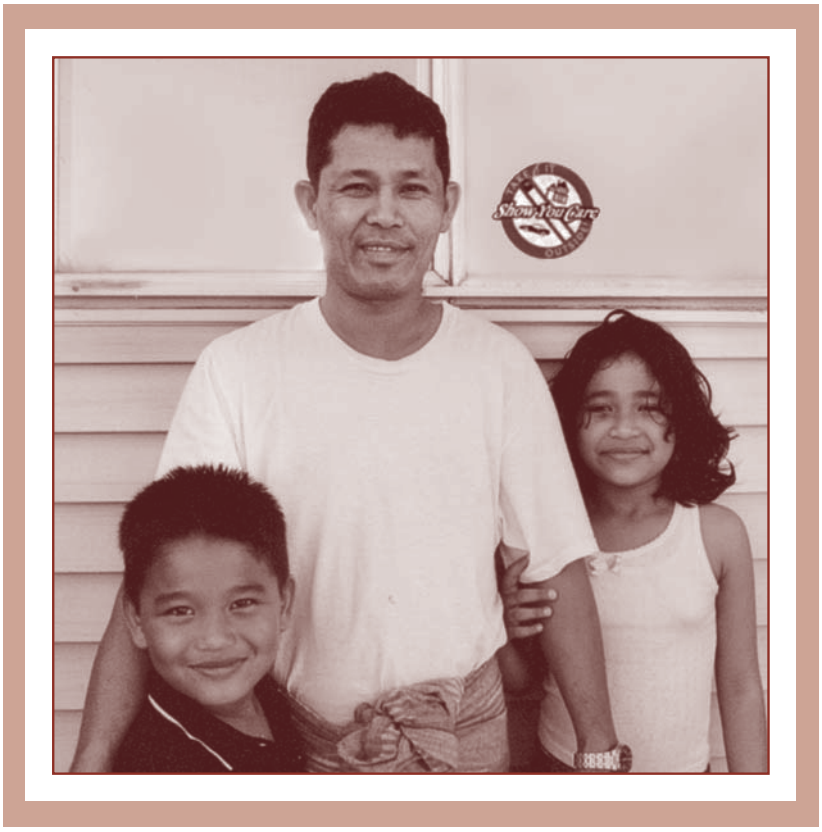
APPEAL

Tobacco Cessation Among Asian American and Pacific Islanders: A Community Approach



The purpose of this kit is to assist Asian American and Pacific Islander (AAPI) communities in implementing tobacco cessation programs and policies. While there are other general cessation kits available, this kit is designed to specifically address issues relevant to AAPIs and to provide examples of culturally competent strategies used within AAPI communities at varying stages of readiness. Please note that this kit will primarily focus on smoking cessation and adults; the issues of cessation and the approaches one takes in addressing it can vary when dealing with adults versus youth.

Through this Cessation Kit you will learn:
(1) what is meant by cessation, (2) how to apply a community readiness approach to cessation, (3) cessation approaches used within communities, (4) culturally tailored approaches, and (5) useful resources.

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Introduction

Tobacco use is a problem in Asian American and Pacific Islander communities. It affects not only the health of individuals who use tobacco, but impacts the health and economics of their family and community members as well. Offering programs and setting up policies that help current smokers quit using tobacco is an essential part of reducing tobacco's harmful effects. By applying APPEAL's Stages of Community Readiness Model, which will be discussed later in this kit, AAPI communities can determine what stage they are at in terms of cessation and how to begin working on cessation programs and policies.

What is Cessation & Why is it Important?

Q: What is smoking or tobacco cessation?

A: Cessation is the ceasing or stopping of tobacco products, including cigarettes, either for good or for some period of time. There are many different ways to approach cessation including community education, media campaigns, tobacco cessation classes, smoke-free policies, or visiting a doctor or acupuncturist for help.

Q: What are the health effects of quitting smoking or tobacco use?

A: Quitting smoking is beneficial to one's health, both immediately and in the long run. When a smoker first quits, circulation, breathing and sleep improve. Within one year of quitting, the extra risk of dying from heart attack is cut by half. Within ten years of quitting, the chances of getting lung cancer drop to half. After fifteen years of quitting, the risk of dying almost returns to that of non-smokers. There is evidence that even after forty or fifty years of smoking, the body can do much to repair itself after a smoker quits. Quitting smoking is also good for the health of those around the smoker.

Q: I'm interested in supporting community efforts to provide cessation services. Where would you recommend that I begin?

A: Before jumping into implementing a cessation program, it is important to determine what stage of readiness your community is at regarding cessation. The APPEAL Stages of Readiness Model[1], which will be discussed in greater detail later in this kit, can help you identify inital steps. For example, you may need to start with education, assessment, or promotion work before starting a widespread cessation campaign if: few in your community are ready to quit using tobacco, the challenges tobacco users face when quitting aren't known, or there are no trained culturally competent cessation providers.

[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;9:66-73.

Using a Community Readiness Model to Address Cessation

Psychologists Prochaska and DiClemente found that individuals who are successful at quitting tobacco tend to go through five stages, as described in Figure 2[2]. A key aspect of Prochaska and DiClemente's Transtheoretical Model is that strategies to help the smoker quit should be tailored to the stage of change that the smoker is currently in. For example, if a person isn't thinking about quitting at all (Precontemplation), a tailored message might be aimed at making them more aware of the negative consequences of smoking. However, if a smoker is already aware of those consequences and has already decided to quit (Preparation), an appropriate strategy would be to help them find a cessation program or provide them with self-help materials.

In APPEAL's work, we've noticed that AAPI communities trying to conduct tobacco programs and policies (including cessation) may be at very different stages in terms of readiness to act and having available resources. They too may need to go through similar phases as described above. APPEAL calls its community application of Prochaska and DiClemente's model the APPEAL Stages of Community Readiness Model. See Figure 1 for a summary of different stages a community might be at when faced with carrying out cessation programs or policies.

[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 stage of readiness a community is at regarding cessation efforts has implications for relevant approaches. See Figure 1 for additional information.

Figure 1

Figure 2: Stages of Change

Stage of Change	Applied to Individuals (Prochaska and DiClemente)	Applied to Communities (APPEAL)
PRECONTEMPLATION	A tobacco user hasn't thought about quitting yet	A community has not seriously thought about addressing cessation
CONTEMPLATION	A tobacco user is thinking about quitting, but hasn't really made-up his or her mind yet or taken any steps toward quitting	A community has thought about taking action, but has not developed plans to work on cessation
PREPARATION	A tobacco user has decided to quit relatively soon and is taking steps to help him-/herself prepare, such as talking to their provider, registering for a class, or forming a quit plan	A community has thought about taking action and is developing plans to work on cessation
ACTION	A tobacco user has recently quit using tobacco	A community has taken action around cessation
MAINTENANCE	A tobacco user is trying to stay a "quitter" and not relapse (i.e. start using tobacco again)	A community has been taking action on cessation for an extended period of time and has developed a plan for sustaining its efforts

Figure 1: Stages of Community Readiness to Address Cessation

STAGE OF COMMUNITY READINESS	RELEVANT PROCESSES OF COMMUNITY CHANGE	USEFUL QUESTIONS TO ASK	POSSIBLE ACTIVITIES
PRECONTEMPLATION	• Find ways to relate tobacco to other issues the community cares about • Raise awareness of negative consequences of tobacco use and the benefits of quitting • Gather information on tobacco usage and attitudes that can be shared back with the community	• What forms of tobacco are community members using? • Are people ready to stop using tobacco in my community? • How can I make people more aware of tobacco issues, including cessation?	• Conduct a community assessment (e.g. short questionnaire, focus group) to determine the attitude of community members regarding using and stopping tobacco use • Raise awareness of AAPI tobacco issues (e.g. harmful effects, targeting by tobacco industry) through education or media efforts
CONTEMPLATION	• Rally community support for taking action on tobacco and cessation • Gather information on reasons why the community isn't taking steps toward tobacco cessation • Tailor educational efforts and calls to action to address identified concerns	• Why is the community not focusing on tobacco cessation right now (e.g. other priorities, lack of resources)? • How can I make tobacco cessation more relevant to my community? • Who might be willing to speak out on the importance of the issue?	• Build relationships with community leaders and groups and discuss how you can work together to encourage cessation and promote this message in the community • Hold focus groups with former tobacco users to determine what helped them quit • Recruit former smokers from within the community to speak about quitting
	• Assess current resources, programs, and policies that already exist around tobacco and cessation • Conduct community assessments to determine what types of cessation programs or policies might work best • Train staff and cessation providers on	• What are the best methods to get people in my community to stop using tobacco? • How am I going to implement a cessation program or policy change initiative in my community? • Who should I get involved? Who	• Develop a plan and conduct a community assessment (i.e. short questionnaire, focus group, telephone survey) with community members to determine what their preferred methods are to quitting smoking (see next section on Ways to Approach Cessation) • Provide education about the effects of

PREPARATION	cessation and cultural competence • Research solutions to overcome barriers that may interfere with tobacco users receiving support (e.g. financial need, need for bilingual staff) • Secure necessary resources (e.g. funding, materials, space) • Promote program or policy initiatives	might not support my efforts? • Where am I going to get the resources I need? • How will I ensure my campaign is culturally and linguistically appropriate?	tobacco and secondhand smoke and the benefits of quitting • Search for funding and form partnerships to support your efforts; focus on ways to incorporate cessation into existing efforts • Promote cessation programs or policy campaigns within the community
ACTION	• Begin to conduct new cessation programs or policy initiatives or promote existing ones • Begin to evaluate the short and long-term outcomes of cessation efforts	• What types of cessation programs or policy campaigns are now taking place and how are they being conducted? • How do I know if the cessation programs or policy changes are successful?	• Establish no-smoking policies at community events, churches, or workplaces • Hold cessation classes (group or 1:1) • Have providers ask about their patients' smoking status and encourage smokers to quit • Have an evaluation tool in place to assess the progress and outcome of the program or policy change (e.g. participant satisfaction, quit rates, changes in smoking behavior or motivation to quit). See APPEAL's Evaluation Kit for additional ideas.
MAINTENANCE	• Improve programs and policies using evaluation results • Address long-term sustainability of efforts • Incorporate systems for ongoing training of new staff and providers	• Are the cessation programs or policies continuing to meet my community's needs? Are they continuing to be successful? • How can efforts be embedded in systems, policies, or other efforts to ensure long-term sustainability?	• Develop a sustainability plan • Continue to evaluate the program and have long-term follow up if possible (e.g. quit rates, less smoking at community events) • Evaluate to see if changes need to be made in order to make the program more successful, or if additional components need to be added

Ways to Approach Cessation

There are many different ways of approaching tobacco cessation that you may wish to consider for your community. No one method is the best. Offering a combination of methods will usually help reach different types of smokers at different points of readiness to quit. Included in Figure 3 is a list of common cessation methods used, along with strengths and weaknesses to consider. Some approaches are geared at reaching individuals while others have broader impacts on groups or whole communities.

- POLICY CHANGES
- MEDIA CAMPAIGN
- COMMUNITY EDUCATION
- TOBACCO AS A VITAL SIGN
- CESSATION COUNSELING
- QUIT LINES
- PROVIDER INTERVENTION
- NICOTINE REPLACEMENT THERAPY (NRT)
- BUPROPION SR
- ACUPUNCTURE

Figure 3

Cultural Tailoring

One of the challenges when addressing tobacco cessation in AAPI communities is that although mainstream cessation strategies may be applicable to AAPI smokers, an insensitivity to culture and community norms is likely to reduce their effectiveness.

For example, the reasons individuals started smoking or what may motivate them to quit may vary greatly among certain groups of AAPIs compared to the general population in the U.S. Focus group findings in Chinese and Vietnamese adult men conducted by International Community Health Services (ICHS) in Seattle revealed that interacting with peers and co-workers was a consistent reason men smoked. They reported that within local Chinese and Vietnamese communities, it's seen as necessary for men to both accept cigarettes and give them to others so as not to appear rude, to fit in, and to advance career-wise. On the other hand, researchers and cessation providers have also found that protecting the health of one's family provides strong motivation for some AAPI smokers to quit and is an effective way to frame cessation messages.

Figure 3: Cessation Approaches

APPROACH	DESCRIPTION	LEVEL OF IMPACT	PROS	CONS
POLICY CHANGES	The passing of policies that limit smoking or encourage quitting, such as smoke-free environments or raising the price of tobacco products. Policy changes can occur on organizational, local, state or national levels. Some may be mandatory and others voluntary.	Community or Systems	• Affects large numbers of people at once • Research has shown quit rates go up after smokefree policies or tax increases on tobacco products are passed	• Promotes cessation, but individual quitters may still need other mechanisms of support
MEDIA CAMPAIGN	The use of media to educate the community about cessation and promote cessation programs or policies. Can focus on print media (newspapers, newsletter), billboards, public service announcements on radio or television, posters or flyers.	Community	• Can reach large groups of people • Can reach specific communities (e.g. through ethnic-specific media)	• Paid media spots can be costly • Most effective if efforts run long term over stretch of time
COMMUNITY EDUCATION	Tobacco information and cessation education provided in the community through outreach efforts, presentations at community events, media campaigns, etc.	Group or Community	• Can help raise awareness and motivate those considering quitting • Can help promote available cessation programs	• Effects are short-lived; efforts will need to be repeated frequently
TOBACCO AS A VITAL SIGN	Using a stamp in patient medical charts that documents a patient's smoking status and exposure to secondhand smoke (SHS), along with other routine vital signs, e.g. blood pressure, temperature, and pulse.	Systems	• Enables clinic staff and medical providers to be alerted to a patient's tobacco use or exposure status, providing opportunity for education or brief counseling • Easy to incorporate into the routine taking of vital signs	• Not an intervention in and of itself; must be followed-up by education, advice or counseling
CESSATION COUNSELING	Information and quitting support provided in a group setting or individually by a trained counselor. Counseling can take place either face-to-face, over the telephone or internet.	Group or Individual	• Has been found by research to increase quit rates	• Counseling curriculums developed for non-AAPI communities may need to be reviewed for cultural relevance and adapted in spots to improve effectiveness.

QUIT LINES	Many states now operate Quit Lines through which residents call toll-free numbers to receive smoking cessation counseling over the phone. In certain states, callers may also be eligible to receive free nicotine patches, depending on their income level and insurance status. The toll free national quit line number is: 1 800 QUIT NOW.	Individual	• Supported by a national initiative and call-in number • Convenient	• Unable to reach smokers without phones • Limitations include cultural and linguistic barriers for non-English speaking smokers unless trained bilingual counselors or interpreters are provided
PROVIDER INTERVENTION	Provider advises smokers to quit and provides some level of referral or support. The "5 A's" is a common approach, marking 5 intervention steps: 1) ask about tobacco use, 2) advise to quit; 3) assess willingness to make quit attempt; 4) assist in quit attempt, 5) arrange for follow-up.	Individual	• Studies have shown that when a doctor tells a patient to quit smoking, the patient's chance of success increases by 30%; success rate doubles if 3 minutes of counseling is offered • Can be enhanced by system-level policies, such as Tobacco as a Vital Sign or provider training	• Providers often have limited time with patient already and may be hesitant to add an additional item to their visit • Studies suggest that disparities may exist concerning which patients are advised to quit; disparities may exist based on race, ability to speak English, etc.
NICOTINE REPLACEMENT THERAPY (NRT)	Comes in a variety of forms including patches, lozenges, gum, nasal spray and the inhaler. Helps to lessen the nicotine withdrawal and cravings associated with quitting smoking by supplying the body with nicotine. NRT patches, lozenges, and gum are available over the counter for those 18 years or older. Nasal spray and inhaler require prescriptions.	Individual	• Has been shown to increase quit rates, especially when coupled with cessation counseling	• Cost and access can be an issue if smoker doesn't have health insurance that will cover NRT
BUPROPION SR	A medication taken in pill form that acts centrally in the brain to reduce cravings associated with tobacco. Also known as Wellbutrin, Zyban was originally developed to treat depression. A prescription is required for purchase.	Individual	• Can be used in conjunction with other methods, including counseling and NRT	• Cost and access can be an issue if smoker doesn't have health insurance that will cover Zyban
ACUPUNCTURE	Involves inserting needles into specific points on the body, including the ear, and may be commonly used in certain AAPI communities. Usually requires an average of 10 sessions, often held bi-weekly after the initial treatment.	Individual	• Can help alleviate nicotine withdrawal symptoms, cravings, or both • Can be used in conjunction with other approaches, including Nicotine Replacement Therapy or the drug Zyban	• Treatment costs may not be covered by insurance policies • Evidence of effectiveness is less established

In addition, many AAPIs have only limited knowledge about the effects of tobacco and secondhand smoke and may need more education than some cessation curriculums provide. Among the Chinese population, for example, recent immigrants and non-English speaking individuals are more likely to be smokers than those who speak English and are American born, perhaps due to high rates of smoking in their native countries and barriers to understanding tobacco education efforts. In an Oakland Chinatown study, 40% of Chinese males did not know that smoking could lead to heart disease.[3]

With a large proportion of the AAPI population in the U.S. being immigrants, knowledge and cultural attitudes about tobacco are also affected by what tobacco companies are doing in their countries of origin. Many community members are exposed to double targeting by the tobacco industry in their country of origin and when they come to the U.S. In Vietnam, nearly 73% of men are smokers, the highest reported rate in the world. Seventy-one percent of those who could recall cigarette advertising recalled a non-Vietnamese brand, demonstrating the success of transnational advertising efforts.[4]

Another cultural issue impacting cessation is that certain communities may be using tobacco products other than cigarettes. Therefore, they might not see information geared at quitting cigarette smoking as relevant to them or may not receive the help they need in traditional cessation curriculums. For instance, many Pacific Islanders chew betel nut with tobacco. A study conducted in Palau showed that 76% of the population chewed betel nut, and 83% of those mixed tobacco with betel nut[5]. See **Appendix A** for a description of different forms of tobacco use.

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[3] Chen AM, Lew R. Smoking among Chinese, Vietnamese, and Hispanics--California, 1989-1991. MMWR. 1992;41;362-367.

[4] Jenkins CNH. Tobacco use in Vietnam: Prevalence, predictors, and the role of the transnational tobacco corporations. JAMA. 1997;227:726-1731.

[5] Ysaol J, Chilton HI, Callaghan P.A survey of betel nut chewing in Palau. ISLA J Micronesian Stud.1996;4:244-255.

Finally, seeking help from others, particularly those outside one's community, is not necessarily the norm in some AAPI communities. Common usage of phrases such as "counseling" may have negative connotations and not be equally "inviting" to all communities. All of these factors makes cessation work in the AAPI community even more challenging and require tailoring to address.

Ways to develop culturally designed or tailored approaches include:

- bringing together key community organizations and leaders to learn from their experience and earn their support
- holding focus groups or needs assessment surveys with community members to gather information on factors that support or hinder cessation as well as key cultural elements that may need to be included in cessation efforts
- working with community leaders and local groups to promote or provide cessation services
- hiring bilingual/bicultural staff
- tailoring cessation messages or curriculums to ensure they are sensitive to cultural factors
- being flexible.

When looking at current mainstream cessation programs, few of the items listed above are taken into account. In order for cessation to work in the AAPI community, the development of unique approaches or cultural tailoring of existing ones must occur in order to:

- address each community's language and literacy needs
- provide relevant messages and quitting recommendations
- select cessation strategies that are likely to be well accepted
- use messengers or cessation providers that specific communities are likely to respect and respond to
- build a foundation on which to base other cessation efforts on.

Elements of curriculums that may need cultural tailoring include:

- the reasons AAPIs smoke and motivators for quitting
- the level of knowledge assumed regarding tobacco and secondhand smoke
- culturally appropriate examples of common cessation recommendations, (e.g. exercise and good nutrition), approaches to cessation (i.e. support groups) and terminology (i.e. counseling)
- sensitivity to ethnic-specific gender or age dynamics and norms in regards to tobacco use
- sensitivity to immigration status and acculturation level of tobacco users (e.g. exposure to transnational advertising; language ability)
- measures of success (should be relevant to the community's level of readiness to address tobacco issues and strategies being used; may need to be broader than "quit rates" in communities where increased community education and awareness, improved access to cessation services, passing of voluntary smoke-free policies, or improvement in smoking behavior are goals).

Key Steps
to Implementing Cessation Programs and Policies

Step 1:
Conduct community assessment

Although you may want to jump into starting a cessation program or policy campaign, a good place to start is to conduct a community assessment on tobacco and cessation (if one hasn't been done already). As described previously, thinking about the readiness stage of a community to address cessation provides valuable information on useful next steps. If your community is in an earlier stage and not quite ready for action, lots can be done to develop support, gather resources, and research strategies to help ensure the success of future programs and campaigns.

Step 2:
Locate available resources (AAPI specific and mainstream)

Use the results of your community assessment to determine where resources already exist and where new resources need to be placed. Are there systems already being sustained by other resources into which you can embed your cessation efforts? Will you need to apply for new grants or other sources of funding? Will you need paid staff or volunteers?

Step 3:
Identify cessation strategies

Consider the positives and negatives of the different ways to approach cessation along with results from your community assessment to determine what approaches might work best in your particular community. (See Figure 2 for list of possible strategies.) For broad, lasting impact, consider policy or systems-level strategies that affect large groups of people.

Step 4:
Adopt strategies for cultural appropriateness

Use the results of your community assessment and the expertise of community leaders to think about what aspects of your selected strategy may need to be uniquely designed or tailored to be successful. Review the elements of curriculums that may need tailoring listed in the previous section. Ask yourself whether your approaches build from the resources the community has to offer and are sensitive to barriers that might be keeping people away from participating. (See APPEAL's Community and Cultural Competency Kit for additional information.)

Step 5:

Conduct program or policy campaign

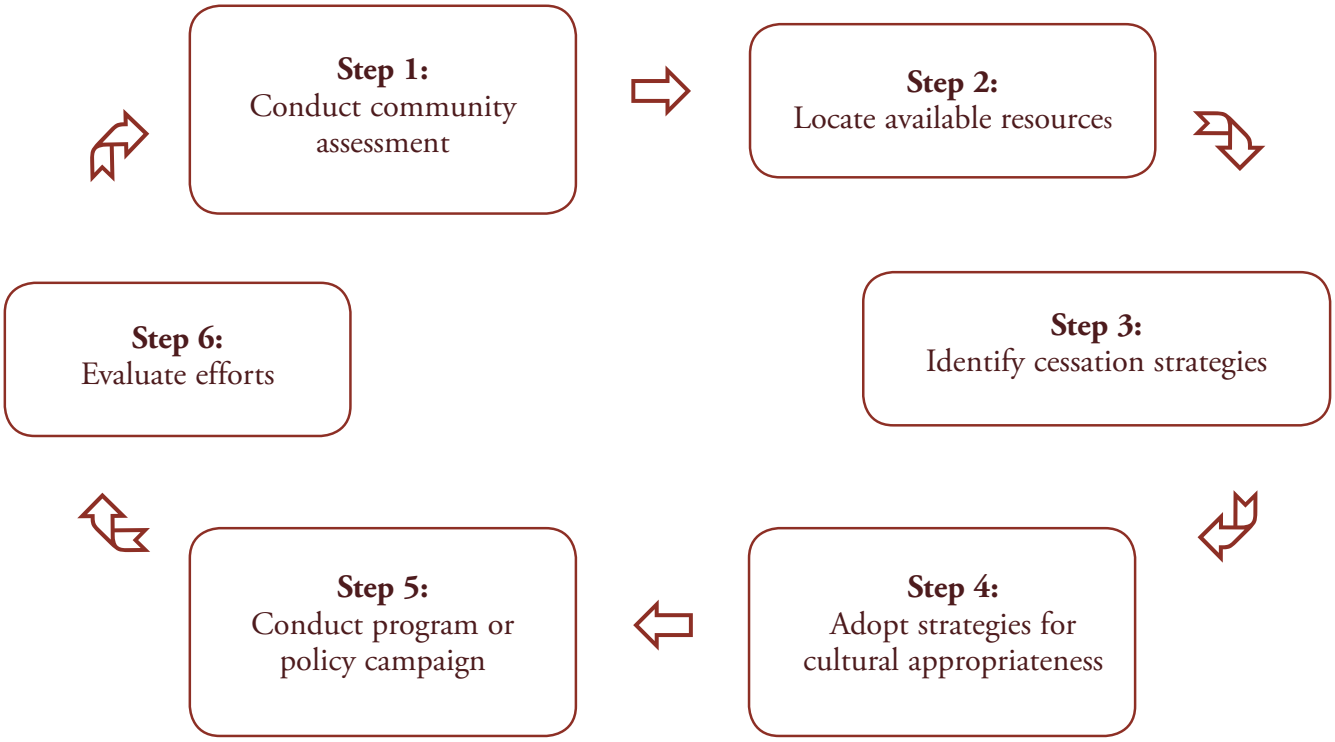
Now that you've done preliminary assessment and worked on developing resources, it's time to actually put your plans into action.

Step 6:

Evaluate efforts

Set up ways to determine whether or not your cessation program or policy is meeting its original goals. Important questions may include who you are reaching, how they feel about your efforts, and how their awareness of or participation in your activities has changed their tobacco use behavior. The evaluation should be detailed enough to help you determine how your efforts could be improved, if necessary. (See APPEAL's Evaluation Kit for additional information.)

Figure 4: Key Steps



Case Studies

Real Life Examples of Community-Wide Smoking Cessation Efforts

The following three case studies demonstrate how AAPI communities have moved from the **contemplation** to **preparation** to **action** stages of readiness on smoking cessation. Although each uses a different combination of the methods described in the previous section, all three groups tailored their selected strategies based on their community's readiness and cultural context. (See Figures 1 and 2). Although the use of smokeless tobacco products is also problematic in certain communities (see Appendices A and B) and should be addressed, few community-tailored approaches to smokeless tobacco cessation among AAPIs have been developed.

Case Study #1:
Contemplation to Preparation to Action Stage

Cessation through Policy Change in the Samoan Community

In an effort to create policy change that would support community cessation, the Union of Pan Asian Communities (UPAC) developed a campaign that focused on working with Samoan church groups in the Greater San Diego area to develop smoke-free church ground policies.

Overall, the Samoan communities in the area were at earlier stages of readiness and capacity to address tobacco cessation issues. Initial focus groups indicated a lack of tobacco education and awareness. Furthermore, Pacific Islander participants felt that their communities were often left out of tobacco control activities and that existing programs didn't address the needs of the Pacific Islander communities.

Focus groups participants advised that in order for this campaign to succeed, Samoan community leaders who are often involved with the church, needed to be involved in order to reach the community. It was decided that the Samoan Church, also known as the "Modern Village," should be the focus of this campaign. Ministers are highly respected leaders in the Samoan communities both in the U.S. and in Samoa. Community members view their opinion as equal if not more important to that of a physician's and they often turn to their ministers for both spiritual and physical guidance. Because Samoan ministers travel between the U.S. mainland and Samoa, they would also be able to bring information learned about tobacco prevention and cessation back to Samoa.

Prior to initiating the community campaign, several key action steps occurred. First, the commitment of three organizations that served Pacific Islanders in the Greater San Diego area was secured for the purpose of working with the Samoan churches. Next, three Samoan churches were identified to participate in the advocacy campaign and relationships began to be developed. Finally, packets were developed which included information about secondhand smoke, tobacco related deaths, chemicals in cigarettes, and transnational

tobacco issues. These packets were distributed during meetings with the Samoan ministers and at the workshops.

Site visits were also conducted at churches that showed interest in participating in the campaign. This was done to determine if policy changes were feasible for each church, as smaller churches often rented out halls from larger churches and thus could not adopt a smoke-free church ground policy. A total of five churches pledged to support and be involved with the campaign. A "Partnership Document" was initially going to be created to formalize the working relationship between the interested churches, however the churches felt more comfortable giving verbal approval to conduct these activities. In the Samoan community a verbal agreement is more culturally appropriate and has more value than a written document.

Over the next thirteen months, staff worked to develop smoke-free church ground policies through anti-tobacco activities and education. They promoted the campaign at the Flag Day celebration, secured media to promote the campaign, and met with youth coordinators at the involved churches. When meeting with the youth coordinators, they expressed interest in training their youth to conduct surveys at local community events including the annual Pacific Islander Festival Association (PIFA) event and incorporating tobacco education into Sunday school and youth group activities. Pre and post surveys were collected which measured knowledge, attitudes, and behaviors of PIFA participants regarding tobacco, and the survey revealed that the youth did increase their knowledge of the impact of tobacco. Additionally during the PIFA event, the emcee presented tobacco messages, youth collected signatures to support smoke-free church grounds, and the Samoan cultural dancers included tobacco education messages on their costumes. During White Sunday, children and youth organized the church services and included tobacco education in the church bulletins. During the Easter Youth Rally, their efforts resulted in success when four Samoan churches signed and formally adopted the smoke-free church grounds policy.

Passing smoke-free policies within the community is an important way of changing community norms around tobacco and supporting tobacco cessation. By prioritizing the involvement of respected faith leaders and laying the groundwork with community assessment, education, and outreach, UPAC was extremely successful in building the Samoan community's readiness for tobacco cessation.

Case Study #2:
Preparation to Action Stage

Project HABIT (Hmong Against Big Tobacco)

Through Project HABIT, the Hmong community and La Crosse County Health Department (LCHD) in Wisconsin have been working together to provide tobacco cessation services in a variety of ways. As this was a community at a very early stage of readiness in terms of tobacco cessation, Project HABIT started by gathering community input and conducting surveys to learn about community issues and garner support in a culturally sensitive manner. Other important steps included community-wide education and offering tailored cessation counseling. LCHD subcontracted funds to three Hmong serving agencies or

Hmong Mutual Assistance Associations (HMAAs). The La Crosse Area HMAA provided Hmong health educators to be trained as smoking cessation specialists, and recruit, meet, and arrange workshops and 1:1 interventions. Funding for Project HABIT was provided by American Legacy Foundation.

Community Input and Assessment: Prior to implementing any activities, meetings were held with members of the HMAA, clan leaders, and key members of the Hmong community to get their input. As the Hmong community is patriarchal in nature and respect is paid to its elders, these factors had to be interwoven into the delivery of services in order for them to be successful.

Since very little published data exists on tobacco use within the Hmong community that can be used to develop or evaluate cessation programs, a written, convenience sample survey was conducted early on which looked at tobacco use, attitudes, exposure, health knowledge and consequences. Findings revealed high rates of tobacco use and exposure through family members who smoked, and that some smokers reported using tobacco for medicinal purposes.

Community Education: To increase awareness of tobacco issues and encourage smokers to quit, educational workshops on tobacco use lasting 60-90 minutes were offered. To promote attendance, the workshops were offered as part of a concurrent day-long program for Hmong parents providing workshops in other areas such as "How to Help Your Child Succeed in School." Guest speakers included Hmong physicians, mental health specialists, clan leaders, ex-smokers, and key community leaders. For the Hmong community, it is important to talk with and see individuals who have suffered from the health effects of tobacco in order for them to believe these facts.

Individual Counseling: In addition to community education, cessation counseling was offered to individual smokers interested in quitting. Below is a short description of the program and ways in which a unique cessation approach for the Hmong community was developed.

Curriculum: The American Lung Association's Freedom From Smoking ® curriculum was culturally tailored for use in the Hmong cessation program. The nuts and bolts of the curriculum were all included, however, since additional time was needed by bilingual facilitators to discuss methods of quitting, other parts of the curriculum had to be shortened. Based on focus groups run with Hmong elders and clan leaders, information on exercise and nutrition was omitted primarily due to length and the recommendation that they could be covered later in other ways. The curriculum was translated at a middle school level; however some of the elderly required a lower literacy level. Certain tobacco related diseases (i.e. emphysema, asthma, bronchitis) had no direct translation into Hmong and had to be described in longer detail. For example, "emphysema" was translated as "a disease smokers get which destroys their lung tissue and tiny air sacs; as a result it affects the smokers breathing." It was very important for the Hmong participants to see pictures of the tobacco related diseases, and the information was considered more credible if presented by a physician.

Venue: In the first year of the project, tobacco cessation was provided in a group setting. Due to the varying schedules of participants, difficulty in getting participants to attend all 8 weeks, and the small numbers attending classes, a decision was made to switch to 1:1 counseling in the 2nd and 3rd year. Telephone counseling was felt to not have the same impact as face-to-face counseling as it is essential to the culture to develop personal relationships.

It has been crucial that the counselor develops a relationship with the patient on the first visit before tobacco cessation counseling is provided. If the patient is not familiar with the counselor, time must be taken to develop the relationship. If the counselor is much younger then the patient, additional time must also be taken to build rapport due to the cultural issues of respecting the elders in the Hmong community. Because only three home visits are made on average, the counseling portion has been abbreviated, with emphasis being placed on the basics. Participants are offered free Nicotine Replacement Therapy (NRT), however many of the community members require education about what NRT is before they are willing to use it.

After completing the 1:1 sessions, additional follow up for at least three months is provided. If a participant has been unsuccessful at quitting smoking after this time, it is recommended they make an appointment with their physician. Typically 20-30 hours on average is spent with each cessation participant.

Tobacco Prevention and Cessation Video: Due to the high illiteracy rate among the Hmong elderly, a tobacco prevention and cessation video was developed to support education and counseling efforts. The video is made up of five components: 1) introducing the tobacco problem and why it's important to quit, 2) health effects, 3) secondhand smoke and its effects, 4) quitting including NRT and non-NRT options, and 5) available resources. Both Hmong and American physicians are featured in the video, along with ex-smokers. Video footage was reviewed with clan leaders before the final version was completed.

Working with the WI Quit Line: Currently less than 1% of the Southeast Asian population in Wisconsin calls the Quit Line, although a Hmong counselor is available. In the Hmong community it is not a traditional practice to call someone you don't know. Through an innovative approach, Project HABIT is working with the WI Quit Line to obtain written consent from smokers which enables the Quit Line to call the smoker directly rather than waiting for them to call in. A total of four telephone calls are typically made to provide counseling. Free NRT is also available through this approach as well.

Project HABIT is a good example of how a cessation program can ensure cultural appropriateness by taking the time to form relationships within the community, being flexible to community input, and ensuring that important community values are respected. Although cessation counseling services were based on an existing curriculum, a thorough understanding of the community helped developers make many important revisions to its content, length, format, and materials.

Case Study #3:
Contemplation to Preparation to Action Stage

Cessation Research and Materials for Native Hawaiian Smokers

Native Hawaiians suffer from high tobacco use rates, but like other communities at earlier stages of readiness, have less capacity for conducting community-wide tobacco cessation initiatives in part due to limited ownership over initiatives and resources. Papa Ola Lokahi (POL), found that a community assessment method (called participatory action research) followed by the development of culturally designed educational materials were necessary steps to addressing cessation within Native Hawaiian communities. POL is a consortium of agencies that functions as the advocacy entity for five Native Hawaiian Health Care Systems (NHHCS) located on the islands of Maui, Hawai'i, Kaua'i, O'ahu, and Moloka'i.

Participatory Action Research: Although some of the NHHCS have participated in previous research studies in collaboration with mainstream health systems, most were reluctant to participate again because of past experiences in which: 1) there was little or no compensation for staff time, 2) the research was either irrelevant or considered "low priority," 3) the role of the community was limited to recruiting participants, 4) findings were rarely shared with the participants or the participating agencies prior to publication, often resulting in harmful profiling and stereotyping, and 5) there were no tangible benefits for the community.

So, when the Hawai`i Department of Health's Tobacco Prevention & Control Program (TPCP) requested the assistance of Papa Ola Lokahi and NHHCS to determine cigarette brand preferences and other cessation-related issues among Native Hawaiian smokers, NHHCS' leaders requested that the research be carried out using participatory action research practices. They insisted that: 1) participation in the survey should lead to tangible outcomes and that participants should get something in return for their contributions (such as smoking cessation information and referrals to smoking cessation programs); 2) the survey should be expanded to include questions of interest and practical use to NHHCS; 3) NHHCS staff time should be compensated; and 4) NCCHS should have control over how the data was reported, disseminated, and applied.

TPCP agreed and made revisions to the survey questions and methodology. This process of listening and being flexible to each other's concerns and needs was important for establishment of a meaningful collaboration based on trust that would ensure the success of the research and future cessation efforts that stemmed from it as well. The five NHHCS agreed to participate.

Two key findings from the 511 surveys collected were as follows: 1) While the majority of Native Hawaiian smokers reported that they did not feel that smoking jeopardized their health, they did list that they currently had smoking-related health conditions such as heart disease, asthma, etc. This indicated that additional education focusing on the impact of smoking health conditions other than lung cancer alone may be warranted; 2) The majority of participants also stated that they did not want their children exposed to secondhand smoke. This finding highlighted the value respondents placed on the health and wellness of their children — a potential motivator that smoking cessation programs can stress for Native Hawaiian smokers.

Research results, in turn, leveraged additional funding and served as the catalyst for the development of tailored health education materials (two of which are described below).

"Why You Should Quit Smoking" Brochure: Working together with the Native Hawaiian Health Care Systems on smoking cessation identified a glaring gap—the lack of smoking cessation materials tailored for Native Hawaiian smokers. 'Imi Hale – Native Hawaiian Cancer Network addressed this gap by developing an informational brochure for the Native Hawaiian community on "quitting smoking."

Development of the brochure incorporated data from past focus groups and the previously described Native Hawaiian Smoker Survey. Important community issues identified by the research beyond those listed above included the following: 1) physicians were identified as having the strongest influence on Native Hawaiian smokers to quit smoking, 2) the Hawaiian community was proud of the growing number of Native Hawaiian physicians in the past decade, 3) peer support was both important and valued, and 4) personal "stories" are a culturally appropriate way to share information. The brochure content was written with a "local" language style and readability was at an 8th-9th grade reading level to accommodate those with more limited reading skills. A lot of time was invested in identifying former Hawaiian smokers and Hawaiian physicians to be featured in the brochure. Requests were made to all the islands, resulting in representation from different Hawaiian island communities.

Dr. R. Kekuni Blaisdell, a well respected and well known Native Hawaiian physician, was chosen to deliver the "It's Anti-Hawaiian to Smoke" message for the cover of the brochure. Dr. Blaisdell is well connected in the community due to his many years of medical practice, his mentorship of most of the Native Hawaiian physicians, and his reputation as a proponent for the self-determination of Hawaiians. Other Hawaiian physicians were included to emphasize the message to quit.

Since peer support is highly valued in the Native Hawaiian community, both former Native Hawaiian smokers along with Native Hawaiian physicians were featured in the brochure. By highlighting other peers who had quit smoking, it emphasized the message: "If I can do it, you can do it too...I'm not a movie star, I'm just like you." Their quotes or "stories" personalized the message.

Multiple rounds of pre-testing were conducted to assess appropriateness of the message, acceptability of the format and visuals, and verification that the message was getting across. The `Ahahui O Na Kauka (Native Hawaiian Physicians' Association) also reviewed the brochure and was given an opportunity to make comments and changes. Once printed, the network of Hawaiian Civic Clubs community health centers, and the NHHCS helped to distribute the brochure.

Quit Kit: After development of the brochure, a quit smoking kit was developed which promotes the message that "Smoking is NOT a Hawaiian Tradition". Items in the Quit Kit included things to keep one's hands busy (stress ball, rubber band), items to help with the oral fixation (gum, lollipops, cough drops, flavored toothpicks), items to help one stay regular (high fiber bar) and educational materials. Educational materials included are the "Why You Should Quit Smoking" brochure and a brochure from the Department of Health on available resources. The Quit Kits have been very popular and well received by NHHCS' clients.

Using a participatory action research approach was important for conducting community assessment around cessation in Native Hawaiian communities in a manner that built trust, benefited the community, and led to future collaborations. Developing educational materials that included messages from well respected community leaders (i.e. Native Hawaiian physicians) as well as peers, ensured that the educational materials developed were effective and well received.

The Conclusion

Helping current tobacco users quit through broad-reaching programs and policies is a key strategy for achieving a tobacco-free community. Prior to implementing tobacco cessation programs or policies, it is important to assess the needs of your community and its stage of readiness so you can tailor your approaches. APPEAL's Stages of Community Readiness Model is one tool to help you conduct a community assessment. Cessation can be addressed in many ways and the decision on which approaches to use may depend on a community's level of tobacco knowledge, the extent to which organizations or individuals are working on this issue, and available resources. Therefore the approach taken by one ethnic AAPI community may or may not be the best approach for another AAPI ethnic community.

Whatever approach is chosen, it is important to culturally design new or tailor existing cessation programs and policies in order to make them relevant to the community. With the AAPI community having a high rate of smoking in its adult male population, rising youth prevalence rates, and exposure to tobacco industry targeting both in the U.S. and globally, it's necessary to continue to build capacity and infrastructure within the community so community members themselves can lead efforts and get involved with addressing the problem.

Resources

AAPI Cessation Resources & Sample Programs

Asian Pacific Partners for Empowerment, Advocacy and Leadership — offers assistance developing cessation programs or policies and locating existing AAPI cessation educational materials and sample programs. (510) 272-9536, www.appealforcommunities.org.

Asian Health Coalition of Illinois (Chicago, IL) — offers online access to in-language curriculum materials used for Korean cessation classes. www.asianhealth.org

Charles B. Wang Community Health Center (New York, NY) — has developed a smoking cessation program and educational materials for the Chinese community. (212) 226-1661, www.cbwchc.org

International Community Health Services (Seattle, WA) — has developed a clinic-based cessation program for Vietnamese and Chinese men and instituted Tobacco as a Vital Sign. (206)788-3670, www.ichs.com

La Crosse County Health Department (La Crosse, WI) — see case study on Project HABIT. (608) 785-9872, www.co.la-crosse.wi.us/health/education

Papa Ola Lokahi (Honolulu, Hawai'i) — see case study on pages 23-25 of their cessation work in Native Hawaiian community. (808) 597-6550, http://papaolalokahi.org/

Union of Pan Asian Communities (San Diego, CA) — see case study on pages 19-20 of their cessation work in Samoan community. (619) 446-0831, www.upacsd.com

Vietnamese Community Health Promotion Project (San Francisco, CA) — has conducted media and Quit-to-Win campaigns within the Vietnamese community. (415) 476-0557, www.healthisgold.org

General Cessation Resources:

American Cancer Society — offers non-AAPI specific cessation information and Internet quitting program. www.cancer.org

American Lung Association — offers non-AAPI specific cessation trainings and curriculums for adults (Freedom from Smoking) and youth (Not On Tobacco). www.lungusa.org

Center for Tobacco Cessation — offers online cessation resources, including toolkits, an e-newsletter and lists of state cessation activities. http://ctcinfo.org/

National Toll Free Quit Line Number: 1 800 QUIT NOW — a toll free number that will automatically connect callers to their state-sponsored quit line, if available, or to the National Cancer Institute's quit line. California's Smokers Helpline offers services in four Asian languages for CA residents.

Appendices

Appendix A:
Tobacco Comes in Different Forms

Tobacco use within AAPI communities may include forms of tobacco other than cigarettes. It's important to be aware of common uses within the community and consider them when doing research, developing programs, or creating policies to promote cessation.

Smoking Tobacco

Cigarettes: Can be hand rolled or manufactured. Manufactured cigarettes consist of shredded or reconstituted tobacco that is processed with hundreds of chemicals, of which over 40 are known to cause cancer. Cigarettes can be filtered or unfiltered.

Cigars: Any roll of tobacco that is air cured or fermented with a tobacco wrapper. Cigars come in many sizes and shapes. Cigars deliver more carbon monoxide per gram of tobacco burned than a regular cigarette. One cigar contains as much nicotine as almost three packs of cigarettes. Smoking cigars causes similar diseases as smoking cigarettes.

Pipes: Can be made of briar, slate, clay, or other substances. Tobacco is placed in the bowl and inhaled through the stem or sometimes through a water filled chamber.

Hookah: A water pipe that originated in West Asia. Tobacco is heated by charcoal and the tobacco smoke passes through a water-filled chamber, cooling the smoke before being inhaled by the smoker. Preliminary research indicates that hookahs increase carbon monoxide and nicotine exposure and are linked to cancer and heart disease. Hookahs are becoming popular in the US particularly among college students and young adults.

Hookah

Bidis (Beedies): Hand rolled cigarettes containing a small amount of tobacco. They are available in a variety of scents and flavors that hide the harsh taste of tobacco. Bidis are unfiltered and deliver a high yield of tar, nicotine, carbon monoxide, and other chemicals compared to manufactured cigarettes. Studies reveal that more than 325,000 children, some as young as ten years old, work in the bidis industry in India. Bidis are widely used in India, where they are known as the "poor man's tobacco" and are popular among young people in the US as well.

Kreteks: Clove flavored cigarettes that are made in Indonesia. They contain a range of exotic flavorings and a chemical called eugenol that has a numbing effect.

Chew Tobacco

Betel Nut: Areca nut, the seed of the fruit of the oriental palm, is thinly sliced and mixed with a variety of substances including lime paste and spices such as cardamom, coconut, and saffron. It may be wrapped in the leaf of the piper betel plant giving it the more common name betel nut. It is used both alone and mixed with tobacco. Areca nut is used by an estimated 200-400 million people, mainly Southeast Asians, Pacific Islanders, and those from India. Chewing betel nut has been found to cause pre-cancerous changes in the mouth that can lead to oral cancer.

Paan: Otherwise known as a betel quid, paan is a mixture of small pieces of areca nut combined with several other ingredients, sometimes tobacco, and then wrapped in a betel leaf and chewed. Paan is commonly used among South Asian communities.

> **Paan masala:** Ready made packets of paan that may also contain other sweetening or flavoring agents.

For more information on tobacco use in AAPI communities, including prevalence rates and information on how the tobacco industry targets AAPIs, visit www.appealforcommunities.org or review APPEAL's Making Tobacco Relevant Education Kit.

Appendix B:
Common Questions on Information Provided in Cessation Programs

Q: I thought it was only important to stop smoking cigarettes. Why is it important to encourage people to stop using other tobacco products?

A: Other tobacco products used by the AAPI community, such as cigars, chew tobacco, tobacco mixed with betel nut, bidis, and paan, are just as dangerous as smoking cigarettes. Each of these products is known to cause cancer. For example, both betel nut and paan increase the risk of mouth cancer. Also, by using any of these forms of tobacco, tobacco users are sending a message to friends, children and grandchildren that it is o.k. to use these products. See Appendix A for a description of different forms of tobacco use.

Q: Should we encourage smokers to try low tar or smokeless products instead?

A: There is no safe cigarette or smokeless tobacco product. The National Cancer Institute (NCI) recently concluded that light cigarettes provide no benefit to a smoker's health, and that individuals who switch to light cigarettes are likely to inhale the same amount of hazardous chemicals and remain at high risk for developing smoking related cancers and other diseases. The low tar and low nicotine numbers on light cigarette packaging comes from numbers generated by smoking-machines that smoke every cigarette tested the same way. These numbers don't reflect the actual amount of tar and nicotine a smoker gets because people don't smoke the same way machines do. In real life, most smokers will adjust how they inhale or the number of puffs they take to make up the difference. Smokeless tobacco products have also been found to cause serious health problems, including oral cancer of the lip, tongue, cheeks, gums, and mouth.

Q: What do you recommend if someone doesn't want to quit smoking?

A: Individual tobacco users may go through varying stages of thinking and planning before being ready to quit (see Prochaska and DiClemente's Transtheoretical Model described on page 6). Or they may have tried before but gone back to smoking and are afraid of failing if they try again. Cessation programs and policies should try to include activities relevant to tobacco users at various points in their efforts to quit. For example, for AAPI smokers that have limited knowledge about the effects of smoking and secondhand smoke, educational campaigns aimed at helping them learn more about the effects of smoking and secondhand smoke may motivate them to consider cutting down or try quitting. Some smokers may not

be fully committed to quitting at the present time, but could be encouraged to begin preparing by smoking outside of the house and away from children or grandchildren as a first step. Having health providers bring up quitting and provide advice during patients' office visits may offer multiple opportunities for encouraging smokers to quit. Look into what resources are available in your community for tobacco users at different stages of readiness in terms of quitting or ask a health care provider for help.

Q: How should my program address smokers that have tried quitting in the past, but have started again?

A: On average, a smoker makes eight quit attempts before they are able to successfully quit smoking. If a person has been able to quit smoking in the past for even a short period of time, remind them that he or she was able to do it before and can do it again this time! Ask about the reasons why they started again (i.e. relapsed), and help them come up with strategies to deal with those situations if they encounter them again. Encourage them to get support from family and friends. It is important to look into resources in the community such as cessation classes, state quit lines, and medical providers that can help provide support.

Have questions? Call, write, or e-mail us at:
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Also check APPEAL's web page at www.appealforcommunities.org

APPEAL

Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL) is a national network of individuals and organizations committed to working towards social justice and a tobacco-free Asian American and Pacific Islander (AAPI) community. APPEAL's mission is to prevent tobacco use and improve the health status in the AAPI community through network development, capacity building, education, advocacy, and leadership.

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