed the Network of current mainstream tobacco control initiatives and resources. Ideas and information were often exchanged during the meetings that provided support for increased collaboration. For example, the New York City Department of Health's "Quit Yet?" Campaign provided resources and assistance to CBWCHC to conduct focus groups and to field test their in-language educational materials.

Clean Indoor Air Policy: As communication improved and relationships developed between community, city, and state organizations, the Network increased its participation in advocating for the passage of the NYC Indoor Smoke-Free Air Act and the state legislation banning smoking in all workplaces. Policy change included advocacy not only with legislators, but also within AAPI communities. This work on policy allowed the Network to educate their community about the benefit of legislative advocacy as well as the legislation itself. It also highlighted the importance of having a strong infrastructure and program to work closely with those directly impacted by the smoke-free air act, namely AAPI businesses and restaurants. These businesses were not necessarily reached by mainstream campaigns, but through tailored approaches, they became aware of the regulations and the importance of enforcing the legislation.

The legislation not only resulted in linkages with mainstream organizations, but also resulted in the development of relationships with AAPI businesses and other community based organizations — important allies in mobilizing the community for future programs and initiatives.

CBWCHC staff unites with AAPI community leaders from the US and Pacific Islands at the APPEAL Leadership Summit. The leadership summit focused on advocating for policy change to promote tobacco control for the AAPI community.

Cessation: One such program that flourished as a result of the smoke-free legislation was the Network's cessation work; the new policies that banned smoking also encouraged current smokers to reduce or quit their tobacco use. The education and community outreach from the smoke-free legislation policy work also laid the foundation for community awareness of the tobacco issue and facilitated the movement from contemplation to preparation to action stage.

The Network also continues to advocate for culturally and linguistically tailored tobacco cessation programs. CBWCHC was able to develop effective cessation materials by first conducting a survey to measure the importance of tobacco as a health issue among Chinese American families. The assessment indicated that a large majority (98%) believed smoking to be harmful to the children living at home, yet only 21% stated that they banned smoking within the home. Using the information gathered, CBWCHC was able to selectively target their health education materials to Chinese American families and obtain a maximum impact. This illustrates how a focus on research and data can lead to the implementation of effective community programs.

✤ Lessons Learned

Throughout its growth, the Network also faced many challenges. The varying objectives and agendas of Network members made it difficult to coordinate training activities. The lack of movement in the *Representation in AAPI Coalitions* category (the extent to which tobacco issues are incorporated into the work of broader AAPI coalitions) was due partly to these challenges but also due to funding constraints. There have been few resources to support local Network members to address the many issues that their communities face. And although improved relationships with mainstream organizations have been an outcome of this work, it continues to be a challenge for this advocacy to be translated into more resources and representation of AAPIs in mainstream tobacco organizations.

Despite the challenges, the Network continues to provide an opportunity to share information, strategies, and resources, and coordinate efforts. The Network's agenda is decided by members who understand the AAPI community's unique issues and needs, thus increasing community relevance. Yet although there are many who join the Network with the understanding that their efforts will be strengthened through collaboration, there are others who will not join due to time and resource constraints. Given the current environment, the long-term goals of the Network are to sustain current activities, maintain the Network, and identify ways to continue to collaborate on tobacco control projects.

The Network found the Community Readiness Model especially useful in the beginning stages when direction was needed to determine their priority areas. The Network found it helpful to do the assessment together as a group to plan and prioritize their needs and areas of focus. Overall, the Community Readiness Model provided the Network with a framework that was helpful in terms of planning and prioritizing the areas to work on.

Washington State

Initial Readiness Stage: Preparation

Final Readiness Stage: Action

Geographic Area: Washington State (Greater Seattle-King County Area)

Regional Partner: Washington API Families Against Substance Abuse (WAPIFASA)

Washington Asian Pacific Islander Families Against Substance Abuse (WAPIFASA) is a non-profit agency advocating for and providing effective alcohol, tobacco and other drug prevention and treatment services to Asian Pacific Islander children, youth, adults, families and communities in the Seattle-King county area in a culturally competent and language appropriate manner. WAPIFASA is also the driving force behind the creation of the Asian Pacific Islander Coalition Against Tobacco (APICAT).

WAPIFASA used the APPEAL Community Stages of Readiness Model to help the Asian American and Pacific Islander (AAPI) communities in Washington State move from the Preparation to the Action stages. The Community Readiness Model provided an important tool for prioritizing issues, planning and evaluating activities and programs, and mobilizing community members on advocacy campaigns. WAPIFASA focused particularly on building community capacity through leadership, the statewide AAPI coalition, and the mobilization of AAPI youth.

✳ Baseline Assessment

Washington State has more than 346,000 Asian Americans and Pacific Islander (AAPI) residents. AAPIs are the fastest growing minority population in Washington, increasing 109% in the last decade.

WAPIFASA focused its tobacco control work in the greater Seattle-King County area within Washington State. AAPIs are the largest ethnic minority population in this area, comprising of 13.1% of Seattle's population and 10.8% of King County.[3] These groups are comprised of more than 60 separate ethnic/racial groups and subgroups, and are very heterogeneous, differing in their histories and experience in the United States as well as in their languages/dialects, religions, cultures, socioeconomic status, and immigrant status (foreign born versus U.S. born, etc.).

When WAPIFASA first used the APPEAL Community Stages of Readiness Model, they assessed the AAPI community overall at the **Preparation** stage because only a few AAPI organizations had been involved in tobacco prevention and control activities. Using the Community Readiness Model, WAPIFASA assessed each tobacco control area as follows:

[3] US Census 2000

APICAT youth team up during the APICAT youth retreat.

- **Research and Data (Preparation):** AAPI communities were beginning to collect tobacco-related data, advocate for culturally appropriate methodology in tobacco research, and develop plans to conduct additional research.

- **Infrastructure (Action):** AAPI communities were actively involved in leadership trainings, coalition building, seeking funding from various sources for tobacco prevention and control, and building relationships with key leaders.

- **Program (Preparation):** AAPI communities were beginning to develop a plan to counter tobacco industry messages, mobilize youth, address secondhand smoke issues, and determine how to evaluate tobacco control activities.

- **Policy (Preparation/Action):** Although AAPI communities were becoming actively involved in activities such as adopting tobacco-free policies, recommending systemic changes about AAPI tobacco issues with political leaders and the general community, and conducting some merchant education activities, they were only beginning to work with legislators on developing recommendations for the allocation of settlement funds to priority populations.

✿ APPLICATION OF THE COMMUNITY READINESS MODEL

The Community Readiness Model contributed in several ways to Washington State's AAPI communities and to WAPIFASA, including prioritization of issues, planning and evaluation, advocacy, and developing community leaders.

Determination of Priority Areas

During the process of staging the greater Seattle-King County area, the Community Readiness Model highlighted the many important issues related to tobacco in the AAPI community. WAPIFASA found it challenging to prioritize all of these issues and it may have been impossible without this staging process. They ultimately identified the following three priorities to work on:

Tobacco Coalition of Local AAPI Community Leaders (Action): The Community Readiness Model clearly showed that much work needed to be done in all areas of tobacco prevention, control and social justice. It reinforced the importance of considering tobacco in a broader community context and the relationship between tobacco control and other important community issues, such as: substance abuse, economics, the environment, and wellness. All of these factors identified the need for a tobacco coalition of local AAPI community leaders who could reach out to this very heterogeneous population and recruit their support for the seriously under-funded tobacco issues.

AAPI youth tobacco control advocates march the streets of Seattle.

Youth Mobilization and Tobacco Use Prevention (Preparation): Although WAPIFASA was created to serve AAPI youth in substance abuse issues, tobacco had not been a major focus. When it came time to identify tobacco control priority areas, it was only natural to identify tobacco prevention and youth mobilization as priorities since program development was the lifeblood of the agency and youth leaders were vital to sustaining the education and prevention activities.

Availability of Data (Preparation): While some work was beginning in the greater Seattle-King County AAPI community, it was clear that very little tobacco-related data existed on ethnic specific AAPI populations, such as Samoans and Cambodians, and virtually no data existed for this geographic region. This was identified as a priority area because data is essential for effective advocacy for resources as well as for policy activities. Data is also necessary to begin effective, culturally competent tobacco education both within and outside of the AAPI community.

Planning and Evaluation

WAPIFASA used the Community Readiness Model internally for planning and to help set organizational direction in the tobacco arena. Initially WAPIFASA's executive director used it for developing program plans and determining staffing needs. But as the Community Readiness Model became more refined, other staff were involved in the discussions for planning and program evaluation. Then as APICAT formed, it became a tool for the development of the tobacco control coalition. It provided a clear and comprehensive picture of assessing tobacco's impact on the region and provided a roadmap for both WAPIFASA and APICAT.

Advocacy

In 2002, the BREATHE Alliance was funded by The Robert Wood Johnson Foundation to implement tobacco control policies in Washington State. WAPIFASA and the Center for Multicultural Health were members of the BREATHE Alliance, along with mainstream voluntary health organizations such as the American Cancer Society, American Lung Association, and American Heart Association. BREATHE members supported legislation to ban smoking in public places throughout the state. WAPIFASA Field Staff used the Community

Readiness Model to present the AAPI community's readiness stages and to evaluate the state's activities. This information was then passed on to the supporters of the legislation for garnering community grassroots support during legislative visits held in February 2003.

Leadership Development

The Community Readiness Model helped WAPIFASA and the AAPI community recognize the importance of AAPI leadership in tobacco control. As a result, one of the most significant applications of the Community Readiness Model has been the creation of the Asian Pacific Islander Coalition Against Tobacco (APICAT), a very active, ongoing coalition off AAPI leaders working on tobacco control issues within the AAPI community statewide. While it started out with only a few members in King County, APICAT grew particularly with the involvement of fellows from the APPEAL Leadership Program. Many of these new leaders had not been involved with tobacco control previously, including representatives from Yakima and Spokane in eastern Washington.

In addition, APICAT was invited to represent AAPI communities on the Cross Cultural Workgroup on Tobacco (CCWGT) committee sponsored by the Washington State Department of Health (DOH). APICAT's representative, Ms. Elaine Ishihara, introduced the DOH and CCWGT to the success of the APPEAL Leadership Model and the APPEAL Community Stages of Readiness Model as starting points for eliminating tobacco disparities and working towards parity. CCWGT accepted the recommendation of these models and DOH provided funding for the Cross Cultural Leadership Institute (CCLI) involving all five community partners (AAPIs, African Americans, Hispanics/Latinos, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) and Urban Indians) and facilitated by APPEAL. To date, APPEAL has helped facilitate two CCLIs and two trainings on the Community Stages of Readiness Model.

APICAT youth and adults collaborate at the APICAT retreat.

� Key Outcomes

Overall Movement along the Community Readiness Model

During the five years of the project, the AAPI tobacco control movement in Washington advanced from the **Preparation to Action** stage and its priority areas moved between **Preparation**, **Action**, and **Maintenance** stages. (see table 4).

Table 4: Staging of WAPIFASA's Priority Areas from 2001-2005

	Research & Data	Infrastructure	Programs	Policy		
	Availability of Data	Coalition Building, Community-Based Resources	Youth Mobilization	Clean Indoor Air	Local & State Legislation	Organizational Policy
Pre-contemplation						
Contemplation						
Preparation	2001	2001-2002	2001			
Action	2002-2004	2003-2005	2002-2004	2001, 2003, 2005	2002, 2005	2001, 2003
Maintenance	2005			2004	2003	2004-2005

⟶ = *direction of movement along the Community Readiness Model*

The following are outcomes from each of WAPIFASA's priority areas.

Availability of Data: In the beginning, virtually no data existed on AAPIs in the Seattle-King County area. WAPIFASA realized that data was essential for assessing the needs of the community, producing effective tools and advocacy for resources and tobacco control policies. A community assessment was conducted and the information proved to be important for planning and identifying next steps using the Community Readiness Model. An assessment survey was also developed for API youths on cessation needs and for the API community in Washington on secondhand smoke attitudes and beliefs. The data has been beneficial in advocacy activities, presentations and in applications for funding. Funding was made available to APICAT partners, who were awarded a grant through the American Legacy Foundation to study Vietnamese and Chinese male tobacco use and cessation.

AAPI Tobacco Coalition: As previously mentioned, tobacco was not a high priority issue in the AAPI community; therefore, WAPIFASA focused on gathering the support from other community based organizations to assist in making tobacco "more relevant" for the community. They also focused primarily on building capacity, mobilizing, applying for funding to sustain their work and expanding the coalition beyond the greater Puget Sound area. The Community Readiness Model made it easier to recognize the importance of accomplishing small steps in making tobacco more relevant for the AAPI community.

WAPIFASA successfully applied for funding at the state level to support the ongoing needs of tobacco control activities in the AAPI community. APICAT, through WAPIFASA, received three-year funding from DOH to

implement its action plan on providing prevention, education, policy and advocacy. APICAT is able to meet monthly and continues to participate in the CCWGT to support not only AAPI but cross cultural collaborations and activities. This success in acquiring funding and resources has helped to mobilize and build the community's capacity in tackling tobacco issues so that the communities moved forward from a Preparation to Action stage.

Youth Mobilization: While tobacco became a priority among the adult AAPI community, youth were also mobilizing to advocate on tobacco issues. WAPIFASA's Youth Council Program hosted a Teens Against Tobacco Use (TATU) training to learn about the danger of tobacco use. APICAT funding was also provided to CBO's on a mini-grant basis to conduct tobacco control projects for a year. For this, WAPIFASA Youth Council held a Hip Hop Show to promote tobacco-free API communities and to keep youth from getting into the habit of smoking.

Policy: WAPIFASA's and APICAT's increased capacity, funding and community awareness of tobacco issues enabled them to focus on policy, an area that was not originally a priority in their initial assessment. They hosted a legislative forum for legislators and the AAPI community to learn about emerging tobacco issues and taking action. WAPIFASA shared information identified in the Community Readiness Model with the Asian Pacific Islander Coalition (APIC), a coalition that works with legislative policy issues advocating for the needs of APIs, but who in the past had never before considered tobacco an issue. As a result of their collaboration, about 3,000 AAPIs gathered at the state capitol, with the tobacco issue included on its agenda, to ask their legislators to support a statewide ban on smoking in all public places.

Another key outcome included organizational smoke-free policies. Working with the member organizations under APICAT, they provided technical assistance and training to executive directors and prevention staffs of organizations interested in developing their own organizational smoke-free policies. As of now, all of the APICAT member organizations have a well defined smoke-free policy in their places of employment and property.

✳ Lessons Learned

The next proposed steps will be to seek additional funding through local health departments and foundations to keep their agency in track with prevention services.

The Community Readiness Model may be challenging at first, particularly for new staff. For an organization to be successful in this Model, it must commit a full time staff in learning and applying the Model to the regular work of the organization. It can be a new learning experience and it will work well within an organization that provides full support of the Model.

The Community Readiness Model provided WAPIFASA and APICAT with a tool to thoroughly analyze and evaluate progress on eliminating tobacco disparities and how to make tobacco more relevant to the AAPI community. WAPIFASA has been successful in accomplishing many of their objectives and priorities identified at the beginning of the funding from APPEAL. Tobacco has become an "accessible" issue to the community and WAPIFASA and APICAT are now seen as the experts on AAPI tobacco issues by the AAPI community and tobacco control advocates in Washington State.

STATE OF HAWAI`I

STARTING READINESS STAGE: CONTEMPLATION

ENDING READINESS STAGE: ACTION

GEOGRAPHIC AREA: NATIVE HAWAIIAN POPULATION SERVED BY THE NATIVE HAWAIIAN HEALTH CARE SYSTEMS, LOCATED ON O`AHU, HAWAI`I, MAUI, MOLOKA`I AND KAUA`I

REGIONAL PARTNER: PAPA OLA LŌKAHI

Papa Ola Lōkahi was established by the Native Hawaiian Health Care Improvement Act of 1988. It is a non-profit consortium of public agencies and Native Hawaiian organizations focused on the singular effort to improve the health and wellness of Native Hawaiians in Hawai'i. It serves as a coordinating entity for five Native Hawaiian Health Care Systems and provides a focal point for advocacy, research and training and technical assistance in the state. The Native Hawaiian Health Care Systems (NHHCS) include: Hui Mālama Ola Nā 'Ōiwi (Hawai'i Island), Hui No Ke Ola Pono (Maui), Hō'ola Lāhui Hawai'i (Kaua'i), Ke Ola Mamo (O'ahu) and Nā Pu'uwai (Moloka'i and Lāna'i). Their efforts focus on disease prevention, health promotion and enabling services, with developing capacities for primary care delivery either directly or through contracts and referrals.

'Imi Hale – Native Hawaiian Cancer Network ('Imi Hale) is a program of Papa Ola Lōkahi, funded by the Center to Reduce Cancer Health Disparities of the National Cancer Institute. 'Imi Hale works with the five

Lehua Abrigo, JoAnn Tsark, and Lorrie Ann Santos (l-r) from `Imi Hale.

Native Hawaiian Health Care Systems statewide to support and implement cancer education and awareness in Hawaiian communities and to increase community based participatory research addressing cancer prevention and control led by indigenous researchers.

Papa Ola Lōkahi (POL) became an APPEAL partner in 2002 and utilized the APPEAL Community Stages of Readiness Model to assess tobacco prevention and control activities. Over the past five years the NHHCS have taken strategic, incremental steps to better prepare and execute tobacco cessation programs beginning with data collection (Native Hawaiian Smokers Survey), skill building among staff (APPEAL Leadership Training and Tobacco Cessation training), securing program funding through 'Imi Hale and foundation grants, and sharing program successes (Kaua'i and Moloka'i) with the other NHHCS.

✤ Baseline Assessment

The total population for the State of Hawai'i based on the 2000 Census is 1,211,537 residents, which represents a 9.3% increase over the 1990 population of 1,108,229 residents. Papa Ola Lōkahi's defined service region for this APPEAL initiative included the medically underserved Native Hawaiian (NH) population and communities in the State of Hawai'i.

Papa Ola Lōkahi

When Papa Ola Lōkahi initially staged their efforts, their region was staged overall at Contemplation. The APPEAL Community Stages of Readiness Model proved helpful in highlighting both strengths and gaps in Papa Ola Lōkahi's tobacco prevention and control efforts. The staging of each overall tobacco control area was as follows:

- **Research and Data (Action):** Action for Availability and Utilization of Data reflected the comprehensive surveillance mechanisms in Hawai'i that collects Hawaiian-specific data including: the Behavioral Risk Factor Surveillance System, Hawai'i Tumor Registry, and Hawai'i Health Survey, as well as, Papa Ola Lōkahi's ongoing utilization of the published and web/report posted findings. 'Imi Hale has been actively involved in developing cancer prevention and control research pilot projects utilizing community based participatory research processes.

- **Infrastructure (Action):** Papa Ola Lōkahi, through the 'Imi Hale program reported Action for most Infrastructure components except for support for local elected officials. There has been an increase in staff involvement in both local and national coalitions and an increase in applications submitted and awards received.

- **Programs (Contemplation/Preparation):** In the Program area, activities have been initiated by the Native Hawaiian Health Care Systems in adult cessation and community education and awareness activities. There have been no activities initiated by Papa Ola Lōkahi in Countering Industry and ETS but 'Imi Hale staff is involved in these activities through their membership in the State Coalition for a Tobacco-Free Hawai'i, which included the development of a 5-year Strategic Plan for Tobacco Use Prevention and Control in Hawai'i.

- **Policy (Pre-Contemplation):** The Policy area was assessed to be at the earliest stage of readiness with the exception of Allocation of Settlement Funds. Papa Ola Lōkahi's staff has been involved in state forums and advisory committees related to the tobacco settlement funds. Gaps in policy have been addressed more recently (2005-2006) with the development of a Policy Committee for 'Imi Hale and designated staff time to manage this effort. State legislative activity in the 2006 session included the submittal of written testimony, which contributed to enactment of SB 3262 (SD 1, HD1) — prohibiting smoking in places open to the public and places of employment.

The Native Hawaiian Health Care Systems (NHHCS)

In 2004, the APPEAL Community Stages of Readiness Model was also used to initially assess the five Native Hawaiian Health Care Systems (NHHCS) (see Table 5).

Table 5. Staging of the Native Hawaiian Health Care Systems (NHHCS) by Island and the Staging of Papa Ola Lōkahi (POL) in 2004

	Research & Data	Infrastructure	Programs	Policy
Pre-contemplation				Hawaiʻi, Maui, Molokaʻi/Lānaʻi, Oʻahu
Contemplation		Hawaiʻi, Maui, Molokaʻi/Lānaʻi, Oʻahu	Hawaiʻi, Maui, Oʻahu	POL
Preparation				
Action	Hawaiʻi, Kauaʻi, Maui, Molokaʻi/Lānaʻi, Oʻahu, POL	Kauaʻi, POL	Kauaʻi, Molokaʻi/Lānaʻi, POL	Kauaʻi
Maintenance				

All five systems reported being in the Action phase for Research and Data since each participated in a Native Hawaiian Smoker's Survey in 1999. The survey was used to determine knowledge, attitudes and practices among smokers in the respective islands. Subsequently, survey findings were incorporated into programming and grant applications. This survey was repeated five years later in 2004. The Policy area is the most undeveloped among the NHHCS while Infrastructure and Programs reflect the increase in resources and staff across all systems in tobacco prevention and control. Small grant funds, newly generated data, and dedicated staff to cancer education and awareness accounts for the growing activities in this area. The NHHCS for the island of Kauaʻi shows Action in all areas, including Policy, that is a direct result of their assertiveness in developing an institutional tobacco cessation program with funds from the Hawaii tobacco settlement funds, administered through a competitive grant process.

✿ Application of the Community Readiness Model

Using the APPEAL Community Stages of Readiness Model since 2002, Papa Ola Lōkahi identified gaps in Policy, Programming and Infrastructure. This information alerted staff of the ʻImi Hale program to areas that needed development in order to best support the outreach efforts of the Native Hawaiian Health Care Systems (NHHCS). With the growth of ʻImi Hale programs, more resources and training were focused on both identifying and addressing tobacco prevention and control concerns of the NHHCS. These included finding additional funds for education materials and activities; developing tailored printed materials and supporting training of outreach staff of the NHHCS.
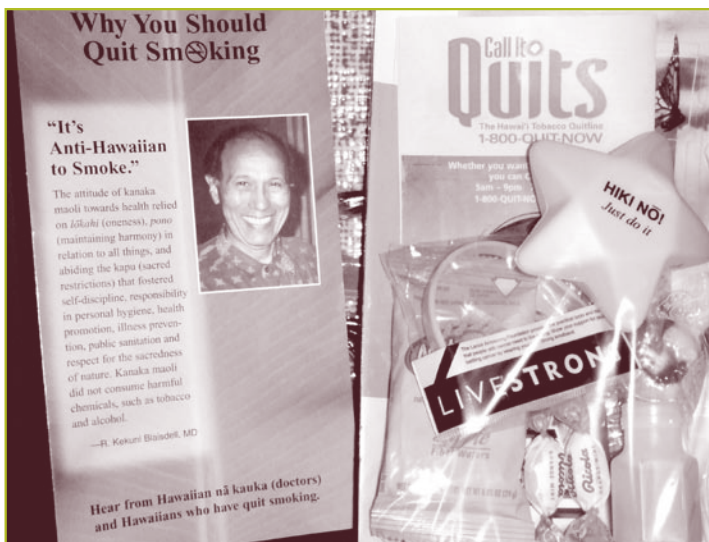
Quit Smoking brochure and Quit Kits developed for the Native Hawaiian community.

'Imi Hale staff also utilized the Community Readiness Model in 2004 for assessing each NHHCS to provide each system with a "snapshot" of their efforts in tobacco prevention and control across the domain of the Community Readiness Model. As mentioned previously, this process initiated focused discussion and action to address achievable goals that built efforts statewide in Hawaiian communities. The assessment also provided an additional opportunity for the NHHCS to discuss how they collectively (across all systems) address identified needs. One explicit example was the need to develop tobacco control competency among their community outreach staff. Each NHHCS invested time for outreach staff to receive training and collectively, with leadership from 'Imi Hale staff, submitted a proposal to a local foundation who manages the tobacco settlement funds. The NHHCS agreed to adopt the program developed by the Kaua'i NHHCS and implement a standardized protocol for assessing and addressing all clients who smoke. This proposal was funded and is currently in progress. It continues to be a forum for collective growth and innovation for the community outreach staff and represents the first institutionalized effort for addressing tobacco cessation in Hawaiian communities.

DETERMINATION OF PRIORITY AREAS

After staging their region, the NHHCS discussed two questions to identify priorities: (1) What opportunities were currently available to the NHHCS; and (2) What needed to be done so that the NHHCS effectively addressed tobacco prevention and control?

The discussion was synthesized to crosscutting solutions and actions that benefited all the NHHCS, including:

- Access to information about available resources,
- Access to current data on smokers' knowledge, attitudes and practices, beginning with a 5-year follow up to the 1999 Native Hawaiian Smoker's Survey,
- Development of tailored education materials for Hawaiian audiences,
- Increasing and developing capacity of the outreach staff through APPEAL's leadership trainings,
- Proactively seeking funds to support tobacco cessation education, and
- Supporting training of outreach staff in community-mobilization.

In 2002, these priority areas were identified and initially staged in the following domains of the Community Readiness Model:

- **Community-Based and Funding Resources** (Action)
- **Local AAPI Community Leaders** (Preparation)
- **Tobacco Control Competent Staff / Organizational Development** (Action)
- **Cessation** (Action)
- **Availability and Utilization of Data** (Action)

❈ Key Outcomes

Overall Movement along the Community Readiness Model

When considering all categories within the APPEAL Community Stages of Readiness Model throughout the five years of the project, the communities as a whole moved from the **contemplation to action** stage in tobacco prevention and control, but each of the individual islands have moved at a different pace. When considering movement for Papa Ola Lōkahi's priority areas, progress generally occurred within the **Action** stage of readiness (see Table 6), with the community laying claim to many key accomplishments.

Table 6: Staging of POL's Priority Areas from 2002-2005

	Research & Data	Infrastructure				Programs
	Availability & Utilization of Data	Funding & Community Based Resources	Tobacco Control Competent Staff	Local AAPI Community Leaders	Organizational Development	Cessation
Pre-contemplation						
Contemplation						
Preparation			2004	2002-2003		
Action	2002-2005	2002-2005	2002, 2003, 2005	2004-2005	2002-2005	2002-2005
Maintenance						

⟶ = *direction of movement along the Community Readiness Model*

Availability and Utilization of Data: The NHHCS involvement in the first Native Hawaiian Smoker's Survey (1999) launched their involvement in actively collecting Hawaiian and island-specific data that could be used in program grants and program planning. The purpose of this survey was to prepare the NHHCS for anticipated program funds that were becoming available through the tobacco settlement funds for Hawaii. In 2002, the NHHCS unanimously requested smoking cessation interventions for their communities. Both local and national resources were hard-pressed to provide successful models of community based programs. Support was limited to culturally inappropriate quit-smoking programs and referral lists, or inaccessible interventions that were costly and not covered by insurance.

Infrastructure Development (particularly Community-Based and Funding Resources, Local AAPI Community Leaders, Tobacco Control Competent Staff, Organizational Development): Papa Ola Lōkahi, through the 'Imi Hale program, developed an infrastructure to support: 1) cancer education, of which lifestyle issues (smoking, diet and exercise) are one of five priority areas, and the development of Hawaiian researchers. Staff of 'Imi Hale and the NHHCS increased their capacity in tobacco cessation, and their participation in the statewide coalitions and national forums.

Through Papa Ola Lōkahi's funding from the tobacco settlement monies, each NHHCS hired a part-time staff person (50% PTE) to coordinate tobacco cessation activities. Each of the NHHCS are moving towards hav-

ing all outreach staff trained to provide brief intervention and replicating the Kauaʻi NHHCS tobacco cessation program components, with inclusion of the 11-week Intensive Intervention program for a comprehensive tobacco cessation program that is institutionalized across the NHHCS.

Cessation: ʻImi Hale invested in outreach staff training and cancer education programming to heighten tobacco cessation activities. Since the initial staging in 2004 of the NHHCS, all five are now implementing tobacco cessation programs. One NHHCS staff member is an APPEAL Fellow and is certified in cessation intervention by the University of Massachusetts and the Hawaiʻi Department of Health. Other NHHCS staff are trained in providing Brief Intervention and are also certified by the Hawaiʻi Department of Health to train NHHCS staff and others in Brief Intervention. Additionally, at least one qualified staff from each of the NHHCS will be trained to provide intensive intervention through an 11-week program developed by Dr. Jill Oliveira, a licensed, clinically trained Native Hawaiian psychologist. Dr. Oliveira currently implements the 11-week Intensive Intervention program for the NHHCS on the island of Molokaʻi.

Advocates working to promote healthy communities in Hawaiʻi.

� Lessons Learned

Tobacco prevention and control is at the top of the priority list for the NHHCS because the prevalence of smoking in the Native Hawaiian communities continues to be the highest in the state and its contribution to the disparately high morbidity and mortality rates of heart disease, stroke, lung cancer, diabetes, asthma and other chronic diseases among Native Hawaiians is sobering.

The APPEAL Community Stages of Readiness Model is a helpful tool in mapping the progress of small and measured steps. The four main tobacco control areas emphasize the important facets to comprehensive tobacco prevention and control and disaggregating these components affords us insight to gaps in our strategies and programs.

The Community Readiness Model identified the unique needs of each of the systems and provided an impetus to discuss how we can better address the tobacco control issues of each community. This work reaffirmed the need to provide opportunities to the Native Hawaiian Health Care Systems to control the tobacco control agenda as it relates to them, such as developing surveys and receiving training for data collection, and then having a say in how that data will be used to help the community and procure program funds.

California

Starting Readiness Stage: Maintenance

Ending Readiness Stage: Action

Geographic Area: California

Regional Partner: Asian & Pacific Islander American Health Forum (APIAHF)

Regional Partners Amy Wong and Roxanna Bautista (l-r) share strategies for implementing tobacco control programs in CA.

Asian & Pacific Islander American Health Forum (APIAHF) is a national advocacy organization dedicated to promoting policy, program, and research efforts to improve the health and well-being of Asian American and Pacific Islander (AAPI) communities. APIAHF's work around the APPEAL Stages of Community Readiness Model focused on tobacco control efforts throughout the state of California.

In terms of tobacco control, California's staging is quite unique when examining the state as a whole or as specific regions. In five years, APIAHF focused on two priority areas (infrastructure and policy) in both regional and statewide settings. While it was a challenge to address both the regional and statewide needs simultaneously, APIAHF worked to address the most pressing needs in specific regions to increase the community's readiness around tobacco control issues. Through continued evaluation of programmatic activities and the effects of environmental changes, it was demonstrated that the movement throughout the APPEAL Stages of Community Readiness Model usually moved forward and in some cases backwards in response to statewide tobacco control activities.

✤ Baseline Assessment

According to the Census 2000 data, there were approximately 3.7 million individuals who indicated they are Asian alone while 116,961 individuals indicated they are Native Hawaiian and Other Pacific Islander (NHOPI) alone in California. Asians represent 11.5% and NHOPI represent 0.4% of the total Californian population; this does not include those individuals who may have indicated two or more races on the Census 2000. When combined with individuals who indicated a combination of Asian and one or more race, the percent total

Members of APIAHF staff and the API Partnership Advisory Committee.

increases to 12%; when combined with individuals who indicated a combination of NHOPI with one or more race, the percent total increases to 0.6%. The top five Asian groups with the largest population in California were Filipino, Chinese, Korean, Vietnamese, and Asian Indians. The top five NHOPI groups with the largest population in California were Samoan, Guamanian (Chamorro), Native Hawaiian, Tongan, and Fijian.

Tobacco control activities were implemented for Asian American and Pacific Islander (AAPI) communities in both rural and urban regions of California. However, APIAHF's efforts are focused on regions with large concentrations of specific AAPI communities due to the limitations in resources. APIAHF primarily focused on four regions throughout the four years - greater San Diego region, greater Los Angeles region, San Francisco/Bay Area, and Central Valley region. In Year 3, activities were expanded to Butte County where there has been a significant influx of Hmong refugees in the past few years.

Through the initial self assessment for the Community Readiness Model, APIAHF determined that the overall tobacco control movement in 2000 fit into the **Maintenance** stage. Factors that led to a favorable tobacco control environment included:

- In 1988, the voters approved the California Tobacco Tax and Health Promotion Act of 1988 (Proposition 99) which increased the state surtax on cigarettes by 25 cents per pack and an equivalent amount on other tobacco products. The revenue generated by the tax is earmarked for health education efforts aimed at the prevention and reduction of tobacco use.

- In California, there were several ongoing studies in AAPI tobacco use and the Tobacco Related Disease Research Program supported tobacco research on ethnic communities.

- In 2000, Proposition 99 revenue supported a variety of local AAPI community based organizations (CBOs) to focus efforts on different tobacco control efforts. Along with the funding provided to local

CBOs, the APIAHF Asian & Pacific Islander Tobacco Education Network (APITEN) program had already been coordinating statewide AAPI tobacco control movement for nine years.

- Since 1991, APIAHF has worked with local CBOs, local city/county health departments, and other tobacco control programs to provide technical assistance, trainings, and capacity building assistance.

In examining the specific regions and counties, the stage placement varied depending on the local activities of each community. For example, in the greater Los Angeles region there were more resources and programs addressing tobacco control issues in comparison to the Central Valley region where the programs concentrated on tobacco education. However, APIAHF chose the **Maintenance** stage due to the sustained funding (Prop 99), infrastructure developed through the various tobacco control programs/projects, number of AAPI representatives in mainstream coalitions, and established linkages with other ethnic communities/priority populations.

✳ APPLICATION OF THE COMMUNITY READINESS MODEL

Outreach to the Vietnamese community in CA.

Since the tobacco control movement in California was not in its infancy, the APPEAL Stages of Community Readiness Model was used to evaluate the progress of activities and assisted in the planning of upcoming activities. APIAHF staff used the Stages of Readiness Model within the organization to plan for activities in the upcoming year. Periodically the Model was used to evaluate the program's progress and impact at the community level.

Current and past Program Directors and Program Coordinators utilized the Community Readiness Model primarily to evaluate the progress of the program activities on a bi-annual basis. In addition, the Community Readiness Model assisted all staff in communicating gaps not being addressed in terms of AAPI tobacco control within the state.

The Community Readiness Model was also used once a year during the evaluation teleconferences with APPEAL staff. For assessment and planning purposes, APIAHF staff referred to the Model as an additional resource for the program. However, the Model was used primarily to evaluate the progress of the activities during the reporting period.

It assisted in providing a critical analysis of a statewide movement and in particular communities where tobacco control efforts and capacity is still in its early stages. The Community Readiness Model assisted in the development of the activities specific to the Hmong community in rural regions by providing a framework to determine the next steps appropriate to their readiness.

DETERMINATION OF PRIORITY AREAS

APIAHF focused on two priority areas — **infrastructure** and **policy**. Since there had been much work at the state level focusing on policy and infrastructure development, it was appropriate to focus on these areas. With APIAHF's role as a national health and policy advocacy organization, it was fitting to address policy

in terms of tobacco control. APIAHF also had 14 years of consistent state funding and experience in the changing atmosphere of infrastructure of tobacco programs. In addition, due to the shifting environment of tobacco control in California throughout the project period, there was a need to examine the effects on the community level.

Challenges Influencing Priorities: Amidst the changes in the tobacco control movement in California from 2000-2005, APIAHF focused on maintaining the voices of the AAPI communities regardless of the level of funding and number of programs. Changes in funding priorities and program budget slowly decreased the number of programs focused on AAPI tobacco control activities. At one time, there were eleven TCS-funded AAPI serving projects, but this number was radically reduced to two in the span of two years. There was a need to continue to advocate within the infrastructure of the tobacco control movement to involve AAPI communities at all levels. As an organization, APIAHF works on policy advocacy, which complements TCS' focus on policy and organizational development.

� KEY OUTCOMES

OVERALL MOVEMENT ALONG THE COMMUNITY READINESS MODEL

Table 7: Staging of APIAHF's Priority Areas from 2001-2005

	Infrastructure			Policy	
	Community-Based Resources	Funding Resources	Representation in AAPI Coalitions	Local & State Legislation	Systems Change
Pre-contemplation					
Contemplation					2003-2005
Preparation			2005		
Action	2003, 2005	2005			2001-2002
Maintenance	2001	2001, 2003	2001, 2003	2001-2005	

⟶ = *direction of movement along the Community Readiness Model*

APIAHF's target priority areas changed throughout the five years of the project (see Table 7). Since APIAHF's region began at the maintenance stage of readiness, movement could not occur as considerably as movement at earlier stages of readiness. In this case, it was sometimes necessary to measure movement by dividing the maintenance stage into three stages: beginning maintenance, intermediate maintenance and advance maintenance. Under the **infrastructure** priority area, the overall AAPI community moved from **maintenance beginning to action**.

For the **policy** priority area, APIAHF focused efforts specifically in the **rural regions** of California and general policy statewide. In the beginning of the project period, the rural regions were in the pre-contemplation stage.

Through the coordination of teleconferences with mainstream tobacco control program and key informant interviews, the regions moved from **pre-contemplation to contemplation**. Policy work throughout the state continued to be in the **maintenance stage** but there was some movement from **beginning to intermediate**.

In the past five years, there have been key outcomes that have moved specific regions of the state forward. Among the accomplishments include:

- APIAHF focused tobacco control efforts in rural regions (Butte County) where there is low capacity to engage in limited programmatic activities. APIAHF conducted key informant interviews with Hmong community in Butte County to determine the readiness of the community. As a product, a summary report was completed and disseminated to mainstream tobacco control advocates in the local region to assist in their development of future activities aimed specifically with Hmong communities.

- A case study highlighting the APIAHF/APITEN Regional Advocacy Campaigns was produced and promoted to engage organizations to replicate the campaigns in local regions. In addition, it was used to assist APIAHF to advocate to mainstream organizations to include activities specific to AAPI communities.

"Protect Our Youth" publication developed for the Samoan community.

- APIAHF secured an additional three years of funding for the AAPI Partnership project to continue to provide technical assistance, capacity building assistance, and training to local AAPI communities throughout California.

✖ Lessons Learned

While APIAHF was able to use the project to progress tobacco control efforts in certain regions, many challenges arose that hindered the overall movement. Since the region began at the maintenance stage, it was challenging to move forward and movement was not to the extent of other regions that began at earlier stages of readiness. After five years, the overall assessment of the region moved backwards as compared to when APIAHF first completed the Community Readiness Model. The following are significant events that contributed to the reversal:

- Continued decrease of overall tobacco control budget at the state and local level over the past four years resulted in a shift in the infrastructure. The loss of the regional linkages project, decrease in local programs (competitive grantees), and decrease in number of organizations providing local county grants and mini-grants all contributed to the infrastructure change.

- Transition from Ethnic Network projects to include priority populations as defined at the federal level. The changes in program include the restructuring of the tobacco program at the APIAHF. As a consequence, APIAHF had to discontinue the consortium partner model. This has resulted in a loss of coordination at the local level as well as having a program staff coordinator that is able to respond to pressing tobacco control needs at each region.

Throughout the project period numerous smoke-free laws were passed, but there has not been enough resources allocated to engage AAPI communities around the laws and other policy initiatives. However, the

Tobacco-free fair held by the Pacific Islander community in CA.

laws have not negatively affected the AAPI tobacco control efforts throughout the state. Due to the gradual decline in tobacco consumption and the securitization of the Master Settlement Agreement funds at the state level, there have been changes in the level of funding provided to community organizations focused on efforts at the community level.

As a part of APIAHF's tobacco control program activities, technical assistance and trainings are a major component of the program. The experiences of the community-based organizations in different states were particularly useful and helpful for APIAHF in terms of providing technical assistance to others in California. Since there has been a decrease in tobacco control funding across the state, many organizations that had a wealth of experience working in tobacco control are no longer in existence. Through the connections with other organizations in different states, APIAHF has been able to share with others their experiences and refer to organizations outside California with similar programs.

APIAHF will continue to develop the infrastructure to increase systems competence, build on policy work, and provide capacity building and technical assistance. In conjunction with other priority populations and local programs, legislative visits and policy advocacy activities will continue to be a focus of development in California due to the need for AAPI communities to engage in local and state policy advocacy activities.

While there will continue to be a gap in readiness with rural AAPI communities, APIAHF will be working with the mainstream organizations and local health departments to encourage the development of tobacco control programs in these regions. Since tobacco control funding is steadily declining, there is a pressing need for APIAHF to work with mainstream organizations to be inclusive of AAPI communities locally.

Depending on how the Model is utilized, it is important to remember to be flexible when working with it and to respond to environmental changes. Since tobacco control programs often cover a large region or diverse community, it is also recommended that the Model encompass manageable or small regions when completing the assessment in order to truly reflect the stage of readiness. The Model can be useful in assisting organizations and programs to determine the next steps appropriate for the community as well as to provide a critical analysis of movement in communities where tobacco control efforts and capacity is in its early stages.

Appendix A

TOBACCO CONTROL AREAS AND SUBCATEGORIES

Research and Data

- Availability of Data
- Utilization of Data
- Culturally Appropriate Research Methods
- Availability of Researchers focused on AAPI Populations
- Linkages between Community and Research Institutions
- Funding and Resources for Research

Infrastructure

- Funding and Resources for Infrastructure
- Tobacco Control Competent Staff
- Identifying and Developing Local AAPI Community Leaders
- Representation in Mainstream Coalitions
- Representation in AAPI Coalitions
- Community-Based Resources
- Support of Local Elected Officials
- Linkages with Priority Population Groups
- Organizational Development
- Systems Competence

Programs

- Countering the Tobacco Industry
- Youth Mobilization and Tobacco Use
- Secondhand Smoke
- Cessation
- Tobacco in the Broader Community Context
- Evaluation
- Transnational

Policy

- Allocation of Settlement Funds
- Industry Sponsorship of Community Groups
- Clean Indoor Air
- Youth Access
- Local and State Legislation
- Organizational Policy
- Systems Change