NACCHO
NATIONAL
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TOBACCO PREVENTION AND CONTROL

Implementing Comprehensive Programs

A Workbook for Local Public Health Agencies

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NACCHO's Tobacco Prevention and Control Project provides education, information, research, and technical assistance to local public health agencies, and facilitates partnerships among local, state, and federal agencies in order to promote and strengthen local public health agency capacity to engage in tobacco use prevention and control.

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Background

NACCHO's Tobacco Prevention and Control Project
NACCHO's [Tobacco Prevention and Control Project](#) strives to strengthen local public health departments' capacity to engage in comprehensive tobacco use prevention and control by providing necessary resources and training. To accomplish this goal, NACCHO collaborates with national, state, and local partner organizations to develop and disseminate policy recommendations, best practices, and current information on tobacco control programs and activities available from the CDC, other federal agencies, and national non-profit organizations. NACCHO also actively participates in the development of national tobacco policy and is a member of the [Partners for Effective Tobacco Policy (PARTNERS)](#), which advocates for the passage of national tobacco control legislation.

Healthy People 2010
Reducing tobacco use and exposure to secondhand smoke are essential community and public health objectives. The *[Healthy People 2010](#)* initiative developed goals to reduce tobacco-related death and disease by reducing exposure to secondhand smoke, decreasing tobacco-use initiation, and increasing tobacco-use cessation. Local governments have a statutory responsibility to address tobacco use as a dominant threat to the health of their communities, especially among vulnerable young people. While the *Healthy People 2010* goals and objectives provide standard goals for the nation, local public health departments must determine that the goals and objectives are relevant to local communities' needs and programs. NACCHO's guidelines and this resource guide provide strategic assistance for local assessment activities.

Community-Based Programs
Evidence from tobacco control programs in California, Massachusetts, and Oregon indicate that the most successful approaches to reducing tobacco use and exposure to secondhand smoke include a comprehensive, community-based program. The California program, implemented since 1988, has prevented 33,300 heart disease deaths due to tobacco use between 1988 and 1997. Lung and bronchial cancer rates in California dropped by 14 percent between 1988 and 1997, compared to less than 3 percent in other parts of the country during the same period of time.[1] Likewise, Oregon, utilizing a comprehensive approach, reports a 20 percent reduction in tobacco use among adults and teens since 1993.[2] In Massachusetts, where a comprehensive program has been implemented since 1993, cigarette consumption declined by 33 percent, while consumption in the rest of the country declined just ten percent.[3] Comprehensive tobacco prevention and control programs that focus on communities, schools, public education through counter-marketing, cessation, enforcement, and are well-funded, well-managed, and evaluated provide a real solution to the public health problem of tobacco use.

Using the Workbook

Workbook Purpose

The National Association of County and City Health Officials (NACCHO) developed this resource guide to assist local public health agencies (LPHAs) and their partners with the implementation of NACCHO's *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs*. Created for tobacco control and prevention LPHA staff, this guide serves as an everyday resource and as a supplement to tobacco control and prevention trainings targeted at LPHAs and their partners.

NACCHO's *Program and Funding Guidelines*, based on CDC's *Best Practices for Comprehensive Tobacco Control Programs*, were developed to address the specific needs and realities of tobacco control programs at the local level. The Guidelines assist local public health officials and their community partners in structuring tobacco control efforts around the seven components of a local, comprehensive tobacco control program recommended by NACCHO and CDC. The workbook expands on NACCHO's guidelines to help inform local public health officials and community partners about selecting and funding evidence-based interventions for reducing and preventing tobacco use, identifying and eliminating health disparities related to tobacco use, and protecting people from secondhand smoke.

Navigating the Workbook

The workbook has four main sections. The first section describes the seven components of a comprehensive tobacco prevention and control program and includes background information, examples, and success stories. After understanding why each of the seven components are necessary for a comprehensive program, readers can use the community assessment worksheets to define or refine program components at their local health departments. Because implementing comprehensive programs also requires strong community collaboration, guidelines for building effective community partnerships are found after the worksheets. In the next section, readers will find worksheets that will help them identify future action steps in implementing their comprehensive tobacco control and prevention programs. Lastly, readers will find program and training resources.

Tobacco Prevention and Control Trainings

This workbook originally accompanied a training that was developed and implemented by a local training coordinator and statewide planning committee comprised of local public health departments and other community stakeholders from throughout the state. The planning committee tailored the training to issues pertinent to local participants and to recruit appropriate community stakeholders to ensure appropriate follow-up and implementation following the training.

This workbook can still be used as a resource during and following LPHA sponsored tobacco control and prevention trainings. Following a training, local training coordinators should monitor program implementation, provide technical assistance, and foster supportive partnerships in communities throughout the state. While trainings introduce essential elements of partnership building, this effort requires ongoing care, energy, and maintenance. Partnership building requires an initial outlay of energy and resources, but the outcomes achieved can be great, as evidenced by communities with well-established tobacco control coalitions throughout the country. Diverse individuals and organizations must work together to create the synergistic effects of a comprehensive tobacco prevention and control program.

Components of Comprehensive Local
Tobacco Prevention and Control Programs

The Centers for Disease Control and Prevention (CDC) has developed "Best Practices for Comprehensive Tobacco Control Programs," which documents the tobacco control program components recommended for states to obtain optimal results in promoting tobacco-free communities. Like state health departments, local public health agencies (LPHAs) need to develop a strong infrastructure to support a broad range of tobacco control activities at the community level. NACCHO has refined the CDC's Best Practices and has identified the seven components below as areas that address the specific needs and realities of tobacco control programs at the local level. The following section provides background information, examples, and success stories for each of the seven components of a comprehensive tobacco prevention and control program.

☑   Administration and Management

☑   Cessation

☑   Community Programs

☑   Counter-Marketing

☑   Enforcement

☑   School Programs

☑   Surveillance and Evaluation

What are administration and management?

Implementation of an effective tobacco control program requires strong administrative and management structures that can perform strategic planning, staffing and staff training, and fiscal management functions. Experience dictates that roughly 5 percent of the total program budget be dedicated to program administration and management.

What is the purpose of administration and management?

- Recruit and develop qualified and diverse technical, program, and administrative staff.
- Develop a sound fiscal management system.
- Award and monitor program contracts and grants, coordinate competent integration of implementation across program areas, and assess program performance.
- Coordinate with the state health department, other local public health agencies, and various partner organizations.
- Create an effective internal and external communication system.
- Develop and maintain access to up-to-date tobacco resources and information.
- Provide technical assistance and training to coalitions and outreach workers.

Why are administration and management important?

- With ten years of experience, California has documented examples of the lessons learned regarding organizational issues and the need for adequate staffing and management structures.[57]
- California recommends that the statewide program structure be decentralized, and that existing county or city public health departments or similar organizations be used as local lead agencies, with appropriate funding levels.[57]
- Experience in other states demonstrates the importance of having all the program components coordinated and working together.
- Because a comprehensive program involves multiple factions of local government (health, education, law enforcement), as well as numerous health-related voluntaries, coalitions, and community groups, program management and coordination is a challenging task, requiring adequate funding and staffing.
- Effective administration and management assure accountability to policy makers, funders, community partners, and tax payers as applicable.

CESSATION PROGRAMS TO REDUCE TOBACCO USE

What are cessation programs?

The vast majority of smokers want to quit, and those who do quit greatly reduce their risk of smoking-related disease and early death. Programs that successfully assist young and adult smokers in quitting have the potential to produce a larger short-term public health benefit than any other non-cessation related component of a comprehensive tobacco control program. Cessation alone, however, will not provide the results of the combined effect of cessation with the other components of a comprehensive program. NACCHO recommends $1.00 per adult for assessment of smoking status, $2.00 per smoker for brief counseling, $137.50 per smoker served per year for publicly supported cessation programs.

What is the purpose of cessation programs?

Effective tobacco use cessation programs should include the following elements:

- Educate health care providers on the Public Health Service's Clinical Practice Guidelines for cessation.
- Establish population-based counseling and treatment programs, such as cessation clinics, telephone help lines, and utilize new innovations such as online programs.
- Cover treatment for tobacco use under both public and private insurance.
- Eliminate cost barriers to treatment for underserved populations, particularly the uninsured.
- Integrate cessation efforts into existing prenatal, well child, family planning, chronic disease, tuberculosis, and other community programs and resources utilizing a counseling approach.
- Provide access to linguistically appropriate information and services.

The next pages will answer the following questions related to cessation programs.

Why are cessation programs important?

What are some examples of cessation programs?

What are some cessation programs success stories?

Why are cessation programs important?

- Smokers who quit smoking before age 50 cut in half their risk of dying from a tobacco-related disease in the next 15 years.[42]
- Most people who use tobacco want to quit, but only a small fraction succeed on their own. Although many who do quit do so without formal programs, treatment programs clearly improve cessation rates.[40]
- Controlled studies report 30-35 percent cessation rates at one year for intensive treatments and 10-29 percent for less intensive treatments.[40]
- Treatment for tobacco product addiction ranks high in cost-effectiveness among health program spending options.[35] The cost savings from reduced tobacco use resulting from the implementation of moderately-priced, effective smoking cessation interventions more than pays for these interventions within 3-4 years.[43]
- Programs that combine behavioral therapies with pharmacotherapies (i.e., medications) have the best results, and evidence-based guidelines recommend that all smokers should be offered both.[40]

- More than 70 percent of smokers visit a primary health care provider at least once a year creating ample intervention opportunities. Systematic reviews conclude that routine, repeated advice and support can increase smoking cessation rates by two to three-fold.[40]
- The Community Guide to Preventive Services strongly recommends healthcare provider reminder and education for cessation as an effective intervention for health care system level interventions (see Appendix E of this manual).[34]
- Smoking trends today will determine how heavy the health burden will be among communities tomorrow. Programs that reflect cultural diversity will be the cornerstone in the battle against tobacco use.[10]
- Certain ethnic/minority groups are disproportionately impacted by tobacco use:
  - Middle-aged and older African Americans are far more likely than their counterparts in the other racial/ethnic minority groups to die from coronary heart disease, stroke, or lung cancer.[10]
  - Nearly 40 percent of American Indian and Alaska Native adults smoke cigarettes. Since 1983, very little progress has been made in reducing tobacco use among this population group. The prevalence of smoking among American Indian and Alaska Native women of reproductive age has remained alarmingly high since 1978.[10]
  - American Indians and Alaska Natives were the only one of the four major U.S. racial/ethnic groups to experience an increase in respiratory cancer death rates in 1990-1995.[10]
  - More than 10 million African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics smoke cigarettes. Without intervention, this number may swell in the coming decade.[10]
- Both direct and secondhand smoke pose special hazards to pregnant women, babies, and young children. Babies and children who are exposed to tobacco smoke have more ear infections and asthma and die from SIDS more often. Mothers who smoke during pregnancy are more likely to have low birthweight babies and put babies at risk of SIDS.[10]
- Group approaches for quitting are generally not successful with members of racial/ethnic minority groups, possibly because the processes used are not culturally relevant or because of lack of transportation, money, or access to health care.[10] Community groups are in the ideal position to determine the best approaches for their own community members.
- Most successful cessation programs do more than deliver age, gender, language, and culturally appropriate messages. They provide practical information about the health consequences of tobacco use, resources to help people quit, and specific techniques for quitting.[10]

What are some examples of cessation programs?

Successful cessation services must be accessible, affordable, and include a range of services:

❖ Brief cessation counseling by a medical provider, including Smoke-Free Families' 5 A's (*ask* about smoking behavior at appropriate opportunities, *advise* all smokers to stop, *assess* willingness to stop, *assist* smokers to stop, and *arrange* follow-up visits).

❖ Interventions such as individual, group, telephone, or online counseling, which provide social support and enhance problem solving ability.

❖ Providing over-the-counter nicotine replacement therapy including patches, gum, and nasal spray, as needed.

❖ Providing prescription medication, as needed.

❖ Making system changes recommended by the Agency for Healthcare Research and Quality (AHRQ)[41], including:
  - Implementing a tobacco-use screening system.
  - Implementing healthcare provider training and feedback.
  - Designating staff to be responsible for the treatment program.
  - Providing insurance coverage for proven treatments.

What are some cessation program success stories?

FREEDOM FROM SMOKING
The American Lung Association's cessation program is available as a group program and as a self-help program. Evaluations indicate a 27 percent continuous quit rate one year following the program for the group program and an 18 percent nonsmoking prevalence at 12-month follow up for the self-help program. In February 2001, the ALA also launched its Freedom From Smoking Online Program which is available free of charge to participants. Approximately 10,000 participants have registered for the online program since its launch, including participants from every state and 41 countries outside the United States.[29]

NOT-ON-TOBACCO (N-O-T)
N-O-T is the American Lung Association's research-based, gender-specific, ten-session smoking cessation program. Initial evaluative data from West Virginia and Florida indicate that teens completing the N-O-T program have a chemically validated quit rate of 20.8 percent, as opposed to 4.4 percent for teens receiving only a brief intervention. N-O-T has met the CDC *Programs That Work* criteria.[29]

QUITNET
QuitNet is an online cessation program conducted in association with Boston University School of Public Health. A March 2000 E-mail survey sent to 25,000 past registrants and completed by 5,000 participants indicates that of those who responded, 52 percent were not smoking a year after they first registered on QuitNet. Data indicate that quit rates increased with increased participation in QuitNet. While this is by no means a definitive measurement of efficacy, these results suggest that even in the "worst case scenario" – in which the assumption is made that everyone who did not reply or wasn't reached is still smoking – the success rate would still be more than 10 percent.[44]

THE SMOKER'S QUITLINE
A telephone quitline and a website, both managed by the American Cancer Society, provide public information and self-help materials, referrals, and counseling to smokers who want to quit.[45]

SMOKE-FREE FAMILIES
Experts attending the 1998 Consensus Workshop on Smoking Cessation in Pregnancy (sponsored by Robert Wood Johnson Foundation's Smoke-Free Families Program, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention) concluded that brief cessation counseling of 5 to 15 minutes, when delivered by a trained provider with the provision of pregnancy-specific, self-help materials, results in at least a 30 percent higher smoking cessation rate for women receiving the intervention. The group concluded that this intervention would have a beneficial impact on improving the outcome of pregnancy and would be cost-effective.[46]

> Recognizing that improving smoking cessation success rates is especially important in certain target populations, Massachusetts placed an emphasis on reducing smoking among pregnant women because it would produce long-lasting benefits for the prospective mothers who smoked during pregnancy and reduce risks to their children. As a result, the number of mothers who smoked during pregnancy dropped by almost 48 percent during 1990-1996, a rate far ahead that of any other state.[3]

COMMUNITY PROGRAMS TO REDUCE TOBACCO USE

What are community programs?
Local community programs to change public attitudes and behaviors about tobacco, as well as the way tobacco products are marketed, sold, and used, are the first line of defense in prevention efforts. These community interventions can affect policies to influence societal organizations, systems, and networks to encourage individuals to stay or become tobacco-free. Typically a local coalition or partnership of area parents, youth, business leaders, and health professionals work together to solve the tobacco problem in their own areas. NACCHO recommends $.70 to $2.00 per capita per year for local governments and community-based organizations for community programs.

What is the purpose of community programs?
The most effective community programs focus on several action areas:
- Prevent youth initiation of tobacco use
- Help tobacco users quit.
- Protect non-users from secondhand smoke
- Eliminate the disparities in tobacco use among specific populations

The next pages will answer the following questions related to community programs.

Why are community programs important?

What are some examples of community programs?

What are some community program success stories?

Why are community programs important?

- Evaluation data show that funding local community programs produces measurable progress toward statewide tobacco control measures.

- In Massachusetts and California, local community programs were instrumental in the adoption of an increasing number of local ordinances or other provisions restricting smoking in public places.[4,5] In both states, these policies contributed to a steady decrease in the percentage of nonsmoking adults reporting exposure to secondhand smoke.[6,7]

- California's and Massachusetts' local coalitions and community youth programs produced declines in the percentage of successful attempts by minors to buy tobacco.[1,5]

- In Oregon, funding of community programs through the county public health departments produced an impressive diversity of coalitions, partners, and local actions as well as declines in tobacco use.[8,9]

- Tobacco companies garner community loyalty by hiring community members, providing communities with tobacco sales and advertising revenues, funding community organizations, and supporting educational, political, cultural, and sports activities.[10] Community programs let communities take back their control from the tobacco industry by educating community leaders on tobacco industry tactics and can lead to community actions such as refusing tobacco company donations and making socially responsible decisions.

- According to the 1998 Surgeon General's Report, cigarette smoking is a major cause of death and disease in the four population groups comprising most communities in the United States: African Americans, American Indians/Alaska natives, Asian Americans/Pacific Islanders, Hispanics, and Whites.[10]

- No single factor determines patterns of tobacco use among racial/ethnic minority groups; these patterns are the result of complex interactions of multiple factors, such as socioeconomic status, cultural characteristics, acculturation, stress, biological elements, targeted advertising, price of tobacco products, and varying capacities of communities to conduct effective tobacco control programs.[10]

- Funding nongovernmental community partners can be an effective means to reach specific vulnerable populations, including women, racial/ethnic minority populations, and blue-collar workers. In Kansas City, Missouri, the involvement of culturally diverse communities in the planning and implementation of tobacco control efforts proved an effective means to reach these vulnerable populations.[11]

- Young people who come from a low-income family and have fewer than two adults living in their household are especially at risk for becoming smokers.[12] Community programs can identify these at-risk youth and provide services for them.

When communities plan adoption of local ordinances or other provisions restricting smoking in public places, restricting access to tobacco products, and other policy objectives they should be aware that the tobacco industry has developed active opposition to these local tobacco control strategies. See the American Nonsmokers' Rights resource listing in Appendix F for *Tobacco Industry Opposition to Local Clean Indoor Air Policies* and related documents for opposition tactics your community can expect from the tobacco industry in response to your community programs and successful strategies to overcome them.

What are some examples of community programs?

❖ Developing partnerships with local organizations.

❖ Creating a local tobacco control coalition or re-energizing an inactive coalition.

❖ Working towards the adoption of local tobacco control ordinances or other provisions eliminating smoking in workplaces and public places.

❖ Working towards the adoption of local ordinances or other provisions restricting access to tobacco products, and other policy objectives.

❖ Conducting community programs to decrease the percentage of successful attempts by minors to buy tobacco.

❖ Conducting tobacco control educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others to reach a policy goal.

❖ Engaging young people to plan and conduct community tobacco prevention and education events and campaigns to reach a policy goal.

❖ Working with judges and retailers to develop education and diversion programs.

❖ Developing educational presentations and establishing tobacco use policies in schools and community and day care centers that eliminate secondhand smoke.

❖ Educating parents about the hazards of secondhand smoke to children to achieve the goal of parents not smoking in the presence of children.

❖ Conducting countywide assessments of tobacco advertising and implementing tobacco product and advertising placement policies.

❖ Conducting countywide assessments of tobacco company sponsorship of public events and developing policies to reduce such sponsorship.

❖ Offering smoking cessation programs through various community agencies, existing prenatal, well child, family planning, chronic disease, tuberculosis, cardiovascular disease prevention, other community programs, and advocating for systems change to provide coverage for treatment.

❖ Training dental providers to counsel their patients on the role of tobacco use in the development of oral cancer.

❖ Using tribal, ethnic, and non-English newspapers and community presentations by youth to educate specific populations about tobacco use and the tobacco industry's advertising and promotion methods geared toward specific vulnerable populations.

What are some community program success stories?

<u>OREGON</u>

Oregon's community programs, funded by a tobacco tax increase approved by voters in 1996 and implemented through county public health departments, have produced diverse coalitions, partners, and local actions. Tobacco product consumption has declined by more than 20 percent in Oregon since establishing their comprehensive tobacco prevention and education program.[2] Examples of Oregon's community activities include:

- Engaging young people to plan and conduct community tobacco prevention and education events and campaigns.
- Working with judges and retailers to develop education and diversion programs.
- Developing educational presentations and strengthening tobacco use policies in schools and community day care centers.
- Conducting a campaign on the effects of smoking in the home.
- Conducting youth-led countywide assessments of tobacco advertising and developing plans to reduce tobacco sponsorship of public events.
- Offering smoking cessation programs by drug and alcohol prevention agencies.
- Using tribal newspapers and community presentations by Indian Reservation youth to educate the tribal community about tobacco use and the tobacco industry's advertising and promotion on the Reservation.

<u>MASSACHUSETTS</u>

Massachusetts' community programs were the center of the Massachusetts Tobacco Control Program's (MTCP) activities. MTCP's Targeted Community Smoking Intervention Programs have included[3]:

- Innovative Outreach and Intervention Programs to reach targeted populations at home, at public events, and in other public settings. Programs were developed to creative smoking intervention strategies responsive to the particular needs of the targeted population. Strategies included educating community leaders and engaging them in health promotion and tobacco control policy-related activities.
- Innovative Intervention for Risk-Taking Youth Programs were youth skill-building programs that fostered youth leadership in tobacco control. Programs included activities such as designing and conducting attitude and behavior surveys; mapping industry advertising practices in the community; developing, passing, and enforcing a tobacco regulation or law; and advocating tobacco control through the media. Programs also offered smoking cessation and relapse prevention interventions for youth participants to prevent or interrupt habituated use.
- Institutional Casefinding Programs implemented models designed by health and human services providers to identify smokers within their existing client or patient population and institutionalize intervention strategies. Models were based on the Public Health Service Clinical Practice Guideline 5A's: ask about tobacco use at appropriate opportunities; advise all tobacco users to quit; assess willingness to quit; assist with quitting; and arrange follow-up visits.
- Unit Rate Cessation Services were agency-based smoking cessation specialty services which offered individual and/or group counseling to assist smokers quit and prevent relapse. Programs promoted nicotine replacement therapy (NRT).

<u>CALIFORNIA</u>

The Monterey County Health Department in California developed a community program utilizing local coalition members and youth to eliminate tobacco sponsorship from county events. Adult and youth participants made contracts, educated community members, and provided counter-marketing including organized protests at events and letters to the editor. As a result of the multi-faceted program, the coalition documented a reduction in sponsorship at five events resulting in 155,000 fewer people exposed to tobacco messages. Adult smoking rates in the community have also decreased from 18.9 percent in 1990 to 16.5 percent in 1996. Teen smoking rates have decreased from 12.4 percent in 1990 to 8.9 percent in 1996.[13]

COUNTER-MARKETING TO REDUCE TOBACCO USE

What is counter-marketing?

Counter-marketing attempts to counter pro-tobacco influences and increase pro-health messages and influences throughout a state, region, or community. Counter-marketing consists of a wide range of efforts, including paid television, radio, billboards, and print counter-advertising; local television public service announcements; media advocacy and other public relations techniques such as press releases, local events, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. NACCHO recommends $.50 to $1.50 per person, per year to support local counter-marketing activities.

What is the purpose of counter-marketing?

When linked to other policy and environmental strategies, counter-marketing can:

- Counter the advertising and promotion done by tobacco manufacturers.
- Change public attitudes and behaviors about tobacco use.
- Set a supportive social climate for school and community efforts.
- Involve community members to plan and carry out public awareness campaigns.
- Increase the number of smoke-free workplaces and public places.
- Increase the number of quit attempts made by tobacco users.
- Empower local citizens to speak out on health matters that affect their communities.
- Encourage responsible coverage of tobacco issues through active engagement with the media.
- Target both adults and young people.
- Address both individual behaviors and public policies.
- Include grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins to support and reinforce a statewide campaign.
- Maximize the number, variety, and novelty of messages and production styles rather than communicating a few messages repeatedly.
- Provide sufficient reach, frequency, and duration to be successful.
- Use non-authoritarian appeals that avoid direct exhortations not to smoke.

> It is important to note that not all counter-marketing campaigns meet the criteria outlined above. For example, Phillip Morris claims to conduct "counter-marketing campaigns." Advocates should distinguish between tobacco industry sponsored youth counter-marketing campaigns and public health campaigns.

The next pages will answer the following questions related to counter-marketing.

Why is counter-marketing important?

What are some examples of counter-marketing?

What are some counter-marketing success stories?

Why is counter-marketing important?

- Studies show that tobacco advertising and promotional activities stimulate adult consumption and increase the risk of youth initiation.[12]

- Children buy the most heavily advertised brands[30] and are three times more affected by advertising than are adults.[31]

- Up to 34 percent of all youth experimentation with smoking in California between 1993 and 1996 can be attributed to tobacco promotional activities.[32]

- Tobacco products are advertised and promoted disproportionately to racial/ethnic minority communities. Examples of targeted promotions include the introduction of a cigarette named "Dorado," which was advertised and promoted to the Hispanic American community.[10]

- To increase its credibility in the Hispanic community, the tobacco industry contributes to programs that enhance the education of children, funds universities and colleges, and supports scholarship programs targeting Hispanics. Tobacco companies also place advertising in many Hispanic publications and contribute to cultural Hispanic events and the Hispanic art community.[10]

- To target American Indians and Alaska Natives, tobacco product advertisements used visual images, such as American Indian warriors. American Spirit cigarettes were promoted as "natural" cigarettes; the package featured an American Indian smoking a pipe.[10]

- A one-year study found that the three major African American publications – *Ebony, Jet,* and *Essence* – received proportionately higher profits from cigarette advertisements than did other magazines.[10]

- The tobacco industry attempts to maintain a positive image and public support among African Americans by supporting cultural events and making contributions to minority higher education institutions, elected officials, civic and community organizations, and scholarship programs.[10]

- A 1993 study found that the highest proportion of tobacco product billboards were posted in Asian American communities and the lowest proportion were in white communities.[10]

- Tobacco industry marketing is a factor influencing susceptibility to and initiation of smoking among girls. Many examples of tobacco ads and promotions targeted to women indicate that such marketing is dominated by themes of social desirability and independence. These themes are conveyed through ads featuring slim, attractive, athletic models, images very much at odds with the serious health consequences experienced by so many women who smoke.[33]

- Counter-marketing efforts of comparable intensity for each gender, age, and ethnic/racial group are needed to alter the environmental context of tobacco use.

- The Task Force on Community Preventive Services strongly recommends mass media education campaigns featuring long-term, high-intensity counter-marketing as effective for reducing tobacco use initiation and increasing cessation, particularly when combined with other interventions including tobacco price increases and community or school-based education programs (see Appendix E of this manual).[34]

- The Fairness Doctrine campaign of 1967-1970 documented that an intensive mass media campaign can produce significant declines in both adult and youth smoking.[35]

What are some counter-marketing success stories?

FLORIDA

The Florida Pilot Program on Tobacco Control implemented activities to combat tobacco use among youth aged less than 18 years and tobacco's attractiveness to youth. The program's major component was a youth-oriented, counter-marketing media campaign developed to reduce the allure of smoking. Community partnerships in all 67 Florida counties, an education and training initiative, and enhanced enforcement of youth tobacco access laws were the other program components. From 1998 to 1999, the percentage of Florida middle and high school students who smoked cigarettes decreased significantly and the percentage of middle school students who smoked cigars and used smokeless tobacco products also decreased significantly.[36]

MASSACHUSETTS

The Massachusetts Tobacco Control Program (MTCP) worked to ensure that similar themes and images were presented statewide and locally, in the mass media, and at community or school events. MTCP provided funds for local public relations initiatives, enabling statewide media specialists to teach local program staff how to reach audiences more efficiently and effectively. Program staff members learned how to develop relationships with local media, such as community newspapers and radio stations, to increase coverage of tobacco control events and issues. They also learned how to buy ads, which can increase the presence and reach of successful ad campaigns. For example, building on an MTCP television ad that youth found particularly effective, the Reading/Stoneham Tobacco Control Program and media specialists developed a video and curriculum for schools and community-based organizations to use in teaching about the negative effects of smoking.[37]

ILLINOIS

By collaborating with other public health departments, television stations, and educational agencies, the McDonough County Health Department (MCHD) met its objective of providing a cost-effective television campaign to complement its existing programs. Each of three health departments contributed $4,500 to the media campaign. This was 15 percent of McDonough County's total tobacco settlement award, or about $0.14 per capita. After a match by WGEM (the NBC affiliate in Quincy, Illinois), the campaign totaled $27,000. This brought the per capita budget for counter-marketing to $0.76 per capita, within the level of $0.50-$1.50 per person suggested by NACCHO's *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs*. The media campaign reached 110,740-targeted households in a tri-state area at an investment of $0.14 per capita. For small, rural public health departments with limited resources, this collaborative approach to a media campaign works extremely well.[38]

NEW MEXICO

The New Mexico Media Literacy Project (NMMLP) provides media literacy CD-ROMS, videos and curricula that are used in thousands of schools, worldwide. In the school years, 1998-2000, NMMLP visited approximately 70 schools throughout New Mexico. The presentations made approximately 10,000 middle school and high school students aware of the techniques and tactics used by all advertisers, but particularly tobacco advertisers who appeal to middle school students. Developed over four years, the ninety-minute presentation is modeled after the psychological strategies of the immensely successful Florida anti-smoking media campaign. Posttests given to about 700 sixth to twelfth grade students at 14 schools one week after the presentations revealed that 73 percent of non-smokers were less likely to smoke as a result of seeing the presentation. Sixty-four percent of smokers had considered quitting, and 54 percent of smokers had actually tried quitting since seeing the media literacy tobacco presentation. Fifty-three percent of students said they were angry with tobacco companies for their misleading advertisements, and perhaps most importantly, 97 percent of students felt tobacco companies did not care about their welfare. The presentations dealt primarily with issues of tobacco advertising, but additional information was provided on topics concerning alcohol advertising, violence, body image, nutrition and other unhealthy lifestyles as time permitted.[39]

Another lesson learned about counter-marketing……

Counter-marketing and public education campaigns have become standard elements of tobacco control, although their funding levels and aggressiveness vary considerably among the states. Counter-marketing campaigns can convey a variety of messages and can be aimed at different audiences. An evaluation of the California tobacco control program concluded that it was most effective in its early years, when the highest-impact advertisements emphasized deceptive practices undertaken by tobacco companies. Evaluators concluded that the program became less effective when spending for counter-advertising dropped (from $16 million in 1991 to $6.6 million in 1995) and when the advertisements began to focus on health risks rather than tobacco industry practices. As a result, the program's advisory committee made its foremost 1997 goal to "vigorously expose tobacco industry tactics."[39]

Any efforts to expose tobacco industry practices or eliminate or replace local tobacco industry sponsorships and promotions may be met with active opposition from the tobacco industry. See the American Nonsmokers' Rights Foundation's resource listing in Appendix F for *Tobacco Industry Opposition to Local Clean Indoor Air Policies* and related resources for opposition tactics your community can expect from the tobacco industry in response to your counter-marketing efforts and successful strategies to overcome them.

ENFORCEMENT TO REDUCE TOBACCO USE

What is enforcement?

The two primary areas addressed by local policies that require enforcement are laws restricting minors' access to tobacco and restrictions on smoking in worksites and public places (clean indoor air). Both require enforcement for maximum impact, if violators are to be deterred, and if the message is to be conveyed to the public that community leaders believe the policies are important. As other policy restrictions on advertising and promotion are adopted, they also will need to be enforced. NACCHO recommends $.43 to $.80 per person, per year for enforcement of tobacco control policies and regulations at the local level.

What is the purpose of enforcement?

Enforces laws that prohibit tobacco sales to minors.

- Educates merchants to reduce illegal sales of tobacco to minors.
- Enforces advertising restrictions and other ordinances that exist locally.
- Protects the health of nonsmokers by enforcing public and private policies that reduce or eliminate exposure to secondhand smoke.

The next pages will answer the following questions related to enforcement.

Why is enforcement important?

What are some examples of enforcement?

What are some enforcement success stories?

Why is enforcement important?

Minors' Access:
- All 50 states and the District of Columbia prohibit the sale of tobacco products to minors. The Federal Synar Amendment ties federal block grant monies to improved compliance with state laws prohibiting such sales. States risk reduced payments from the Substance Abuse and Mental Health Administration if they fail to meet compliance targets.

- Numerous studies show that the combination of enforcing laws that restrict tobacco sales to minors and educating merchants can reduce sales of tobacco to minors.[47,48]

- In order for youth access laws to be meaningful, they must be enforced. [40]

- The small body of evidence on the effects of enforcement on youth tobacco use suggests that it is an important and essential element of a comprehensive effort to reduce young people's use of tobacco.[49,50]

- Enforcing restrictions on minor's access to tobacco products contributes to a changing social norm with regard to tobacco use and may influence prevalence directly.[51]

- Appropriate local enforcement should include retailer education programs before enforcement activity begins. Education programs are necessary to build support among retailers for enforcing sales restrictions. These programs should include discussion of tobacco's health effects, a topic avoided in tobacco industry-sponsored programs such as "We Card."[48] Beware of tobacco industry efforts to co-opt the youth access enforcement issue by promoting their own ineffective programs – programs that shield retailers from facing fines for selling tobacco products to minors (see *Tobacco Industry 'Prevention' Programs* and related resources listed in Appendix F of this manual).

Clean Indoor Air:
- The health of nonsmokers is protected by the enforcement of public and private policies that reduce or eliminate exposure to secondhand smoke.[52]

- Studies show that enforcement of worksite smoking bans protects nonsmokers and decreases the number of cigarettes that employees smoke during the workday.[52, 53]

- Enforcement of clean indoor air laws is usually passive: complaints by the public are investigated by state or local officials who base enforcement on a graduated series of civil warnings and penalties.[52]

- Before smoking restrictions are implemented, educating the public, employers, and employees about the health effects of secondhand smoke and the need for these restrictions can build support for the restrictions and increase compliance.

What are some examples of enforcement?

❖ Conducting frequent retailer compliance checks to identify retailers who sell tobacco to minors.

❖ Conducting vendor and retail organization education.

❖ Establishing local licensing systems that impose a graduated series of civil penalties on retailers who sell tobacco products to minors, including license revocation for repeat offenses if possible.

❖ Eliminating tobacco vending machines and self-service displays.

❖ Establishing and publicizing telephone hotlines for reporting violations of clean indoor air ordinances and laws and investigating reports received.

❖ Reporting violations noted by state and local officials performing health, environmental, and other routine inspections.

❖ Establishing and enforcing restrictions on tobacco product placement.

❖ Establishing and enforcing tobacco advertising restrictions.

What are some enforcement success stories?

CALIFORNIA

In California, Operation Storefront was funded to help local coalitions stem the proliferation of tobacco advertising and promotion at the community level. Youth and adult volunteers in 52 California counties documented point-of-purchase tobacco advertising and promotion levels and developed community action plans to mobilize their communities to limit exposure through restrictions and enforcement. Evaluations and case studies of 19 of these innovative efforts have been documented.[54]

In Los Angeles County, a multi-faceted approach to tobacco control brought together law enforcement personnel, restaurant inspectors, community based agencies, and public health professionals to work collaboratively on increasing compliance with the California Smoke-Free Workplace Law to protect the health of bar and restaurant workers, as well as patrons of those establishments. The strategies employed included a media-based educational campaign, newsletter and educational pamphlet development and distribution to all bars and restaurant/bar establishments in the county, press conferences, and training for law enforcement personnel on the details of tobacco control laws. Compliance checks were conducted and citations were issued to violators of the California Smoke-Free Workplace Law. As a result of these efforts, Los Angeles County experienced an increase in overall compliance for both restaurant/bars and stand-alone bars from 79 percent in 1998 to 92 percent in 2000. Compliance among stand-alone bars increased from 46 percent in 1998 to 67 percent in 2000.[55]

MASSACHUSETTS

In Massachusetts, Boards of Health, often working with young participants of other local Massachusetts Tobacco Control Program (MTCP)-funded programs, enforce provisions designed to limit youth access to tobacco products. To date, their monitoring and enforcement activities include:

- Almost 60,000 checks of retail premises to make sure that they had appropriate signs indicating it is illegal to sell tobacco products to minors;
- 36,838 underage buy attempts, in which youth under age 18 attempted to purchase cigarettes and reported on the results; and
- 7,997 checks of compliance with vending machine restrictions.

As a result of these activities, retailers have become more careful about sales to minors, with the violation rate decreasing from 48 percent of all attempted underage sales in 1994 to 10 percent in 1999.[37]

Forty-four states have laws penalizing minors for tobacco-related offenses. When communities plan effective comprehensive tobacco prevention and control programs, they should note that penalizing children is not a proven technique to reduce underage tobacco use. In fact, penalties may adversely affect existing programs that are proven to be effective and are required, such as compliance checks utilizing young people.[56] According to Americans for Nonsmokers Rights, effective tobacco control policies should avoid all appearance or effect of punishing youth and place responsibility and punishment firmly on the tobacco industry.

SCHOOL PROGRAMS TO REDUCE TOBACCO USE

What are school programs?
School-based program formats range from age-specific classroom curricula to teacher training, special school projects, media literacy, peer education programs, and cessation programs for staff, parents, and students. Classroom curricula may encompass comprehensive health education programs or focus coverage on targeted tobacco prevention lessons. To reinforce tobacco use prevention messages, school-based efforts should be linked with community efforts by sharing common resources and messages. NACCHO recommends $4.00 to $6.00 per student in grades K-12 for annual awards to school districts.

What is the purpose of school programs?
- Prevent the initiation of tobacco use among young people.
- Educate youth, staff, and parents about the dangers of tobacco use and secondhand smoke.
- Teach personal life skills, refusal skills, and media literacy in order to enable youth to resist the influence of peers and tobacco marketers.
- Provide an opportunity for youth who already use tobacco products to quit.
- Promote tobacco-free school environments by educating administrators to adopt policies that support tobacco use prevention curricula.
- Provide linkages to community programs by sharing common resources and messages.

The next pages will answer the following questions related to school programs.

Why are school programs important?

What are some examples of school programs?

What are some school programs success stories?

Why are school programs important?

- Tobacco use usually begins in early adolescence, typically by age 16. Most first use occurs before young people graduate from high school. If young people can be kept tobacco-free, most will remain tobacco-free for the rest of their lives.[12]

- Nicotine is generally the first drug used by young people who use alcohol, marijuana, and other drugs. Adolescent tobacco use is also associated with being in fights, carrying weapons, and engaging in higher-risk sexual behavior.[12]

- The 1994 Institute of Medicine Report *Growing Up Tobacco Free* noted that school-based programs should be part of a comprehensive tobacco control strategy because educating school-age children and adolescents about the consequences of tobacco use is clearly important to sustain a smoke-free norm.[14]

- High-risk youth attending alternative high schools use tobacco at particularly high rates: 59.8 percent and 67.7 percent for females and males respectively. Cigar and smokeless tobacco use rates are also higher among these teens. Alternative high schools provide important opportunities for delivering cessation services to these vulnerable young people.[15] These schools also help to prevent high-risk youth from dropping out of school – a characteristic highly associated with increased tobacco use in adults. Adults with 9-11 years of education have significantly higher smoking rates than adults with 12 or more years of education.[16]

- Several studies show that school-based tobacco prevention programs that identify the social influences that promote tobacco use among youth and that teach skills to resist such influences can significantly reduce or delay adolescent smoking.[12]

- School-based programs that vary in format, scope, delivery methods, and community setting have produced differences in smoking prevalence between intervention and non-intervention groups ranging from 25 percent to 60 percent and persisting for 1 to 5 years after completion of the program.[14, 17-21]

- Studies show that the effectiveness of school-based tobacco prevention programs is enhanced by booster sessions and community-wide programs involving parents and community organizations and including school policies, mass media, and restrictions on youth access.[22-27]

- Thirty-six percent of high school students were current smokers in 1997, compared with 28 percent in 1991. Nine percent of high school students use smokeless (snuff, chewing, or spit) tobacco and 22 percent have smoked a cigar in the last 30 days.[28]

- The CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* recommend that schools provide access to cessation programs that help students and staff stop using tobacco rather than punishing them for violating tobacco-use policies.[28]

What are some examples of school programs?

❖ Implementing *CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction,* including tobacco-free policies, evidence-based curricula, teacher training, parental involvement, and cessation services.

❖ Linking school-based efforts with local community coalitions to share common resources and allow students, parents, and school personnel to participate in the broader societal efforts.

❖ Linking school-based efforts with local and statewide counter-advertising programs by incorporating counter-advertising messages into school programs and sharing resources.

❖ Implementing and incorporating evidence-based curricula identified through CDC's Research to Classroom Project into a comprehensive school program to prevent tobacco use and addiction.

What are some school program success stories?

The following two school curricula are identified as CDC *Programs That Work* because they have been evaluated and have met CDC's criteria for evidence of sustained impact on youth smoking rates. Both of these programs show reduced tobacco use among adolescents:

LIFE SKILLS TRAINING [20]
Life Skills Training is a middle school program focusing on tobacco, alcohol, and other drugs. The curriculum focuses on teaching information and skills for resisting social pressures to smoke or drink as well as teaching self-management skills and social skills. An elementary school Life Skills Training Program is also available for students in grades 3-5.

PROJECT TOWARDS NO TOBACCO USE (PROJECT TNT) [21]
Project TNT is a middle school tobacco use prevention curriculum that addresses the three most common factors found to influence tobacco use among adolescents: 1) seeking peer approval by using tobacco; 2) seeking a desired social image associated with tobacco use; and 3) lack of knowledge about physical consequences resulting from tobacco use. The curriculum addresses both cigarettes and smokeless tobacco.

Other school-based programs that influence knowledge, attitudes, and/or behavior include:

TEENS AGAINST TOBACCO USE (T.A.T.U.) [29]
The American Lung Association's peer-teaching program focuses on the addictive nature of tobacco and how the tobacco industry manipulates people. Teens teach elementary school students in school and community settings. Local evaluations by the American Lung Association show an increase in knowledge and anti-tobacco attitudes among teens participating in the program.

NOT-ON-TOBACCO (N-O-T) [29]
N-O-T is the American Lung Association's research-based, gender-specific, ten-session smoking cessation program for high school youth. Initial evaluative data from West Virginia and Florida indicate that teens completing the N-O-T program have a chemically validated quit rate of 20.8 percent, as opposed to 4.4 percent for teens receiving only a brief intervention.

ALTERNATIVE TO SUSPENSION PROGRAM [29]
The American Lung Association's Alternative To Suspension (ATS) program is offered in lieu of punitive suspension for teen smokers who violate school tobacco control policies. ATS was designed to help move students along in their stage of change; that is, the program attempts to move teens closer to thinking about or preparing to quit smoking. The American Lung Association has evaluated this program in three states, with promising results.

OREGON
The Oregon Health Division's school-based tobacco prevention program reports dramatic declines in tobacco use among eighth graders [2]:
▪ Overall, smoking in schools with funded prevention programs dropped from 16.6 percent of students in 1999 to 13 percent in 2000.
▪ In schools with no funded prevention programs, smoking declined by 8 percent, reflecting the overall impact of Oregon's comprehensive tobacco prevention program and national efforts. These schools had a drop from 17 percent of eighth graders smoking in 1999 to 15.7 percent in 2000.

SCHOOL PROGRAMS TO REDUCE TOBACCO USE

▪ Funded schools that did the best job of implementing Oregon's program had the largest reduction in smoking among eighth graders, 42 percent. This represents a drop from 14 percent of eighth graders smoking in 1999 to 8.1 percent in 2000.

> The most successful school programs in Oregon relied on a multi-faceted approach, not simply one activity or strategy. Their approaches included:
> - Putting policies in place to ban tobacco use by youth and adults on school grounds and at all school events.
> - Working with parents and community coalitions to prevent tobacco use.
> - Promoting cessation for young people who already use tobacco.
> - Using proven anti-tobacco curricula to teach children the dangers of tobacco use and the skills to refuse peer pressure to use tobacco.

SURVEILLANCE AND EVALUATION TO REDUCE TOBACCO USE

What are surveillance and evaluation?
Surveillance and evaluation are essential elements of a comprehensive tobacco control program. Surveillance is the continuous monitoring of measures over time to inform program and policy directions. Evaluation provides in-depth information about the status of intermediate outcomes, such as knowledge, attitudes, and policies, which are the short-term target of an intervention. The evaluation component also monitors program activities to ensure that they are conducted as planned.   It is important to integrate evaluation with all other program elements and activities. NACCHO recommends that 10 percent of a local comprehensive program be dedicated to surveillance and evaluation activities.

What is the purpose of surveillance and evaluation?
- Monitor program objectives to determine if they achieve goals, such as including decreasing prevalence of tobacco use among young people and adults, per-capita tobacco consumption, and exposure to secondhand smoke.
- Document intermediate indicators of program effectiveness for mid-course corrections and future enhancements and improvements.
- Monitor the prevalence of pro-tobacco influences, including advertising, promotions, and events that glamorize tobacco use.
- Allow for training and technical assistance pertaining to surveillance and evaluation.
- Allow for collection and analysis of data.
- Result in reporting and dissemination of data.

The next pages will answer the following questions related to surveillance and evaluation.
Why are surveillance and evaluation important?

What are some examples of surveillance and evaluation?

What are some surveillance and evaluation success stories?

Why are surveillance and evaluation important?

- Experience in California and Massachusetts demonstrates the importance of evaluation data in verifying program results for policy makers.[1, 7, 58]

- The CDC's *Framework for Program Evaluation in Public Health* notes that program evaluation is an essential organizational practice in public health that includes a) using science as a basis for decision-making; b) expanding the quest for social equity through public health action; c) performing effectively as a service agency; d) making efforts outcome-oriented; and e) being accountable.[59]

What are some examples of surveillance and evaluation?

- ❖ The Behavioral Risk Factor Surveillance System applied to a representative sample at the local level.

- ❖ Adult tobacco survey applied to a representative sample at the local level.

- ❖ The Youth Tobacco Survey applied to a representative sample at the local level.

- ❖ The Youth Risk Behavior Survey applied to a representative sample at the local level.

- ❖ Working with local universities and researchers to develop and implement surveys for collection of local baseline data.

- ❖ Surveys of smoke-free policies in worksites and public places.

- ❖ Assessments of tobacco industry advertising, sponsorship, promotional activities, and pricing.

- ❖ Special phone, mail, or door-to-door surveys to assess the knowledge, attitudes, and tobacco use behavior of high-risk populations.

- ❖ Tracking of media coverage of tobacco issues, including number of favorable, unfavorable, and neutral placements.

- ❖ Outcome, impact, and process evaluation of the tobacco control program components.

What are some surveillance and evaluation success stories?

CDC's Office on Smoking and Health created a "Surveillance and Evaluation Options Paper" based on experience in working with California, Massachusetts, Oregon, Maine, Mississippi, Florida, Texas, and Minnesota. The following are examples of current best practices in surveillance and evaluation activities[60]:

CDC SURVEILLANCE SYSTEMS
Participation in national surveillance systems (e.g., the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Survey, the Youth Tobacco Survey, and the Pregnancy Risk Assessment Monitoring System) enables states and local communities to evaluate program efforts in relation to ongoing efforts and initiatives in other states or localities. These national data can be used to compare state and local program impact and outcomes with national trends. In addition, states and communities have enhanced these national systems by adding state-and local-specific questions and modules, increasing sample size to capture local and special population data, and modifying sampling procedures to provide more data on intermediate performance objectives.

STATE AND LOCAL SURVEYS
Several states and localities have conducted tobacco-specific surveys to complement the broader surveillance data systems. These include school-based youth tobacco surveys; surveys of adults, school administrators, teachers, opinion leaders, and health care providers; local program monitoring surveys; state and local policy tracking; monitoring of pro-tobacco activities; and local media monitoring. The methodology for many of these tobacco-specific evaluation systems is described in the California Independent Evaluation Report.[1]

In 1998, Mississippi, Florida, and Texas conducted the Youth Tobacco Survey (YTS), a school-based statewide survey of young people in grades 6 through 12. This survey assessed students' attitudes, knowledge, and behaviors related to tobacco use and exposure to secondhand smoke, as well as their exposure to prevention curricula, community programs, and media messages aimed at preventing and reducing youth tobacco use. It also collected information on the effectiveness of enforcement measures. Baseline data from YTS and other tobacco-specific surveys can demonstrate to policymakers the seriousness of the tobacco problem and the types of performance objectives that can be monitored.[60]

Periodic special statewide surveys of adults and young people have been conducted in several states to evaluate exposure to participation in major program elements, particularly media. The methodology for these types of surveys is described in California's evaluation reports.[1, 58]

NATIONAL SURVEYS
The 1999 National Youth Tobacco Survey provides current information on all forms of tobacco use among middle school students, including novel tobacco products such as bidis and kreteks (clove cigarettes), providing an in-depth look at current trends to help focus program planning and implementation.[61]

COMPONENTS OF A COMPREHENSIVE
TOBACCO CONTROL PROGRAM ARE INTERRELATED

The seven components of an effective comprehensive tobacco control program are often more easily implemented than they may appear at first glance. Many inherent links exist between each of the components. Strong comprehensive programs are well integrated with already existing services and resources throughout the community; the components blend together and enhance each other. Enhancing the interrelated aspects of the components can create the synergy your community needs to tackle even the most complicated tobacco use issues. The chart on the next page identifies some of the links between the components. With your local community partners, identify specific linkages that will be helpful in your community.

Please note that because Administration and Management and Surveillance and Evaluation are clearly integral to each of the other components, they have been omitted from this chart.

	Community Programs	School Programs	Counter-Marketing	Cessation	Enforcement
Community Programs		Similar services can be offered at school and community venues making use of shared resources and consistent messages and social norms. Publicity for tobacco prevention and control within the community can support school programs and vice versa.	Participants in existing community programs (i.e., Boys and Girls Clubs, Scouts, Parks and recreation programs, etc.) can monitor pro-tobacco influences in the community to help provide a tailored counter-marketing campaign.	Existing community programs (i.e., WIC, TB, well-child, etc.) can incorporate cessation messages and provide appropriate referrals.	Community programs can educate retailers and the hospitality industry about the law and enhance enforcement activities.
School Programs			School programs can include student-created counter-marketing campaigns as part of health, language arts, social studies, and after school club activities. Schools can also incorporate community-wide counter-marketing messages for a cohesive comprehensive program.	Schools provide direct access to in-school youth who use tobacco and can provide cessation services in an accessible, youth-friendly manner.	Providing effective school programs may reduce the need for future enforcement. Enforcing school smoke-free policies sets a social standard of behavior and assures that the policies are meaningful.
Counter-Marketing				Counter-marketing messages can include referrals to cessation services. Cessation programs can also include counter-marketing messages. Cessation program "graduates" make good spokespersons for counter-marketing messages.	Counter-marketing messages can expose tobacco industry opposition to effective local ordinances and increase support for effective laws and enforcement.
Cessation					Enforcement of clean indoor air laws can link to cessation programs by providing referrals to "offenders." Take care, however, not to make cessation programs mandatory; effective cessation programs are voluntary.

Community Assessment Worksheets

The following worksheets will help you assess how comprehensive the tobacco prevention and control programs are in your community. Each worksheet covers one of the seven components of a comprehensive tobacco prevention and control program.

1. Community programs
2. School programs
3. Enforcement of existing policies
4. Counter-marketing
5. Cessation programs
6. Surveillance and evaluation
7. Administration and management

Complete the worksheets individually and then collaborate with your colleagues and community partners to identify areas of strength, areas in need of improvement, and areas that have yet to be developed. This activity will help you as you begin to develop a comprehensive community tobacco prevention and control plan.

Administration and Management

Fill in the worksheet below.

1. List your LPHA's tobacco prevention and control administration and management efforts.

Examples of administrative and management include:

- Recruit and develop staff
- Fiscal management
- Monitoring program contracts and grants
- Technical assistance and training
- Integration and coordination of program components

2. What are your health department's <u>areas of strength</u> in administration and management?

3. How can your health department <u>improve</u> administration and management?

4. What areas of administration and management are <u>in development</u>?

5. *Please check the box next to statement that applies to your administration and management..*

Overall, I feel
❑ My LPHA's administration and management are strong.
❑ My LPHA's administration and management need improvement.
❑ Action in my LPHA has yet to be taken.
❑ I don't know.

Cessation

Fill in the worksheet below.

1. List your LPHA's tobacco prevention and control cessation programs.

Examples of cessation programs include:

- Cessation programs for adults (including smoking and spit tobacco programs)
- Cessation programs for youth (including smoking and spit tobacco programs)
- Cessation programs targeting vulnerable populations (i.e., youth, ethnic/racial groups, women, and other groups)
- Cessation programs incorporating secondhand smoke messages

2. What are your health department's <u>areas of strength</u> in implementing cessation programs?

3. How can your health department <u>improve</u> cessation programs?

4. What areas of cessation are <u>in development</u>?

5. *Please check the box next to statement that applies to your cessation programs.*

  Overall, I feel ❑ My LPHA's cessation programs are strong.
           ❑ My LPHA's cessation programs need improvement.
           ❑ Action in my LPHA has yet to be taken.
           ❑ I don't know.

Community Programs

Fill in the worksheet below.

1. List your LPHA's tobacco prevention and control community programs.

2. What are your health department's <u>areas of strength</u> in implementing community programs?

3. How can your health department <u>improve</u> community programs?

4. What areas of community programming are <u>in development</u>?

5. *Please check the box next to statement that applies to your community programs.*

Overall, I feel ❑ My LPHA's community programs are strong.

❑ My LPHA's community programs need improvement.

❑ Action in my LPHA has yet to be taken.

❑ I don't know.

Counter-Marketing

Fill in the worksheet below.

Examples of counter-marketing efforts include:

- Restrictions on tobacco advertising, marketing, promotion, and product placement

- Monitor prevalence of pro-tobacco influences (advertising, marketing, promotion, product placement)

- Variety of public education efforts to change attitudes and behaviors relating to tobacco use and secondhand smoke

- Efforts targeting vulnerable populations (i.e., youth, ethnic/racial groups, women, and other groups)

1. List your LPHA's tobacco prevention and control counter-marketing efforts.

2. What are your health department's <u>areas of strength</u> in implementing counter-marketing programs?

3. How can your health department <u>improve</u> counter-marketing?

4. What areas of counter-marketing are <u>in development</u>?

5. *Please check the box next to statement that applies to your counter-marketing efforts.*

Overall, I feel ❑ My LPHA's counter-marketing are strong.
❑ My LPHA's counter-marketing need improvement.
❑ Action in my LPHA has yet to be taken.
❑ I don't know.

Enforcement

Fill in the worksheet below.

1. List your LPHA's tobacco prevention and control enforcement efforts.

Examples of enforcement efforts include:

- Enforcement of laws/ordinances restricting sales of tobacco products to minors
- Enforcement of smoking bans (worksite and public places)
- Educating about laws and ordinances affecting the community
- Enforcing tobacco advertising restrictions

2. What are your health department's <u>areas of strength</u> in enforcement?

3. How can your health department <u>improve</u> enforcement?

4. What areas of enforcement are <u>in development</u>?

5. *Please check the box next to statement that applies to your enforcement efforts.*

Overall, I feel   ❑ My LPHA's enforcement efforts are strong.
❑ My LPHA's enforcement efforts need improvement.
❑ Action in my LPHA has yet to be taken.
❑ I don't know.

School Programs

Fill in the worksheet below.

1. List your LPHA's tobacco prevention and control school programs.

Examples of school programs include:

- Coordinated school health programs (with tobacco use prevention components)
- Link school-based efforts with community efforts
- Tobacco- free school policies
- Cessation programs for students and staff
- Programs targeting vulnerable populations (i.e., youth, ethnic/racial groups, women, and other groups)

2. What are your health department's <u>areas of strength</u> in implementing school programs?

3. How can your health department improve school programs?

4. What areas of school programming are <u>in development</u>?

5. *Please check the box next to statement that applies to your school programs.*

Overall, I feel
- ❑ My LPHA's community programs are strong.
- ❑ My LPHA's community programs need improvement.
- ❑ Action in my LPHA has yet to be taken.
- ❑ I don't know.

Surveillance and Evaluation

Fill in the worksheet below.

1. List your LPHA's tobacco prevention and control surveillance and evaluation efforts.

2. What are your health department's <u>areas of strength</u> in surveillance and evaluation?

3. How can your health department <u>improve</u> surveillance and evaluation?

4. What areas of surveillance and evaluation are <u>in development</u>?

5. *Please check the box next to statement that applies to your surveillance and evaluation efforts.*

Overall, I feel ❑ My LPHA's surveillance and evaluation are strong.
❑ My LPHA's surveillance and evaluation need improvement.
❑ Action in my LPHA has yet to be taken.
❑ I don't know.

Building Effective Community Partnerships/Coalitions[*]

The Importance of Community Partnerships

Building healthier cities and communities involves local people working together to transform the conditions and outcomes that matter to them. This work demands various core competencies such as community assessment, planning, community mobilization, intervention, advocacy, evaluation, and marketing successful efforts. Collaborative partnerships are a powerful way to improve communities. That is, to improve our communities, we must all work together to solve problems.

Collaborative Partnerships: Alliances that are used to improve the health of a community.

Collaborative partnerships encourage people to get together and make a difference. For example, an effort to decrease tobacco use rates in a community might involve health officials, community organizations, school officials, business people, law enforcement officials, and diverse and non-traditional partners such as faith communities, ethnic/racial communities, youth groups, women's groups, and gay and lesbian groups. Because these partnerships bring people together from all parts of the community, their efforts often have the weight to be successful.

The following seven factors have been identified by the University of Kansas' *Community Tool Box* as important in determining whether a community effort succeeds or fails:

1. **Targeted Mission**
   Having a clear focus – that is, a targeted mission – is one of the most important factors in whether or not a community group is effective.

   A **mission statement** is your organization's or coalition's statement of purpose; it tells what the organization is going to do and why. The mission describes your special task and it tells what specific motivation binds together members of the group who want to make a difference.

2. **Action Planning**
   Action planning means identifying specific changes in the community or broader system, and identifying related action steps to bring them about. In action planning, community partnerships identify:

   - ❑ The community or system changes (new or altered programs, policies, and practices) to be sought
   - ❑ The actions that will bring about desired community or systems changes
   - ❑ Who will take those actions

---

[*] *This section on community partnerships was adapted with permission from the Community Tool Box (*http://ctb.1si.ukans.edu/tools.htm)

❑ By when they will be done
❑ What resources are needed to get the job done

When partnerships develop a plan of action, they are consistently more successful in changing their communities.

3. Changes in Leadership

Involving competent, inspired leaders with a clear vision for the organization helps change to occur more rapidly. Such leaders see community partnerships as a way to mobilize the community, draw out everyone's strengths, and to celebrate members' accomplishments. These leaders are likely to head very effective partnerships.

The down side of this is that when such leaders leave an organization, groups' accomplishments suffer. Finding a way to ease transitions and groom leadership within the group is an important factor for groups with long, successful lives.

4. Resources for Community Mobilizers

One thing that is very clear is that there need to be people who act as catalysts – community mobilizers who will get things going in the community. They are the ones who will start the ball rolling on the actions that the group decides on. By hiring or recruiting community mobilizers, groups consistently make more changes happen.

5. Documentation and Feedback

To know whether a community group's efforts are really making a difference, it is important that the group documents efforts and results. Such information about the group's accomplishments should be used to improve the group's ongoing efforts.

Documentation should occur for intermediate outcomes, such as community and systems changes. Tracking these changes, as well as the "bottom line" of achieving groups' long term goals, can help the collaborative partnerships understand, celebrate, and improve their overall efforts.

6. Technical Assistance

Good leaders work to attract competent people with skills that complement those of other people in the organization. By doing so, team members grow and become stronger in their work.

Outside help, which may take the form of technical assistance, can be a breath of fresh air for your organization. That's because the core competencies necessary for community organizations often transcend the variety of targeted missions and specialties people work in. For example, action planning will be important to community work on environmental advocacy, child abuse, mental health, or almost any other community issue.

The goal of technical assistance should always be the same: to build the community's ability to take care of the things that matter to its members.

7. Making Outcomes Matter

- ❑ Make renewal of community investments (for example, the continuation of a grant) conditional on evidence of progress by the group.
- ❑ Establish and report on intermediate and more distant outcomes – such as high rates of important community and systems changes for community-determined goals.
- ❑ Award bonus grants to encourage progress and outstanding accomplishments.

Since a coalition or partnership is composed of many different groups, each group must be prepared to compromise on what they will accept as goals, methods, and outcomes of the partnership. Working in a coalition requires diplomacy; each group won't get exactly what they want in each situation, but if the coalition adheres to the factors listed above, each group will get more of what they want than if they acted alone. Partnership building is complicated and takes time.

A healthy community is a form of living democracy: people working together to address what matters to them. Building healthier communities blends the local and the universal, the particular and broader contexts. Such efforts are grounded locally: the family, the neighborhood, and other familiar communities. To be effective, however, we must also bring diverse groups of people and organizations together to transform the broader conditions that affect local work. Non-traditional partners such as faith communities, ethnic/racial communities, youth groups, women's groups, and gay and lesbian groups can all add valuable competencies to reach community goals. This inclusion requires courage, doubt, and faith: the courage to trust those outside our immediate experience, the doubt to question what already exists, and the faith to believe that, together, we will make a difference.

The work of building healthier communities takes time: our time, that of our children, and that of our children's children. A Jewish proverb counsels: "You are not bound to finish the work, but neither are you free to give it up." In our emerging ties across place and time, we join others in an attempt to create environments worthy of all our children.

Action Steps Worksheet

This worksheet will help you plan your next steps. Work with others from your community to review these steps and commit to accomplishing them. The following questions will help you identify tasks for completion, the person responsible for the task, when each task should be completed and potential challenges (e.g., staffing, resources, local politics, etc) that you anticipate. After completing each question, use the calendar to help you visualize or next steps.

Who, <u>within</u> your organization, needs the information you received in this workbook?
Answer:
Lead Staff:
Date for Completion:
Potential Challenges:
Task Details:

What will you do to ensure that this information reaches the appropriate people?
Answer:
Lead Staff:
Date for Completion:
Potential Challenges:
Task Details:

Who, <u>outside</u> your organization, needs the information you received in this workbook?
Answer:
Lead Staff:
Date for Completion:
Potential Challenges:
Task Details:

What will you do to begin conversations with people outside your organization?
Answer:
Lead Staff:
Date for Completion:
Potential Challenges:
Task Details:

Do you have a community planning group in place?
Answer:
If yes, how could you be a more effective contributor to the community planning process?
Answer:
Lead Staff:
Date for Completion:
Potential Challenges:
Task Details:
If no, what steps do you need to take to ensure broader diversity?
Answer:
Lead Staff:
Date for Completion:
Potential Challenges:
Task Details:
If no, what steps will you take, by what specific date, to begin to develop a comprehensive tobacco prevention and control program?
Answer:

| Lead Staff: |
| Date for Completion: |
| Potential Challenges: |
| Task Details: |
| |

Specifically, what resources (time, money, data, staff) will you commit over the next 3-6 months to develop a more comprehensive tobacco prevention and control program in your community?

| Answer: |
| |
| Lead Staff: |
| Date for Completion: |
| Potential Challenges: |
| Task Details: |
| |

What additional information do you need in order to develop your community comprehensive tobacco prevention and control program?

| Answer: |
| |
| Lead Staff: |
| Date for Completion: |
| Potential Challenges: |
| Task Details: |
| |

NACCHO   Tobacco Prevention and Control Training

TOBACCO PREVENTION AND CONTROL RESOURCES

A brief list of resources can be found below by subject area. A comprehensive and up-to-date list of Tobacco Prevention and Control Resources can be found at NACCHO's website at www.naccho.org/general1065.cfm.

<table>
<tr><td>Community Assessment</td><td>Coalition/Partnership Building</td></tr>
<tr><td>Community Programs</td><td>Counter-Marketing</td></tr>
<tr><td>Cessation Programs</td><td>Enforcement</td></tr>
<tr><td>School Programs</td><td>General Resources</td></tr>
<tr><td>Surveillance and Evaluation</td><td></td></tr>
</table>

Community Assessment   back to top
Communities of Excellence in Tobacco Control Community Planning Guide
American Cancer Society
National Home Office
(404) 320-3333
www.cancer.org

Coalition/Partnership Building   back to top
Collaboration handbook--Creating, Sustaining, and Enjoying the Journey,
Amhearst H. Wilder Foundation, 1994.
www.wilder.org/pubs/collab_hndbk/collab_hndbk_info.html

From the Ground Up!
A Workbook on Coalition Building and Community Development
AHEC Community Partners, 1997
http://www.jointogether.org/sa/resources/database/reader/0,1884,254858,00.html

Community Tool Box
University of Kansas Community Development
 ctb.lsi.ukans.edu

Community Programs   back to top
American Cancer Society (local offices)
(800) ACS-2345
www.cancer.org

American Heart Association (local offices)
(800) 242-8721
www.americanheart.org

American Lung Association (local offices)
(800) LUNG-USA
www.lungusa.org

Americans for Nonsmokers' Rights Foundation (ANR)
(510) 841-3032
www.no-smoke.org

Activism 2000
This national clearinghouse conducts youth oriented advocacy trainings and offers other
resources including the 130-page book, Youth! The 26 percent Solution ($14.95 plus $4
shipping)
(800) KID-POWER
www.youthactivism.com

Monterey County Health Department, California
(831) 647-7910

Oregon Health Division
www.ohd.hr.state.or.us

"Take Action: Teen Voices for Change" Video
Stanford Center for Research in Disease Prevention
This 20-minute video follows three groups of teens in San Jose, California, as they advocate for
change in their community.
(650) 723-0003
distribution@SCRDP.stanford.edu

Youth Advocacy Guide: How to Integrate Youth Into Tobacco Prevention Programs
This comprehensive manual draws on the lessons learned from the California Youth Advocacy
Network and its numerous successful projects. Toucaned Publications info@toucaned.com

Counter-Marketing   back to top
American Legacy Foundation
(202) 454-555
www.americanlegacy.org

California Tobacco Control Section
www.dhs.ca.gov/ps/cdic/ccb/TCS/index.htm

Campaign for Tobacco Free Kids
(202) 296-5469
www.tobaccofreekids.org

Massachusetts Tobacco Control Program
For more information, contact: Doug Wood-Boyle
(617) 624-5909
www.state.ma.us/dph/mtcp/media.htm

The New Mexico Media Literacy Project
Phone (505) 828-3129
www.nmmlp.org

Reducing Tobacco Product Marketing at Retail Stores: Challenges and Opportunities.
Patricia Jensen and Sara Kole, 1996.
Center for Research in Disease Prevention
Stanford School of Medicine
100 Welch Road, Palo Alto, CA 94304-1825

<u>Cessation Programs</u>   <u>back to top</u>
Freedom From Smoking
American Lung Association
(800) LUNG-USA
www.lungusa.org/ffs

Fresh Start
(contact local offices of American Cancer Society)
(800) ACS-2345
www.cancer.org

National Cancer Institute
(800) 4-CANCER
www.nci.nih.gov

Not-On-Tobacco (N-O-T)
(Cessation program for teens)
American Lung Association
1-800-LUNG-USA
www.lungusa.org

QuitNet
Boston University School of Public Health
www.quitnet.com

Smoke-Free Families
Robert Wood Johnson Foundation and University of Alabama at Birmingham
www.smokefreefamilies.org

The Smoker's Quitline
American Cancer Society
1-800-TRY-TO-STOP
www.trytostop.org

State Tobacco Control Program Quit-Line
(Contact your state tobacco control representative)

Clinical Practice Guidelines: Treating Tobacco Use and Dependence Guidelines
U.S. Public Health Service
U.S. Department of Health and Human Services
www.ahcpr.gov

Enforcement   back to top
Full Court Press
(520) 321-7989
E-mail: fcp@rtd.com

Smoke-Free Bar Program
Los Angeles County Department of Health Services
NACCHO 2001 Champion for a Tobacco-Free Communities Award
Tobacco Control and Prevention Program
(213) 351-7786

Operation Storefront Manual: Youth Against Tobacco Advertising and Promotion
California Department of Health Services
Tobacco Prevention Programs Local Programs Unit
Tobacco Control Section
(916) 445-2563

School Programs   back to top
American Cancer Society (local offices)
(800) ACS-2345
www.cancer.org

American Heart Association (local offices)
(800) 242-8721
www.americanheart.org

American Lung Association (local offices)
(800) LUNG-USA
www.lungusa.org

Centers for Disease Control and Prevention
www.cdc.gov

Life Skills Training
(609) 921-0540
www.lifeskillstraining.com

Oregon Health Division
www.ohd.hr.state.or.us

Project TNT
(800) 321-4407

<u>Surveillance and Evaluation</u>   <u>back to top</u>
Centers for Disease Control and Prevention
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs
(770) 488-5703 (Press 3 to speak to an information specialist)
www.cdc.gov/tobacco/evaluation_manual/contents.htm

<u>General Resources</u>   <u>back to top</u>
American Cancer Society (local offices)
(800) ACS-2345
www.cancer.org

American Heart Association (local offices)
(800) 242-8721
www.americanheart.org

American Lung Association (local offices)
(800) LUNG-USA
www.lungusa.org

Association of State and Territorial Health Officials
www.astho.org

California Tobacco Control Section
www.dhs.ca.gov/ps/cdic/ccb/TCS/index.htm

The Campaign for Tobacco Free Kids
www.tobaccofreekids.org

Centers for Disease Control and Prevention
- Office on Smoking and Health
  (770) 488-5705 or
  (800) CDC-1311
  www.cdc.gov/tobacco
  E-mail: tobaccoinfo@cdc.gov
- National Youth Tobacco Survey
  www.cdc.gov/tobacco/research_data/survey/mmwr4903fs.htm
- *Best Practices for Comprehensive Tobacco Control Programs*, August 1999
  www.cdc.gov/tobacco/bestprac.htm

Environmental Protection Agency
Indoor Environments Division
www.epa.gov/iaq

Florida Tobacco Control Clearinghouse
www.ftcc.fsu.edu

Florida Online Tobacco Education
www9.myflorida.com/tobacco/index.html

Massachusetts Tobacco Control Program
www.state.ma.us/dph/mtcp/home.htm

Massachusetts Tobacco Education Clearinghouse
(617) 482-9485
E-mail: mtec@jsi.com

National Association of County and City Health Officials
www.naccho.org

National Association of Local Boards of Health
www.nalboh.org

Oregon Health Division
www.ohd.hr.state.or.us

SmokeLess States Program
www.smokelessstates.org/

The Guide to Community Preventive Services: Tobacco Use Prevention and Control
The Task Force on Community Preventive Services
www.thecommunityguide.org

Tobacco Bulletin Board System
www.tobacco.org

Tobacco Education Clearinghouse of California
(800) 258-9090

TRAINING RESOURCES

Sample Training Objectives

By the end of the training, participants will be able to:

1. Identify the seven components of a local comprehensive tobacco prevention and control program;

2. Identify specific areas for improving local tobacco control activities in their communities;

3. Divide roles and responsibilities among stakeholders to ensure an equitable and efficient partnership among community organizations concerned with comprehensive tobacco prevention and control;

4. Recognize and access additional programmatic and financial resources that will be useful for implementing a local comprehensive tobacco prevention and control program;

5. Develop three action steps as part of a plan to address identified needs, community partners, and service areas.

Sample Tobacco Prevention and Control Training Agendas

Sample Two-Day Training Agenda:

<u>Day 1</u>

8:00-8:30	Registration and Continental Breakfast
	• Collect required participant information
8:30-9:00	Introductions and Welcome
	• Who is here, why we are here, and what we will accomplish
	• Role of Local Public Health and Partners in Tobacco Prevention and Control
9:00-9:45	"Community Assessment Snapshot" Activity
9:45-10:00	*Break*
10:00-11:00	Building Effective Community Partnerships/Coalitions
11:00-12:00	Introduction to Comprehensive Tobacco Prevention and Control
	• Community Programs
	• School Programs
12:00-1:00	*Lunch*
1:00-3:00	Comprehensive Tobacco Prevention and Control (continued)
	• Counter-Marketing
	• Cessation
	• Enforcement
	• Administration and Management
	• Surveillance and Evaluation
3:00-3:15	*Break*
3:15-4:00	Working with State Elected and Appointed Officials (Optional)
4:00-4:45	MSA Allocations (Optional)
4:45-5:00	Housekeeping Comments

<u>Day 2</u>

8:00-8:30	Continental Breakfast
8:30-8:40	Housekeeping Comments
8:40-9:30	Ordinance Development (Optional)
9:30-10:00	Tobacco Proponent Strategies (Optional)
10:00-10:15	*Break*
10:15-11:00	Alliances between Tobacco Growers and Public Health Advocates (Optional)
11:00-11:45	Working With the Media (Optional)
11:45-12:45	*Lunch*
12:45-1:30	Developing a Media and Outreach Campaign (Optional)
1:30-2:15	Funding and Program Resources
2:15-3:45	Putting it all Together – Participant Action Steps
3:45-4:00	Wrap up and Evaluations
4:00	Adjourn

Sample One-Day Training Agenda:

8:00-8:30	Registration and Continental Breakfast
	• Collect required participant information
8:30-9:00	Introductions and Welcome
	• Who is here, why we are here, and what we will accomplish
	• Role of Local Public Health in Tobacco Prevention and Control
9:00-9:30	"Community Assessment Snapshot" Activity
9:30-10:15	Building Effective Community Partnerships/Coalitions
10:15-10:30	*Break*
	Introduction to Comprehensive Local Tobacco Prevention and Control
10:30-11:00	• Community Programs
11:00-11:30	• School Programs
11:30-12:00	• Counter-Marketing

12:00-12:45	*Lunch*
	Introduction to Comprehensive Local Tobacco Prevention and Control (cont.)
12:45-1:15	● Cessation
1:15-1:45	● Enforcement
1:45-2:15	● Administration and Management
2:15-2:45	● Surveillance and Evaluation
2:45-3:00	*Break*
3:00-3:45	Putting it all Together – Participant Action Steps
3:45-4:00	Wrap up and Evaluations
4:00	Adjourn

Learning Center Tip Sheet: Delivering a Presentation

When adults are surveyed about their worst fears, "speaking before a group" often tops the list. Surprisingly, this response elicits more fear than other, more destructive, or "final" situations. Some people even say they fear public speaking more than death! Many of us perceive the occasion to publicly present our views publicly as dreaded burdens, rather than an opportunity to share and communicate our thoughts with other people.

The skill of the presenter at delivering information can determine how much you enhance the level of learning while you plan and deliver your presentation.

These basic guidelines will help you convey your message more effectively with less anxiety:

- Prepare, prepare, prepare! This can't be stressed enough, especially for the opening and closing of your presentation.
- Practice exactly what you are going to say. If possible, video or audiotape your presentation to see and hear yourself before getting in front of the audience.
- Know your subject as well as you possibly can without feeling you must know all the answers. Don't be afraid to admit you don't know something.
- Notes help you remember what you are going to say and can organize your presentation. The type of notes you use depends on your personal style and what you are comfortable using.
- Focus your presentation to only the most important points. Many presenters try to cover too much material and the important points are lost.
- Draw upon the participants in a group to provide the answers to some questions. Simply repeat a question and ask the group what the answer(s) might be.
- Remember, "silence is golden." Don't be afraid to pause it helps your audience think about what you have said and lets you gather your thoughts for your next point.
- Learn as much about your audience as possible. For example, what do they already know about the subject, what specifically do they need you to cover, etc.
- Wear clothing that is comfortable.
- Use hand gestures that come naturally and feel comfortable to you.
- Use the extra energy caused by the "butterflies in your stomach" by walking around before you are "on stage." Taking deep breaths will also help.
- Become familiar with the site of your presentation. Arrive early, look the place over, and if possible, set up before your participants arrive.
- Practice using audiovisuals in advance. To avoid fumbling with the equipment, have your audiovisuals ready to use before starting your presentation (e.g., have your videotape set to the start of the segment you want to show; have your overhead transparency lined up and focused; etc.).
- Think of the presentation as an opportunity to share and communicate your views with other people.
- Set the temperature cooler rather than warmer; however, avoid the "meat locker" effect. The lower end of the comfort zone (72°F - 76°F) is recommended.
- Select a seating arrangement conducive to learning. Remember, the more active individuals are during a learning opportunity, the more they will learn. An arrangement that allows for maximum visual contact among participants tends to encourage participation; circles and "U"s are suggested.

- Eliminate physical barriers between you and your audience to establish better rapport. Use a desk, podium, or table to help hold needed items such as your notes, but don't "hide" behind them. When possible, move around and into the audience.
- Structure your presentation with an opening, middle, and conclusion. The opening lets your audience know what kind of "journey" they will be taking, the middle leads them along a logical path that provides an explanation of the main points, and the conclusion reinforces what they have learned.
- Personalize your presentation by speaking to the audience in familiar language. Enact the KISS rule: Keep it simple, stupid! And try to share some of yourself by giving personal examples, using the word "you," and exercising your sense of humor. An additional rule: Whenever possible, avoid using jargon.
- Determine how the audience will benefit from the information you provide and be sure to spell out those benefits somewhere in your presentation.
- Provide visual enhancement when appropriate. Sixty percent of the information we process is visual. Be careful to avoid visual "noise" such as too many flip charts and unconnected handouts.
- Organize information in groups of seven points or less to help the audience process information easily.
- Provide the audience with an opportunity to use the information they have learned by planning a hands-on activity (e.g. application exercise, written action plan, discussion, etc.)
- Vary your presentation methods to compensate for the variety of different ways the individuals in your audience learn. Use a combination of audio, visual, and action-oriented techniques as you present your information.
- Vary your tone, volume, and rate when you speak.
- Express your feelings accurately through your voice. Your voice can show excitement, seriousness, hope, fear, joy, etc. as it relates to the topic you are discussing.
- Smile, look surprised, show concern, etc. Your face indicates what you are feeling inside, complements what you are saying, and shows your audience that you are connected to them.
- Use pauses to highlight important points, transition to another topic, think about the answer to a question, etc.
- Establish eye contact with all members of the audience.
- Your dress and mannerisms will make a lasting impression. Remember you are representing your organization.
- Stand or sit upright, but don't be too stiff. Square your shoulders to the audience, place your hands at your side, keep feet shoulder width apart, and balance weight evenly on both feet.
- Use natural hand gestures to complement what you are saying.

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**For more information on how you can support to fight lung disease,
the third leading cause of death in the U.S., please contact The American Lung
Association at 1-800-LUNG-USA (1-800-586-4872) or logon to the website at
www.lungusa.org.**

Facilitator Refresher

Facilitation…
… the art of making human interactions <u>easier</u> by helping an individual or group obtain the maximum benefit from <u>everyone</u> present to achieve the maximum <u>results</u> for solving a problem or completing a task.

Basic Goals
- Develop or refine a structure and/or process that promotes achievement of the work session's desired outcomes
- Make certain that information and data is shared, understood and processed in an open collaborative environment
- Remove any internal blockages hindering the accomplishment of the session's desired outcomes

The Facilitation Model
- Define purpose of group (why this group was formed)
- Set ground rules
- Specify objectives (what needs to be accomplished; outcomes, who/what affected, time line, $$)
- Analyze the situation (factual data, assignments to gather information)
- Identify options (based upon information received, need to fit reality of situation)
- Prepare and implement the action plan (transfer analysis and options into workable action plan; answers 4 questions: What action is required? Who will do it? When will it be done? How much will it cost?)
- Follow up (primary purpose to evaluate what happened when the action plan was implemented)

Effective Facilitators
- Provide structure
- Focus on results
- Manage time and the agenda
- Encourage participation
- Show empathy
- Remain objective
- Avoid manipulating or embarrassing anyone
- Stay committed to the process
- Are prepared

Learning Center Tip Sheet:
PREPARING EFFECTIVE VISUALS

"A picture is worth a thousand words" is a Chinese proverb we all know well. Using "pictures" or visuals during a presentation adds considerably to the information we provide to the resource. Research shows that the ability of a resource to recall information dramatically increases (anywhere from 38 percent to 200 percent) when visuals are used. We also know that visuals can be ineffective when they are not prepared correctly, in fact they can become distracting. We have all heard presenters say, "I know this is difficult to read..." and then proceed to use the visual anyway.

These basic suggestions (focusing on overheads and slides) will help you prepare visuals that will enhance your presentations:

Use Visuals to:
- Provide a springboard for statements.
- Arouse interest.
- Ask and answer questions.
- Encourage participation.
- Provide clarity.
- Add humor.
- Enhance credibility.
- Reinforce ideas.
- Save time.
- Focus attention.

Tips on Developing Visuals
- KISS - Keep It Simple & Short (or whatever variation you use).
- Use one idea per overhead or slide; don't overload the visual.
- Choose words carefully (think in bullets):
    o No more than six lines
    o No more than six words per line
- Be visual (think in pictures), add appropriate illustrations, charts, graphs.
- Use color, but use it sparingly (2-3 colors per overhead or slide).
- Use dark letters on a light background for the text of your message.
- Highlight points of emphasis or headings by using dark letters on a light background or by changing color.
- Write bullet points in upper and lowercase letters, it's easier for the resource to read.
- Avoid vertical lettering, it's very difficult to read.
- Use no more than two typefaces.
- Use a series of bullet points rather than numbers (unless there is a priority order to the points you are making).
- Use a point size large enough to be read from a distance of 6 feet (when it is not being projected), 32-point is ideal.

Tips on Using Visuals While Presenting

- Face and speak toward the audience, not toward the screen.
- Stand to the side of the screen, never in front of it.
- Turn an overhead projector off when you have time gaps between slides. It will decrease the audience's eyestrain.
- Keep the lights on except those aimed at the screen.
- Point with a pen or letter opener directly on the overhead when you want to point something out to the audience, don't use your finger or try to point on the screen unless you have an electronic pointer.

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For more information on how you can support to fight lung disease, the third leading cause of death in the U.S., please contact The American Lung Association at 1-800-LUNG-USA (1-800-586-4872) or logon to the website at www.lungusa.org.

End Note References

1. Independent Evaluation Consortium. Final report of the independent evaluation of the California Tobacco Control Prevention and Education Program: Wave I Data, 1996-1997. Rockville, MD: The Gallup Organization, 1998.

2. Oregon Health Division. School-based tobacco prevention programs reduce student smoking. April 2001. (www.ohd.hr.state.or.us/news/2001/0425tob.htm)

3. Massachusetts Tobacco Control Program. (www.state.ma.us/dph/mtcp/)

4. Patten, CA, Pierce JP, Cavin SW, et al. Progress in protecting nonsmokers from environmental tobacco smoke in California workplaces. *Tob Control* 1995;4:139-44.

5. Abt Associates, Inc. Independent evaluation of the Massachusetts Tobacco Control Program. Third annual report, January 1994-June 1996. Cambridge, MA: Abt Associates, Inc, 1996.

6. Pierce JP, Gilpin EA, Emery SL, et al. Has the California tobacco control program reduced smoking? *JAMA* 1998;280(10):893-9.

7. Abt Associates, Inc. Independent evaluation of the Massachusetts Tobacco Control Program. Fourth annual report, January 1994-June 1997. Cambridge, MA: Abt Associates, Inc, 1997.

8. Centers for Disease Control and Prevention. Decline in cigarette consumption following implementation of a comprehensive tobacco prevention and education program – Oregon, 1996-1998. *MMWR* 1999;48:140-3.

9. Oregon Tobacco Prevention and Education Program. Report to the Governor and Legislature. Portland, OR: Oregon Health Division, 1999.

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11. Fisher EB, Auslander WF, Munro JF, et al. Neighbors for a smokefree north side: evaluation of a community organization approach to promoting smoking cessation among African Americans. *Am J Public Health* 1998;88(11):1658-63.

12. Centers for Disease Control and Prevention. Preventing tobacco use among young people: a report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, 1994:209-92.

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