Moving Beyond Data to Making a Difference
Implementing Goal Four of CDC Best Practices for Comprehensive Tobacco Control Programs

Policy Advocacy on Tobacco and Health (PATH) Initiative

The Praxis Project
www.thepraxisproject.org
July 2005

ACKNOWLEDGMENTS

It all started with the question, "Where do we begin?" It was a question that kept coming up in trainings and phone calls, emails and memos from staff working to address disparities in tobacco control. This guide provides background and planning tips on how to develop an implementation plan to address Goal Four of the Centers for Disease Control's *Best Practices for Comprehensive Tobacco Control Programs* – identifying and eliminating disparities in tobacco use and impact. Of course, given the unique context of any state, this guide is designed to be adapted, to generate more questions, and to encourage research and outreach that will help staff and community groups develop a plan that best meets local needs.

Our thanks to Joon-HoYu, Praxis board member and a leading thinker on implementing initiatives to advance health equity, for accepting our "invitation" to address this nettlesome issue. He threw himself into the task wholeheartedly and after talking with state staffers, advocates and others, turned a laundry list of comments and issues into the first draft of this thoughtful, detailed publication.

Thanks are also due to Juan Carlos Velazquez for his editorial feedback and to Juan Carlos Vega for his work on the Resources section. Makani Themba-Nixon provided overall editorial and project coordination, John Sankofa did the next generation of editing and Annie Ro, our 2005 Summer Intern, contributed significantly to the final product (and to Praxis) with additional research, writing and editing. Annie does UC Berkeley's School of Public Health quite proud.

We are grateful to the Robert Wood Johnson Foundation for their continued support of the PATH Initiative and the many others who contribute to the success of the initiative. However, The Praxis Project is solely responsible for this publication and any analysis therein.

For questions, comments or for more tailored technical assistance on these issues, please contact Juan Carlos Velazquez at cvelazquez@thepraxisproject.org.

PATH
The Praxis Project
1750 Columbia Rd, NW
Second Floor
Washington, DC 20009
(202) 234-5921
www.thepraxisproject.org

This is a publication of the Policy Advocacy on Tobacco and Health (PATH) Initiative

INTRODUCTION

Goal 4: Identifying and eliminating the disparities related to tobacco use and its effects among different population groups

- Best Practices for Comprehensive Tobacco Control Programs

How should state-run tobacco control programs adapt the CDC's model for comprehensive tobacco control?

The CDC *Best Practices for Comprehensive Tobacco Control* (available at http://www.cdc.gov/tobacco/bestprac.htm) recommends that states work toward "eliminating disparities in tobacco use among populations." The impact of targeting on tobacco use and its related health consequences for people of color, sexual minorities, and those living with disabilities is well-evidenced, ongoing, and deeply troubling. Yet for many state programs, the matter of how to begin addressing tobacco use disparities remains a mystery. This document provides a framework for the development of an implementation plan to address CDC's Goal Four– reducing tobacco-related disparities[1]. Although the primary audience is state level tobacco control program staff (working in public or private agencies), this document also speaks to the many community stakeholders who share the goal of moving tobacco control forward and addressing the deadly impact of tobacco on these targeted communities.

Nine different categories comprise the CDC's recommended strategies:

- Community Programs to Reduce Tobacco Use
- Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases
- School Programs
- Enforcement
- Statewide Programs
- Counter-Marketing
- Cessation Programs
- Surveillance and Evaluation
- Administration and Management

There are many examples of successful tobacco control campaigns that fall into one of these categories. However, simply replicating successful campaigns does not supplant the need for states to develop and implement a cohesive strategic plan that melds these nine categories into the operational realities of state programming. In other words, the challenge facing tobacco control advocates and public health professionals is to reconcile how to achieve the goal of eliminating disparities in tobacco use through the strategies given in each of these nine categories. For most states, overcoming this challenge will require developing strategies outside of the CDC's explicit definition of a comprehensive tobacco control program, and this may call for additional resources than those proposed by the CDC.

Using the Guide

The guide is divided into three sections. Section 1 provides the theoretical background for the document, presenting guidelines that explain the basis for understanding tobacco disparities within a larger historical context. This section also introduces cross-cutting strategies that can be used across each of the nine CDC-identified components. These strategies can produce action steps that are relevant for communities of color, LBGT and people living with disabilities. Each of the strategies contain a checklist of items that breakdown the key principles of each strategy. Each point is cross-referenced to a relevant section in another part of the guide where guidelines and examples are provided. Section 2 discusses each of the nine components identified by the CDC *Best Practices* document, recasting them in light of disparities experienced by undeserved communities. Case studies are also introduced that provide real-life examples of programs that have addressed disparities in their activities. Section 3 provides a list of resources for further information and support.

In the Cross Cutting Strategies section, beginning on page seven, a chart is provided where key principles are cross-referenced with the in-text location of information on implementation strategies for each principle. Given the breadth and complexity of thesubject matter, we recommend a read through of the entire document first, then use the chart or index for easy reference.

SECTION 1: ADDRESSING DISPARITIES IN TOBACCO CONTROL IN THE CONTEXT OF COMMUNITY

The Importance of Goal Four: Guiding Principles

Health equity and social justice are at the heart of the tobacco control mission. Accordingly, key principles are the foundation of any implementation plan.

Principle 1: **History matters**
The reality of social inequality must inform our overall strategies for tobacco control and disparity intervention. That is, the political nature of "disparities work" calls for the awareness that, historically and today, there are distinct social patterns of unequal access to resources and power. This longstanding problem of uneven access plays a central role in producing sizeable health gaps and other social inequities between communities—whether defined by race, ethnicity, socioeconomic status, sexual orientation, religion, or by admixtures of such groupings. It is within this vibrant sociopolitical and cultural landscape that we carry out our work.

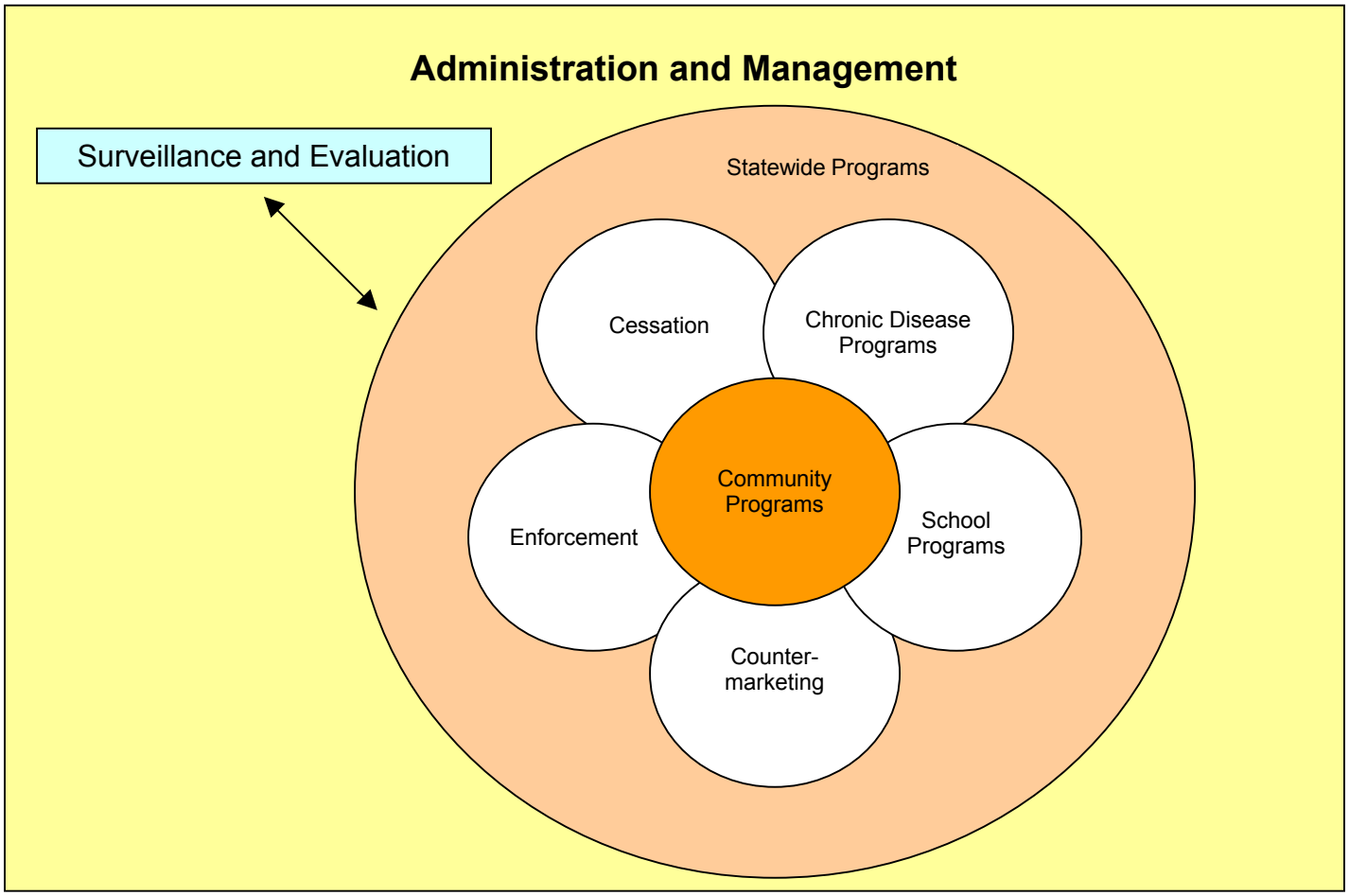
Principle 2: **Community is central**
It is the starting point and endpoint of our total efforts. It is the *culturally-specific community*—that is, the community defined not simply by race and ethnicity but by the more complex configurations of social, cultural, even geographic realities—that frames our basic understanding of community health needs and health demands.

Principle 3: **Initiatives should place diverse community members at the center and in leadership of efforts to eliminate tobacco-related disparities**
We cannot view our tobacco control work in isolation to community, its voice, or its self-determined priorities. It's also important to remember that diversity ranges from racial and ethnic groups to class, geography as well as less obvious groupings like military veterans, sexual orientation, people living with disabilities or HIV status.

Principle 4: **Industry regulation and public policy play key roles**
Even our most diligent control efforts will not likely reach the ultimate aim of stamping out all tobacco-related disparities without major changes in the policy environment. Without attention to equitable distribution of effective policies like clean indoor air ordinances, advertising restrictions, access to cessation, etc., even as some gaps close for certain communities, other disparities will crop up along the social landscape. This requires us to shift away from targeting communities in crisis, and prompts us to build models with core elements that guide how we conduct our work.

Weaving Goal Four into an Overall Plan

The diagram below represents how we envision the anatomy of the CDC's nine *Best Practice* components for comprehensive tobacco control. *Administration* and *management* comprise the backbone that supports all tobacco control efforts. *Surveillance* and *evaluation*, which drive priorities and planning, are cyclical functions that allow for periodic reevaluation and adjustment to keep pace with changing needs and ensure overall effectiveness. *Statewide programs* principally support and coordinate tobacco control efforts, and are especially vital to addressing community needs that span local geographic boundaries. At the heart of the tobacco control movement are *community programs* which advance all other strategic efforts, including School, Cessation, Chronic Disease, Enforcement, and Counter-marketing programs. While there are other possible configurations for the nine components, this interpretive model is consistent with the overarching values and guiding principles discussed above.



Cross-Cutting Strategies

Like an interstate highway system with its network of roadways, bridges and tunnels, the nine CDC components intersect at key junctures. Regardless of destination—of programmatic goals or target communities, effective cross-cutting strategies can help managers successfully navigate these junctures and build a comprehensive plan at program outset.

Strategy 1: Adapting a Culturally-Specific Approach

An alternative to following strictly defined racial and ethnic classifiers is to consider a group's "culturally-specific" characteristics. For example, instead of lumping together African Americans, consider nation status, age, language or if newly migrated to the area. A 'culturally-specific' lens captures the fuller range of underserved populations needing intervention, thereby offering a distinct advantage over the conventional race/ethnicity paradigm.

KEY PRINCIPLES	IN-TEXT REFERENCE
Establish culturally-specific goals	• *Define Disparities* (Component 9: Surveillance and Evaluation) • *Establish Culturally Specific Goals* (Component 9: Surveillance and Evaluation)
Create culturally competent strategies	• *Identify Chronic Diseases that Disproportionately Affect Communities of Color/LGBT/Disabled* (Component 2: Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases) • *Work with Business Owners* (Component 4: Enforcement) • *Create an Ethnic Network* (Component 5: Statewide Programs) • *Ensure the Message is Linguistically and Culturally Appropriate* (Component 6: Counter-Marketing) • *Contact Minority Media and Public Relations Firms* (Component 6: Counter-Marketing) • *Develop Culturally Competent Staff* (Component 8: Administration and Management) • *Set Priorities that Inform Planning* (Component 9: Surveillance and Evaluation) *Conducting Evaluations* (Component 9: Surveillance and Evaluation)
Develop culturally competent activities	• *Use Culturally Competent Curricula* (Component 3: School Programs) *Develop and Utilize Culturally and Linguistically Appropriate Cessation Services* (Component 7: Cessation Programs)

Strategy 2: Participant Centered Data and Research

Solid data collection is the most basic and essential aspect of any planned tobacco control effort. It provides the operating instructions for virtually all components, particularly management and administration, and surveillance and evaluation. Nonetheless, given the troubling history of the exploitation of racial and ethnic minorities in research studies, it is no surprise that many members of these communities, as well as researchers themselves, raise an eyebrow at research involving minority subjects. At the same time, National Institutes of Health (NIH) guidelines, along with many leading public health organizations, call for greater inclusion of women, people of color, sexual minorities and other populations in research. As a result, planners and researchers increasingly and rightly concern themselves with the appropriateness of data collection in diverse communities.

KEY PRINCIPLES	IN-TEXT REFERENCES
Work in Partnerships that Inform Relevant Research	• *Use Community to Inform Research* (Component 1: Community Programs to Reduce Tobacco Use)
Collect Data Separated by Race/Ethnicity	• *Use Community to Inform Research* (Component 1: Community Programs to Reduce Tobacco Use)
Report Findings to Communities Using: 1. Alternative and Ethnic Media 2. Release plan informed by community members 3. Culturally sensitive and aware methods	• *Leverage Community Programs' Existing Resources* (Component 1: Community Programs to Reduce Tobacco Use) • *Work with Community Members to Develop a Message and Dissemination Tactics* (Component 6: Counter-Marketing) • *Contact Minority Media Associations and Public Relations Firms* (Component 6: Counter-Marketing)

Strategy 3: Community Outreach and Education: Building Relationships, Catalyzing Community

As discussed and illustrated in the diagram on page 6, community is front and center in eliminating tobacco-related disparities. The work of the community is reiterated throughout each of the nine CDC recommended components of tobacco programs.

KEY PRINCIPLES	IN-TEXT REFERENCES
Incorporate Community Input in Program Planning	• *Develop Representative Advisory Boards and Work Groups* (Component 1: Community Programs to Reduce Tobacco Use) • *Using Community Input to Inform Research* (Component 1: Community Programs to Reduce Tobacco Use) • *Work with Community Members to Develop a Message and Dissemination Tactics* (Component 6: Counter-Marketing)
Identify Needs Specific to the Population	• *Use the Community Action Model* (Component 1: Community Programs to Reduce Tobacco Use) • *Identify Chronic Disease that Disproportionately Affect Communities of Color/ LGBT/ Disabled* (Component 2: Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases) • *Integrate Program Objectives into Comprehensive Approach to Community Health* (Component 2: Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases) • *Integrate Cross-Over Issues* (Component 3: School Programs)

Strategy 4: Integrating Tobacco Control into Multi-Issue Policy Advocacy

Advancing the tobacco control policy agenda requires a diverse base of leaders, institutions, and organizations that prioritize community health and social justice. Regrettably, there is often an assumption in the tobacco control arena that communities of color lack the requisite skills, readiness, or savvy to engage in policy advocacy. Organizations that engage in policy work in these communities are less likely to be a part of the social and political networks where paid tobacco control advocates work and are therefore less likely to be a part of the "universe" of "selected" communities where initiatives are launched. There are other challenges as well including historic racial and cultural tensions, fear of the unknown, and lack of trusting relationships on which to build work together. These factors not only affect tobacco control work in communities of color but also affect work with young adults, those living with disabilities and significant numbers of Lesbian, Gay, Bisexual and Transgendered (LGBT) who also tend to live in urban pockets and/or operate outside of traditional social and political networks.

For communities that have little experience working in the tobacco control field, policy advocacy is an area ripe for capacity building which can bear valuable fruit. However, such an effort should not translate into capacity building to advance irrelevant policy initiatives. Instead, abiding by the principle of self-determination, capacity building efforts should assist communities in developing policy work around their own informed agenda.

KEY PRINCIPLES	IN-TEXT REFERENCES
Assess Community Policy Priorities	• *Use the Community Action Model* (Component 1: Community Programs to Reduce Tobacco Use) • *Address Unequal Disbursement of School Dollars* (Component 3: School Programs) • *Ensure Equitable Application of Justice Activities* (Component 4: Enforcement) • *Ensure Access to Cessation Services* (Component 7: Cessation Programs)
Provide Technical Assistance	• *Building Community Capacity* (Component 1: Community Programs to Reduce Tobacco Use)

SECTION 2: THE ANATOMY OF THE CDC'S COMPREHENSIVE TOBACCO CONTROL MODEL

Component 1: Community Programs to Reduce Tobacco Use

Arguably, community programs are the most vital component of our work because of the critical role they play in voicing community health needs, collaborating with state tobacco control programs and a host of other groups and institutions, including schools, disease management and cessation programs, and enforcement agencies. Community programs are also the most visible representation of tobacco control efforts for most community residents.

Leverage Community Programs' Existing Resources

There is enormous potential when working with community-based initiatives in communities of color. These programs' existing relationships provide effective outreach to underserved populations that maximize linguistic and cultural competency. Their first-hand knowledge of the community provides valuable insight about specific issues regarding tobacco use and control. The work of community programs includes:

- Outreach to underserved communities affected by tobacco use
- Partnering with community leaders, organizations concerned with health inequity and social justice
- Mobilizing and organizing community advocates for tobacco control

- Identifying and voicing the community's priorities
- Assisting leaders and organizations with integrating tobacco control with other community priorities
- Planning and implementing awareness and education programs
- Carrying out capacity-building efforts that enable community organizations to address tobacco control
- Conducting long-term programs and initiatives that advance community vision of health and well being.

Sharing the Agenda

Most community organizations work on several social justice issues and therefore may be able to incorporate tobacco control and tobacco-related health issues into existing outreach and education programs. While funders tend to focus on outcomes tied only to their specific category of interest, greater program integration offers added-value (as discussed in Component 2: Chronic Disease Programs) and provides greater incentive for groups to engage in tobacco control work as part of a comprehensive community development plan.

Develop Representative Advisory Boards

At the community level, standing advisory committees and working groups provide venues for growing community relationships and for developing group capacities to sustain and advance tobacco control work. An important first step in creating formal community partnerships is to ensure that there is adequate funding and resources for implementation. Without these resources, community groups have short life spans and greatly reduced impact. Like any working groups, advisory groups require facilitation and resources to continue their efforts. A common misuse of community advisory groups is to utilize these resources solely for the purpose of "community representation." Although this function is important, the key to developing an effective group is to emphasize action.

Advisory committees are not static but dynamic entities. Their work requires long-term vision, clear understanding of community history and mission, and a regular infusion of new membership. By comparison, working groups are often comprised of individuals focused on a specific, time-limited activity or goal and often serve as substructures to advisory committees.

State tobacco control programs can mandate the inclusion of these community vehicles into tobacco control programming. For example, state programs can require county tobacco control programs to include community members on their advisory committees. States can also require county programs to consider the development of working groups to address the tobacco control needs of culturally specific communities. In addition to using mandates and funding mechanisms, the state must also view its investment as structural and long-term. For example, convening a multicultural forum can help jumpstart advisory committees and working groups. However, a long-term investment calls for follow-up, planned relationship building, and subsequent communication structures that allow the initial convening to take on a life of its own.

Use the Community Action Model

As with many interventions, a great deal of public health efforts to reduce tobacco use among minority communities focuses on changing individual lifestyles and behaviors. Although these strategies can alter some individual-level factors, they typically fail to address the underlying environmental and economic conditions in a community that can give rise to patterns of unhealthy behavior. The San Francisco Tobacco Free Project has promoted a promising multidimensional strategy called the *Community Action Model*[2]. In this innovative framework, community members acquire the skills and resources to investigate the health determinants in their environment and then plan, implement, and evaluate actions designed to create a healthier environment.

The Community Action Model is comprised of five steps (curriculum is available at http://www.dph.sf.ca.us/CHPP/CAM/cam.htm):

1. Recruit and train members of the Community Action Team
2. Conduct a community diagnosis: Identify a community concern, find the root causes of the issue, and identify the resources or changes needed to overcome it.
3. Choose an action to address the concern: The action should be achievable, potentially sustainability, and compelling enough for a group, agency, or organization to change the environment for the well-being of all who live there.
4. Develop and implement an action plan: To carry out the intervention, the Community Action Team develops and carries out an action plan, which may address outreach, media advocacy, policy development, policy advocacy, team presentations, and evaluation.
5. Enforce and maintain the action: After successfully completing the action, the team focuses on ensuring the efforts are maintained and enforced over the long term.

Developing Community-Informed Research

Data can be a powerful ally when implementing tobacco control efforts; however, there is little data that is disaggregated by ethnicity or culture. As a result most data relevant to communities of color, LGBT and disabled populations are collected by community organizations themselves. Almost as important as having the data available is making sure that its implications and use are relevant to community needs. To ensure the most useful data, be prepared to develop community-research partnerships and share resources to ensure that underrepresented community members are included. At the earliest stages of the research planning process, work with state and local epidemiologists, surveillance units, and program evaluations specialists to plan for appropriate data collection, tracking, analysis and reporting.

When disseminating findings, involving communities in media advocacy is a good strategy to ensure that communities are abreast of issues pertaining to tobacco use, related health issues, and tobacco control developments. However, negative research findings do pose the risk of promoting or perpetuating group stigmatization. Indeed, hearing yet again that your community leads the way in unemployment, violent crimes, and virtually every negative health status indicator does little to bolster a community's image and esteem. Developing release strategies in collaboration with community members can help ensure that approaches are sensitive and appropriate.

Building Community Capacity

Community capacity is a key determinant of a community's readiness to collaborate in tobacco control. Community capacity building is defined as the process of developing knowledge, skills, resources, infrastructure, and the necessary power to achieve community objectives. This process as occurs on two levels:

- *Community members*: Individuals participating in tobacco control related activities. This level is typically not the realm of a tobacco control agency but is often the level at which community based organizations conduct their work.
- C*ommunity-based organizations:* Organizations, networks and other institutional actors. This level is a more appropriate target for state-sponsored capacity building efforts as state tobacco control programs.

Strategies to build capacity include:

1. *Infrastructure:* Developing inclusive, diverse and comprehensive approaches to tobacco control requires networked institutions that work effectively together. Are there stable, well-suited institutions with the necessary capacity and skills to advance tobacco control? Do these organizations have the capacity to communicate and collaborate with one another? Do they have the capacity to advocate? Conduct and interpret research? Engage the media? In collaboration with key stakeholders, identify standards for comprehensive tobacco control in each targeted community and map assets and gaps in the development of a clear plan for building infrastructure. Establishing working groups and regional networks can be effective vehicles for needs assessment while building organizational capacity. This is especially the case for volunteers or novice staff in community-based organizations who can use their participation in a working group to develop skills and find mentoring relationships.

2. *Funding:* Mini-grants and other small, short-term funding sources can provide some opportunities for community organization staff to develop capacity in project planning, implementation, budgeting and fiscal management, and evaluation. As shown in California, these funding devices often lead to greater participation as well as additional funding opportunities for community organizations. However, mini-grants do not result in building infrastructure. More substantial, sustained and strategic investment must be made in targeted communities if these communities are to develop the necessary infrastructure for comprehensive tobacco control. Multi-year funding can be difficult given the political and perennial nature of most state budget processes. However, the development of clear priorities and plans tied to a comprehensive, integrated assessment of tobacco control infrastructure within and between communities can help focus funding most effectively.

3. *Training and Technical Assistance:* National and statewide programs often provide these services to community based organizations that are engaged in local tobacco control activities. Be sure to require technical assistance providers to provide clear plans for capacity building that are grounded in *community-based* needs assessment and *community-specific* goals for infrastructure and capacity development.

   The state is uniquely positioned to provide technical assistance for community-based organizations to develop culturally-specific policy campaigns. Programs such as Policy

Advocacy on Tobacco and Health (PATH) and the national tobacco control ethnic networks are available in many states to help local programs address tobacco policy issues. For policy concerns to be adequately addressed, training must be made available within a culturally/community competent framework for diverse community-based organizations. This may require identifying and contracting with established community-based organizations, such as the national networks, that have the necessary cultural and tobacco control competence.

Creating Community-based Initiatives: Community Voices Tobacco Initiative

The American Legacy and the W.K. Kellogg Foundations partnered to create a national initiative, Community Voices: Health Care for the Underserved, to improve health care access and quality. The Community Voices Tobacco Initiative funds local health organizations around the country to promote tobacco cessation and prevention services in underserved communities. One such site is the Alameda Health Consortium (AHC), an association of eight non-profit community health centers in Alameda County, California. The AHC serves a large and diverse immigrant community, as well as a large uninsured population. Through the initiative, the organization intends to identify and implement tobacco-use intervention services that are appropriate for its populations[3]. For more information, see www.legacycv.org

Community Change Model: APPEAL

The Asian Pacific Partners for Empowerment and Leadership (APPEAL) provides a compelling model for organizing communities into phases of tobacco control activity[4]. In their adaptation of the Prochaska's Stages of Change Model, APPEAL categorizes communities into identifiable stages: pre-contemplation, contemplation, preparatory, implementation, and maintenance. These stages, in turn, correlate to specific tobacco control activities such as capacity-building, tobacco control programming, research, or policy development. Within this phased framework, early milestones might include establishing a task force of community leaders to assess local tobacco use and tobacco control efforts, securing the commitment of community organizations to help push forward tobacco-free policies, or setting up tobacco control networks to serve specific communities. More advanced milestones might include strengthening the involvement of community members in tobacco control activities, increasing the reciprocal involvement of tobacco control advocates in other community priorities, or building coalitions or non-profit organizations specifically to address community tobacco use. See www.appealforcommunities for more information.

Component 2: Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases

Disparities among racial and ethnic groups are not limited solely to tobacco use. The chronic disease programs described in the CDC's *Best Practices* also address serious health challenges that disproportionately affect many racial and ethnic groups in the United States.

Identify chronic diseases that disproportionately affect communities of color/LBGT and other targeted communities

Making explicit the links between tobacco control efforts and preventing chronic diseases can help contextualize the impact of tobacco for potential community partners grappling with other priorities. For example, Vietnamese-American women have the highest incidence rate of cervical cancer compared to all other ethnic groups. In addition to risks related to HPV infection and delayed screening, higher smoking prevalence contributes to an incidence rate of 7.4 times higher than the rate of the lowest ethnic group, Japanese Americans[5]. Women who smoke are at a two-fold risk for cervical cancer, making smoking cessation a priority.

Integrate program objectives into an agenda to holistically address community needs

An effective tobacco control effort should orient its mission and resources to support community health priorities in ways that facilitate synergy between addressing tobacco use and impact and chronic disease prevention. Tobacco's role in the prevalence of cancer, heart disease, stroke, diabetes and so many other chronic diseases suggests that current community initiatives targeting disease disparities will only enhance the effort to reduce tobacco use. This is the added-value of integrating program objectives with community needs.

Integrating Tobacco Cessation with Other Health Behaviors:
Project S.E.L.F. Improvement

Strengthening the Black Family Inc. in Raleigh, North Carolina received funding to create and implement Project S.E.L.F., a five-year community-based health awareness program that seeks to reduce the risk of chronic disease stemming from lack of physical activity, poor nutrition and tobacco use. The program's goals are tri-fold: increase the number of individuals who engage in moderate physical activity, increase the number of individuals who consume five fruits and vegetables a day and delay the age adolescents use tobacco products. Through using community and peer educators, the program hopes to change the perception of chronic disease from one of inevitability to one of preventability.

See http://kbrselfimprove.mc.duke.edu/community_sub14.html for more information.[6,7]

Component 3: School Programs

CDC's *Best Practices* states that school programs that prevent the onset of smoking among children under 18 are crucial for comprehensive tobacco control. However, school-based programs run the risk of being ineffective if they use inappropriate methods and essentially ignoring the needs of students of color, LGBT youth and young people living with disabilities.

Address unequal disbursement of school dollars

To make effective school programs that target school-aged children from underserved communities, state tobacco control efforts should take a hard look at the overall inequity in their education system. Often, school-based programs in higher income communities have the means to create and support health-related programs. Conversely, schools in low-income communities are plagued with budget shortfalls that do not permit additional programs outside of government-mandated curriculum. Therefore, state budget advocacy must take into account the connection between effective tobacco control and adequate funding for the range of public agencies and systems upon which effective tobacco control depends.

Integrate cross-over issues

Racial and ethnic groups are disproportionately represented among children suffering from chronic diseases, like asthma, and too often have inadequate and irregular access to care. As a result, school-based programs must take an integrated approach that incorporates such "crossover" issues as nutrition, physical fitness, media literacy and asthma management.

Use culturally competent curricula

Program managers should also concern themselves with tailoring the program to ensure that curricula and cessation programs are age and culturally-appropriate. To achieve this, school-based programs must work closely with diverse, community-based stakeholders.

Culturally Competent School Programs: Pathways to Health

Pathways to Health is an in-school program developed specifically for American Indian children and their families. The program links tobacco education to other related health issues. The purpose of the project is to develop, implement and evaluate a curriculum to prevent smoking and the use of smokeless tobacco and to promote a low-fat and high-fiber diet. The intervention integrates traditional Native American teaching methods, such as storytelling, poems, songs and games, with classroom instruction on four major topic areas: nutrition, tobacco and the skills needed to resist social influences, while encouraging responsibility for one's health. Native American customs and values are acknowledged and included into the curriculum. For example, tradition and ceremonial uses of tobacco are distinguished from daily and recreational use of commercial tobacco. Elders from the communities are also included as teachers in the curriculum.[8]

Component 4: Enforcement

Tobacco control enforcement carries out tobacco control policy in the real world. The activities of this component span the sometimes volatile terrain of compliance with youth access laws, smoke-free bar codes, and other indoor air regulations. In addition, this component monitors compliance with advertising restrictions in stores and at public events, and with prohibitions on tobacco product marketing practices outlined in the Master Settlement Agreement (MSA)

Ensure enforcement of tobacco laws in areas where underserved communities are most targeted

Communities of color/LGBT are directly targeted by tobacco advertisers, making them the most vulnerable to tobacco use. Some enforcement activities related to reducing disparities may include:

- Ensuring compliance with youth access laws
- Smoke-free workplaces and clean indoor air regulations
- Advertising restrictions in specific neighborhoods

California-based "smoke-free bars" campaigns, promoting the health interest of Asian-American communities, exemplify the promise and proven success of backing culturally enforcement specific activities. The Asian Pacific Islander Tobacco Control Network pushed a smoke-free campaign that focused on Asian-American venues and cultural nights. After local bars went "smoke-free," campaign activities shifted to enforcement as Network members joined with local BREATH advocates (the California Smoke-free Bars, Workplaces and Communities Program) to monitor compliance at venues catering to Asian-American patrons. This effort also provided a valuable opportunity to appraise the community impact of smoke-free laws while raising general awareness of the perils of tobacco use in these communities.[9]

Work with business owners

Tobacco outlets are heavily concentrated in low-income areas with large communities of color. However, many owners of neighborhood tobacco outlets are themselves immigrants and racial minorities who have not received adequate training on tobacco enforcement. When ensuring compliance with tobacco laws, it is imperative to use culturally sensitive approaches that embrace building relationships with business owners. Having outreach workers who can communicate in the appropriate ethnic or cultural language can facilitate constructive dialogue around enforcement. These outreach workers can offer on-site general education on tobacco enforcement and tips on reversing strategic advertising and underage tobacco access. The working partnerships between community organizations and business owners can be the basis for future tobacco control efforts, as well as for related health issues such as nutrition and alcohol use.

Ensure equitable application of enforcement activities

It is important to demonstrate even-handed application of enforcement activities, given the historically strained relationships between the criminal justice systems and diverse communities that are already over-represented on many areas of the criminal justice system. Nonetheless,

higher rates of violations of tobacco control laws in a specific community may well reflect the greater concentration and impact of tobacco outlets in that community—a situation that may be addressed most effectively through policy initiatives that decrease outlet concentration along with culturally competent efforts to promote compliance.

Culturally Competent Enforcement in Los Angeles' Koreatown

When community businesses are the subject of enforcement, targeted compliance efforts can provide an excellent opportunity to encourage law abiding behavior and social responsibility to the customer base, while potentially reducing the expenses of long-term enforcement efforts. In Los Angeles' Koreatown, community-driven campaigns to educate local merchants about the consequences of tobacco sales to minors have been effective at reducing youth access violations. The campaign's success is due in no small part to the strategic involvement of local business leaders and business associations, and the use of culturally competent approaches to educating the Korean-American business community about compliance with tobacco control laws.[10]

Component 5: Statewide Programs

Statewide networks offer great promise as a vehicle for advancing collaborative multilevel work. The CDC guidelines conclude that "supporting organizations that have statewide access to racial, ethnic, and diverse communities can help eliminate the disparities in tobacco use among the state's various population groups."

Create an Ethnic Network

Increasingly common, these supporting organizations, often called "ethnic networks," show success in reaching diverse communities and in developing relationships between these communities and local tobacco control agencies. However, this approach is best-suited for those states where such characteristics as target population size, geographic distribution, and community infrastructure create viable opportunities for network programming.

Some features of a successful Ethnic Network Model include:

- Capacity and credibility to outreach to a statewide constituency.
- A Statewide system of representation, most often taking the form of an advisory committee and regional agency partners or staff.
- Development of state campaigns to address one or more of the CDC components (e.g. counter-marketing, enforcement, etc.).
- Clear mutual goals and priorities. Resource constraints and competing needs often force networks to make tough programmatic choices.
- Networks functioning as connectors and brokers between communities and local and state tobacco control agencies.

- Collaboration *between* networks on tobacco control issues affecting many special populations is potent. Cross-network solidarity can produce results that are greater than the efforts of a network alone.

Setting out to build an ethnic network requires consideration of targeted outcomes within the context of the overall mission balanced with an in-depth assessment of both the suitability and feasibility of the potential network. (See Building Diverse Community Coalitions at http://www.thepraxisproject.org/tools/Coalition_Building_2pdf.pdf for more information.)

1. First, research various examples of ethnic networks developed in other states and determine if a particular model is most appropriate for your state.
2. Establish the desired initial outcomes, recognizing that these goals may sometime differ from those voiced by communities, and map community-based resources, institutions, and leadership from which to solicit input and gather information.
3. To assess community interest and existing capacity, provide venues for dialogue with community leaders and institutions working on public health and/or other social justice issues. Typical venues include roundtable discussions, one-on-one interviews, and focus groups.
4. If the network is deemed feasible, and community support is given, set up a representative advisory committee to guide the collaborative effort of network development.

Wisconsin Statewide Ethnic Tobacco Network

The Wisconsin Statewide Ethnic Tobacco Network is comprised of three member organizations representing the African-American, Hispanic/Latino and Southeast Asian populations. Together, the organizations monitor tobacco control policies and programs affecting their respective communities, facilitate training and share culturally and linguistically appropriate ideas for tobacco control. The agencies in WENC include the Black Health Coalition (BHC), United Migrant Opportunity Services (UMOS) and the Wisconsin United Coalition of Mutual Assistance Associations (WUCMAA). Through the Collaborative, communities of color can confront tobacco issues with respect to their individual communities and develop creative ways to combat tobacco use that do not contradict or ignore cultural beliefs. See www.umos.org/health/other_programs.aspx?sm=26 for more information.

Component 6: Counter-Marketing

It has long been known that communities of color and LGBTQ communities have been targeted by tobacco advertising. Countering the marketing machinery of the tobacco industry requires innovation, information, and strategic partnerships with community programs.

Work with community members to develop a message and dissemination tactics

Effective counter-marketing requires the thoughtful engagement of community members and partner organizations and their direct support in developing and implementing media activities. Strategies include creating and disseminating tobacco control messages to the public via print, web, radio, and video media; utilizing the media to engage in public relations or advocacy work; and replacing tobacco industry sponsorship and promotion. These counter-marketing strategies are all highly inter-dependent. For instance, replacing industry sponsorship without media advocacy means a missed opportunity to help inform a shift in the public conversation on tobacco marketing, the dangers of tobacco use and inspire greater disengagement from the tobacco industry in culturally-specific communities.

Ensure the messages are linguistically and culturally appropriate

If messages matter, then ensuring appropriate translation – translations that effectively convey the words, images, meaning and appropriate cultural context – are key. Counter-marketing messages should be in the appropriate language and convey a message that is relevant to targeted audiences. Often, it takes some investment in focus group research to fine-tune messages and address problems before campaigns are launched. The investment in testing counter marketing up front is well worth avoiding costly mistakes when a campaign is in full swing.

Contact minority media associations and public relations firms

Ethnic media groups are a valuable resource for identifying potential media outlets and developing innovative, culturally-appropriate media campaigns. Depending on the capacity of the local community, it may be necessary to directly support local minority media in order to increase the available capacity to address tobacco control and related health issues. Consider the following potential media resources when developing counter-marketing initiatives:

- National Association of Hispanic Publications (Latino/Hispanic newspapers and magazines)
- Independent Press Association (community media and small ethnic presses)
- National Newspaper Publishers Association (African American newspapers)
- Asian Pacific Publishers Association
- Native Web (Native American publications)
- National Association of Black Journalists
- National Association of Hispanic Journalists (NAHJ)
- National Lesbian and Gay Journalists Association (NLGJA)
- National Newspaper Publishers Association (NNPA)
- South Asian Journalists Association (SAJA)

Counter Marketing Strategies:
National African American Tobacco Prevention Network's FightKOOL Campaign

In 2004, the National African American Tobacco Prevention Network (NAATPN) launched FightKOOL, a national campaign to counter Brown and Williamson's "KOOL Mixx" advertising and promotional effort. KOOL Mixx was a thinly veiled attempt to target African American youth by exploiting hip-hop. The KOOL Mixx promotion was billed as a "celebration" of hip-hop music and culture and featured a hip-hop DJ mixing competition with a $10,000 cash prize, a "House of Menthol" website for the competition, a CD-ROM with mixing software and music files and special edition Kool cigarette packs with hip-hop design graphics.[11] FightKOOL was a collaborative effort that included the Universal Zulu Nation of Hip Hop, the National Medical Association, VOTE, New Zion Christian Association, Committees for a Better Chicago and representatives from the City of Chicago Health Department. NAATPN and its partners took quick action by educating tobacco retail outlet owners, releasing Internet alerts, letter writing media events and a hip-hop celebration night scheduled the same day as the KOOL Mixx DJ event.

Component 7: Cessation Programs

Cessation programs are indispensable self-help stations along the frontline of tobacco control. The challenge for the public health community, given its mandate of tobacco use prevention, is to develop *comprehensive* treatment models for culturally-specific communities that address the far-reaching health and social impact of tobacco use in their daily lives. These models are not the stuff of fantasy, however, as comprehensive, community recovery models are in use in the treatment of alcohol and illicit drugs.

Develop and utilize culturally and linguistically appropriate cessation services

When addressing tobacco cessation, it is important to incorporate issues that are specific to the population. Take into account population characteristics when designing cessation programs. For example, toll-free tobacco quitlines may be appropriate for populations who do not have access to cessation programs in clinical settings due to lack of insurance, social stigma or transportation or language difficulties. Curriculum should incorporate larger social issues that factor into smoking cessation and motivation to quit, such as acculturation, marginalization and cultural norms and beliefs. Finally, cessation staff should be able to communicate effectively in the language in which participants are most comfortable.

Ensure access to cessation services

Currently, accessibility to cessation service is primarily a function of health insurance coverage. Racial and ethnic minority groups are much more likely than Whites to be uninsured, and are less likely to have job-based health insurance coverage. Efforts to secure insurance provisions

for comprehensive cessation services are underway in various states. However, for the many low wage and no wage workers without coverage who smoke, public funding of cessation will be key. Funding strategies include private-public partnerships to secure hospitals' commitment to a portion of charity to cessation, creating deductible tax revenues through tobacco expense taxes or MSA dollars and ensuring Medicaid coverage of cessation.

Improving Cessation Coverage: The Next Generation Alliance in California

Minority-led health policy organizations in The Next Generation Alliance in California (http://www.tobaccofreealliance.org) are propelling efforts to improve cessation coverage. This collaborative work has led to the broadening of policy issues, including advocacy for insurance coverage and the provision of culturally-competent services. This kind of collaboration holds great potential for meeting the multiple needs of communities.

Culturally Competent Curricula: Pathways to Freedom

Pathways to Freedom is a culturally-specific cessation guidebook produced by the CDC in partnership with African-American churches, service organizations, and educational institutions. Under the theme of "freedom from tobacco," the curriculum addresses key issues specific to the African-American community such as targeted advertising, the support role of friends and family, the advocacy role of community leaders, and historical and cultural influences on health behavior choices. More information on *Pathways to Freedom* is available at http://www.cdc.gov/tobacco/quit/pathways.htm).

Culturally Competent Services: Smokers Helpline

In California, one example of culturally competent cessation services is the Smokers Helpline, which provides services communicated in Spanish, Mandarin, Cantonese, Korean, and Vietnamese (http://www.californiasmokershelpline.org/). These languages represent the largest segments of linguistically isolated populations with high rates of tobacco use in California. Other states have also adopted this model. However, this model generally provides telephone counseling and referral services for individuals trying to quit smoking, but does not address actual access to individual or group therapy, to pharmaceutical therapies, or to language services for smaller, linguistically isolated populations. The jury is still out as to whether the helpline model is the best medium for communities with diverse linguistic and cultural characteristics or whether phone support is appropriate for geographically isolated, rural communities to get help with smoking cessation. One alternative is the *promotora* model where community-based members are trained to become health workers in their own neighborhoods. These health workers/neighbors provide personalized support in the comfort of their neighbors' own home. Vision y Compromiso is one source for staff and community training in promotora methods (http://clnet.sscnet.ucla.edu/community/promotoras/).

Component 8: Administration and Management

The CDC's concept of the administration and management component of tobacco control emphasizes the need for strong oversight to develop and manage collaborative partnerships. It also emphasizes the importance of fiscal capacity in managing multiple, long-term grants and contracts. In our view, another important aspect of administration and management is the need to ensure that tobacco control programs and affiliated personnel operate in a culturally-competent way both in their dealings with community partners and their program management.

Develop culturally competent staff

Failure to address cultural competence across-the-board—in program design, development, implementation, evaluation, or other community-related activities such as network development, will result in ill-spent resources and misguided efforts. This failure can also burn bridges to future opportunities for community-level collaboration. State programs will surely benefit from full participation in department-wide efforts that address cultural competence and organizational diversity. Several resources are available to assist states in this effort, including the CDC National Tobacco Control Networks (http://www.nntpp.org/natnet.html) and the Training and Technical Assistance Consortium (http://www.ttac.org).

When building an effective staff, program managers should routinely take action in four key areas:

1. *Appraise staff-level cultural and community competencies*.
   Do staffers possess the needed set of skills and experiences that can facilitate the culturally and community competent design, development, implementation, and evaluation of programs for the target populations? Examples of qualifiers include applicable grassroots experience in community development and organizing, concordant linguistic skills, or relevant experiences in community-based advocacy or service delivery.

2. *Promote organizational diversity.*
   Promote diversity through personnel hiring, transfer, promotion, and committee/advisory board appointment opportunities, so that organizational composition reflects the actual skill and experience assets needed to carry out the mission of reducing tobacco use in culturally-specific communities.

3. *Provide ongoing opportunities for staff members to build on their skills and experiences.*
   This includes cultural competence training, conferences, in-house workshops, and community forums.

4. *Ensure the "cultural integrity" of data collection systems*.
   This involves developing clear and systematic methods for collecting information that informs the socio-cultural context of the program. Typical quantitative and qualitative data include target population demographics, community historical background, community health profile, and comprehensive needs assessment. Program planners should use this information early in the process and managers should continue to use it throughout project development.

Building a Culturally Competent Staff: Washington State Department of Health

The Community and Family Health (CFH) Division within the Washington State Department of Health has explored innovative ways to incorporate cultural competence within their staff. Beginning with a grass-roots effort through informal staff groups, the CFH has since formalized a Multicultural Work Group, coordinated a Cultural Awareness and Assessment workshop for all staff, and created cultural competence goals with the input of all staff. The division has also addressed systemic change, ranging from increasing community involvement in funding and collecting comprehensive data collection. For more information, the department has produced a workbook, *Building Cultural Competence: A Blueprint for Action*: www.doh.wa.gov/cfh/Pubs/Blueprint%20for%20Action.pdf.

Component 9: Surveillance and Evaluation

At their best, surveillance and evaluation are interactive efforts that allow for periodic appraisals and subsequent adjustments that help keep the program on track. It needs not be intimidating; it is simply a systematic way of answering the questions, "What are you trying to do?", "How will know when we get there?" and "Did we do what we said we were going to do?"

In the California Endowment publication *Commissioning Multicultural Evaluations: A Foundation Resource Guide*, multicultural evaluations are foremost characterized by reciprocity.[12] Although the evaluator shares her own expertise, she does not presume to understand the cultural context of the diverse community at hand. As a result, there is a fundamental shift in how the evaluation is conceptualized; the power and knowledge is shared between the evaluator and community members.

The guide identifies five guiding principles of multicultural evaluation:

1. Inclusion in design and implementation
2. Acknowledgement/infusion of multiple world views
3. Appropriate measures of success
4. Cultural and systems analysis
5. Relevance to diverse communities

Define disparities

Disparities go beyond gaps in prevalence. Our communities have experiences of disparities in service, treatment, opportunities and access that go beyond traditional statistics. When addressing disparities, program staff should solicit the residents' personal stories in order to develop a fuller picture and design their programs accordingly. Community-based participatory research is a paradigm that has developed a strong following in public health and in tobacco control and may provide a useful approach to evaluating the impact of state efforts to address tobacco use disparities.[13]

Set priorities that inform planning

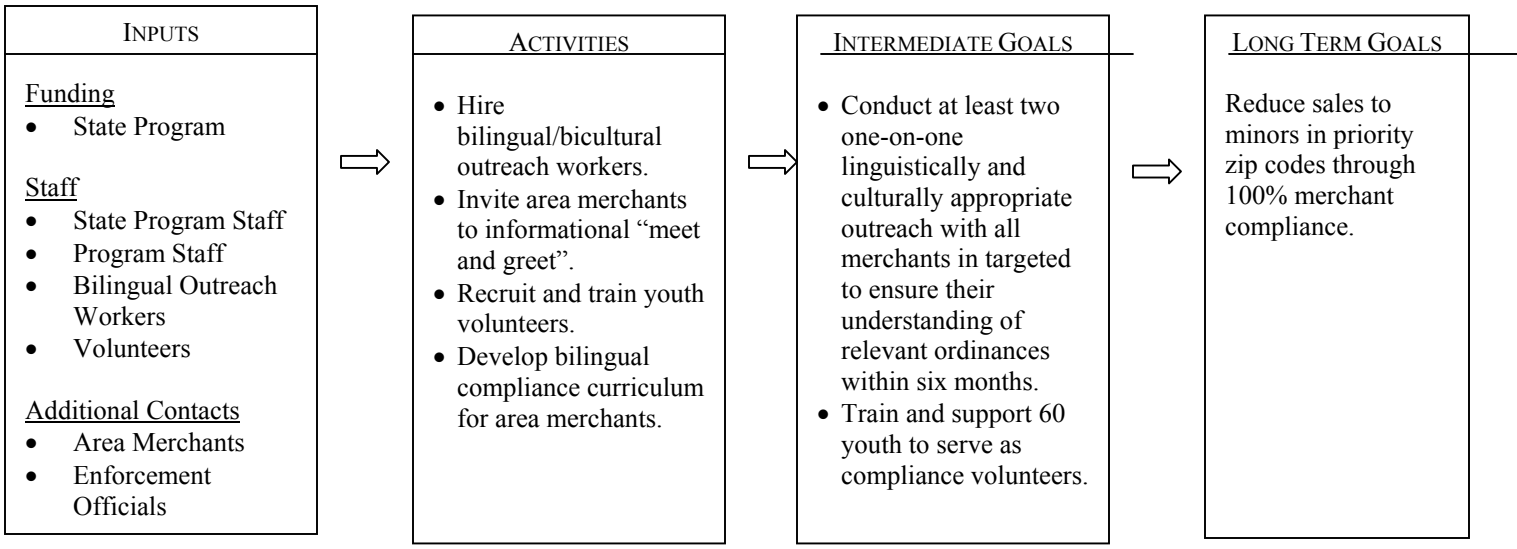
Stage-appropriate measures are critical for successful evaluation. For instance, an emphasis on evaluating capacity building and establishing institutional relationships is quite appropriate in early phases. As initiatives unfold, evaluation efforts that examine campaign outcomes, including first attempts at media advocacy and policy advocacy, should follow. In addition to campaign or program evaluation, managers should also assess the involvement of community members and community organizations in tobacco control, and the involvement of local and state agency staff with specific communities, which are both important intermediary measures of success in developing relationships. Relationship assessments should consider both the degree of involvement and the quality or overall satisfaction of established relationships.

Establish Culturally Specific Goals

During the evaluation planning stages, set goals that are specific to the characteristics of the population. Within each of the goals, develop intermediate goals that include aspects of the nine components, including community partnerships, data collection, staff development and policy advocacy. If possible, create a logic model that details the processes by which the program inputs will lead to the intermediate goals.

Sample Logic Model

Sample Goal: Reduce sales to minors in priority zip codes to 100% merchant compliance



Sample Culturally Specific Goals

Sample Goals	**Sample Intermediate Goals**
Reduce tobacco use among Vietnamese men under 40 by 50%	• Establish funding for at least three funded agencies to work on tobacco control in the community • Hire a community organizer to conduct outreach and build relationships in targeted communities • Conduct at least four focus group meetings with members of the community • Develop faith-based outreach initiative that reaches a minimum of 75% of faith institutions in the community • Develop restaurant worker outreach initiative that provides at least 1,000 hours of counseling and support referral for addressing occupational health and safety including cessation and second hand smoke • Work with ethnic media to create regular health column in community paper in Vietnamese • Ensure that culturally/ linguistically appropriate cessation services are available at no charge and are locally accessible • Identify key gathering places for social networking and ensure they are targeted for clean indoor air policies.
Reduce sales to minors in priority zip codes through 100% merchant compliance	• Conduct at least six one-on-one linguistically and culturally appropriate outreach meeting with all merchants in targeted to ensure their understanding of relevant ordinances within six months. • Train and support 60 youth to serve as compliance volunteers.
Reduce tobacco use in disability communities by 50%	• Establish cessation services and referrals for every group home and independent living center in the target area • Conduct 25 trainings for cessation treatment providers on the unique issues in providing cessation support to those living with disabilities

Conducting Evaluations

Well-conducted evaluations not only serve as an assessment for the program's effectiveness, but can also be valuable during the program planning stages as well. The steps below detail key points when conducting evaluations (Adapted from the work of R. Labonte and J. Feather[14])

1. *Start with the questions:* Every evaluation should ask five basic questions
    - **What?** Did we do what we said we would do? (Description of Activities)
    - **Why?** What did we learn about what worked and what didn't work? (Reasons for success)
    - **So What?** What difference did it make that we did this work? (Impact)
    - **Now What?** What could we do differently? (Future of this and other projects)
    - **Then What?** How do we plan to use evaluation findings for continuous learning?

2. *Evaluation Steps:* The basic process for phasing evaluations should include:
    - Assessing the goals and objectives set with community partners at the outset
    - Establishing methods for measurement, and then appraising progress at future intervals
    - Both survey and key informant methodologies

3. *Measures of tobacco control partnerships:* Specific intermediate measures of tobacco control partnerships with culturally specific communities should include such measures as:
    - Actual number of community organizations participating in a network
    - Degrees of participation
    - Network member satisfaction with the body's decision-making processes

4. *Ecological Measures:* Intermediate, ecological measures should include assessing how tobacco control resources are distributed across culturally specific groups and across under-represented/underserved geographies. A comparative appraisal of resource distribution and tobacco control activity and policy efforts may help locate intervention shortfalls and missed disparities. Accordingly, this component helps define disparities, sets priorities, informs planning, and measures actual outcomes against the yardstick of mission success.

    Key activities include data collection, research, and analysis. At its very best, surveillance and evaluation are both the headlights and the roadmap on the journey to reducing tobacco use in culturally-specific communities. However, an important caveat is that undoing "disparities" is a long term goal and, therefore, much of the impact of current efforts will not be visible for years to come. Consequently, intermediate markers of progress are necessary.

Community-Led Evaluation: The East Side Village Health Worker Partnership

The East Side Village Health Worker Partnership is a Detroit-based initiative that employs community-oriented action research to uncover and address social determinants of health disparities. The Partnership uses a lay health advisor model to address social determinants of disease. The community-based public health research principles that steer the Partnership incorporate the population's various viewpoints throughout the planning, implementation and evaluation stages. The Partnership was able to surface community health priorities by conducting a health survey that identified five priorities for intervention: policing and safety, strengthening social support for parents, improving access to health care, addressing the financial vulnerability of many East Side residents and addressing community factors that influence the risk of diabetes and cardiovascular disease. Program evaluators were selected because they were either residents of the community or had been involved with the community for many years. For more information on the Partnership, see: http://www.publichealthreports.org/userfiles/116_6/116548.pdf

SOME PARTING THOUGHTS

Goal 4 of the CDC Best Practices for Comprehensive Tobacco Control Programs – to identify and eliminate tobacco use disparities and its affects among different populations – is challenging but attainable. To achieve it, state programs must thoughtfully develop and assiduously implement long term collaborative strategies with a focus on lasting change. Programs must move beyond the conventional use of broad racial categories to identify target populations and embrace approaches that recognize multiple communities within communities. However, we cannot stop there. We must move from focusing on individual demographics to addressing environments, systems and policies that affect the conditions we aim to change.

Such an integrated approach will yield more effective and sustainable relationships for tobacco control. Cross-cutting strategies such as capacity building, "subgroup" appraisals, and cross-issue analysis, will ensure that despite waning resources and changing state priorities, communities will continue to move forward to reduce inequities and improve health.

As agencies and intermediaries, we must develop clear benchmarks that not only measure outcome regarding prevalence and such; we must measure *our* process outcomes and impact as "significant" institutional actors. Our funding policies, service delivery framework, staffing and more are all a critical part of the infrastructure for successful tobacco control.

Feel free to call on us for help and support. We are all in this together.

REFERENCES

1. Centers for Disease Control and Prevention. (1999). *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

2. San Francisco Department of Health. (2004). Community *Action Model*. Retrieved June 17, 2005 from San Francisco Department of Health Website: http://www.dph.sf.ca.us/CHPP/CAM/cam.htm

3. American Legacy Foundation. (2003). American *Legacy Foundation and W.K. Kellogg Foundation: Partnering to Reduce Tobacco Use in Underserved Communities*. Retrieved June 5, 2005 from The American Legacy Foundation Community Voice Tobacco Initiative Website: http://www.legacycv.org/initiative.html

4. Lew, R., Tanjasiri, S. P., Kagawa-Singer, M., and Yu, J. H. (2001). *Using a stages of readiness model to address community capacity on tobacco control in the Asian American and Pacific Islander community*. Asian Am Pac Isl J Health, *9:* 66-73.

5. Miller BA, Kolonel LN, Bernstein L, Young, Jr. JL, Swanson GM, West D, Key CR, Liff JM, Glover CS, Alexander GA, et al. (eds). (1996). Racial/Ethnic Patterns of Cancer in the United States 1988-1992, National Cancer Institute. NIH Pub. No. 96-4104. Bethesda, MD. Retrieved June 21, 2005 from National Cancer Center Website, "Cervix Uteri Cancer: U.S. Racial/Ethnic Cancer Patterns": http://www.nci.nih.gov/statistics/cancertype/cervix-uteri-racial-ethnic

6. Grantmakers in Health. (2003). Community-Based Strategies for Addressing Chronic Disease: Findings from the Grantmakers in Health Resource Center. Retrieved June 15, 2005, from The Grantmakers in Health Website: http://www.gih.org/usr_doc/chronic_disease.pdf

7. Strengthening the Black Family. (2000). *Project SELF Overview*. Retrieved from the Strengthening the Black Family website on June 11, 2005: http://kbrselfimprove.mc.duke.edu/Self_STBFOverview.ppt

8. Davis, S.M., Lambert L.C., Cunninghamsabo, L., Skipper, B.J. (1995). Tobacco Use: Baseline Results from *Pathways to Health*, a School-Based Project for Southwestern American-Indian Youth. *Preventative Medicine*, 24(5), 454-460.

9. Asian and Pacific Islander American Health Forum. *Asian and Pacific Islander Tobacco Education Network.* Retrieved June 5, 2005 from the Asian and Pacific Islander American Health Forum Website: http://www.apiahf.org/programs/apiten/

10. Chang, Charles. (2004) “Korean Youth and Community Center Conducts Compliance Checks Alcohol and Tobacco Sales to Minors,” *Thinking Strategically About for Collaboration: Tobacco and Alcohol Control Policy*. Chicago, IL: American Medical Association.

11. Anderson, Makebra. (2005). *Anti-tobacco campaign fights back with hip-hop*. Retrieved July 25, 2005 from Frost Illustrated website: http://www.frostillustrated.com/news/2005/0518/Arts_And_Entertainment/023.html

12. Inoye, T.E., Yu, H.C, Adefuin, J. (2005). Commissioning *Multicultural Evaluation: A Foundation Resource Guide*. Woodland Hills, California: The California Endowment.

13. Minkler, M. and Wallerstein, N. (2003). *Community based participatory research for health,* San Francisco, CA: Jossey-Bass. p. xxxiii, 490 p.

14. Labonte, R., & Feather, J. (1996). *Handbook on using stories in health promotion practice.* Ottawa: Minister of Supply and Services.

Section 3: RESOURCES

For additional resources, please visit our website at www.thepraxisproject.org *or email us at* info@thepraxisproject.org

TOBACCO CONTROL
Asian Pacific Partners for Empowerment & Leadership (APPEAL)
http://www.appealforcommunities.org/
National Latino Council on Alcohol and Tobacco Prevention (LCAT) http://www.nlcatp.org/
National African-American Tobacco Prevention Network (NAATPN) http://www.naatpn.org/
National Tobacco Independence Campaign (NTIC) www.tobaccoindependencecampaign.com
National Tribal Tobacco Prevention Network http://www.npaihb.org/tnet/
Tobacco Technical Assistance Consortium (TTAC) http://www.ttac.org/

HEALTH GROUPS:
National Association of County & City Health Officials (NACCHO) (www.naccho.org)
National Coalition for LGBT Health www.lgbthealth.net
The Onyx Group www.onyx-group.com
Asian and Pacific Islander American Health Forum (APIAHF) (www.apiahf.org)
Rural Information Services http://www.nal.usda.gov/ric/
Office of Minority Health http://www.cdc.gov/omh/

DATA and STATISTICS:
Agency for Healthcare Research Quality (AHRQ) http://www.ahcpr.gov/research/minorix.htm
National Center for Health Statistics http://www.cdc.gov/nchs/
U.S. Census Bureau http://www.census.gov/

MEDIA AND JOURNALISM:
National Association of Hispanic Publications
Independent Press Association
National Newspaper Publishers Association
Asian Pacific Publishers Association
Native Web
National Association of Black Journalists
National Association of Hispanic Journalists (NAHJ)
National Lesbian and Gay Journalists Association (NLGJA)
National Newspaper Publishers Association (NNPA)
South Asian Journalists Association (SAJA)

DOCUMENTS AND REPORTS:
Centers for Disease Control, Women and Smoking: A Report of the Surgeon General, 2001
http://www.cdc.gov/tobacco/sgr/sgr_forwomen/index.htm

Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General, 1998 http://www.cdc.gov/tobacco/sgr/sgr_1998/index.htm