



APPEAL

ASIAN PACIFIC PARTNERS FOR EMPOWERMENT AND LEADERSHIP

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Enhancing Cultural and Community Competence for Tobacco Control for Asian Americans and Pacific Islanders



This toolkit is designed to assist in the initial assessment of institutional cultural and community competency and to encourage agencies to engage in the on-going process of developing cultural competence while working with Asian American and Pacific Islander (AAPI) communities. It does not attempt to provide answers or a detailed roadmap, but rather emphasizes the importance of institutionalizing cultural competency activities in policies, programs, staff, volunteers, and coalitions.

Introduction to Cultural Competency for AAPI Communities and Tobacco Control

Why is cultural competency important to tobacco control?

Tobacco control works to alter social norms or environments by changing public policies, changing attitudes about tobacco, and countering the tobacco industry so that communities will ultimately be free of tobacco and its deadly effects. The tobacco control movement should recognize that systemic, comprehensive change is critical to reducing the impact of the tobacco industry and tobacco use. Part of that comprehensive strategy is to have an impact on how different communities address tobacco. Working toward becoming a more culturally competent program, agency, or institution is an important step in comprehensively addressing tobacco in all our communities.

The existence of disparities in tobacco-related diseases means that tobacco control institutions must address diverse communities to make headway against the disproportionate impact and burden of tobacco. When



Common Definitions

Culture is one's worldview, values, beliefs, customs, and behaviors influenced by one's race, ethnicity, national origin, primary language, religious beliefs/spirituality, class/socioeconomic status, gender, sexual orientation, history, geography, etc.

Competency is a required level of knowledge, skills, and experience. Cultural competency refers to possessing sufficient knowledge, skills, and experience to communicate effectively with and work together with someone from a different culture.

considering the impact of tobacco use in AAPI communities, one must consider not only the equal risk of ill health effects among all people who use tobacco, but also the unequal burden of death and disease on AAPIs due to compounding factors such as barriers to health care access (e.g., uninsured or underinsured status) and cultural and linguistic barriers.

What is cultural competency?

The terms multicultural and *diversity* often come up in discussions about cultural competency. How often have we heard of a program described as multicultural in nature, a staff member as bicultural or bilingual, or a board as valuing diversity? What's important is that these terms are often used to describe a tangible goal or vision of what we want our programs, organizations, and staff to look like, but in essence these terms are static and only describe how things visibly appear.

Being culturally competent means something different from the terms multicultural or diversity. It means possessing sufficient knowledge, skills, and experience to communicate effectively with and work together with someone from a different culture or community. Two important things we gain from this definition are: 1) an emphasis on the process of working together with people from different cultures, and 2) the proposition that communication is an important mechanism for successfully engaging in this process.

Finally, there are many different models of cultural competency. Although this kit does not address these specific models, some are cited in the resources section for your own investigation.

What is the difference between diversity and inclusivity?

Having a diverse group is often thought of as being the end goal for many tobacco control coalitions and organizations. While diversity achieves the short term objective of having a person or particular persons in the room, diversity does not guarantee that your group or institution is anywhere closer to achieving *parity*. *Inclusivity* refers to inclusion of different people, often those not included in the past, in the processes of the group. True inclusivity is a much more active and involved description of working toward parity. So, inclusivity refers more to the processes of a group, organization, or institution rather than its make-up. Parity can be defined as being equal in the process, as well as the outcomes attained in tobacco control. It can also be defined as the ability of representatives from heterogeneous communities to equally participate in the planning and implementation of key activities, programs, and policies. (See the APPEAL educational kit, *Moving Toward Health: Achieving Parity through Tobacco Control for All Communities*, for more information.)

Types of Diversity

Types of diversity include cultural, language, geographic, socioeconomic status, sexual orientation, and many others. Key issues relating to diversity and inclusivity are: 1) understanding the impact of tobacco on a community, 2) knowing the history and issues of a community, 3) recognizing the level of community readiness or capacity to engage in tobacco control, and 4) recognizing cultural patterns and communication styles.



Another Point of View: Community Competence

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It can be argued that the idea and practice of cultural competence should be replaced by the broader construct of community competence. Community competence, which evolves from the concept of cultural competence, is comprised of the following elements: history, culture, context, geography, language, literacy, positive and salient imagery, multiple generations, and diversity. Programs, materials, survey instruments and intervention protocols that consider and reflect these elements will better express the complexity of the communities or related audiences. Models that rely on the construct of cultural competence may be limited because of the underlying assumption that culture is the critical essence of particular population groups.

Communities are more than the sum of their culture. Population groups will reflect different historical, cultural, contextual and geographical experiences. For example, surveys addressing Cambodians may have to avoid the term "study" because this was the reference used during the removal from urban to rural areas by the Khmer Rouge. Issues of language, literacy, imagery and multiple generations are generic, but still need to be addressed based on specific community assessments.

Diversity makes explicit the immense heterogeneity within national communities, such as the 500+ tribes comprising Native Americans and the multiple ethnic groups within the respective communities of Asian Americans, Blacks and Latinos.

Community competence provides an explicit protocol for assessment and evaluation of initiatives. It provides flexibility in addressing the needs of large aggregations, such as communities, as well as smaller strata, such as youth or persons of low socioeconomic status. Critically, because community competence is responsive to the complexity of populations, a strategic planning process is facilitated that is best suited to the strategic goal of defining and eliminating disparities.



What does cultural competency for AAPIs mean to tobacco control?

A culturally competent tobacco control program, coalition, or institution engages in an on-going effort to develop its competence. Its activities and processes are inclusive, and it engages in on-going planning, implementation, and evaluation of cultural competency efforts at various levels of its leadership, membership, and staff.



A useful visual in conceptualizing cultural competency is the Balancing Act of Tobacco Control by David Nakashima. The diagram is a wheel with three components: *People*, *Product*, and *Process*. These words should be familiar to us in tobacco control, but we

rarely see them presented in this way. Each represents something that we value in our work. Some value people. They might believe that at the end of the day, when all is said and done, “I want to make sure that the people I work with are still my friends.” These folks value relationships over all other things. For some, the process we adhere to or steps we go through to work together is most important. These folks often want everything to be “fair and even.”

Finally, others firmly believe that achieving the product is the most important thing. They often say, “Forget about process. I don’t need all of us to be friends, I just want us to reduce tobacco use in my community.” Each of us may lean in one direction or another, or find that we value to varying degrees all three of these principles. For many communities of color, process and people are more important than the product. But in tobacco control, we often value or are expected to value the product, perhaps at the loss of people and process.

What might cultural competency mean for AAPI communities?

At the very least, cultural competency for AAPIs means recognizing the diversity of culture, socioeconomic status, and experience in the United States.

It means recognizing that the broad categorical term “Asian American and Pacific Islander” fails to adequately represent the extreme diversity of ethnic groups and communities that fall under it.

Cultural perceptions about tobacco vary among AAPI communities. In the Hmong community, for example, tobacco is given as a gift during weddings where it serves a specific social function. Furthermore, beliefs about health and health practices greatly impact how people perceive tobacco and tobacco-related diseases. In some communities, a pervading sense of fatalism may overshadow the importance of health; the absence of hope often experienced in populations suffering from extreme poverty, isolation, social stigma, and political oppression makes health less of a priority. This sense of hopelessness may mean that some community members may view tobacco cessation and prevention as a pointless effort.

The tobacco industry continues to use culture to promote their products. It has even been suggested that the tobacco industry is more “culturally competent” than the tobacco control movement. For example,

in 1999 Philip Morris launched a new advertising campaign for its Virginia Slims cigarettes to target ethnic minority women. The “Find Your Voice” campaign focused on promoting the message of modernity and strength to a new generation of young minority women. In addition to marketing in the United States, the tobacco industry has in the past twenty years exponentially increased its presence throughout the world, especially in newly emerging Asian markets. The presence of the industry abroad impacts AAPIs here in the U.S. because many AAPIs frequently travel to their countries of origin and are exposed to those pro-tobacco environments. In addition, a great deal of media and entertainment is imported from countries of origin and consumed by AAPIs.

Tools for developing a plan to address cultural competency

Often the challenge for organizations working to address cultural competency is maintaining momentum. Changes in staffing, changes in leadership, and

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders, or AAPIs, is a term used to describe a diverse and heterogeneous population of people whose ancestral heritage originates from countries in Asia and the Pacific. There is no single AAPI culture. Over fifty (50) different ethnic subgroups, each with distinct cultures, languages, and dialects, are represented in the category of AAPIs. The history of Asian Americans is best characterized by their long history of immigration. Asian immigrants have come to the U.S. seeking economic opportunities, political freedom, and reunification. Whereas Chinese immigrants came to California as early as the 19th century, many Southeast Asians have come to the U.S. as refugees after the Vietnam War over the past 25 years. Pacific Islanders have a history of centuries of European colonization, subsequently replaced by U.S. rule in the 19th century. Several Pacific territories of the U.S. have recently become independent nations, freely associated with the U.S. The remaining jurisdictions include the U.S. territories of Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. The diverse history of AAPIs influences how they interact with government institutions, health providers, and perhaps most importantly with each other. This brief and general history does not even begin to consider the political and cultural factors between AAPI subgroups that shape these communities’ social norms and values about tobacco.



Tobacco Use in AAPI Populations

Tobacco use in AAPI communities varies dramatically. Southeast Asian men (Vietnamese, Cambodian, Laotian) have the highest rates of tobacco use. Also, smokeless tobacco mixed with betelnut is used in some Southeast Asian and Pacific Islander communities. Bidis, a product of India, are imported to the U.S. and their use has become a trend among AAPI youth. Recent data reported by the American Legacy Foundation showed that Asian American youth have the largest increase in tobacco use from 7th-12th grades among all ethnic minority youth. This survey also showed that 25.4% of Hawaiian/Pacific Islander girls smoke during middle school — the highest for all ethnic groups. (See the APPEAL educational kit, *Making Tobacco Relevant for Asian American and Pacific Islander Communities*, for more details.)

other challenges make it easy to get off-track or to give up completely. Therefore, developing a plan to address cultural competency is critical not only for setting concrete goals but also for assessing your organization's progress.

La Frontera, Inc. worked with the U.S. Office of Minority Health and utilized a cultural competency continuum model to develop an organizational cultural competence assessment and planning tool entitled *Building Bridges: Tools for Developing an Organization's Cultural Competence*. This tool can help an organization analyze its organizational environment, public relations/work with the community, human resources, and clinical issues.

After assessment, it is important to develop an action plan. Almost any model for developing an action plan is appropriate as long as it includes clear objectives, activities, persons responsible, timeframe, and process/outcome measures. Unfortunately, action

plans are often developed and quickly forgotten. Incorporate your organization's cultural competency plan or couple the process of developing your cultural competency action plan into annual workplan development, long-term strategic planning, and program and funding proposal development.

What happens when cultural competency is not incorporated in tobacco control?

One answer is that AAPIs and other diverse communities will not be involved in tobacco control and will continue to suffer from the destructive health effects of tobacco use and secondhand smoke. Another answer is that the overall tobacco control movement may lose the opportunity to work with communities that could help the overall goals of the tobacco movement. With the growing numbers of AAPIs and communities of color throughout the U.S., the tobacco control movement will lose ground if we cannot involve these communities in the movement.

A less obvious answer is that tobacco control programs or institutions that are not culturally competent can harm efforts to address tobacco in AAPI communities. For instance, the misperception that AAPIs have low tobacco prevalence and are not at risk for tobacco-related diseases antagonizes efforts to address these health issues in our communities. In addition, culturally destructive programs may hurt existing relationships with AAPI communities and may hurt the relationships between other tobacco control programs and AAPI communities.

Finally, ineffective programs that have limited impact are a big waste of resources. Because there is currently a considerable amount of money in tobacco control and the recognition that reducing tobacco use is the best way to prevent a host of disease and death, culturally negligent programs and institutions waste resources that might be otherwise be used to effectively address tobacco.



Cultural Competency Continuum

A model developed by Terry Cross has been widely adopted as a general continuum through which individuals and organizations may travel in addressing cultural competence. Six points along the continuum include: Destructiveness, Incapacity, Blindness, Pre-Competence, Competence, Proficiency.

Destructiveness:

Individual or agency sees other cultures as inferior and holds practices, attitudes, and policies that seek to destroy other cultures.

Incapacity:

Individual or agency unintentionally destroys other cultures and assumes a paternalistic attitude toward lesser groups by lowering expectations and devaluing groups.

Blindness:

Individual or agency believes that culture, class, or color makes no difference and that universal approaches reach all people; equality is valued over parity or justice.

Pre-Competence:

Individual or agency realizes and tries to address its own weakness in working with other cultures, often though hiring diverse peoples and conducting needs assessments and trainings.

Competence:

Individual or agency accepts and respects differences, puts policies into practice, and continually assesses its own sensitivity to other cultures.

Proficiency:

Individual or agency holds cultures in high esteem, continually seeks to add to knowledge base and develop new approaches, and advocates for cultural competence within all systems and organizations.

What other resources on cultural competency are available?

Center for Cultural Competency
<http://www.georgetown.edu/research/gucdc/nccc/>.

Cross Cultural Health Care Program
<http://www.xculture.org/>.

Cross Currents (newsletter), a newsletter of the Resources for Cross Cultural Health Care network.

Cross, T. Developing a Knowledge Base to Support Cultural Competence. *Family Resource Coalition Report*. Fall/Winter 1995-96;14(3-4): 2-7.

Kagawa-Singer, M. *Bibliography: Cultural Competence and Training*. 2000. Available at <http://www.aancart.org/Bibliography.htm>.

La Frontera, Inc. *Building Bridges: Tools for Developing an Organization's Cultural Competence*. 1995.

National Asian and Pacific Islander HIV Resource Center. Asian and Pacific Islander American Health Forum. *Cultural Competency Resources for Asian and Pacific Islander HIV Prevention Program*. Revised March 1998.

Rodriguez, B.M. From Self to Other: Communications Across Cultures. *Family Resource Coalition Report*. Fall/Winter 1995-96;14(3-4):11-15.

Moving Through the Cultural Competency Continuum

Being cultural competent is recognizing that you need to assess communities' levels of readiness to engage in tobacco control. The APPEAL Stages of Readiness Model (see page 10) provides two resources to do that: 1) a theoretical model, and 2) regional network members that are engaged in the assessment and development of community readiness. It is the responsibility of tobacco control institutions to become more culturally competent, and it is the communities' responsibility to develop capacity and readiness to engage in tobacco control. Capacity building takes time, resources, and commitment in the same way that building cultural competency does.

While AAPI communities are developing their capacity for tobacco control, it is equally important that tobacco control institutions develop their capacity to work with diverse AAPI communities. Addressing individual and institutional cultural competency is a critical step in developing this capacity.



APPEAL Stages of Readiness Model and National Network Members

Asian Pacific Partners for Empowerment and Leadership (APPEAL) has been developing local community tobacco control capacity in almost every region of the U.S. (see APPEAL's website at www.appealforcommunities.org). One of APPEAL's approaches has been the development of a network of regional technical assistance and training partners in Washington, Ohio, New York, California, and Hawaii who are engaged in developing local infrastructure and regional tobacco control activities. These partners have participated in the development of the APPEAL Stages of Readiness model (based on Prochaska and DiClemente's Stages of Change model) which organizes communities into the following five stages of readiness related to tobacco control:

Pre-Contemplation:

A community has not seriously thought about taking action in a particular area of tobacco control.

Contemplation:

A community is thinking about taking action, but hasn't developed any concrete plans.

Preparation:

A community has decided to engage in tobacco control activities and is getting ready to take action.

Action:

A community is actively working on tobacco control issues.

Maintenance:

A community has been conducting tobacco control activities for several years and is working on institutionalizing and sustaining the work.

APPEAL's Stages of Readiness model is useful in helping a local or regional AAPI community assess its own readiness to engage in stage-specific tobacco control activities in the broad categories of infrastructure, programs, policy and research. To learn more about specific regional assessments and activities, contact the following APPEAL Regional Partners:

Asian & Pacific Islander American

Health Forum

Contact: Roxanna Bautista
450 Sutter Street, Suite 600
San Francisco, CA 94102
(415) 954-9988 www.apiahf.org

Asian Services in Action, Inc.

Contact: May Chen
730 Carroll Street
Akron, OH 44304
(330) 535-3263 www.asiainc-ohio.org

Coalition for Tobacco Free Hawai'i

Contact: Clifford Chang
American Cancer Society Hawai'i Pacific Inc.
2370 Nu'uanu Avenue
Honolulu, HI 96817
(808) 595-7500

Charles B. Wang Community

Health Center
Contact: Kenny Kwong
268 Canal Street
New York, NY 10013
(212) 379-6988 www.cbwchc.org

Papa Ola Lokahi

Contact: JoAnn Tsark
894 Queen Street
Honolulu, HI 96813
(808) 597-6550 www.imihale.org

Washington Asian Pacific Islander Families

Against Substance Abuse (WAPIFASA)
Contact: Lee Tanuvasa
606 Maynard Avenue South, Suite 106
Seattle, WA 98104
(206) 223-9578



Assessing institutional cultural competency

Mainstream tobacco control institutions and programs must first assess their own readiness and desire to work with AAPI communities. Consider the following questions in assessing the current or potential involvement of AAPIs in tobacco control:

1. What AAPI subgroups reside in my geographic region?
2. Are there geographical focal points (a certain neighborhood, Koreatown, etc.) where AAPIs reside or work?
3. What does U.S. Census information tell me? What demographic changes have occurred in the last 10 or 20 years?
4. What organizations (health clinics, non-profit organizations, churches, community centers, etc.) serve AAPIs in this region?
5. What are some AAPI institutions (mutual assistance associations, churches/temples, service providers, cultural organizations, etc.) in my region?

6. What is the degree of participation by AAPIs in mainstream institutions at the institutional level (board, staff, policies) and program level (service population, program content, program methodology)?

In working to strengthen cultural competency, four primary targets for assessment, planning, action, and evaluation are **programs**, **institutional policies**, **staffing**, and **coalitions**.

One of the most important and informative ongoing assessments is reflecting on past and current **programs**. Here are some questions about past and current programs that might be useful to ask yourself and your organization:

1. Has there ever been or are there currently any AAPI-specific tobacco control or prevention programs funded by the agency?
2. How involved are AAPI communities in the agency's general tobacco control programs?
3. What programs successfully involved AAPIs? In what way were they successful for the agency? In what way were they successful for the AAPI community? To what do you attribute the success?



4. If past and current programs failed to involve AAPIs, what didn't work? Consider asking those who participated why they think it didn't work.
5. Were resources made available to these communities to conduct program activities? If resources were available, were they adequate from their stand-point? If not available, would the resources have made a difference?
6. Reflect on past or current activities based on the Wheel of Balance: people, product, and process values. Did everyone involved share the same values? Did everyone understand each other's values?
3. What is the organizational culture of the agency? Does it realize the organization's value of inclusion?
4. Does the agency's strategic or long-range plan incorporate cultural competency building goals or objectives?
5. What resources in the budget are allocated to realize these goals and objectives?
6. Do the board, staff, and members have opportunities for examining and developing personal and professional cultural sensitivity or competency?

Institutional policies include critical founding documents, board resolutions, statements, and both formal and informal policies that shape the organization's culture internally and externally. Some questions that may be helpful to consider are:

1. Does the organization have a statement of inclusion?
2. Does the mission or vision of the organization incorporate the value of diversity and inclusion?

Staffing refers not only to the make-up of the staff pool but also staff recruitment/retention, staff development, and evaluation. Some questions that may be helpful to consider are:

1. How and where does your organization recruit staff?
2. Does your agency recruit and retain staff with experience or a commitment to working with diverse communities? Why or why not?
3. What types of cultural competence trainings or staff development opportunities are available to your staff?



4. What are your staff's measures of success in working with diverse communities? Are these appropriate outcomes for AAPI communities as compared to your agency's or program's goals?

Coalitions are critical organizing mechanisms in tobacco control. Although one might view coalition development, management, etc., as an aspect of programs, most tobacco control coalitions have a life, structure, leadership, and culture of their own. Therefore, here are some questions to think about:

1. Is the coalition inclusive? What inclusive processes are practiced to involve everyone in direction, decision making, and credit?
2. What are the requirements for membership? Are they realistic for AAPI communities and can they be met?
3. Does membership require organizational backing? Is there a place for less formal community representatives?
4. What are the values of the coalition: people, product, and process, or all three? How does the coalition resolve conflicts among these values?

5. Are there different ways in which coalition members are involved in the coalition? What are those ways and how do members benefit from their participation?
6. Do members have the opportunity to develop their own understanding of cultural sensitivity and competency? Is there consensus of standards or common understanding in the coalition?

Identifying areas for improvement

The preceding assessment questions may have pointed out several areas for potential change and improvement in the areas of programs, institutional policies, staffing, and coalitions. Hopefully, the assessment also provided some examples of culturally competent practices that can be built on in the future. Some common areas of improvement for most tobacco control organizations are:

1. Begin the dialogue about cultural competency and working with AAPI communities within your organization, coalition, or staff team.



2. Develop an institutional understanding of why cultural competency is important to tobacco control.
3. Educate funding organizations about your agency's priority of becoming a more culturally competent institution or program and desire to work with AAPI communities.
4. Identify human resources, such as consultants and community partners, to assist the organization or program.
5. Consider that it may take several years to develop credibility and a relationship with a community but also recognize the value of the potential relationship.
6. Develop a cultural competency plan based on the areas of improvement you have identified.

Developing a cultural competency plan & sustaining momentum

There is a body of literature and many resources available for developing a cultural competency plan

(see page 8). Developing a plan requires commitment and vision. Without either, a plan is just a piece of paper. In the development of any plan, all parties involved in the plan must have a role in its development. A key factor for success is involvement and investment in people in the planning process. In addition, assessment and planning are only the beginning of a much longer journey in becoming a program or institution that is culturally competent. Finally, developing cultural competence is a long term, perhaps permanent undertaking that will continue to change and develop as your agency, staff, and programs continue to evolve. Invest the time and resources to gain insights, be strategic, and develop long-lasting relationships, processes, and results.

In the next section, hypothetical case studies illustrating some of the issues discussed so far are presented in context of common working scenarios.

Cultural Competency in Action

Scenario #1: Developing a cultural competency plan

The staff of a local tobacco control agency decides to address their organization's cultural competence as part of an overall campaign to better serve the diverse local communities in their region and to reduce health disparities among these communities. A few of the staff participate in a workshop on cultural competency at an annual conference sponsored by the State Department of Public Health, have been exposed to Terry Cross' cultural competency continuum, and have received some tools to assess their own agency's position on the continuum.

The two staff who attended the conference review the workshop materials with four other staff members. Based on their own assessment as a group, they all agree that their agency could be described as "culturally blind" and that this stage is appropriate since the agency's mission is to serve all people in their region. "After all," says the agency Director, "we're trying to reduce health disparities... to me that means making things more equal which means that we have to involve and reach everyone in our community equally."

However, one of the staff that attended the workshop encourages her peers, "But the point is to continue developing cultural competency and to move through the continuum. I think we have to at least

try to move to the pre-competency stage within the next year." So the staff commit to reaching the pre-competency stage by completing their needs assessment worksheets, conducting a cultural competency training for all staff, and working with their human resource person to hire at least one person of color in one of the two open positions: health educator or administrative assistant.

At the end of the year, the staff meet to evaluate their cultural competency activities. During the past year, they successfully completed the needs assessment and presented it along with their planned activities to their board for review. With the board's approval, they held a cultural competency training for all their staff like the one at the state conference, and they hired a Chinese American administrative assistant. The staff conclude that they achieved their objectives and believe the agency has reached the stage of cultural pre-competence.

Analysis

This example is relevant not only to mainstream tobacco control organizations but also to any agency whose service population is undergoing demographic changes (for example, Asian American organizations serving recent Asian immigrant populations). It is all too easy to reduce cultural competency and diversity to a list of internal activities that may or may not



have any significant impact. In addition, one may be falsely led to believe that accomplishing these activities characterizes linear movement through the cultural competency continuum.

As is the case in many institutions, only a few staff have the opportunity to attend external trainings and are compelled to bring outside learning back to the agency. In this case, staff brought back their learning from a cultural competency training to be discussed and digested by the agency, but there was no one with expertise to help decide if the information and methods were appropriate for the agency.

The discussion about cultural blindness is a prime example of how Terry Cross' model can be misunderstood and reminds us of the distinction between equality and parity. As the director points out, the agency's mission values equality which is often inter-

preted as everyone is equal or should be treated equally. Unfortunately, equality falls short of parity in assuming that all communities are the same and are starting in the same place. Therefore, the staff's analysis and discussion fail to engage issues of social justice.

Upon the recommendation of one training participant, the agency staff decides to attempt to move toward the pre-competency stage within a year by conducting a needs assessment, holding a cultural competency training, and hiring diverse staff. Although well intentioned and perhaps a direct result of the recommendations shared during the training, this decision is somewhat uninformed. The needs assessment is nothing more than internal staff discussions on the subject and fails to engage communities, agency membership, or board members. The training is a single event which mirrors the introduction provided at the state training. And the hiring of a Chinese

American in an administrative support position may be a step in the right direction, but it does not guarantee that this person either brings or is in a position to bring any type of change to the agency.

This example shows that having a plan does not necessarily ensure your agency's success in becoming more inclusive or culturally competent. No plan will be successful if it fails to engage actual communities.

Scenario #2: The funder's mandate

A local coalition has received funding to work on the passage of a clean indoor air ordinance that would ban all smoking in restaurants. In response to the funder's mandate to involve more non-traditional communities in this campaign, the coalition leadership decides to hire a diversity consultant to help them address this issue. The consultant first meets with coalition leadership to discuss expectations, but finds that the leadership was hoping for the consultant to bring solutions and people.

The consultant meets with coalition members to assess their capacity to become more inclusive and to reach out to the region's Hmong American and Samoan American communities, and finds that there is little capacity. The consultant recommends that the coalition first begin by addressing its own capacity to engage in outreach, but meets resistance. The coalition and its leadership are frustrated by the passage of time, the lack of outcomes, and the expense of this consultant. The coalition is also experiencing pressure from its funder to see results.

Although there is a great deal of frustration and differences of opinion even within the coalition, there are a few coalition members who take to heart the consultant's message. Although they are dissatisfied with the coalition's lack of responsibility, they take steps to form a task force including members from the coalition and a staff member from the funding organization. Since the majority of the coalition does not want to address the issue of coalition diversity

and inclusivity, the coalition is happy to have a task force take on the challenge. The task force, under the advice of the consultant, begins to develop relationships with members of the Hmong American and Samoan American communities primarily by attending community meetings, talking with staff of community organizations, and getting involved in other community events. At the same time, the consultant, with the support of the task force, implements a series of activities with coalition members to continue the dialogue and develop a sense of responsibility about this issue.

After several months of intensive outreach, the task force is able to report that it has developed a handful of relationships and has identified prospective community members who might be interested in participating in the coalition on an on-going basis. Over the next few months, a few Hmong American and Samoan American community members attend coalition meetings. In addition, the task force slowly starts to learn about the issues most important to these communities and brings them up at coalition meetings. Things move forward, but not without a price; a handful of adamant coalition members stop coming to coalition meetings. However, the departures ease tensions and allow others to speak up and engage in the dialogue.

Analysis

This story is a common story of frustration and unreasonable expectations by everyone. The passing of the proverbial "diversity buck" from funder to coalition, from coalition to consultant, and from consultant back to coalition is not only frustrating but also abdicates responsibility at all levels. This shows the importance of planning, dialogue, and the development of reasonable expectations between funder, coalition, and consultants early in the process.

As the story unfolds, a few individuals who understood their responsibility and potential roles took leadership to begin the process of developing relationships with ethnically diverse communities. The nature of



a coalition is to bring various stakeholders together for a collective issue. Therefore, coalition members often have very different perspectives on what is important and how to work toward their collective objectives. Forming a committee or task force to address a specific issue is a natural institutional approach to engaging in change and can be very effective as long as the task force's findings and recommendations are brought back and valued by the larger body.

Another important feature in this story is the importance of developing relationships. The relationship-building process took several months and required the time of coalition members and consultants. This takes away valuable resources that could be used to reach other coalition objectives. Therefore it is important to incorporate the real expenses of outreach into the coalition's overall timeline, budget, and plan.

One key feature in the task force's approach to outreach was to ask communities about their issues and

concerns. Although this approach may seem obvious, advocates are often very passionate about their issues and believe that everyone should naturally share their beliefs. Although these advocates are often those who lead the group to victory, they do not necessarily have the ability to examine and analyze the different needs of diverse communities and may not be able to identify connections or find common ground among these different priorities. In contrast, a coalition must have coalition builders or networkers who can bring together diverse interests.

Change is often difficult. Some coalition members left while others joined as the coalition underwent changes. Individual coalitions must weigh the disadvantages and benefits to changing membership but coalitions will, and perhaps should, maintain a level of dynamic flexibility in order to grow and become more effective. Static coalitions often lose momentum and the sense of urgency in reaching their objectives.

Glossary and Abbreviations

APPEAL's Stages of Readiness Model: A theoretical framework for assessing, developing, and evaluating community capacity for tobacco control in Asian American and Pacific Islander communities.

Community Competence: A model of competence which holds that communities are more than the sum of their cultures; the model attempts to reflect the complexity of communities and race/ethnic groups by taking the following elements into account: history, culture, context, geography, language, literacy, positive and salient imagery, multiple generations, and diversity.

Competency: A required level of knowledge, skills, and experience.

Culture: One's worldview, values, beliefs, customs, and behaviors influenced by one's race, ethnicity, national origin, primary language, religious beliefs/spirituality, class/socioeconomic status, gender, sexual orientation, history, geography, etc.

Cultural Competence: Possessing sufficient knowledge, skills, and experience to communicate effectively with and work together with someone from a different culture.

Diversity: Having individuals or organizations of different backgrounds belong to a group; refers to the static make-up of a group rather than processes.

Inclusivity: The inclusion of different types of people, often those not included in the past, in the processes of a group.

Parity: Can be defined as being equal in the process, as well as the outcomes attained in tobacco control; it can also be defined as the ability of representatives from heterogeneous communities to equally participate in the planning and implementation of key activities, programs, and policies.

Have questions? Call, write, or e-mail us at:

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Asian Pacific Partners for Empowerment and Leadership (APPEAL) is a national social justice network of individuals and organizations committed to working towards 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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