U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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National Cancer Institute

MONOGRAPH SIXTEEN

16

ASSIST

Shaping the Future of Tobacco Prevention and Control

NCI TOBACCO CONTROL MONOGRAPH SERIES

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NCI TOBACCO CONTROL MONOGRAPH SERIES

Other NCI Tobacco Control Monographs

Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's. Smoking and Tobacco Control Monograph No. 1. NIH Pub. No. 92-3316, December 1991.

Smokeless Tobacco or Health: An International Perspective. Smoking and Tobacco Control Monograph No. 2. NIH Pub. No. 92-3461, September 1992.

Major Local Tobacco Control Ordinances in the United States. Smoking and Tobacco Control Monograph No. 3. NIH Pub. No. 93-3532, May 1993.

Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. Smoking and Tobacco Control Monograph No. 4. NIH Pub. No. 93-3605, August 1993.

Tobacco and the Clinician: Interventions for Medical and Dental Practice. Smoking and Tobacco Control Monograph No. 5. NIH Pub. No. 94-3693, January 1994.

Community-based Interventions for Smokers: The COMMIT Field Experience. Smoking and Tobacco Control Monograph No. 6. NIH Pub. No. 95-4028, August 1995.

The FTC Cigarette Test Method for Determining Tar, Nicotine, and Carbon Monoxide Yields of U.S. Cigarettes. Report of the NCI Expert Committee. Smoking and Tobacco Control Monograph No. 7. NIH Pub. No. 96-4028, August 1996.

Changes in Cigarette Related Disease Risks and Their Implications for Prevention and Control. Smoking and Tobacco Control Monograph No. 8. NIH Pub. No. 97-4213, February 1997.

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Those Who Continue to Smoke. Smoking and Tobacco Control Monograph No. 15. NIH Pub. No. 03-5370, September 2003.

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Dedication

This monograph is dedicated to the thousands of people across the United States and beyond who participated in the ASSIST project in one way or another. ASSIST was a unique, groundbreaking effort in tobacco prevention and control that changed the landscape of the field over the decade of the 1990s. This project could not have been successfully completed without the commitment and tireless efforts of the many people who were part of ASSIST—this book is dedicated to all of you! Numerous practitioners, advocates, and scientists were oriented or trained in the discipline of tobacco prevention and control during the ASSIST years. Many of them have gone on to become or have continued as leaders in tobacco prevention and control and public health across the United States and in several other countries as well.

Virtually every major public health organization in the United States that is a significant player in the tobacco control movement includes people who spent important formative years of their careers contributing to the success and innovations of ASSIST. These people are far too numerous to mention by name, but you know who you are! The Senior Scientific Editors are extraordinarily grateful for your efforts and your resolve. Of these, three important leaders completed their long, dedicated careers of public service in the federal government pursuing the tobacco-use-reduction goals of ASSIST and deserve special recognition for their critical contributions to the project and the field: Mary P. “Mimi” Henry, William R. Lynn, and Donald R. Shopland. Together, they provided more than 101 years of dedicated public service. The tobacco control community and the Senior Scientific Editors are indeed eternally indebted to them.

A Note from the Series Editor

With this volume, the National Cancer Institute (NCI) presents the 16th monograph of the Tobacco Control Monograph series and a new design to facilitate readability.

NCI remains strongly committed to furthering the science of tobacco prevention and control through the timely discussion of evidence-based research, emerging issues, and program and policy applications. By producing and disseminating the Tobacco Control Monographs, NCI seeks to increase the impact of tobacco control research and enhance the translation of research to practice and policy.

Preventing, reducing, and treating tobacco use and tobacco-related cancers across all ages and populations are critical to and in keeping with NCI's goal to reduce the suffering and death due to cancer.

Several other monographs are in production at this time on a wide range of topics. Further details about the new series will be presented in future volumes.

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May 2005

Foreword

I have long been committed to eliminating tobacco use in all its forms throughout the United States and around the world. I have been widely quoted, including in this monograph, as working tirelessly toward a smoke-free society by the year 2000 because I firmly believed that this was then and is now our most important public health goal. I regret that we have not fully achieved this lofty goal. However, I believe that by setting such ambitious goals and working diligently toward their achievement, we have made tremendous strides toward reducing the incredible addiction, disease, disability, and death caused by tobacco use.

The American Stop Smoking Intervention Study for Cancer Prevention, widely known as ASSIST, was conceived while I was Surgeon General and was implemented during the 1990s, a decade of significant progress throughout the entire field of tobacco prevention and control. ASSIST contributed to many of these advances in important ways, including (1) demonstrating a strong emphasis on comprehensive policy change, (2) using a strategic approach to media interventions, (3) creatively using media advocacy to achieve policy goals, and (4) defining a new standard for training and technical assistance to ensure that public health practitioners have the skills and resources needed to attain successfully their ambitious objectives. In addition, ASSIST staff and volunteers learned a great deal about the vast resources of the tobacco industry and its fierce determination to use those resources to thwart any public health efforts that might encroach on their huge profits. This monograph provides new insights regarding tobacco industry strategies to interfere with ASSIST and its public health objectives.

From my vantage point at the national level, I have seen the important role that ASSIST leaders and coalitions played in advancing smoking cessation efforts and tobacco containment. They were in the vanguard of these efforts and helped to fashion the next phase of comprehensive tobacco control interventions. I know that many of the readers of this monograph will have their own views about the lessons from ASSIST but as I have traveled the country, I have heard many of their stories and insights about the impact of this program on broader tobacco prevention and control efforts. In my estimation, several key points stand out as legacies of ASSIST: (1) the field of tobacco control continues to be staffed by many experts who learned about tobacco control issues and skills during ASSIST and who played key roles in implementing the conceptual model of ASSIST, (2) the strong emphasis on policy and media strategies to shift the focus from the individual to population-based interventions has had a long-lasting impact on behavioral health, and (3) designing interventions around a reliable evidence base is critical for building effective programs. I would add—since the ASSIST evaluation pointed out that states with more tobacco control activity had lower per capita cigarette consumption—(4) the lessons of ASSIST are broadly applicable to many public health disciplines and can be used immediately by others attempting to design and implement community-based health interventions.

Unfortunately, we have not yet fully achieved a smoke-free society. Even today, tobacco use remains the leading preventable cause of death in the United States, responsible for the deaths of over 440,000 people annually. But I see this smoke-free society as a clear goal that can be, indeed must be, reached in the foreseeable future. Working together, we have created an active, viable, committed tobacco control movement in the United States that has dramatically reformed our social norms about the acceptability of smoking and tobacco use. Smoking in public is no longer accepted, and the health risks of exposure to environmental tobacco smoke, also widely referred to as secondhand smoke, are known throughout the land. In fact, seven states have prohibited smoking in all workplaces, including restaurants and bars, and four more require all restaurants to be smoke-free. As state legislatures convene, many are considering similar legislation to protect the health and well-being of their citizens. These policies are important for many reasons, including, of course, protecting the health of employees and patrons of these establishments, but also because comprehensive workplace smoking policies do much to encourage quitting among smokers. Furthermore, between 1998 and 2003, 35 states and the District of Columbia raised their excise taxes on tobacco products, a policy device known to all of us as one of the best tools for reducing cigarette consumption.

Now, as better resources and support are available for smokers attempting to quit, we hope to increase their success rates. The National Network of Tobacco Cessation Quitlines is just one new resource available to provide services to smokers who are trying to stop by building on existing state efforts and the expertise of federal health agencies. Many employers are increasingly aware of the costs of their employees' smoking habits and are using a broad range of strategies to address this problem—from shifting costs of higher health insurance premiums to individual employees, to providing additional coverage for cessation medications and counseling, to prohibiting all smoking in company facilities and throughout the surrounding grounds.

One such example is a recent effort by the U.S. Department of Health and Human Services, called Tobacco-Free HHS, to eliminate the use of any tobacco products on all its properties, including buildings and grounds, and provide smoking cessation services to employees who smoke. The goal is to improve employee health by reducing smoking rates among all its employees and to provide a model policy for other employers. We must remember the importance of both supporting individual tobacco users who are trying to stop and providing supportive policies and an environment that encourages positive behavior change. It is critical to remain vigilant in our efforts not to blame the victim, but rather to provide support and evidence-based policies that help move individual behavior change in the right direction. We must never forget that the real source of the problem is an industry that has lied about and misrepresented the addictiveness and health hazards of their products for decades, with the intent of recruiting additional users.

These successes—lower smoking prevalence rates, higher tobacco prices, clean indoor air that is free from secondhand smoke, reduced youth access to tobacco, and reduced exposure to tobacco advertising and promotion—were developed by a large group of individuals, organizations, and programs working collectively to reduce the addiction, disease, disability, and death caused by tobacco use. The public health professionals of ASSIST made key contributions that are described, with numerous case studies and vivid examples, throughout this monograph.

The lessons of ASSIST are essential to the tobacco prevention and control movement and, perhaps even more important, to the entire field of public health. The concepts of building on a strong evidence base; designing interventions that will have broad population impacts; changing social norms in pursuit of greater justice; developing strong partnerships based on common goals and mutual respect; maintaining a determination not to be swayed or pushed off target by one's adversaries; and ensuring a serious commitment to evaluation, self-reflection, and adaptation of strategies in midcourse are not unique to ASSIST. However, ASSIST brought these concepts to life and offered clear examples of how they can be used for advancing tobacco control and public health objectives.

I am sure the reader will find this volume on ASSIST to be a helpful resource as public health practitioners and researchers work toward eradicating tobacco use in our society and designing other effective community-based interventions to improve the public's health. I am grateful to those who made ASSIST the template for public health endeavors that it was.

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Preface

Just as the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) was a major shift in the National Cancer Institute's (NCI's) tobacco prevention and control research and dissemination efforts, this monograph is a significant departure from NCI's previous tobacco control monographs. For many, the ASSIST project represented a logical progression of NCI's phased-research approach to reducing tobacco use. For others, it represented a controversial and overly ambitious leap in a new direction. Similarly, this monograph departs from the traditional quantitative evidence review format to emphasize instead the practical, hands-on experience of program implementation. Traditional research investigators who defend the sanctity of the randomized clinical trial, many of whom were uncomfortable with ASSIST at its outset, will also be uncomfortable with the personal and anecdotal flavor of this monograph. Public health practitioners, on the other hand, as well as those investigators who have immersed themselves in the untidy world of implementation research, will appreciate the detailed historical accounts of the complexities, politics, and outright opposition encountered by the ASSIST team. The collective experiences described in this monograph provide a rich understanding of the gritty struggle against the powerful forces of the tobacco industry and its allies. For students in public health training programs, this work also provides a unique view of the world outside of academia, where commercial, political, and public health interests collide in a struggle to define the policies, norms, and practices that will affect the health of generations.

Moving forward into a new millennium brings a renewed sense of commitment to tobacco prevention and control. Results from the Lung Health Study (LHS), a randomized smoking cessation clinical trial sponsored by the National Heart, Lung, and Blood Institute, strengthen the evidence that smoking is causally responsible for the increased risk for death in smokers.[1] In an editorial about the study, Dr. Jonathan Samet states, "No one can make a serious claim to the contrary in light of this randomized trial evidence."[2(p300)] Released in February 2005, the findings show that lung cancer deaths decreased by more than 50% within 15 years of complete smoking cessation. Lead author Dr. Nicholas Anthonisen relates that lung cancer risk is probably still elevated after 15 years and that the biggest survival benefit accrued to participants 45 years of age and younger; therefore, "it could be argued … that smoking cessation was most effective in preventing truly premature death."[1(p238)]

These findings also contain a key public health message—the importance of preventing tobacco use in the first place. Fewer than one-quarter of LHS's participants were able to stop smoking. The addictive nature of nicotine has been well documented, including in a comprehensive report on this subject in 1988, *The Health Consequences of Smoking: Nicotine Addiction: A Report of the Surgeon General*.[3] ASSIST used an ecological approach not only to help smokers who wanted to quit but also to prevent tobacco use primarily among children, teens, and young adults. A statistically signifi-

cant decrease in smoking prevalence in ASSIST states was found compared with that in non-ASSIST states, and per capita decreases in consumption were associated with policy outcomes. It has been estimated that if the ASSIST project had been implemented nationwide, there would be at least 1,213,000 fewer smokers, with a corresponding decrease in premature death and disease. The evaluation and quantitative results of ASSIST are discussed in detail in a separate publication, Monograph 17 (*Evaluating ASSIST: The Blueprint for Understanding State-Level Tobacco Control*), and are briefly described at the beginning of this volume.

The history of ASSIST began long before 1991, and its impact has continued since its end in 1999. ASSIST was based on research, conducted over the years at NCI and by other researchers, about which interventions were most likely to produce behavior change. Like other studies of this scope conducted in a government setting, ASSIST underwent a thorough concept review process. When conceived, it was called the American Stop Smoking Intervention Study for Cancer Prevention, which over time was informally shortened to the American Stop Smoking Intervention Study, and finally became know by its acronym. As tobacco use is a risk factor for many diseases, deleting "for cancer prevention" from the ASSIST name broadened the focus of the project and helped to expand the partnership to include other agencies and organizations such as the American Heart Association and the American Lung Association.

ASSIST was launched through a collaborative public/private partnership between NCI and the American Cancer Society (ACS) that funded 17 state health departments. While continuing to recognize the importance of helping people to stop smoking, the ASSIST project focused on four policy changes that in turn would support a tobacco-free norm: (1) eliminating exposure to environmental tobacco smoke, (2) promoting higher taxes for tobacco, (3) limiting tobacco advertising and promotions, and (4) reducing minors' access to tobacco products.

ASSIST was the first comprehensive tobacco prevention and control program of its scope. It was originally conceived as a 7-year demonstration project, but leadership within the U.S. Department of Health and Human Services (DHHS) believed that it was important to maintain a commitment to national tobacco control activities and transitioned the administration of state-based programs to one governmental agency. An additional year was required to ensure a seamless transition that merged ASSIST into the newly established National Tobacco Control Program at the Centers for Disease Control and Prevention (CDC).

This monograph is a product of authors and editors who were involved in the project—who had lived and experienced ASSIST for many years. With the exception of part 1 in chapter 8, "Tobacco Industry Challenge to ASSIST," the monograph provides a qualitative and subjective view of the 8-year ASSIST project. The writers are dedicated to tobacco prevention and control and remain passionate about ASSIST. Numerous case studies are presented, not in the form of formal social research, but as stories and vignettes from state and local public health staff and volunteers that describe

their efforts—processes used, barriers encountered, lessons learned, and insights gleaned from these experiences. These case studies provide a flavor of the scope of ASSIST and give voice to the different perspectives of those involved.

The scientific editors envision Monograph 16 being used by a variety of audiences, but the primary audiences are public health practitioners and their community partners. In keeping with NCI's increased focus on the dissemination of research methods and tools, this monograph provides in-depth descriptions of intervention processes, examples of materials and best practices, and resource lists and guidance for activities such as media advocacy campaigns. Also included in appendix 5.A is a bibliography of ASSIST articles of interest and use to readers.

As we release Monograph 16, it should be noted that the world's first tobacco control treaty, the Framework Convention on Tobacco Control, which was negotiated by the World Health Organization, went into effect earlier this year. In addition to requiring ratifying nations to place graphic health warnings on cigarette packs, the treaty calls for actions that were key elements of ASSIST—imposing a ban on tobacco advertising, taking measures to protect nonsmokers from secondhand smoke, and increasing the cost of tobacco products. Although this monograph focuses on the experience in the United States, international readers may find it useful for garnering insight into effective processes for working with communities, the media, governing bodies, and the challenges presented by the tobacco industry. However, it is important to recognize differences in political and economic contexts that may influence efforts to implement policy-level interventions.

Monograph 16 begins with the historical context of ASSIST and the scientific base that informed the design of the project. The conceptual framework and the development of organizational infrastructures for implementation and evaluation are then described. The heart of this monograph is the in-depth descriptions of ASSIST's media advocacy and policy development interventions and the challenges posed by the tobacco industry. The monograph concludes by describing ASSIST's contributions to tobacco control and other behavioral health interventions and the significant challenges that remain.

Chapter 1: The Historical Context. Chapter 1 describes the activities and research foundation at NCI, ACS, and throughout the United States that led to the development of the ASSIST project and presents the evidence-based rationale for its conceptual model.

Chapter 2: The Conceptual Framework. Chapter 2 chronicles the development of the conceptual framework used for planning and implementing each state's ASSIST program.

Chapter 3: Structure and Communications. Chapter 3 describes the national partners and state agencies in their respective roles and the communication linkages among all the structural units that promoted collaborative decision making and were essential for the project to function as a whole.

Chapter 4: Building National, State, and Local Capacity and Capability. This chapter describes the training of project staff and coalition members (1) to plan interventions that were responsive to each community's needs and that were realistic in terms of the program's readiness and resources and (2) to implement tobacco control policy and media advocacy interventions.

Chapter 5: Media Interventions to Promote Tobacco Control Policies. Chapter 5 relates ASSIST's approach to using a variety of media interventions to promote public health policies and illustrates how media advocacy was used to promote policies for a tobacco-free environment.

Chapter 6: Public and Private Policy Interventions. Chapter 6 presents the ASSIST states' intervention strategies to achieve policies that advance objectives in four tobacco control areas: eliminating exposure to environmental tobacco smoke, increasing the price of tobacco products, restricting tobacco advertising and promotions, and reducing youth access to tobacco products. Case studies of interventions and insights of staff and coalition members illustrate the process of mobilizing ordinary citizens to effect major policy change, despite opposition from the tobacco industry.

Chapter 7: Program Services: Reaching the Individual. Chapter 7 describes the ASSIST approach to the delivery of program services. Rather than directly providing program services, ASSIST contractors encouraged, advised, and partnered with appropriate community organizations to ensure that such services were provided.

Chapter 8: Tobacco Industry Challenge to ASSIST. The two parts of chapter 8 present the tobacco industry's challenges to ASSIST. Part 1 affords insights gleaned from previously confidential industry documents that became available as a result of the Minnesota settlement and the Master Settlement Agreement. Part 2 describes the tobacco industry challenges from the point of view of ASSIST personnel who experienced those challenges firsthand and sought ways to respond.

Chapter 9: Planning Strategically for the Future. Chapter 9 chronicles the strategic planning approaches used from 1994 through 1998 at the local, state, and national levels to ensure that tobacco prevention and control programs would be incorporated into state and national infrastructures and would have sufficient funding to sustain the programs.

Chapter 10: From Demonstration Project to Nationwide Program. Chapter 10 describes NCI's and CDC's processes and challenges in disseminating research and demonstration project results to public health practice as ASSIST came to an end.

Chapter 11: The Promise of ASSIST. Chapter 11 relates how the effective application of the ASSIST core elements contributed to a fundamental shift in the approach to tobacco use prevention and control and other behavioral health interventions.

ASSIST represents the continuation of an ongoing evolution in public health, from its roots in controlling diseases to a more activist role in addressing underlying social

determinants of health. As a demonstration project, the most effective interventions were incorporated into ASSIST's community-based study design and successfully implemented in 17 states. The insights and lessons learned from ASSIST that are described in this monograph have (1) advanced our understanding of translating and disseminating research studies and demonstration project results; (2) increased our appreciation of the dose-response relationship between funding levels and effective tobacco prevention and control programs; (3) broken new ground in evaluation methodology for complex public health interventions that are diffused throughout a population; and (4) informed NCI's research agenda to encourage partnerships among scientists, state tobacco control programs, and tobacco control advocates.

Maintaining the capacity built by demonstration projects has been one of our greatest challenges in dissemination. As described in chapter 10, in 1999 NCI achieved one of its major ASSIST-related goals: by the year 2000 to advance from phase V—demonstration and implementation—to phase VI—mass application for the benefit of public health. The processes used to maintain ASSIST's capacity during the transition from NCI to CDC underscore the importance of one of ASSIST's strongest elements for implementing effective community-based, policy-focused public health programs: participatory decision making and inclusion of all partners.

I believe that the experiences and insights described in this monograph provide valuable and practical guidance for public health workers and tobacco prevention and control advocates and provide a rich source of new hypotheses to guide future research.

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The Evaluation of the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST)

The ASSIST evaluation had to address daunting challenges—the project was complex, it was a natural experiment with no clear control sites, and the resources for the evaluation were limited. By necessity, it focused only on those components of the project that could be quantified as part of the evaluation conceptual framework—not all components of the ASSIST project could be evaluated. This monograph, *ASSIST: Shaping the Future of Tobacco Prevention and Control*, and the next in this series, Monograph 17, *Evaluating ASSIST: A Blueprint for Understanding State-Level Tobacco Control*, are designed as companion documents. Whereas Monograph 16 focuses on the conceptualization of the ASSIST project, the processes and interventions used to implement ASSIST, and the transition of ASSIST from a demonstration project to the National Tobacco Control Program, Monograph 17 addresses the evaluation framework, the details of the ASSIST evaluation, and the results of this effort. Following is a brief overview of this upcoming NCI publication.

Monograph 17. *Evaluating ASSIST: A Blueprint for Understanding State-Level Tobacco Control*

The ASSIST evaluation broke new ground in the assessment of public health interventions that are diffused throughout a population and outside the bounds of a randomized controlled clinical trial through the use of a validated metric known as the Strength of Tobacco Control (SoTC) index and a policy outcomes measure, the Initial Outcomes Index (IOI). These measures correlated with eventual public health outcomes, such as changes in smoking prevalence and consumption, and the individual constructs of SoTC—namely, resources, capacity, and efforts—and relate directly to measurable indicators at the state level.

This evaluation demonstrates that the ASSIST project clearly benefited public health. It also documents a successful approach to assessing complex public health programs and can serve as a guide for current and future tobacco control efforts. The evaluation methodologies and indices may also be applied to other complex community-based interventions beyond the field of public health.

Below are the major topics addressed in Monograph 17:

- The ASSIST evaluation framework and key constructs
- The development of the SoTC index, its descriptive characteristics, and examples of how it can be used to assess and improve state tobacco control programs
- Difficulties associated with attempts to measure tobacco industry countereffortts, along with potential solutions

- Documentation of the ASSIST media interventions, including methods used to identify, code, and analyze newspaper coverage of the four priority policy areas
- Methods used to track and measure changes in state and local clean indoor air laws
- A measure created to reflect a state's dependence on tobacco, which may affect implementation of comprehensive tobacco control programs
- Demographic, economic, sociopolitical, and geographic factors that might affect the evaluation of a tobacco control program
- The development of the IOI, which assessed the policy outcomes of states' tobacco control efforts
- The methodology and outcomes of the ASSIST evaluation
- Econometric techniques used to assess the cost-effectiveness of the ASSIST project
- The generalizability of the ASSIST evaluation efforts to other public health initiatives

The evaluation found that ASSIST states showed a statistically significant decrease in smoking prevalence compared with non-ASSIST states and that per capita decreases in consumption were associated with policy outcomes. The evaluators estimated that if the ASSIST program had been implemented nationwide, there would be at least 1,213,000 fewer smokers, with a corresponding decrease in premature death and disease.

Beyond its desired outcomes in tobacco use and public health, the lessons learned from the ASSIST evaluation have important implications for the future of public health. It broke new ground in the assessment of evidence-based public health practices, particularly in situations where randomized controlled trials are not possible. Because of its size and scope, the ASSIST evaluation represents a trend away from simple cause-and-effect relationships toward understanding the behavior of systems. It serves as a precursor to growing systems and network approaches that are helping us to understand more complex and interdependent behavior in real-world public health interventions.

Acronyms List

ACLF	American Constitutional Law Foundation
ACS	American Cancer Society
AFL-CIO	American Federation of Labor-Congress of Industrial Organizations
AHA	American Heart Association
ALA	American Lung Association
ALE	Division of Alcohol Law Enforcement (North Carolina)
AMA	American Medical Association
ANR	Americans for Nonsmokers' Rights
ASSIST	American Stop Smoking Intervention Study for Cancer Prevention
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CEC	Colorado Executive Committee
COMMIT	Community Intervention Trial for Smoking Cessation
CPS	Current Population Survey
CTFC	Coalition for a Tobacco-Free Colorado
CTFK	Campaign for Tobacco-Free Kids
CVD	cardiovascular disease
DCPC	Division of Cancer Prevention and Control
DDA	Downtown Development Authority (Grand Rapids, MI)
DHHS	Department of Health and Human Services
DHS	Department of Human Services (Maine)
DOC	Doctors Ought to Care
DOH	Department of Health
ECS	electronic communications system
EPA	Environmental Protection Agency
ETS	environmental tobacco smoke
FAR	Federal Acquisition Regulations
FASA	Federal Acquisition Streamlining Act
FASS/T	Females Against Secondhand Smoke and Tobacco
FCC	Federal Communications Commission
FDA	Food and Drug Administration
FOIA	Freedom of Information Act
FSHC	Fair Share for Health Committee
FTC	Federal Trade Commission
GASO	Great American Smokeout
HCFA	Health Care Financing Administration
IMPACT	Initiatives to Mobilize for the Prevention and Control of Tobacco Use
INFACT	Infant Formula Action Coalition
IOI	Initial Outcomes Index

IOM	Institute of Medicine
IQ Health	Institute for Quality Health (University of Virginia)
IRC	Internal Revenue Code
JOFOC	Justification of Other Than Full and Open Competition
MASCOT	Multicultural Advocates for Social Change on Tobacco (New Mexico)
MDH	Minnesota Department of Health
MMWR	*Morbidity and Mortality Weekly Report*
MSA	Master Settlement Agreement
MSEC	Mountain States Employers Council
MTCP	Massachusetts Tobacco Control Program
NAAAPI	National Association of African Americans for Positive Imagery
NAACP	National Association for the Advancement of Colored People
NACCHO	National Association of County and City Health Officials
NALBOH	National Association of Local Boards of Health
NCAB	National Cancer Advisory Board
NCI	National Cancer Institute
NCTFK	National Center for Tobacco-Free Kids
NHLBI	National Heart, Lung, and Blood Institute
NIAID	National Institute of Allergy and Infectious Diseases
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NTCP	National Tobacco Control Program
OSH	Office on Smoking and Health
OSHA	Occupational Safety and Health Administration
PM	Philip Morris Inc.
PSA	public service announcement
RJR	R.J. Reynolds Tobacco Company
RWJF	The Robert Wood Johnson Foundation
SAMHSA	Substance Abuse and Mental Health Services Administration
SCARCNet	Smoking Control Advocacy Resource Center Network
SoTC	Strength of Tobacco Control
STAT	Stop Teenage Addiction to Tobacco
STCP	Smoking, Tobacco, and Cancer Program
STN	site trainers network
TAT	training and technical assistance
TRISCI	Tobacco Research Initiative for State and Community Interventions
TRU	Teenage Research Unlimited
TTAC	Tobacco Technical Assistance Consortium
UMF	University of Maine at Farmington
VDH-TUCP	Virginia Department of Health Tobacco Use Control Program

Acknowledgments

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1. The Historical Context

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1. The Historical Context

The American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) dramatically changed the face of tobacco prevention and control efforts in the United States and perhaps around the world. As a public health intervention, ASSIST represents a major shift from primary focus on the individual to include a major focus on the community and the social environment that affect health behavior. This chapter describes activities at the National Cancer Institute (NCI), at the American Cancer Society (ACS), and throughout the United States leading to the development of the ASSIST project and presents the evidence-based rationale for its conceptual model.*

"Create a smoke-free society in the United States by the year 2000"—that was the challenge made to Americans in 1984 by U.S. Surgeon General C. Everett Koop.[1] Since then, a smoke-free society has been a major goal of the tobacco prevention and control movement and the public health establishment. Through the efforts of state and local governments, local health organizations, and many individuals, the United States has advanced steadily, although perhaps slowly, toward achieving that goal. The continuing challenge, however, is of immense proportions. In 2002, approximately 22.5% of adults (46 million people) in the United States were smokers.[2]

Needed: A New Approach

The year was 1987. For 5 years, NCI had been supporting an ambitious research program with the goal of reducing cancer mortality by 50% in the United States by the year 2000. Accomplishing that goal would require reducing the prevalence of smoking by adults to 15% or less.

Research on interventions in the 1960s and 1970s had focused on smokers and potential smokers as individuals and had enabled them to alter their behaviors and resist environmental influences that support smoking. Findings from more than 100 intervention studies (trials) revealed that although many individuals were successful in quitting smoking as a result of these early approaches, overall tobacco use in the United States did not decrease substantially. A major conclusion from these studies was that large-scale reductions in smoking prevalence were unlikely to be achieved solely through interventions that were directed primarily at the individual. Research then shifted toward approaches that included changing the social and environmental influences themselves.

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*The official name for ASSIST was the American Stop Smoking Intervention Study for Cancer Prevention. The title was often shortened to the American Stop Smoking Intervention Study, and it is this shortened form that is used in this monograph.

At the same time, two important reports documented the health hazards of environmental tobacco smoke on nonsmokers: the 1986 National Academy of Sciences report, *Environmental Tobacco Smoke*,[3] and the 1986 surgeon general's report, *The Health Consequences of Involuntary Smoking*.[4] The realization was growing that smoking behavior is strongly influenced by one's social and physical environment; therefore, new research strategies for preventing smoking and promoting cessation were needed.

To address this need, in 1987 NCI convened more than 250 smoking control experts at its 50th anniversary meeting, "NCI Smoking, Tobacco, and Cancer Program and Its Goals for the Year 2000."[5] These experts made recommendations about the types of prevention and cessation programs needed to reduce the use of tobacco. They specifically recommended that NCI focus on large-scale efforts that would affect major segments of the population. The involvement of broad-based coalitions representing entire states and large metropolitan areas was envisioned as the centerpiece for an intervention strategy.

Approval first of the Community Intervention Trial for Smoking Cessation (COMMIT), a community intervention research trial, and then later of ASSIST, a demonstration project, marked a turning point in NCI's battle to reduce smoking and tobacco-related cancers. It was a bold, strategic decision that moved NCI forward from the scientific testing of hypotheses to the translation of accumulated scientific knowledge into effective, multilevel actions that would address the nation's largest public health epidemic.

ASSIST Logo

The Context for Creating ASSIST

The idea of a coalition-based community intervention was not new to NCI in 1987. In the early 1980s, NCI program staff had discussed the concept and COMMIT, a project at that time involving community organizations, had provided important insights about this kind of approach to addressing public health issues. The same science base informed the community-involvement design of both COMMIT and ASSIST. (See page 10.) Leaders at NCI and their external advisors had been conscientious about establishing a science-based rationale before approving and funding a multilevel intervention involving national, state, and community governments and organizations. As the historical context below indicates, three elements essential to support and implement a coalition-based community intervention were brought together: a favorable program structure at NCI, a supportive science base, and a collaborating national voluntary organization.

The National Cancer Institute Is Ready

The first major studies linking cigarette smoking with lung cancer were published in 1950, a little more than a

decade after the founding of NCI in 1937. Reports on studies by Wynder and Graham[6] and Levin and co-workers[7] appeared in the *Journal of the American Medical Association.* The results of two other studies also were published.[8,9] All four studies observed that lung cancer rates were higher for men who were smokers than for men who were nonsmokers. These studies were the foundation of the evidence linking tobacco to cancer. They generated media attention and stimulated efforts to substantiate the far-reaching health consequences of tobacco use.

At that time, although Congress had identified prevention of cancer as one of NCI's three specific functions, the prevailing view of National Institutes of Health (NIH) officials was that the agency's role was to present the facts, not to undertake an organized education campaign to tell citizens to stop smoking. (For a history of the Public Health Service, see M. Parascandola's article.[10]) When pressure mounted from outside the Public Health Service in the early 1960s, the situation began to change, and more substantive action was taken. With passage of the 1971 National Cancer Act, a collaborative system began to mobilize resources in the public and private sectors for prevention. It was not until 1974 that the concept of cancer control included a research approach. In its report from a 1974 conference, the NCI Cancer Control Working Group embraced developmental research as a key program element:

> Cancer control includes developmental research, i.e., the identification of new methods and techniques and their field testing and evaluation in limited community settings, and community demonstration and application activities, i.e., the promotion of community-tested cancer control methods and techniques to ensure their appropriate application and use.[11(p329)]

Creation of the Smoking, Tobacco, and Cancer Program and the Tobacco Prevention and Control Strategy

In 1981, Dr. Peter Greenwald joined NCI to lead the Division of Cancer Prevention and Control (DCPC), and he recruited Dr. Joseph W. Cullen as deputy director of the division. Cullen initiated the Smoking, Tobacco, and Cancer Program (STCP). STCP was the focal point for NCI's disease prevention and health promotion research activities related to tobacco use and cancer. The goal of the program was to decrease the incidence and mortality of cancers caused by or related to smoking and the use of other tobacco products.

The following year, to set national priorities, DCPC launched a participatory process (described later in this chapter). These activities were undertaken with several guiding principles in mind. The first is that the scientific method—close observation, measurement, quantitative analysis, and analytic thought—is as important to cancer control as to basic or clinical research. The second is that the pursuit of excellence in science has priority over other considerations. The third premise, wrote Greenwald and Cullen, is that

> we must build on our strengths, across the spectrum from etiology to treatment. We aim to integrate cancer

Research Precedes Interventions

The basic philosophy guiding the development of ASSIST and the entire cancer control program at NCI was straightforward. Greenwald and Cullen concluded,

> This orderly approach should assure that adequate research precedes widescale intervention efforts. Research and widescale programs must be mutually reinforcing. Only the coordinated planning and implementation of a cancer control research strategy will assure maximum yield from the dollars invested, maximum scientific quality of the activities supported, and maximum probability that the research effort will lead to nationwide public benefits.

Source: Greenwald, P. G., and J. W. Cullen. 1984. The scientific approach to cancer control. *CA-A Cancer Journal for Clinicians* 34 (6): 331–2.

> control as a research effort into the programs of institutions across the country, including cancer centers, universities, community hospitals, state and local governments, and schools of public health.[12(p331)]

They explained cancer control to be

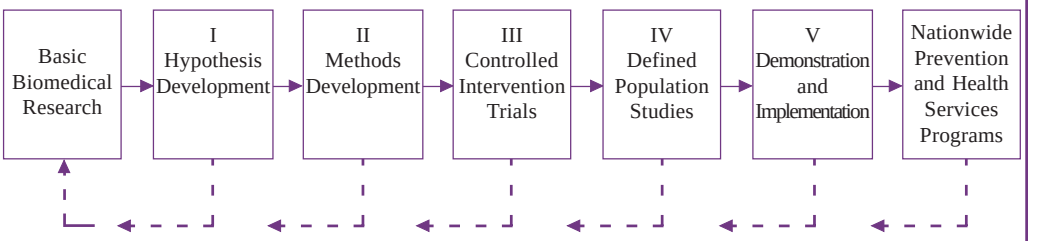
> the reduction of cancer incidence, morbidity, and mortality through an orderly sequence from research on interventions and their impact in defined populations to the broad, systematic application of the research results.
>
> "Interventions" is a key word. For example, an epidemiologic study that examines an etiologic factor, but does not involve interceding for the benefit of a specific patient or the general public, would not be considered cancer control.[12(p329)]

The Five Phases of Cancer Control

This focus on cancer control, with its specific emphasis on interventions, provided the foundation on which the ASSIST project was built. DCPC developed a sound model that covered all the phases of cancer control research and provided a structure to guide innovative cancer control efforts. As a management and planning tool, the model was instrumental in developing NCI's cancer control plans. This model of cancer control phases classifies research efforts according to an organized sequence of five progressive phases from hypothesis development (phase I) through large-scale demonstration projects (phase V). Operational criteria are applied between the phases to determine whether research outcomes warrant a progression to the next phase of research. At the completion of phase IV, a proven intervention with a demonstrated public health benefit in reducing cancer incidence, morbidity, or mortality would be ready for implementation nationwide. (See figure 1.1.)

The research priorities for the new STCP grew from a systematic, participatory planning process that used state-of-the-art reviews and consensus-development techniques involving hundreds of scientists and public health professionals. The process was a two-part strategy. The first part was to study intervention methods—interventions that were school based, community based, or self-help; were delivered by physicians or dentists; or involved the mass media. The second part of the strategy was to identify specific populations that were at greatest risk for developing cancer or

Figure 1.1. National Cancer Institute's Five Phases of Cancer Control Research



Phase I: Hypothesis Development: Synthesizes available scientific evidence to develop a testable hypothesis.

Phase II: Methods Development: Characterizes the variables that must be controlled or monitored in subsequent studies and ensures that procedures are valid.

Phase III: Controlled Intervention Trials: Tests the efficacy of an intervention on a group of individuals (case-control, cohort, or cross-sectional studies).

Phase IV: Defined Population Studies: Measures the effects of an intervention in a sizable, distinct, well-characterized population.

Phase V: Demonstration and Implementation: Applies the intervention in a community at large and measures the public health impact.

Sources: Greenwald, P. G., and J. W. Cullen. 1984. The scientific approach to cancer control. *CA-A Cancer Journal for Clinicians* 34 (6): 330–1. National Cancer Institute. 1990. *Smoking, tobacco, and cancer program: 1985–1989 status report* (NIH publication no. 90-3107). Bethesda, MD: U.S. Department of Health and Human Services (p. vi).

that were receptive to prevention approaches. These populations included youths, minority and ethnic groups, women, heavy smokers, and smokeless tobacco users.[5]

Building on this two-part strategy, in 1982 Cullen and other STCP staff developed an aggressive plan to decrease tobacco use in the United States. The strategy proposed a comprehensive research program, initially including phase III and IV trials from 1982 to 1989, to test a variety of interventions with selected populations. These trials involved more than 10 million people in 33 states across more than 200 North American communities. Nearly $250 million was spent on this systematic research, making NCI's STCP the largest program of its kind in the world. (See figure 1.2.)

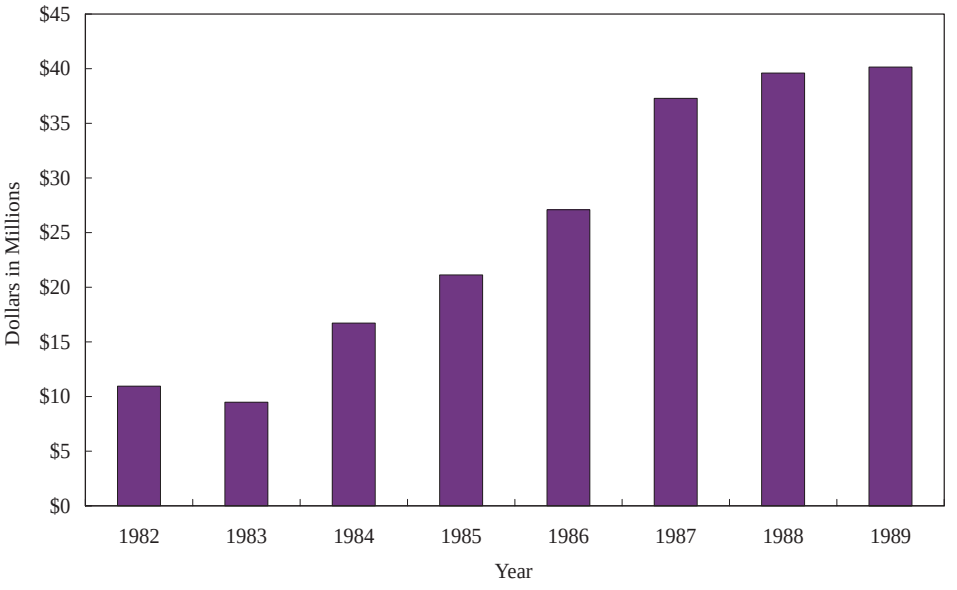
Studies Establish a Scientific Basis for Community-based Interventions

By 1982, sufficient phase I and II studies on smoking already existed, enabling NCI to move directly to funding phase III and IV intervention studies. During the 1970s and 1980s, a number of multifactor studies of heart disease prevention demonstrated the potential impact of broad community-based prevention programs and contributed to the knowledge base for the design of the ASSIST interventions. This type of research contributed to the shift from a

primary emphasis on individual-based interventions to interventions designed to reach large population groups and helped to verify the importance of the community and environmental factors in tobacco prevention and control.[5,13] The following examples are representative of pre-ASSIST community-based studies:

- The Stanford Three-Community Study, initiated in 1972, demonstrated the effectiveness of mass media and intensive face-to-face interventions in decreasing the number of cigarettes smoked per day and the risk for cardiovascular disease.[14]
- One study component of the Minnesota Heart Health Program was the Class of 1989 Study, which tested the efficacy of a smoking prevention intervention as one part of a larger program to reduce heart disease in entire communities. After the program ended and at the cohort's completion of high school, the smoking rate for adolescents in the intervention community was 40% lower than in the reference community.[15]
- The Midwestern Prevention Project was another longitudinal intervention study that was implemented in 50 middle/junior high schools in Kansas City and Indianapolis. The media-based interventions included schools, media, parent and community organizations, and health policy programs that focused on resistance skills training and environmental support for not using cigarettes or drugs. The smoking rates for students in intervention schools increased

Figure 1.2. The National Cancer Institute Funding for Smoking, Tobacco, and Cancer



Source: National Cancer Institute. 1990. *Smoking, tobacco, and cancer program: 1985–1989 status report* (NIH publication no. 90-3107). Bethesda, MD: U.S. Department of Health and Human Services.

significantly less than those for students in comparison schools.[16]

- The Australian North Coast health lifestyle program, "Quit for Life," used a social marketing approach to community intervention.[17] Among smokers who reported quitting, most reported that they quit smoking on their own, a finding that emphasized the importance of creating a social environment that encourages and supports self-initiated quit attempts.
- The Sydney Quit for Life antismoking campaign used mass media to reduce smoking prevalence in two Australian cities, Sydney and Melbourne. Long-term effects were greatest for men in Sydney, where smoking prevalence dropped 2.5% in the first 6 months of the intervention and continued to decline at a rate of 1.12% per year.[18,19]
- The North Karelia Project, a comprehensive community program to reduce cardiovascular disease in the province of North Karelia in Finland, initiated in 1972, reduced cigarette smoking by men in one community. The study also showed lower smoking rates after classroom interventions were taught to 13- to 15-year-old students. The lower rates were attributed to the context of the community program in which the school interventions were implemented. The health education component of the project included introducing environmental changes such as heart-healthy menus in institutions and smoking prohibitions.[20]
- The National Research Program in Switzerland found that light and moderate smokers were more likely to quit than were heavy smokers as a result of a community education intervention that mobilized personal and community resources to promote a healthful lifestyle. The program was integrated into existing local health and social services, and efforts toward individual action were supplemented by mass media and other community interventions.[21]

A Major Shift

"At its meeting of October 26–27, 1984, the Subcommittee on Smoking of the American Heart Association concluded that attaining the Surgeon General's objective [a smoke-free society by the year 2000] requires the development and implementation of public policies designed to facilitate the transition from a smoking to a nonsmoking society. The need for public policies recognizes the role of the contemporary social and legal environment in encouraging the initiation and maintenance of smoking, and hence the need for social and legal steps to alter this environment to one supportive of a nonsmoking society."

Source: Warner, K. E., V. L. Ernster, J. H. Holbrook, E. M. Lewit, M. Pertschuk, J. L. Steinfeld, and E. M. Whelan. 1986. Public policy on smoking and health: Toward a smoke-free generation by the year 2000. *Circulation* 73:381A.

Positive effects on the prevalence of cigarette smoking also were produced by the Community Hypertension, Atherosclerosis, and Diabetes Program in Israel,[22] the Cardiovascular Disease Prevention Program in an Austrian community,[23] and the Coronary Risk Factor Study in South Africa.[24]

From COMMIT to ASSIST

In a conversation with Robert E. Vollinger Jr. (April 26, 2000), William R. Lynn, who served as the NCI project officer for the COMMIT contracts and for some ASSIST contracts, explained the relationship between the two major NCI initiatives:

> In COMMIT we were blinded to the outcome; we could not scientifically alter the intervention course based on outcome data. We didn't want the intervention altered—it was designed in a controlled, clinical trial fashion. ASSIST and COMMIT were parts of the same path, with COMMIT as a controlled clinical trial and ASSIST as the demonstration project. ASSIST was being approved during the planning stages before we had the outcome of COMMIT.

As of 1988, STCP had supported 60 studies. At that time, 20% were complete, but by 1991, when ASSIST was slated to begin, 90% would be complete, adding to the body of knowledge guiding the ASSIST interventions during its 2-year planning stage that preceded the 5-year implementation phase to begin in 1993. All the studies were scheduled to be completed by 1992.[25]

COMMIT (1986–92) was a very ambitious research project, designed to significantly reduce smoking prevalence and to assess the effectiveness of comprehensive, community-based interventions in helping all smokers, particularly heavy smokers, quit smoking and remain tobacco-free.[26] COMMIT was a phase IV defined population study that involved 11 experimental communities and 11 control communities. At the time, this community-based focus was considered to be innovative and was based on an increasing knowledge that

> the decision to smoke takes place in a complex web of formal and informal policies and actions that reflect community norms and values. An important feature of the COMMIT trial is the move to a community level intervention designed to influence not only individuals, but also the broader social context.[27(p188)]

The Rationale for a Commitment to the Community Approach

These community studies provided several observations on which to base a rationale for designing and moving forward on the ASSIST concept as a phase V intervention. First and most obvious, a community approach has a wider reach than do individual-based interventions. Organizing an entire community around a health promotion project requires that more people and organizations get involved. Messages about behavioral change become widespread throughout the community, and it becomes difficult to avoid exposure to them.[27] (The ASSIST guidelines and early documents frequently used the term *consistent and inescapable cues* to reinforce this point.)

Second, a community-based approach can integrate interventions into the community's institutions, thereby enhancing the likelihood of long-term sustainable change. Interventions conducted through community groups and with their financial support can become a permanent part of the local resources and services, extending their life beyond the period of federal funding. In ASSIST, this concept

was termed *institutionalization* after extensive discussion and some hesitation about the potential negative connotations of the word.

Third, a community approach can cast a health issue as a public health issue that affects the entire population rather than as a problem of individuals. This approach considers health behavior such as smoking within a social context and builds on the principles that large-scale change requires a change in the social context and that change is more likely to occur when the people affected by a particular problem are defining the problem and are engaged in solving it. Partnership and collaboration among multiple organizations are essential to success. Community members must be involved throughout the whole project, and they must have significant decision-making authority.

A fourth observation emerged during the early years of ASSIST and became fundamental to the interventions. Evidence had accumulated showing that an effective way to reduce tobacco use is to promote a tobacco-free norm through public and private policies that pose barriers to the marketing, purchase, and use of tobacco—for example, cigarette taxes, restrictions against smoking in the workplace, and placement of tobacco ads. (See chapter 6 regarding the ASSIST focus on policy interventions.)

The American Cancer Society as a Partner

NCI recognized the value of a community-based approach in changing the social and physical environment to support a tobacco-free norm and sought the best mechanisms for implementing ASSIST as a multilevel, national-state-community-based intervention. A community-based intervention at the local level is sometimes best implemented and sustained when a key leadership role is assumed by a private-sector partner—especially a voluntary organization with links to local chapters. Given the coalition nature of the ASSIST project and the strong focus on policy change, NCI would need a strong private partner to make the project fully successful.

ACS, as a nonprofit voluntary health organization, had consistently been on the frontline of tobacco prevention and control efforts. ACS viewed the ASSIST concept as an opportunity to further engage in activities to reduce tobacco use and cancer. ACS was willing to join NCI as a partner in ASSIST, an arrangement that would establish a unique partnership between a government agency and a voluntary organization. In fact, ACS approached NCI and asked, as phrased by Cullen:

> "How come we are not doing this with you?" And we said, "Well, why not?" So, I give the credit to the American Cancer Society for opening this door, and I think it is a door that is of immense importance because of the number of people who can get to what I like to call the fabric of America.[25(p230)]

Clearly it was important for ACS to be a strong partner in this initiative, and partnership would provide ACS with valuable visibility. At the same time, NCI was aware of the importance of balancing its need for a partner with the interests of other health organizations that

wanted to be involved. However, NCI needed a primary partner that would make a commitment of the magnitude that ACS was offering. Together, NCI and ACS, working with state health departments and their coalitions, could provide critical leadership for individuals at the state and local levels to organize their communities to achieve policy and environmental changes for tobacco control.

Approval Is Sought

To proceed with the ASSIST concept as a major phase V demonstration project derived from the effective interventions in the previous phases, STCP had to have approval from DCPC's Board of Scientific Counselors. This outside technical scientific review group had to endorse all new initiatives before they could go forward for NCI funding approval and allocation. NCI staff members realized that much of the future of tobacco prevention and control efforts was at stake and that they needed to present a strong, science-based rationale to convince the board of the merits of this bold undertaking. Failing to win the board's approval would seem to make all the models of sound scientific theory meaningless. With these realizations, NCI staff presented the ASSIST project to the board on Friday, October 7, 1988.

Dr. Joseph W. Cullen, representing STCP, and Dr. Harmon J. Eyre, representing ACS, made the principal presentations to the Board of Scientific Counselors and outlined the history of STCP and NCI and selected intervention trials that had already been funded. Cullen provided the history, context, and rationale for the project. He also explained the proposed, unprecedented arrangement between ACS and NCI. Although NCI was quite familiar with funding scientific research grants, it had no track record of partnering with voluntary health organizations. To explain and to reassure this board of scientists about this new model for demonstrating tobacco prevention and control programs, he used the metaphor that NCI cannot do tobacco prevention and control without an army and that ACS could provide this army because it had 3,400 units, 57 divisions, and 2,000,000 volunteers. Cullen said that these large numbers would be required as NCI moved from science to public health application.[25(p231)]

Anticipating questions about why STCP was seeking approval in 1988 for a project that was not expected to begin until 1991, Cullen explained that ASSIST was a very large demonstration project, requiring many coalitions and a great amount of complex planning. In addition, approval from the ACS Board was necessary, though the ACS Executive Committee had already endorsed the concept.

Donald R. Shopland, one of the key NCI staff working on ASSIST in the early phase, emphasized the importance of the coalition model:

> First of all, we have to recognize that tobacco control is both too large and too complex an issue for any one organization to address independently. Coalitions are, also, the best vehicle for tobacco control because they serve very useful functions . . . they allow for comprehensive planning of the interventions.[25(pp243–4)]

Shopland pointed out that comprehensive tobacco prevention and control required active participation of all interested parties in a community or a state in a coordinated manner, that diverse groups must be involved in both the planning and delivery of the intervention, and that these coalitions are important because they build on existing local resources and "promote a sense of local ownership of the project."[25(p244)]

A number of questions focusing on the scope of the project and its management structure and mechanisms were raised and answered at the board meeting. Dr. Kenneth E. Warner, an experienced tobacco researcher, took issue with a reference to a smoke-free generation and recommended adopting terminology (e.g., tobacco free) that would be more inclusive and reflect a broader scope. He expressed concern about the potential for segmentation of the health community by the exclusive focus on cancer—tobacco use also causes heart disease, chronic obstructive lung disease, and many other health problems. He commended the American Cancer Society, the American Heart Association, and the American Lung Association for forming the Coalition on Smoking OR Health, a major step in collaboration among three of the most powerful voluntary health organizations in the nation. He raised the potential problem of naming a single primary partner in states where one of the other health voluntaries is the strongest tobacco prevention and control organization. (In fact, this issue of primary partners persisted throughout ASSIST.) Warner also emphasized the importance of including an evaluation component at the outset and raised questions about the wisdom of proceeding with ASSIST before all data from the COMMIT trials were analyzed.

Cullen acknowledged that these were difficult issues that had been raised, but he addressed them to the satisfaction of the board. He explained that to sustain the momentum of NCI's tobacco prevention and control efforts, STCP wanted to begin ASSIST before results were available from COMMIT. The ASSIST site analyses and planning would already be underway while analyses of the COMMIT data were being completed. A readiness would be established for ASSIST's implementation phase to be immediately informed by results and lessons learned from COMMIT during ASSIST's implementation of interventions.[28,29] To resolve the problem of segmenting the health community, he suggested building a model that would involve other health and community groups in the coalitions. Eyre also brought up this issue in his remarks and referred to the Rocky Mountain Tobacco-Free Challenge, a regional coalition of eight states, formed by the directors of health education of each state. The coalition annually assessed progress in tobacco control with specific measures of policy change, new programs, coalition development, national data surveys, and others. Eyre noted that each of the eight states already had coalitions that involved the major health organizations. He said that the coalitions were evolving and finding solutions—for example, they found ways to deal with the issue of who has the lead role. In fact, this process of evolving was to become the experience in many states

Concerns and Issues Expressed to the Board of Scientific Counselors

- Broaden the terminology to tobacco free.
- Avoid segmenting the public health community by disease categories.
- Involve all in coalitions.
- Prevent alienation of other voluntary organizations as a reaction to the ACS partnership.
- Clarify the different roles of NCI and ACS.
- Prepare for the lack of administrative experience in contracting with state departments of health.
- Include an evaluation design from the beginning.

throughout the life of the ASSIST project. To promote collaboration, the ACS leaders had already met with the chief executive officers of the American Heart Association and the American Lung Association.

Dr. William Darrity asked why contracts, not grants, would be awarded, and Cullen responded that awarding funds as contracts to the state health departments would retain NCI's legal responsibility to manage the funds:

> The reason for the contract is that I cannot imagine that a grant would ever work here because we would have no control over it. People could do what they wanted. It would be the end. We would give up the money, and we would run into nothing but difficulties in dealing with problems and negotiations and difficulties that developed.[25(p274)]

A benefit of the contract mechanism rather than the grant mechanism later became apparent once the ASSIST project was underway. In contrast to the grant mechanism, the contract required that the states agree to specific deliverables. By having these deliverables built into the funding commitment, NCI was able to maintain consistency and the states were able to resist the pressures of individuals who might have been politically motivated.

The funding arrangement between the states and NCI would require ongoing discussion throughout the duration of the project. However, the benefits of making the awards to state health departments were recognized. The states were to channel a significant portion of the funds to local organizations and to various subcontractors who would be members of the coalitions and who would be involved in delivering the interventions.

ACS would have a clear responsibility as a resource to the states regarding activities focused on policy issues. Legislation and policy go hand in hand, and ACS had the ability to lead legislative efforts. ACS was preeminent in its ability to effect state and national policy changes and would continue to do so in pursuit of public health goals for preventing tobacco use.

After the discussion ended, the Board of Scientific Counselors approved the concept as proposed and unanimously recommended funding for the ASSIST project.

Readiness to Go Forward

Despite the scientific, organizational, political, and other challenges to undertaking an innovative initiative of such

scope as the proposed ASSIST project, NCI was ready to undertake the project. Fundamental factors that motivated STCP staff and NCI are listed below.

- Tobacco is the number one preventable cause of death in the United States.
- Tobacco is responsible for more than one-third of all cancers.
- Leaders with perseverance were committed to implementing a new approach to tobacco control.
- NCI had been conducting trials and funding tobacco prevention and control research for many years—the time had come to build and to test a phase V demonstration project based on the findings generated from years of research.
- The time was right for a major shift—to change the way tobacco prevention and control efforts were conducted in the United States from interventions focused on individuals to a population-based, public health approach.

This historical context built on the foundation provided in the first NCI tobacco monograph, *Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's:*

> The NCI's Smoking and Tobacco Control Program has operated under the philosophy that research, in and of itself, is not capable of producing large-scale national change in smoking prevalence rates. It was recognized from the outset that there must be a concerted effort to systematically and comprehensively apply the knowledge gained from the intervention trials. Thus, from its inception, the STCP has continually used information from such studies to plan the next steps for implementation of a national strategy to significantly reduce smoking in the 1990's.[30(px)]

Having the approval to go ahead with the ASSIST project, NCI's next task was to clearly define the essential principles, or standards, of the conceptual framework that would be described in a request for proposals to conduct comprehensive tobacco prevention and control interventions.

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Additional Resource

1. Guide to Community Preventive Services: Tobacco Use Prevention and Control. www.thecommunityguide.org/tobacco/default.htm.

2. The Conceptual Framework

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2. The Conceptual Framework

During the year following the approval of the American Stop Smoking Intervention Study (ASSIST) project by the Board of Scientific Counselors, the National Cancer Institute (NCI) staff formalized a description of the components—programmatic, organizational, and operational—that would be required in a comprehensive tobacco prevention program. Those components would be incorporated as program standards in a request for proposals, the mechanism the government uses to offer contracts for work to be performed. The standards presented the critical elements for an effective comprehensive intervention for tobacco prevention and control. They were based on the NCI research database, the cumulative body of smoking and behavioral change research literature, and the experience of public health professionals. As such, the standards represented the state of the science in smoking prevention and control at that time.

The standards informed the development of the "ASSIST Program Guidelines for Tobacco-Free Communities" and later served as the foundation for The Robert Wood Johnson Foundation's SmokeLess States Program and the Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT) program of the Centers for Disease Control and Prevention. They also provided guidance for programs in California, Massachusetts, and other states. This chapter describes the conceptual framework used for planning and implementing each state's ASSIST program.

The Fundamental Premises of ASSIST: Preventing Tobacco Use through the Public Health Model

Concurrent with the efforts to formalize the concept for the ASSIST model, public health professionals throughout the United States were beginning to understand more fully the relationships between health behaviors and social and physical environments. Tobacco use is developed and shaped by social context in addition to an individual's biological responses. Changes in the social and physical environment that can influence the initiation and cessation of tobacco use and exposure to environmental tobacco smoke include tobacco prices, antitobacco media campaigns, declining social acceptability of smoking, limitations on where tobacco use is permitted, and limitations on access to tobacco products.

Given the broader perspective, smoking was seen as a public health problem requiring population-based interventions that extend beyond individual counseling and education. The agent-host-environment triad is commonly used to conceptualize and address public health problems, thereby providing more strategic options for controlling diseases and promoting health. (See figure 2.1.)

This public health model is a fundamental component of epidemiology and health behavioral sciences. The ecological systems model, or a social-environmental model, depicts connections and interrelationships between people and their environments and builds on the triad. Applied to tobacco control, it focuses attention on four priority actions:

1. Promoting a tobacco-free social norm through widespread policy changes and media messages
2. Preventing the initiation of tobacco use and thereby the development of nicotine addiction
3. Making support for quitting widely available to tobacco users
4. Protecting nonsmokers from exposure to environmental tobacco smoke[1]

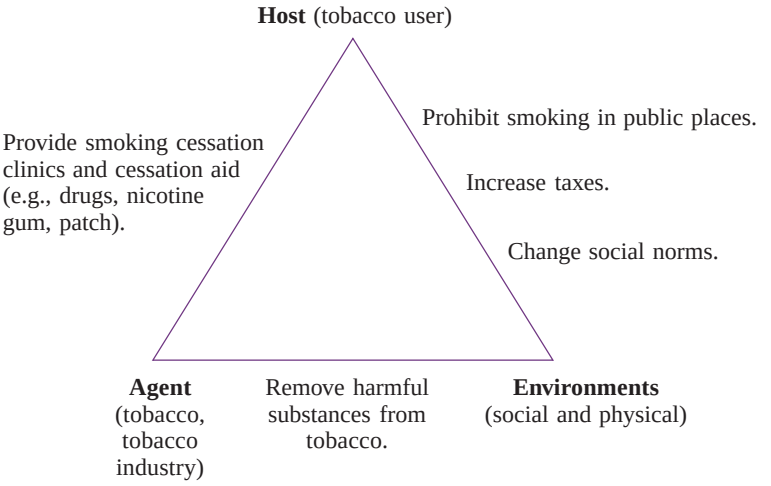
Based on the ecological model, the ASSIST conceptual framework emphasizes how the influences of social relationships, environmental conditions, and societal phenomena, such as public policies that affect tobacco use and health, provide a structure for designing media and policy interventions for multiple channels and populations. (See figure 2.2.)

Eligibility for ASSIST Contracts

"Health departments, because of their commitment to public health, their experience in working in a society of institutional partnerships to accomplish their goals, their access to target populations of smokers, and their guaranteed continued presence, will be the only eligible recipients of ASSIST contracts."

Source: National Cancer Institute. 1990. *The American Stop Smoking Intervention Study (ASSIST) request for proposals* (Publication no. NCI-CN-95165-38). Bethesda, MD: National Cancer Institute, 30.

Figure 2.1. The Public Health Model



Note: See the 2003 Institute of Medicine report, *The Future of the Public's Health in the 21st Century,* p. 51, for a discussion of the triad.

Given the public health conceptualization of the tobacco problem, important assumptions were identified and articulated as ASSIST program guidelines:

1. When a community affected by change is involved in initiating and promoting the development of that change, there is an increased probability that the change will be successful and permanent. This involvement includes participation by community representatives in defining the problem and in planning and instituting steps to resolve the problem.
2. Smoking control interventions should be targeted at broad social and environmental change rather than individual change. Therefore, efforts to achieve priority public policy objectives should take precedence over efforts to support service delivery.
3. Interventions should be directed toward efforts that will have the greatest potential for producing a major impact on smoking control. Usually, this would suggest targeting at the highest structural level of the site (i.e., state or region). However, this should not unduly preempt a careful weighing of the strategic benefits of local efforts.
4. Interventions targeted at populations at higher risk for smoking are likely to be more cost effective than undifferentiated initiatives targeted at the population as a whole. However, where policy advocacy is the appropriate intervention, the defined target audiences may not be representative of the target population but of other segments of the general public that would have a greater impact on implementing the policy.
5. Staff energies should be devoted to building capacity within the coalition and the site rather than directly carrying out interventions.
6. ASSIST resources will augment the existing resources of coalition members and other community organizations to accomplish ASSIST objectives. Rather than supplanting resources, ASSIST will stimulate and enhance existing resources to expand beyond their current smoking control activities. Conversely, ASSIST staff resources will be amplified by contributions of coalition members and other community organizations.[1(Overview, pp4–5)]

Coalition Building: Involving and Mobilizing the Community

Working with and through communities was a central operational and structural approach of ASSIST. If a program's primary focus is on social- and system-oriented changes, stakeholders and key influential persons in the system must be involved and active.

The ability to develop and use statewide and local tobacco control coalitions was a fundamental underpinning for operationalizing the ASSIST conceptual framework and was a requirement in the request for proposals. The requirement conveyed NCI's commitment to the community-based approach. The coalition model,[2,3] as the organizational structure for the ASSIST framework, enables diverse groups to work together to plan, support, and coordinate tobacco control efforts. (An extensive description of the coalition model is presented in chapter 4.) ASSIST coalitions would be responsible for a variety of functions, including the following:

- Reaching out and engaging community groups and individuals who have the potential to contribute to community tobacco control mobilization on all intervention fronts and in all channels
- Mobilizing the organizations and human resources needed to collaborate with ASSIST staff in conducting site analyses, developing comprehensive tobacco control plans, and developing annual action plans
- Overseeing and implementing the program interventions defined in the annual action plans

Whatever the chosen structure and form of governance, each coalition was required by the ASSIST program guidelines to develop responsive leadership and certain capabilities to conduct interventions successfully.

The ASSIST Conceptual Framework: Priority Populations, Channels, and Interventions

The ASSIST conceptual framework, an adaptation of the ecological model, approaches the prevention of tobacco use through three priority strategies: community organization and mobilization through coalition-building, mass media interventions, and policy advocacy. The framework incorporates three axes, which became the project's planning model: priority populations,* channels, and interventions. The ASSIST conceptual framework (known as *the cube*) depicts the channels for delivering intervention activities to priority populations. (See figure 2.2. This early version of the cube has four channels. The Community Environment channel was added later.)

Axis 1: Priority Populations

ASSIST was designed to reach groups with high rates of tobacco use, with limited access to information about tobacco use and cessation services, and at high risk for initiating tobacco use. National prevalence data revealed that the population groups with the highest rates of tobacco use were adolescents, ethnic minorities, blue-collar workers, unemployed people, and women. Because of the potential for the greatest long-term impact, youths were identified as a major priority population.

The ASSIST model readily integrates the social marketing concept of priority populations with a community development orientation; that is, it views involvement of community groups as important for reaching the priority populations and even engages the priority populations in implementing interventions. For example, to reach adolescents, the coalitions

*At the outset of ASSIST, the term *target populations* was used. The term *target* is commonly used in marketing disciplines to refer to population groups. However, in the early 1990s, because many in the public found the term *target* offensive and even threatening, ASSIST replaced the term with *priority*. In the glossary to the "ASSIST Program Guidelines for Tobacco-Free Communities," target (priority) populations are defined as follows: "segments of the general population that merit special attention based on their higher risk for cancer (e.g., heavy smokers), potentially higher risk of smoking (e.g., youths and teenagers), or lack of access to smoking control services" (p. 6).

worked with adolescents themselves and gave them the lead in advocacy interventions, such as media events and making presentations to city councils.

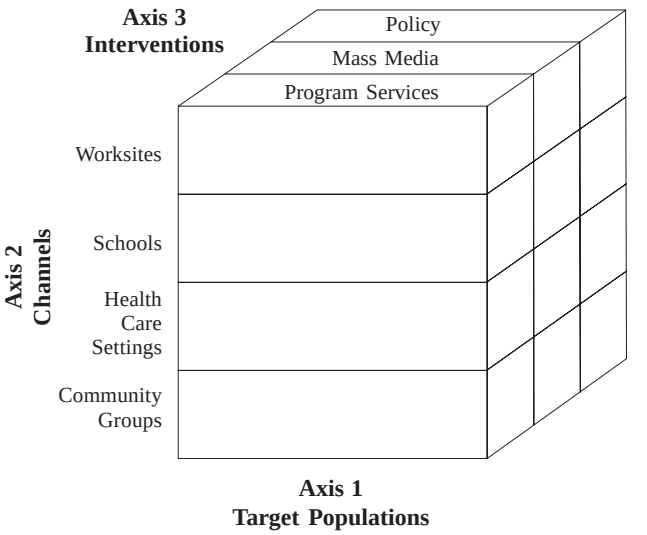
Axis 2: Channels

The following channels for prevention and control of tobacco use are the settings through which intervention program activities reach the specific individuals and groups:

- Community environment
- Worksites
- Schools
- Healthcare settings
- Community groups

Promoting a tobacco-free social norm in each of these settings establishes and reinforces a tobacco-free norm community-wide. The channel of *community environment* includes smoke-free restaurants, bars, and other public buildings. Through the *worksite* channel, businesses can become involved in creating smoke-free workplaces and in developing cessation programs for employees and their spouses who use tobacco. *Schools* are settings in which tobacco use policies should be enacted and enforced—in school buildings, on school grounds, at school sporting events, and at school-related meetings. Schools also offer the means for outreach to teachers and students with strategies and interventions to prevent tobacco use and to become an empowering vehicle for change. *Healthcare* settings ensure that

Figure 2.2. The ASSIST Conceptual Framework



Source: ASSIST Coordinating Center. 1991. Overview of ASSIST. In ASSIST program guidelines for tobacco-free communities. Internal document, ASSIST Coordinating Center, Rockville, MD (p. 9).

Critical Planning Issues

Several elements are critical to planning a comprehensive smoking prevention and control program. Whether for a small community, city, major metropolitan area, state, or the nation, the following three issues should be considered:

1. Tobacco use is a public health problem. Participants in the program must ensure that all communications describe the issue as a problem for all members of a community, not just for smokers. Blaming and ostracizing tobacco users can polarize the public and cause hard feelings that undermine tobacco prevention and control efforts.
2. A careful assessment of the community's needs and assets is essential to effective allocation of resources. Such an assessment includes defining the tobacco problem; identifying priority groups; surveying the current level of program services, policies, and various types of media; and analyzing the potential of the healthcare system, worksites, schools, community networks, and the community environment to reach smokers. This process is time-consuming and delays moving into action but is critical to the success of tobacco control efforts.
3. A comprehensive long-term plan must be developed to integrate and coordinate the use of various types of media, develop policies, and deliver program services to the appropriate audiences to achieve significant reductions in tobacco use.

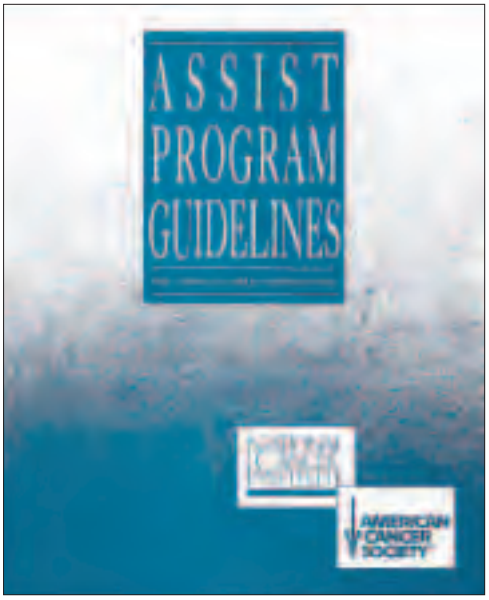
smoking is an element in the patient assessment. *Community groups*, such as Rotary clubs, agree to no smoking at their meetings. (The subsection below on program objectives elaborates on these channels.)

Axis 3: Interventions

In the ASSIST conceptual framework and planning model, three types of interventions are delivered through the channels—policy, mass media, and program services. Tobacco control research shows that the social and physical environment surrounding smokers and potential smokers influences their behavior. Smoking rates among large populations appear to be related to certain public and private policies on tobacco use and to tobacco marketing. Policies can take the form of legislation, such as excise tax increases, access and advertising restrictions, or private rules, such as voluntary adoption of workplace or restaurant smoking bans that are implemented without a public mandate. Each category of intervention includes a variety of specific activities, some that can be delivered through all five channels (e.g., self-help materials or large community-based magnet events, such as the Great American Smokeout) and some that are most appropriately delivered within a specific channel (e.g., brief counseling by healthcare providers, school-based smoking prevention programs, or messages designed specifically for priority populations).

The aim of the interventions is to alter the environmental and social influences affecting the population's use of tobacco; therefore, the strongest emphasis is on media and public and private policy interventions. In the ASSIST model, four policy areas are priorities:

1. Eliminating exposure to environmental tobacco smoke
2. Promoting higher taxes for tobacco
3. Limiting tobacco advertising and promotions
4. Reducing minors' access to tobacco products



ASSIST Program Guidelines

For example, *policy efforts* can be directed at promoting clean indoor air policies, promoting higher excise taxes for tobacco products, limiting tobacco advertising, and restricting minors' access to tobacco. *Media activities* should support these policy initiatives through well-designed media campaigns, especially campaigns that generate news coverage (sometimes termed *earned* media coverage), although the paid media approach is sometimes preferred to ensure prime-time and adequate coverage. Engaging the media strategically to bring attention to an issue or to promote a policy is known as *media advocacy*. Media advocacy was a critical strategy in the ASSIST project, which advanced its application as an intervention in the public health model of prevention.

Though proven to be effective interventions, the relative impacts of these different types of policies and restrictions have not yet been conclusively established. However, the *Community Guide to Preventive Services* is an excellent resource that considers the strength of the evidence base for policy interventions and provides very helpful recommendations regarding their relative effectiveness. See http://www.thecommunityguide.org/tobacco/default.htm.[4] (For more information about the scientific basis and rationale behind these policy areas, see chapters 5–7.)

At the time the conceptual framework was developed, the impact of increases in cigarette excise taxes on smoking behavior was already documented.[5] Analyses demonstrated that a price increase of 10% produces a decrease of about 4% in demand for cigarettes, particularly among men 20 to 25 years old. This decrease results largely from people choosing not to smoke at all; the remainder is attributable to decreases in daily consumption rates by men 35 and older who continue to smoke.[5] Analyses also showed that youths are sensitive to price changes. An 8-cent decrease in the federal tax would induce up to 1 million young persons aged 12 to 25 to smoke, whereas without the tax decrease, they would not smoke. Conversely, an 8- to 16-cent tax increase would influence from 1 to 2 million persons ages 12 to 25 and from 800,000 to 1.5 million adults to quit smoking or not to start. Thus, the effect of a tax increase would translate into the prevention of hundreds of thousands of premature smoking-related deaths.[6]

Restrictions on indoor smoking and tobacco advertising may also influence

smoking behavior. By the time the ASSIST framework was developed, several longitudinal studies had documented decreases in prevalence and increases in smoking cessation after the enactment of smoking restrictions in individual worksites and healthcare settings, whereas other studies did not.[7–11] Several studies had suggested that reductions in smoking prevalence can be achieved by implementing significant restrictions on tobacco promotion and advertising.[12–16] Many types of restrictions had been suggested. These restrictions included a total ban on advertising; removal of cartoon characters, color, or people from ads; bans on point-of-purchase advertising; bans on event sponsorship; and removal of outdoor advertising near schools and parks.

Program services are likely to be needed once media and policy efforts have been successful in putting tobacco use policies in place and in creating a tobacco-free norm. Program services were originally defined in the ASSIST program guidelines as those smoking control activities involved in directly assisting individuals to make behavioral changes consistent with nonsmoking norms, but the concept later evolved to include all forms of tobacco use. For purposes of ASSIST, three main kinds of services were identified:

1. Use of cessation resources to help people stop smoking
2. Services to prevent smoking initiation
3. Smoking education for the general public

ASSIST Program Objectives and Evaluation

The request for proposals set forth program objectives based on a public health perspective. The program objectives would provide strategic direction and priorities for the coalitions, but it would be the responsibility of the coalition members to develop the tactics, or intervention activities, that would achieve the objectives. The ASSIST approach to achieving the objectives encompassed two phases:

1. A 2-year planning phase, during which state-level analyses of resources were made and comprehensive smoking control plans were developed
2. A 5-year implementation phase*

The program objectives were revised early in the ASSIST project and were set forth in the "ASSIST Program Guidelines for Tobacco-Free Communities," as presented in table 2.1.

The following sections elaborate on the program objectives in terms of the channels to be used in implementing the ASSIST planning model.

Community Environment

All urban areas and regions of the country comprise various smaller communities that can be geographically, ethnically, or culturally defined. *Community environment* refers to the general physical and social environment in identified areas within the intervention site.

*The ASSIST project was originally scheduled to end in 1998 but was later extended through the end of September 1999.

Table 2.1. ASSIST Program Objectives by 1998

Channel	Objective
Community Environment	By 1998, cues and messages supporting nonsmoking will have increased, and pro-smoking cues and messages will have decreased.
	By 1998, sites will substantially increase and strengthen public support of policies which a) mandate clean indoor air; b) restrict access to tobacco by minors; c) increase economic incentives and taxation to discourage the use of tobacco products; and d) restrict the advertising and promotion of tobacco.
Community Groups	By 1998, major community groups and organizations that represent the priority populations and have broad-based statewide reach should be involved in ASSIST activities.
Worksites	By 1998, proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace should increase to at least 75 percent.
	By 1998, worksites reaching major populations will adopt and maintain a tobacco use cessation focus.
Schools	By 1998, 100 percent of schools serving grades K through 12 and public vocation/technical/trade schools will be tobacco free.
	By 1998, 100 percent of all schools serving grades K through 12 will use a tested, efficacious tobacco use prevention curriculum.
Healthcare Settings	By 1998, at least 75 percent of primary medical and dental care providers will routinely advise cessation and provide assistance and followup for all of their tobacco-using patients.
	By 1998, all public health facilities, both outpatient and inpatient, will have enforced smoke-free policies.

Source: ASSIST Coordinating Center. 1992. Resource materials section. In ASSIST training materials. Vol. III. Site analysis and comprehensive smoking control plan. July 20–21. Internal document, ASSIST Coordinating Center, Rockville, MD.

The community environment as a channel consists of the multiple community outlets that reach all citizens regardless of employment, educational, health, social, or smoking status. The presence and salience of messages promoting tobacco use or cessation, the availability (or lack) of cigarettes and smokeless tobacco, and the social norms for smoking in public places all contribute to a community environment that may or may not support tobacco use. An effective strategy for increasing awareness of the tobacco control issue and changing the social environment is to involve numerous organizations and groups in planning, initiating, and implementing tobacco control activities at the local level.

Worksites

Worksites are ready-made locations for implementing and supporting tobacco-free policies and smoking cessation programs. Worksites also provide an opportunity to reach the ASSIST priority populations: women, blue-collar workers,

and people of low educational attainment. Worksites are an important channel for involving nonsmokers in tobacco control efforts, particularly through the promotion of nonsmoking policies. Restrictions on smoking in the workplace protect nonsmokers from exposure to the tobacco smoke of others. Thus, successful worksite smoking control programs consist of two major components:

1. Motivation and support for smoking cessation attempts
2. A clear nonsmoking policy that is strictly enforced

It is important in implementing worksite smoking control programs that employees take responsibility for planning and implementing smoking control policies and programs in their own worksites.

Schools

Schools provide another important channel for preventing tobacco use because they represent a primary channel for reaching youths and adolescents and provide an opportunity for reaching individuals who may not be reached through worksites. Schools also provide a forum for reinforcing parental messages delivered through worksite programs. The school environment is established to support learning and, thus, naturally provides the skills and support for the delivery of prevention and cessation programs to students, faculty, and staff. Further, during class time, students may be receptive to learning about the health consequences of tobacco use and the benefits of cessation. Finally, as self-governing establishments, schools provide important opportunities for implementing tobacco-free policies. School-based prevention and control activities should be conducted through all private and public primary, secondary, and post-secondary schools.

Healthcare Settings

Because of the potential for healthcare providers to reach a substantial number of smokers, healthcare settings can be highly effective channels for smoking cessation and prevention activities. In addition, influential healthcare providers who are interested in playing a leadership role in tobacco control should be identified. They should be encouraged to influence their colleagues directly by training their peers in intervention techniques and indirectly by raising the topic at meetings and social events.

Community Groups

Community groups of individuals who gather regularly for some mutual purpose are considered to be networks. Such networks range in structure from formal (social clubs and some service organizations) to informal (e.g., block associations, neighborhood centers) and are representative racially and ethnically of the community. Community groups are an important channel for preventing tobacco use because they provide an opportunity to reach individuals who may not be reached through healthcare settings, worksites, or schools. In addition, the groups create an expanded capacity for ongoing support of nonsmoking norms at all levels of the community. Community networks include youth organizations, service and social clubs,

and religious and professional organizations. They include large organizations that meet regularly and small groups that have the potential to reach priority groups of smokers. Small groups vary greatly in structure and function and may be uniquely able to reach certain groups of smokers. They include such entities as childcare co-ops, block associations, after-school programs, and social clubs.

The Evaluation Plan for ASSIST

The main outcome expected from the ASSIST project was a trend of decreasing smoking prevalence in ASSIST states that would be greater than a trend in non-ASSIST states. To evaluate those trends, data would be needed at the state level and the national level. Because ASSIST was a national demonstration project, it would have been difficult for individual states to independently evaluate their own efforts and then combine those evaluations with evaluations from the other states. Consequently, no funds were allocated to the states for evaluation. Rather, as recommended by the ASSIST Scientific Advisory Committee, NCI staff decided to have the evaluation conducted centrally at NCI. Even so, the resources devoted to evaluation were quite modest relative to the total budget of the project. Thus, for the most part, existing databases had to be used, and designing the evaluation of this complex project proved to be a considerable challenge.[17] In addition, during the planning process, the lack of adequate scientific methodology for evaluating such a large-scale, multi-site demonstration became evident, and a number of revisions to the original plan became necessary.

To help address the inherent challenges of the ASSIST evaluation, ad hoc advisory groups were convened in 1990 and met during several months to assist NCI in developing the initial design for process and outcome evaluations and for impact substudies. Later in 1992, a broad-based ASSIST Evaluation Committee was established to advise NCI and the ASSIST Coordinating Center (which provided technical assistance to the states) on the evaluation plan and to address the various issues surrounding the evaluation. The committee identified potential evaluation and research questions, suggested secondary data sources, recommended priorities for evaluation activities, reviewed proposed analytic approaches and data collection and measurement methodologies, and provided feedback on draft documents related to the ASSIST evaluation.[18]

The advisory groups and the committee had to address a number of theoretical challenges. As a demonstration project, ASSIST was not a randomized experiment but rather a purposeful sample. Would comparisons to non-ASSIST states be valid measures of the effect of ASSIST? States were selected for participation in ASSIST because of their capabilities to deliver the three types of interventions to reach populations having the highest smoking rates. These criteria set them apart from most other states. Complicating the concept was the fact that two states, California and Massachusetts, received financial windfalls about the time that ASSIST was being funded. Massachusetts was an ASSIST state, but the committee had to consider whether California should be included

for comparison and if so, how it fit in because of the large spectrum of capabilities represented by the tobacco control program. In addition, some non-ASSIST states had started to implement programs that had elements similar to components of the ASSIST model, and a large amount of natural contamination (diffusion) to non-ASSIST states was to be expected from a nationwide program (personal communication from L. Kessler to C. Backinger, 2001).

In 1996, a technical expert panel was formed to address the methodological issues implied by the theoretical challenges. The panel developed a conceptual model to guide the evaluation, to determine the research questions and the specific set of measures to be used in the evaluation, and to identify the data collection needs and existing data sources.[19]

The ASSIST Evaluation Model

The evaluation plan took into consideration the fact that environmental change occurs incrementally at a modest pace; therefore, multiple outcome points would be needed for tracking the continuum of change over the course of the project.[17] To put the evaluation in perspective, the evaluation model explains the sequential process of change resulting from statewide tobacco control efforts. The evaluation model shows all the components to be measured that led to the reduction of tobacco use. Since 1996, the model has been simplified. The current model is depicted in figure 2.3.

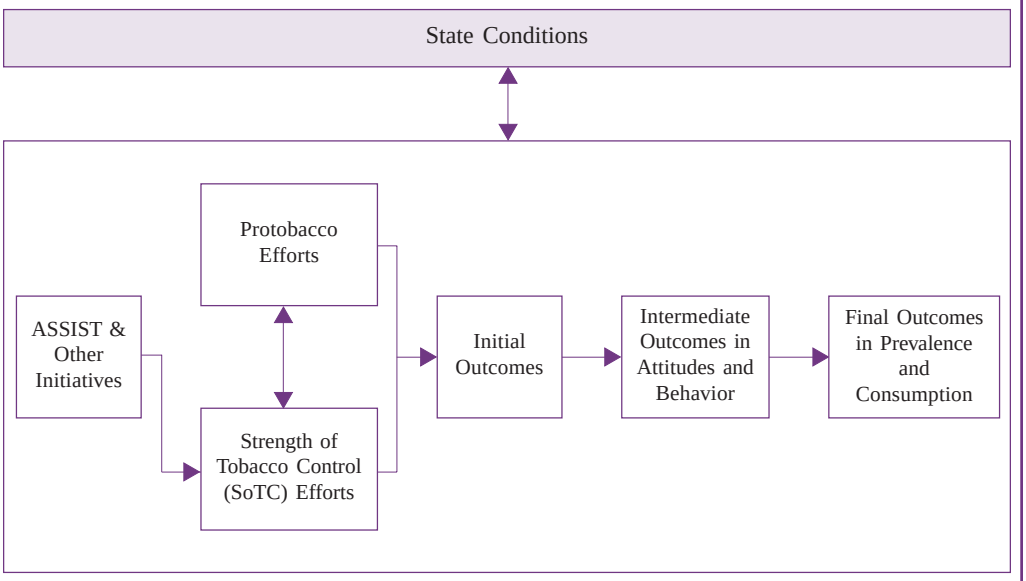
Strength of Tobacco Control Index

A method was developed as an indirect measure for the program effects of ASSIST—the Strength of Tobacco Control index (SoTC). The method summarizes three constructs (resources, capacity, and antitobacco efforts) to form an overall exposure measure of tobacco control efforts at the state level: strength of tobacco control. Instead of measuring the individual effects of all the different tobacco control programs, this exposure measure summarizes this complex construct and the multiple facets and components of tobacco control efforts.[19] SoTC data were collected for 1998–99 from key informants at state-level tobacco control organizations in all 50 states. Analyses of the data were conducted at the end of the ASSIST project. Peer-reviewed articles have been published, and an NCI monograph on the ASSIST evaluation is forthcoming.

Data Sources

Conducting an evaluation required consistent, comparable data across all the states in the country—data that would enable analyses of state-level norms and tobacco control outcomes, such as media coverage, worksite clean air policies, and legislation. These data would be independent measures collected about all the states and not tied directly to ASSIST. A number of data sources, described below, were considered for the outcome and process evaluations of ASSIST. Two of these—site analyses and coalition assessment—guided the states during the planning and implementation phases. The other sources became integral to the ASSIST evaluation model: Tobacco Use Supplement—Current Population Survey, cigarette consumption data, databases on state

Figure 2.3. The ASSIST Evaluation Model



Source: Adapted from Stillman, F., A. Hartman, B. Graubard, E. Gilpin, D. Chavis, J. Garcia, L.-M. Wun, W. Lynn, and M. Manley. 1999. The American Stop Smoking Intervention Study: Conceptual framework and evaluation design. *Evaluation Review* 23 (3): 259–80.

and local legislation, and the media tracking database.

Site Analyses. Each ASSIST state was required to conduct a site analysis to provide the baseline information that it needed to develop a comprehensive tobacco control plan and to monitor the implementation of its plan and progress toward its objectives. The site analysis documented the distribution of tobacco use by age, gender, and geographical area; the economic burden of tobacco use; and the social and political climate for enacting and enforcing tobacco control policies. It included an assessment of the state's potential resource strengths and weaknesses for implementing ASSIST, including finances, equipment, facilities, personnel, expertise, organizational relationships and structure, existing policies for tobacco control, and media relationships. (See chapter 4 for more details.) Using the information from the site analysis, each state developed site-specific numerical objectives that expressed the number of persons in the state who would quit smoking as a result of interventions and the number of persons who would not initiate tobacco use.[20]

Coalition Assessment. Because the statewide coalition approach was a relatively new concept in health promotion, NCI undertook a study to examine how this approach was implemented in different contexts. The study was based on

a conceptual framework of factors hypothesized to influence coalition effectiveness. The factors represent specific coalition characteristics identified in a review of research on community coalitions. A coalition advisory group of 11 individuals selected for their expertise in assessing or developing community coalitions made recommendations for the study design. The underlying theoretical proposition was that certain environmental, structural, and functional characteristics of coalitions are indicative of their intermediate success as well as their long-term effectiveness. The assessment focused on the concept and experience of using state and local coalitions to implement tobacco control activities rather than on the relative performance of individual sites.[18] (See chapter 4 for more details.)

Tobacco Use Supplement for the Current Population Survey. For a national measure of outcome goals for smoking prevalence, the committee chose the Current Population Survey (CPS) with its state-specific estimates on smoking. The CPS is a household sample telephone survey of the civilian noninstitutionalized population. Since 1950, the U.S. Bureau of the Census has conducted the CPS at regular intervals to provide estimates of employment, unemployment, and other characteristics of the general labor force, the population as a whole, and various other subgroups of the population. It was chosen for ASSIST because it is the only ongoing survey funded by the federal government that provides a sufficient state-level sample size to compare all states and individual states.

To acquire state-specific year-by-year data, NCI contracted the Bureau of the Census to conduct a Tobacco Use Supplement to the CPS that could be used to compare data over time and across states. The supplement was designed to closely mirror other surveys for comparability. It includes questions about attitudes toward tobacco use as well as individual patterns of smoking and using smokeless tobacco. The supplement consists of 40 self-report items that are asked of persons who are 15 or older residing in sampled households.

The baseline survey was conducted in three waves during a 1-year period—September 1992, January 1993, and May 1993—with approximately 115,000 individuals being interviewed for each wave. The surveys were repeated during the same months in 1995 to 1996 and 1998 to 1999. Computer-generated tables summarizing national and state-specific baseline findings were distributed to the ASSIST states, as were data tapes that included all of the baseline data.[19,21]

Cigarette Consumption Data. Another important source of data for tracking the effect of ASSIST was per capita cigarette consumption. These estimates, which are derived from tobacco sales tax data, are more sensitive than prevalence data to intervention effects. National and state-level per capita consumption data for cigarettes are available on a monthly basis and were included in the overall outcome evaluation.[22]

Legislative Databases. The State Cancer Legislative Database, developed and maintained since 1989 by NCI, is the pri-

mary data source for measuring changes in state tobacco control policies. (The Americans for Nonsmokers' Rights [ANR] data are referenced in chapter 6.) The database includes information about all enacted state legislation related to cancer control, including tobacco control, breast cancer early detection, cervical cancer early detection, diet modification, state-of-the-art treatment, and selected topics on environmental and occupational exposures. Information about each law, including an abstract describing the provisions of each law, is maintained in a single computerized record.

To meet the needs of the ASSIST evaluation, the database was expanded to enable annual tracking of state legislation in each of the four policy areas:

1. Clean indoor air
2. Restricted access to tobacco by minors
3. Economic disincentives to discourage the use of tobacco products
4. Restricted advertising and promotion of tobacco

The database also tracks legislation related to smokers' rights. (The database can be accessed at www.scld-nci.net.)

Similarly, the ANR Foundation maintains a database that tracks information on tobacco-related legislation and policies at the local level. This data source was used in the evaluation to assess the outcomes of ASSIST activities in communities, especially clean indoor air and tobacco taxes.

ASSIST Newspaper Clippings Database. A study was designed to systematically track local newspaper coverage of tobacco-related policy issues during the 6-year implementation period of ASSIST. The expectation was that tobacco control advocacy would increase in general across the United States during the project period, with the ASSIST sites taking the lead in comprehensiveness and frequency of activity, and that this pattern would be reflected in the print media. Burrelle's Press Clipping Service was contracted to collect the print articles for the media analyses, and ASSIST Coordinating Center staff categorized the articles for relevance to type of smoking policy (clean indoor air, restriction of access by minors, economic incentives, advertising and promotion of tobacco, or miscellaneous), point of view (pro–tobacco control, anti–tobacco control, or neutral), origin of story (national or local), type of article, and whether the article appeared on the front page of the newspaper. Quarterly reports were produced summarizing the frequency of articles in each category and comparing ASSIST sites with non-ASSIST sites. (See chapter 5 for a detailed description.)

The Selection of States

On January 15, 1990, NCI issued its request for proposals for tobacco control programs from state health agencies in collaboration with state-level affiliates of the American Cancer Society (ACS). More than 35 states initially responded by submitting proposals. NCI formally reviewed all proposals for their technical merits, which included their proposed infrastructure and ability to mobilize community coalitions. The

proposals were reviewed in three review meetings, and 23 were judged to be technically acceptable.[23] However, technical merit was only one of several criteria applied in the award process.

The process of reviewing and scoring the proposals raised a complex decision problem: how to follow a process for making awards among the competing proposals that not only would consider technical merit and cost, but also would balance other considerations critical to the long-term viability and effectiveness of tobacco prevention and control. Those considerations included representing the United States geographically and ethnically in the states to be chosen for the ASSIST project. To address the problem, the director of NCI's Division of Cancer Prevention and Control engaged the services of NCI's Applied Research Branch to develop a mathematical optimization model for making ASSIST project funding decisions that would take into account various configurations of three major considerations: technical merit, cost, and secondary criteria mentioned in the request for proposals. The model was to provide a process both for scoring the proposals and for ranking them.[23]

Experts in the division were involved in a modified Delphi approach (a process of interviewing and group techniques to acquire input) to determine which criteria to include in the model and the relative weight of their values (see the Hall et al. article for details on the modifications).[23] From these experts, in a series of input formats, it was determined that geographical distribution was an unambiguous concept needing no further specification except that three states from each of the Census Bureau's four regions would be an appropriate standard. In contrast, the criterion of smoking prevalence had numerous interpretations. The main question was whether states should be selected according to overall smoking rates (states with large numbers of smokers) or according to how smokers in the states were statistically distributed by demographics (e.g., socioeconomic status, ethnic group, age) and historical factors (e.g., rate of decline of smoking prevalence between 1985 and 1989). The resulting three constraints were set for the model:

1. At least 2 states would be chosen from each quartile of the distribution of smoking rates across the 50 states and the District of Columbia.
2. At least 2 states would be chosen from each quartile of the distribution of decline in smoking rates for the preceding few years across the 50 states and the District of Columbia.
3. The proportions of African Americans and Hispanics/Latinos in state populations would be assessed as more important than the absolute numbers.[23]

Although the ranking of the proposals according to technical merit was to be given primary importance in the award assessments, the constraints also figured into the formula.

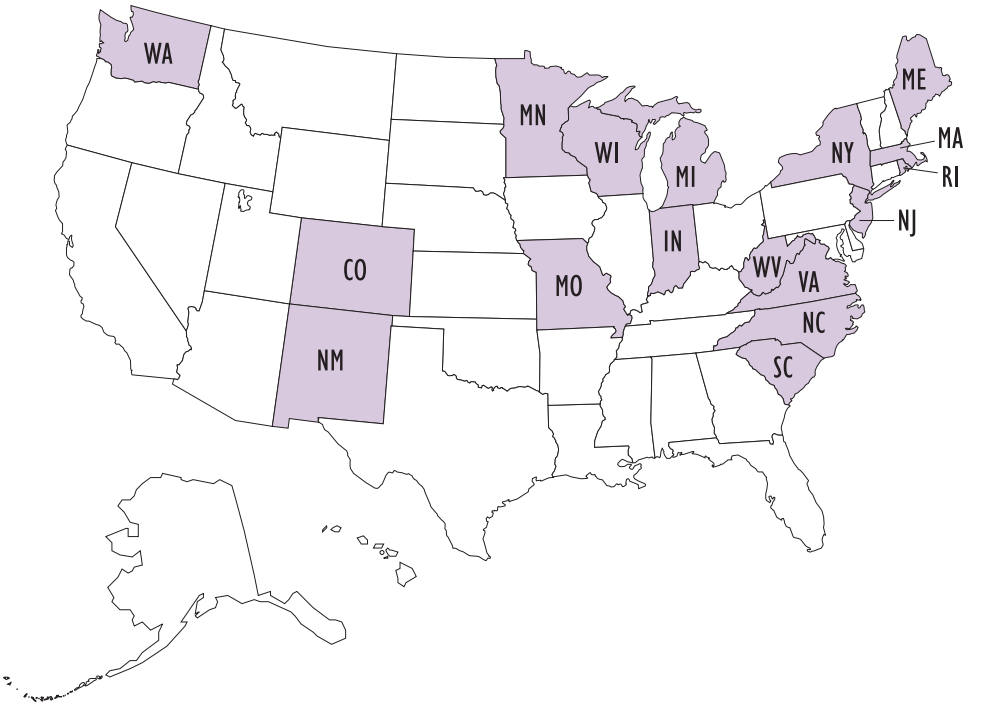
In October 1991, NCI awarded contracts to 17 state health departments to partner with their state-level ACS affiliate and other community organizations to design and implement statewide public health interventions based on the ASSIST conceptual framework. The

states that were awarded contracts are highlighted in figure 2.4. The eligibility of health departments for those funds was appropriate because of their commitment to protect and promote the public's health, experience working in institutional partnerships to accomplish their goals, access to priority populations, and guaranteed longevity. Combined, the population of the ASSIST states was 91 million people, more than a third of the U.S. population and closely reflecting the total American population in ethnic and geographic diversity. The ASSIST population included more than 10 million African Americans and 7 million people of Hispanic/Latino or other ethnic minority groups.[20]

In a press release announcing the contract awards on October 4, 1991, U.S. Department of Health and Human Services Secretary Louis W. Sullivan emphasized the role of communities in the ASSIST project:

> What sets ASSIST apart from other government antismoking programs is its emphasis on the development of community-based coalitions throughout entire states. Ultimately, it will be our communities and individual Americans that decide how best to tackle their tobacco problems. ASSIST will empower them by providing the information and help that they need to change attitudes about smoking and counter the sinister marketing strategies of the tobacco industry.[24]

Figure 2.4. States Awarded ASSIST Contracts



Time to Act

In summary, the ASSIST conceptual framework casts tobacco use as a public health problem and presents tobacco use as a social behavior; therefore, tobacco use is an issue that can be effectively addressed only at a population level through a combination of societal and individual interventions. In the late 1980s and early 1990s, the ASSIST model represented a major change in perspective—a paradigm shift—and changed the orientation of tobacco control across the United States.

All of the pre-ASSIST preparations were complete by October 1991. NCI had completed all the important processes:

1. Clearly describing the ASSIST project as a conceptual framework
2. Writing a request for proposals based on that framework
3. Releasing the request for proposals and receiving the proposals from the states
4. Reviewing the proposals and awarding 17 contracts
5. Awarding a contract for a coordinating center to provide technical assistance and training to the states

The principal mechanisms and the major forces were all in place. It was time to bring the ASSIST partners together and begin. The first task for the partners, as described in chapter 3, was to clarify and solidify the operational infrastructure and establish linkages among the participants.

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3. Structure and Communications

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3. Structure and Communications

In 1989, the National Cancer Institute (NCI) and the American Cancer Society (ACS) signed a memorandum of understanding to join in an unprecedented 7-year collaboration to mobilize state and local communities around tobacco control issues. In October 1991, NCI and the state health agencies of 17 states also signed contracts for 7 years. The state agencies would be responsible for planning and implementing tobacco control strategies and activities according to the American Stop Smoking Intervention Study (ASSIST) conceptual framework, under the codirection of NCI and ACS. In 1990, NCI signed a contract with Prospect Associates Ltd., which would serve the states as a coordinating center for technical assistance and training. The organizational units and the contracts were in place to begin ASSIST.*

This chapter describes the national partners and state agencies in their respective roles and the communication linkages among all the structural units that were essential for the project to function as a whole and for collaborative decision making. The strong structure and the rapid communication systems were the organizational forces supporting the implementation of interventions throughout the ASSIST states.

Linking the Units of a Complex Structure

To achieve a strong and lasting effect on tobacco use and its health consequences, the ASSIST project required strategic alliances among organizations and agencies with common or compatible missions. Although numerous groups across the nation were involved with tobacco control efforts, no large, coordinated tobacco control movement existed. Structurally, ASSIST was a network of partnerships between governmental agencies and nongovernmental organizations that linked national, state, and local agencies and organizations to work toward common goals. At the national level, NCI was the agency providing vision, direction, and most of the funding to the states. In partnership with NCI at the national level, ACS provided some funding to the states, program direction through its state and local divisions, and access to networks of essential volunteers in all states. At the state level, each health department was required to perform three tasks:

1. Establish a comprehensive tobacco control program
2. Build a coalition for tobacco control
3. Provide leadership for additional coalitions at the community level

Although each ASSIST state had individual needs and autonomy in implementing interventions tailored to those needs, the project as a whole had to function as a coher-

*The project was originally planned to end in 1998 but was extended through the end of September 1999.

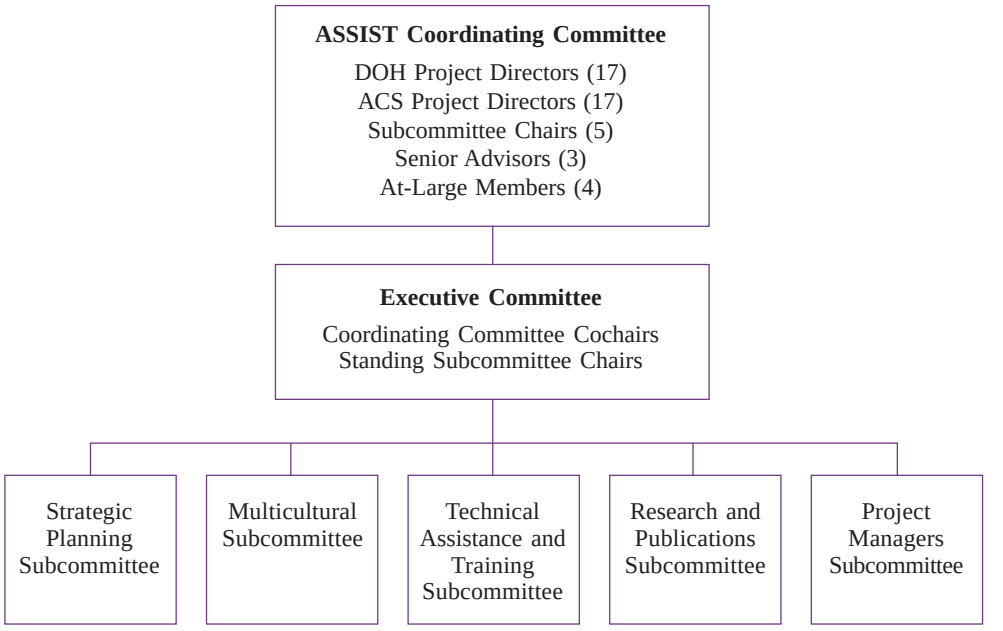
ASSIST Coordinating Committee Materials

ent, unified program. Achieving that cohesiveness was a challenge. The structural units of ASSIST were numerous, complex, and geographically distant, with the needs of the partners and coalitions evolving in response to unforeseen circumstances. By 1996, the 17 ASSIST states had 255 state and local coalitions with more than 2,900 members.[1] Linking all these units required clearly defined, effective systems of communications and decision making throughout the structure.

As a phase V demonstration project, in contrast to a research trial, ASSIST did not have a fixed protocol for all states to follow. However, there were tobacco control standards, fundamental program objectives, priority populations and channels, and specific types of interventions that had to remain intact and be reasonably consistent among the 17 states and the national organizations during the 8-year life of the project. In other words, the theoretical basis for ASSIST had to be developed into a practical, reality-based plan of action. Many systems, processes, and materials were needed, and multiple decisions had to be made. NCI funding for ASSIST through contracts with state health departments (in contrast to the more common cooperative agreements of the Centers for Disease Control and Prevention [CDC]) meant that many new checks and balances had to be established and consistently put in place. The requirements for the contracts were more prescriptive than the requirements for cooperative agreements, which the state health departments were accustomed to, and the contracts required specific, scheduled deliverables.

To enable orderly operation of the project according to established federal policies and procedures, systems for communication and collaborative decision making were put in place to serve the administrative functions and for networking and conducting outreach to those not directly funded by the project. For example, support, involvement, and effective communication mechanisms with the media, school systems, local government, and potential coalition members were critical to explain the project activities and efforts to the community at large, to counter tobacco industry attacks, and to protect program resources. As the project unfolded, new communication requirements emerged, and new issues and priorities evolved;

Figure 3.1. ASSIST: National Organizational Structure[a]



Source: This chart was developed by the ASSIST Coordinating Center, Rockville, MD.

Notes: DOH indicates Department of Health. ACS indicates American Cancer Society.

[a] This structure developed over time.

they necessitated revisions to the communication processes and decision-making systems.

Most of the mechanisms used for communication at the national level were replicated at, or adapted to, the state and local levels. For example, all states conducted meetings that included orientation and training events on the core concepts of ASSIST, which had been presented to state personnel at national training workshops in 1991 and 1992. In 1994, all states participated in a national training workshop on policy advocacy, and by the end of June 1995, nine states had conducted similar trainings locally. Reflecting the initial priorities established by NCI, the training emphasized the elements essential in the paradigm shift from primarily an individual behavioral change to a major emphasis on policy interventions and media advocacy. Because other features, such as state decision-making structures, were by design different from the national model, a more diverse array of mechanisms was developed to meet the specific circumstances of each state.

Figure 3.1 depicts the interrelationships of the national organizational units of ASSIST. NCI's Division of Cancer Prevention and Control was responsible for the design and implementation of the ASSIST project in terms of technical

scope, financial resources, and contracting mechanisms. NCI's Board of Scientific Counselors provided guidance and feedback regarding the ASSIST model and objectives.

The structure of ASSIST nationally comprised the Division of Cancer Prevention and Control of NCI, the national office of ACS, the health departments of the 17 contracted states, and the ACS division in those states. The ASSIST Coordinating Committee was established as a liaison to bring together representatives of each of those organizational units for purposes of coordination, planning, and communication.

Two NCI-led committees were established specifically to support the ASSIST project. The Scientific Advisory Committee regularly reviewed the overall progress of the 17 states in reaching their objectives and provided strategic input regarding science and policy issues. This group also shared pertinent information from other tobacco control interventions occurring throughout the United States. Membership of this committee included representatives of federal and state government agencies, ACS staff and volunteers, the ASSIST senior advisors, social scientists, and other researchers.

The Evaluation Committee was established to provide input and advice to the overall ASSIST evaluation plan. This committee identified key evaluation and research questions and answers, suggested secondary data sources, recommended priorities for evaluation activities, reviewed proposed analytic approaches and data collection methodology, and provided feedback on draft evaluation documents. Membership of this committee was composed of representatives from federal agencies and public health and academic settings.

At the national level, representatives of the ACS home office were members of both the Scientific Advisory Committee and the Evaluation Committee. Similarly, health department and ACS representatives from the 17 ASSIST states played a role at the national level primarily as members of the ASSIST Coordinating Committee.

The Major Organizational Units

The National Cancer Institute

The Smoking, Tobacco, and Cancer Program (see chapter 1), which spearheaded the ASSIST project, was part of NCI, 1 of 11 institutes (at the time) of the National Institutes of Health (NIH) supporting research on health and disease conditions. NIH is an agency within the U.S. Department of Health and Human Services established to acquire new knowledge through research to help prevent, detect, diagnose, and treat disease and disability. NCI was established as "the Federal Government's principal agency for cancer research and training."[2] Beginning in September 1990, NCI contracted with Prospect Associates Ltd. to serve as a coordinating center for the project over a period of 10.5 years for a total of more than $23 million.

Historically, NCI had funded cancer research mainly through grants awarded to public and private universities and

organizations throughout the United States. In contrast, through ASSIST, NCI would directly contract with state health departments, agencies that typically had not received funds directly from NCI. The unique nature of the contractual relationship between NCI and state health departments posed challenges that had to be addressed throughout the first several years of the project as it advanced from the planning to the implementation phase. In addressing those challenges, NCI's roles and relationships became multifaceted and complex. NCI served in the following six roles:

1. Scientific authority
2. Issuer of the project's request for proposals
3. Reviewer of the states' proposals
4. Funder and contract administrator
5. Technical consultant
6. Partner

As will become apparent in subsequent chapters, all of the roles evolved over time; they required NCI to be decision maker in some instances, to seek consensus in others, to yield to peer views, and to support and encourage the ASSIST staff and coalitions, while always being mindful of regulations, responsibilities, and the public trust.

The American Cancer Society

ACS had supported groundbreaking epidemiologic studies in the 1950s and 1960s that were important in establishing the link between smoking and cancer. Public education exhorting smokers to quit had long been part of ACS activities, including memorable public service announcements and stop-smoking messages during its annual Great American Smokeout. ACS had developed smoking cessation programs over the years; these programs were offered in communities to smokers at no charge. Name recognition of ACS was high, and the organization maintained strong credibility with the American public.

Left to right: Marc Manley, former Chief, Tobacco Control Research Branch, NCI; Jerie Jordan, former National Manager, ASSIST Project, ACS; and R. Neal Graham, Executive Director, Virginia Primary Care Association; ASSIST conference, Bethesda, MD, 1999.

ACS, along with the American Lung Association and the American Heart Association, formed the Coalition on Smoking OR Health in 1982. This coalition gave the three organizations a unified voice with which to support diverse efforts to advocate for tobacco prevention and control.

The coalition prepared information for its state-level groups, including position statements, drafts of model legislation, and tracking of state laws affecting tobacco.

The organizational structure of ACS offered the ASSIST project a nationwide network of people already committed to preventing cancer and tobacco use. The ACS structure comprised a national office in Atlanta and typically one division in each state. Divisions were further subdivided into local units. The national organization had a board of directors, as did each division and, in most cases, each unit. ACS took great pride in its volunteers, who served on boards and committees, administered programs, raised funds, and spoke on behalf of the organization.

ACS shared with NCI a mission of reducing the burden of cancer in the United States. As a nongovernmental organization, however, ACS could advocate for public policies and speak out against the tobacco industry in ways that a government agency was precluded from doing. As a member of the Coalition on Smoking OR Health, ACS had challenged the tobacco industry on several issues. With their long histories of cancer research and applications and their different advantages in legal status, staff, and membership, ACS and NCI formed a strategic alliance that was a natural evolution in the new approach of public-private partnerships for preventing and controlling tobacco use.

To document the partnership between NCI and ACS, the two entities signed a memorandum of understanding outlining their agreement and their respective contributions to the ASSIST project. (See appendix 3.A.) In this document, ACS pledged to contribute 15% of the amount that NCI would spend on ASSIST each year. This 15% would cover staff, training, travel, and materials. ACS specifically agreed to receive "no Federal, state, or local public funds for its participation in this effort, in keeping with its longstanding national policy."[3(p3)] Although ACS later changed its policy about accepting government funds, the organization continued to use only its own funds for ASSIST. These funds had fewer legal restrictions and allowed ACS to continue its advocacy and lobbying activities at the national and state levels.

The ACS national office provided the states with a tobacco control manager and technical assistance resources, and the divisions provided resources of funding, staff, and volunteer efforts. Staff directed advocacy efforts, built coalitions, participated in all aspects of national planning, and developed and delivered training programs. The total value of resources committed by ACS to the ASSIST states and national or state organizations was estimated to be between $25 million and $30 million over the life of the project.[4] By the end of the seventh year of the project, the ACS national office had spent $4.4 million in direct grants to ACS divisions for ASSIST.[5]

State Health Departments and ACS State Affiliates

ASSIST guidelines required state health departments to form a primary public-private partnership at the state

ASSIST Orientation Guide

ASSIST informational brochure

level to mirror that of NCI-ACS at the national level. The national ACS office vigorously promoted this partnership with their state divisions. Although technically other primary partnerships were possible under the guidelines, all 17 state health departments in fact partnered with state divisions of ACS. Although slight variations existed, most states named a member of their state health department as a project director and a member of the state ACS division as a project manager. All state health departments and ACS divisions were linked to the national structure through the ASSIST Coordinating Committee. (See page 55.) In some instances, the health department ASSIST project director and the ACS project manager served as the state's representative to the ASSIST Coordinating Committee meetings, conference calls, and workshops. Directors and managers, along with their respective state project executive committees, oversaw the programs at the state level.

State Project Executive Committees

Initially, the ASSIST contract guidelines prescribed decision-making structures. Each state was required to establish a small executive committee, with membership specified as follows: a maximum of 12 members, with equal representation from the state's health department and from ACS and with a maximum of 2 members from other agencies. These bodies were responsible for making decisions and for creating mechanisms for operations. As the program developed, however, coalition leaders took on this role. Moreover, many states found the initial formula too restrictive; in effect, it excluded potentially important partners from a significant decision-making role that would encourage their full participation in the project. As a result, some states, such as Minnesota and Wisconsin, included additional representatives on an *ex officio* basis, that is, they participated on committees and attended meetings but did not have voting privileges. New Mexico and Michigan gave more decision-making responsibility to their coalitions than did other states. Some state health departments, for example, those of Michigan and Minnesota, found it unnecessary for the committee to meet on a regular

basis, because members communicated daily.

The effectiveness of the primary partnership between state health departments and state ACS divisions varied considerably among states on the basis of many factors, including prior history of relationships between ACS and state health departments, tobacco control leadership contributions made by other voluntary health associations and agencies, and the collaborative arrangements already in place. In many states, the ASSIST-mandated partnership opened new lines of communication between the state health agency and the state division of ACS.

Local Organizational Structures

Organizational structures of state health departments and ACS are different from state to state. For example, in Colorado, all local health agencies are independent units, not state entities. Each county office in Colorado has autonomy and is on equal footing with the state office based in Denver. In Wisconsin, the state health department funds the 65 county health departments, each of which reports directly to the state. In North Carolina, the local health departments functions largely independently of but under contract to the state.

Along with the organizational structure came staff linkages. Most of the ASSIST programs were housed within the chronic disease program or the health education branch of a state health department. Where ASSIST was housed often determined the overall approach that the staff took in working with local affiliates and in developing coalitions. For example, in Maine, the ASSIST program was located in the Division of Health Promotion and Education and had direct linkages with the state health commissioner. In Indiana, the program was housed in the health education area and was a component of the overall media and public health education program without direct links to appointed staff or elected officers. Often the level of visibility or authority within the state health department was a direct reflection of the type of support that the staff received from top-level administrators in moving issues forward. In some cases, when ASSIST staff members were further removed, they became skilled at involving top-level management in tobacco prevention and control issues.

The project spanned several electoral cycles; therefore, changes in governors, state legislators, and department heads occurred in many ASSIST states during its 8 years. As these changes occurred, some state projects that were initially organized in environments supportive of active advocacy later found themselves in less-supportive environments. For example, the health departments of New York, Michigan, and New Mexico were restrained from submitting official comments on the need for the regulations proposed by the Food and Drug Administration that would limit tobacco industry marketing to youths.

Like the state health departments, ACS also had different organizational structures and linkages in the different states. The ACS ASSIST staff included one full-time person per state, except for New York, which had one project man-

ager serving metropolitan New York City and a second serving the rest of the state. Initially, most ACS ASSIST staffs were located in the ACS division's public education department; later, they tended to be housed in the cancer control department.

At the time ASSIST states were moving from the planning phase to the implementation phase, ACS was reorganizing, with different financial demands and constraints being placed on the affiliates. Overall, linking the program internally with other state health department priorities and ACS priorities was challenging yet necessary for overall consistency in delivering interventions and later for institutionalization. ACS found that another key challenge at the beginning of the program was that it was not the lead nonprofit organization on tobacco issues in a number of states. In many states, the American Lung Association or the American Heart Association was the key organization. These groups questioned the designation of their ACS counterpart as the lead voluntary health organization in their states, which posed organizational challenges for many coalitions.

Newsletter covers from Kent County Health Department, Grand Rapids (MI) and Coalition for a Tobacco-Free West Virginia, Charleston (WV)

Policy Advocacy Issues

Because of the tobacco industry's determined efforts to undermine ASSIST and to prevent the states from conducting policy advocacy activities (described in chapter 8), some ASSIST personnel were extremely conservative in interpreting the federal policies restricting lobbying and even feared restrictions that were actually legitimate practices of policy support and advocacy. Some commissioners and legislative staff became concerned about even the appearance of impropriety, so they placed even higher restrictions on staff than was required by federal law.

ASSIST states were careful to comply with federal restrictions prohibiting use of program funds for lobbying activities, defined as activities that directly support a specific bill proposed for legislation. Federal regulations did not restrict policy advocacy and educational activities. Over the course of ASSIST, federal restrictions on lobbying activities became more extensive. The restrictions prohibited activities first at the federal level; then at the state level; and, in 1998 through the Federal Acquisition and Streamlining Act, at the local level. Thus, the advocacy and lobbying roles

of ACS and other private partners became increasingly important with time. Many ASSIST staff within state governments and many subcontractors receiving federal funds began to rely more heavily on nongovernmental partners, such as ACS, to take on the responsibility for advocacy-related communications, including many of the media advocacy activities supporting policy change.

Resources and support for advocacy varied widely among ACS divisions, especially at the beginning of the project. Although the national office had signed the memorandum of understanding with NCI, not every ACS state executive was fully committed to a partnership with such a strong policy emphasis. However, over time, ACS leaders began to better understand their roles as spokespersons and advocates. Within ACS there was reluctance, especially among the staff, when divisions, such as the one in Massachusetts, took on the leadership of campaigns for state cigarette excise taxes. The massively funded tobacco lobby fiercely opposed these campaigns. However, when such campaigns were successful, they reinforced the public identity of ACS volunteers and staff.[6]

As with health departments, whether ACS staff had organizational support for the ASSIST approach to policy and media advocacy depended on where the staff was located within the division's organizational structure. In Indiana, for example, the staff was housed in the cancer treatment section. The emphasis was on cancer research, not policy change; therefore, these staff members had an internal obstacle to overcome in addition to their task of educating external audiences. Later, when the national ACS office made changes that included a policy advocacy component, the Indiana ASSIST staff received the necessary internal support. In Minnesota, the staff was housed in the director's office and had direct access to the organization's leaders.

To help in the transition to the new approach, the ACS national staff produced a video centered on the paradigm shift in tobacco control from individual interventions to public health and policy approaches. The video featured Michael Pertschuk, codirector of the Advocacy Institute, commenting on various news segments; the video was shown at numerous ACS meetings of staff and volunteers. ACS also created *ASSIST: A Guide to Working with the Media,* a compendium of fact sheets, questions and answers, and sample press releases describing the project.[7] The guide was helpful to states in translating the complexities of ASSIST into more media-friendly terms.

Coalitions

With the underlying assumption that social change is more likely to occur when those who will be affected are involved in planning, initiating, and promoting the change, coalitions became the backbone of ASSIST. (See chapter 4 for more on coalitions.) Each ASSIST state was required by contract to already have in place or to establish a state-level coalition for tobacco control and coalitions in communities. The state health departments and the ACS divisions formed coalitions with health organizations, social service agencies, community groups, and private citizens to develop and to imple-

ment comprehensive tobacco control plans.

Public agencies participating in coalitions included state health departments and various levels of local government, including counties, municipalities, townships, school districts, and boards of health and local health departments. Often these entities held subcontracts and were encouraged to form similar partnerships with private agencies, such as local units of voluntary associations, hospitals, clinics, local businesses, service organizations, civic clubs, and youth organizations. Typically, the formation of local coalitions facilitated communication between these local entities.

While the request for proposals had prescribed the state structures, it did not prescribe the operational style and structure of the local coalitions. In Wisconsin, each of the 65 county health departments received state funds through ASSIST to develop and design coalitions replicating the state model. Challenges arose because ACS did not have affiliates or representation in each of those 65 counties and thus could not structure the coalitions in the same manner. However, in other states, such as South Carolina, local coalitions were effectively developed with both ACS and health department representation. Several states developed or identified local coalitions as the need or desire arose. New York grouped its statewide efforts by region: the western region, which included Buffalo; the capital region, which included Albany; and the metropolitan region, which included New York City. In other states, such as New Jersey, local coalitions emerged on their own through the efforts of community leaders.

In an attempt to assist the staff in the field, NCI identified key organizations having state or local affiliates that could eventually be drawn into the coalitions. Organizations having a stake in tobacco control and affiliates in the field included the American Public Health Association, American Medical Association, League of Women Voters, National Association for the Advancement of Colored People, National Organization for Women, and Girl Scouts of America. These groups could be potential allies in the field if national buy-in and support were established.

The states identified and enlisted key individuals at the state and local levels, who became committed tobacco control leaders and advocates in their communities. These individuals brought passion and commitment to the project. They acted as grassroots counterparts to the tobacco industry's grassroots efforts. Widespread involvement reflected the ASSIST project's basic principle that optimal tobacco control occurs when community-based strategies are implemented by partnerships composed of strong health advocates and local leaders.

Mechanisms for Coordination, Decision Making, and Communication

Because of the diversity of the ASSIST partners and coalition members, maintaining a common goal and spirit, advancing the planning and implementation phases of the project simultaneously among all 17 states, and coordinating all partners and activities often were major challenges. Mechanisms for communica-

tion and decision making among the partners and coalitions were critical needs. Partly through NCI's leadership and partly through ideas coming from the states, several mechanisms were set in place.

The ASSIST Coordinating Center

The ASSIST project was designed to make a substantial investment in developing the skills of the staff of the contracted states; therefore, the project's structure included a coordinating center to provide technical assistance and training. NCI developed a statement of work and released a request for proposals to conduct the work of an ASSIST Coordinating Center. NCI's use of a contracted coordinating center allowed for more rapid recruitment and hiring of staff and provision of technical assistance and training. On September 25, 1990, NCI awarded a contract to Prospect Associates Ltd.*

The ASSIST Coordinating Center worked with the staff at NCI to meet the needs of the project through technical assistance, training, communication, networking, and monitoring of performance. Throughout the project, the ASSIST Coordinating Center provided strategic technical consultation and support to the ASSIST committees and subcommittees. The center helped identify the states' priorities and strategic needs for each committee and subcommittee through regular bimonthly and monthly conference calls and semiannual meetings. The ASSIST Coordinating Committee (described in the next section) met at least 17 times, and the subcommittees met semiannually from 1994 to 1995. The amount of staff support required to organize and coordinate all the project's meetings and conference calls was considerable.

The ASSIST Coordinating Center was a critical mechanism for facilitating communication among the 17 states and between NCI and the project sites. In addition, the center developed and produced relevant materials, provided conference support, and conducted data analyses and ancillary studies. The center staff met weekly with NCI staff to discuss the states' needs.

Types of Technical Assistance Provided

From ASSIST's inception to the end of the project, Prospect Associates Ltd. staffed NCI's ASSIST Coordinating Center. It became the hub through which training and technical support services and materials were delivered, such as the following:

- Technical support to the NCI program office
- Training programs and materials
- Resource materials
- A centralized information and materials center
- Administrative support for ASSIST committee meetings
- An electronic communications system to facilitate communications among the sites and NCI
- Development and implementation of state plans to reduce smoking prevalence
- Technical support in organizing community coalitions, assessing needs, and building consensus
- Legal consultation

*In April 2000, Prospect Associates joined the American Institutes for Research (AIR), enhancing AIR's communications capabilities and strengthening the services provided to clients.

The ASSIST Coordinating Center assigned specific technical assistance specialists to work collaboratively with the NCI project officers and the state and ACS project managers for the duration of the project to provide technical assistance, information, and resource materials for capacity building, and to consult with NCI on the states' issues and needs.

In addition to phone conferencing and electronic communications, technical assistance specialists made site visits and were in frequent contact with staff members in the 17 states to discuss their needs for technical support and assistance. (See appendix 3.B for a list of "Key Required Resources.") The technical assistance specialists provided information on how other states were addressing specific problems and put staff members in direct contact with one another to share the ideas and expertise developed in individual states. The ASSIST Coordinating Center shared materials produced by the individual ASSIST states with the other states through monthly mailings. The technical assistance specialists also served as liaisons between the states and NCI staff by gathering information from the states as needed, reporting on the states' progress, and informing NCI staff of states' requests.

The ASSIST Coordinating Center was also responsible for tracking and analyzing newspaper coverage of tobacco control issues. The center designed an ongoing ASSIST newspaper analysis study using a clipping service and database to systematically track newspaper coverage of tobacco-related policy issues in all states. Analyses of the data provided information to the staff on newspaper coverage in their states.

During the early phases of the project, conferences occurred frequently for training and information exchange. The conferences brought together project directors, managers, and key staff from the state health departments and state divisions of ACS, as well as NCI staff, consultants, and support staff from the ASSIST Coordinating Center. The states also were encouraged to send key staff or volunteers from the state and local coalitions and projects.

Platform for Collaboration: The Work of Committees

Committees and their subcommittees played important roles in facilitating and maintaining internal communications among states, NCI project ASSIST staff, and other elements of NCI. The membership, structure, and function of the ASSIST Coordinating Committee and subcommittees evolved over the course of the project as new decision-making issues and communication requirements emerged.

The ASSIST Coordinating Committee

As defined in the ASSIST request for proposals, NCI created the ASSIST Coordinating Committee at the project's inception to

1. help disseminate intervention information,
2. bring unresolved field issues to the attention of project staff,
3. formulate policy questions and recommendations for consideration by the ASSIST Scientific Advisory committee,
4. identify project-wide needs and resources, and

5. oversee project management and accountability.

Membership on the ASSIST Coordinating Committee consisted of two representatives from each state: the project director for the health department and the project director from ACS, or a designee, as depicted in figure 3.1.

During the planning phase, the ASSIST Coordinating Committee played an important role in building collaboration and commitment to the project among the states. Although all project directors had the same role and responsibilities in ASSIST, their backgrounds and preparedness varied in terms of their knowledge of the ASSIST assumptions and contract deliverables. The national meetings were important in providing a platform for developing a common understanding of the project and for decision making.

The meetings were well attended, and state representatives played a pivotal role in determining the agenda and often led discussions on key issues. Leadership for the committee was provided by the following three senior advisors: Helene Brown, an ACS volunteer in California; Sister Mary Madonna Ashton, a Minnesota state health department director; and Dr. Erwin Bettinghaus, a Michigan State University researcher in tobacco control. They were instrumental in guiding the committee during its critical planning phase and served as the link between the NCI ASSIST program and the NCI scientific community. Sister Ashton was the link between the program and state health departments, and Mrs. Brown, a long-time leader with ACS and an immediate past member of NCI's National Cancer Advisory Board, was the link with the national and state ACS affiliates. Dr. Bettinghaus was the study chair for the Community Intervention Trial for Smoking Cessation (COMMIT) and a member of the National Cancer Advisory Board until early 1995, with the responsibility of reporting on ASSIST to that board.[8]

The ASSIST Coordinating Committee played an important role in protecting ASSIST resources. In response to legislative interest in increasing research on breast cancer (and other priorities) and to pressure from the traditional grantee research community, NCI funding priorities shifted away from ASSIST, and the state contracts were reduced in the first year of the ASSIST implementation phase. The initially proposed total budget of $23.3 million for 1993 was reduced to $18.2 million.[9] Through resolutions and letters from the committee, individual state letters, and personal contacts, the ASSIST Coordinating Committee communicated its objections and concerns directly to the NCI administrative authorities responsible for budget cuts. In addition, the committee took the lead in communicating with and organizing the response from those elements of the NCI cancer prevention constituency that continued to be supportive of ASSIST as originally designed.

In an e-mail to the editorial team of this monograph, on June 4, 2002, former ASSIST Senior Advisor Helene Brown noted that at the early date of 1993, the ASSIST states were not prepared to spend all of the funds that would be provided; thus, each state had carry-over

funds from money that had not been spent by the end of the year. In a sense, the cut funds represented a delay in funding rather than a cut because an additional year of funding for the project was proposed. In fact, with the addition of the sixth implementation year, total funding for the project was increased. This experience profoundly reinforced the conviction of the members of the ASSIST Coordinating Committee that a strong participant-defined role for the committee would benefit the project.

The first 2 years of ASSIST were dedicated primarily to translating the ASSIST theoretical model into an operational process, which staff from various organizations with varied backgrounds would implement. NCI staff members viewed initial meetings of the ASSIST Coordinating Committee as opportunities (1) to educate project directors about the objectives of ASSIST, the requirements of the contract, and the contributions that various entities within NCI and national ACS were making to its operation and (2) to discuss how project directors could most effectively implement the project according to the guidelines. NCI staff planned agendas for the meetings; these agendas were based on individual discussions with state project staff and a conference call with the executive committee, which included senior advisors. Meetings consisted of a series of presentations by ACS and NCI staffs, senior advisors, or consultants. At that time, the role of project directors was to receive the information provided, to discuss the implications, and to return to their states better equipped to administer the project according to the prescriptions of NCI staff and senior advisors. As the projects matured, project managers were able to take on more of the leadership roles.

The first 2 years of ASSIST required states to plan a comprehensive and effective program and to develop and mobilize a foundation of coalition partners. All states were operating under the same criteria, but they were in various stages of readiness. The first 2 years were spent getting people from various regions of the country with different backgrounds and expertise to understand the contractual agreement with NCI.

By the committee's meeting on May 13, 1993, the project was in transition from the planning phase to the implementation phase.[10] The project directors believed that a constructive approach would be to recognize and use their considerable state-level experience in implementing tobacco control programs and other health agendas and to involve them in a more interactive and collaborative way. As a result, the project directors took an active role in reorganizing the ASSIST Coordinating Committee, elected officers, took charge of developing and approving the agenda, and expressed the need for flexibility and judgment in determining which planning and intervention steps were appropriate for each state. Recognizing that the approach was consistent with the strategy of community organizing being applied in the ASSIST project sites, NCI supported these changes.

The reorganization of the ASSIST Coordinating Committee created the potential for more effective communication

The Cancer Letter, a privately published newsletter (used with permission of The Cancer Letter*), and* The Link*, published by Smokefree Indiana*

among the states, the ASSIST Coordinating Center, and NCI staff. A number of subcommittees emerged to provide forums for discussion and to identify needs that NCI and the ASSIST Coordinating Center might address: the Program Managers Subcommittee, the Strategic Planning Subcommittee, the Research and Publications Subcommittee, the Technical Assistance and Training Subcommittee, and later the Multicultural Subcommittee. The ASSIST Coordinating Committee and its subcommittees were important linkages through which the states participated in project-wide decision making and shared issues of concern or interest with NCI staff. Also, they were a useful mechanism for communicating with key administrators, policymakers, and opinion leaders at the national and state levels. Most of the subcommittee work was accomplished through regularly scheduled conference calls, but meetings were also held, sometimes in conjunction with the national training and information exchange meetings.

The Strategic Planning Subcommittee

The Strategic Planning Subcommittee began as a task force and was changed to a subcommittee in 1993. This group was charged with the responsibilities of developing plans and making recommendations to the ASSIST Coordinating Committee for those activities that required consideration or decision making at the national level and could have a synergistic effect in advancing policy advocacy goals for tobacco prevention and control. The subcommittee addressed short-term and long-term strategic issues and as needed established working groups to gather more information and make recommendations for action to the full subcommittee. Position papers and recommendations for action were brought before the ASSIST Coordinating Committee once the subcommittee had reached a consensus.

From the beginning, the subcommittee established strong links with the Technical Assistance and Training Subcommittee. Representatives of the two groups were routinely invited to attend each other's conference calls, and the Strategic Planning Subcommittee occasionally provided suggestions for specific training topics related to strategic

planning issues. For example, in October 1996, a Site Trainers' Network module on durability planning was delivered at the suggestion of the Strategic Planning Subcommittee. This collaboration helped integrate project activities to ensure that learning occurred at the appropriate levels and times.

The Strategic Planning Subcommittee played a principal role in the following five noteworthy accomplishments:

1. The 1-year extension of ASSIST support
2. Collaboration with the Multicultural Subcommittee to promote diversity and cross-cultural competence throughout all aspects of the ASSIST project
3. Substantial increase in financial support for the 33 states participating in CDC's Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT) project
4. Development of visionary papers for advancing a national comprehensive tobacco prevention and control plan
5. Leadership for developing a national tobacco control movement that included participation by all 50 states, the District of Columbia, and the U.S. territories

As the ASSIST project reached the midpoint of the implementation phase, issues related to the planned termination became important for the ASSIST Coordinating Committee. As a result, the Strategic Planning Subcommittee was charged with new priorities and objectives. Eventually, this led to the creation of new communication and decision-making structures to provide a basis for joint planning that included states outside of the ASSIST project. (See chapter 9.)

Initial efforts were directed internally to raise consciousness about the implications that the termination of ASSIST would have for ASSIST participants, for health department administrations, for state ACS affiliates, and within NCI. Later, communication efforts focused on multiple outreach activities to engage non-ASSIST states, national organizations, and other appropriate groups in forging a consensus of support for a plan that had been developed to address the critical issues. (See chapter 9.)

The Multicultural Subcommittee

When it became apparent that ASSIST was not successfully engaging communities of color, a multicultural task force, which later became the Multicultural Subcommittee, was formed to serve as a forum for discussing and providing input to the national program requirements for ASSIST. The cochairs of the Multicultural Subcommittee were appointed to the ASSIST Coordinating Committee.

The ASSIST project's response to the need to address ethnic minority and cultural diversity issues more effectively was an example of a communication process that began at the local level among field staff and worked its way back through the project structure to project managers, directors, and NCI staff. At training and information exchange conferences held in October and December of 1993, a number of project field staff expressed concern that ASSIST

was not adequately addressing the needs of minority communities. As a result, the Strategic Planning Subcommittee sponsored an ad hoc task force of those interested in multicultural issues. Nearly all participants were field staff from the ASSIST project sites or members of local coalitions. The task force had several teleconferences with support from the ASSIST Coordinating Center before the May 1994 training and information exchange conference. At this conference, the task force developed recommendations to be presented at the ASSIST Coordinating Committee meeting that followed the conference. The conference included participants from projects funded by the CDC and The Robert Wood Johnson Foundation, and a number of these individuals joined the multicultural task force. Their participation stimulated the task force to articulate the need for a national effort that would extend beyond the ASSIST states.

The task force reported to the ASSIST Coordinating Committee that states should be doing a better job of conducting outreach to minority communities and of meeting the objectives related to the needs of these communities and that NCI should make addressing these objectives a higher priority in training and program evaluation. The task force pointed out that the coordinating committee was seriously underrepresented by persons of color—only 3 persons of color out of 68 ACS and state health department project managers and directors sat on the committee. The task force made the following recommendations regarding its own role and composition:

- It should be given a permanent status.
- Its membership should include persons from states not participating in ASSIST.
- It should be given the responsibility of developing specific criteria by which to evaluate each state project's performance in reaching objectives related to minority communities.
- It should be given the responsibility of assessing performance relative to those criteria.

The report was received with mixed reactions. Most controversial was the report's recommendation that the task force develop criteria and evaluate state efforts to reach minority communities. Some project directors felt that the very formation of the task force represented unjust criticism of their efforts. They felt that they had not been adequately consulted about the formation of the task force and questioned the inclusion of individuals who were not with ASSIST.

NCI staff members attempted to reassure task force members that reaching minority populations was an important priority and cited examples of efforts being made to address the issue. However, many task force members interpreted this response as minimizing the problem. When the ASSIST Coordinating Committee closed its initial session by adopting a resolution thanking the task force for its work but essentially ignoring its recommendations, task force members were disillusioned. Several committee members, after talking with other task force members, agreed to ask the committee to revisit the issue the next day. At the next session, the committee voted to rescind its initial resolu-

tion, passed a new resolution that adopted a mission statement drafted by the task force, and asked the task force to develop specific suggestions for improving ASSIST's ability to obtain input from culturally diverse communities and for more effectively achieving ASSIST objectives related to reducing tobacco use in minority communities.

Subsequently, the cochairs of the ASSIST Coordinating Committee met with NCI staff and the cochairs of the multicultural task force. It was decided that a permanent multicultural subcommittee should be formed and that a cochair of the subcommittee would be a full member of the ASSIST Coordinating Committee. It was also decided that the membership and business of the new subcommittee would be specific to the ASSIST project, that others could consult with the subcommittee, and a member of the Multicultural Subcommittee would be involved in responding to requests about multicultural issues. All cultural groups were not represented on the ASSIST Coordinating Committee because membership was a function of who occupied the positions of project director and ACS project director in the states. Therefore, it was agreed that, in addition to a representative of the Multicultural Subcommittee, four at-large positions would be created to introduce additional ethnic diversity to the ASSIST Coordinating Committee. The Multicultural Subcommittee would be asked to recommend and help recruit persons to provide input from African American, Hispanic/Latino, American Indian/Alaska Native, and Asian American/Pacific Islander communities. Last, it was agreed that at least two project directors should serve on the Multicultural Subcommittee to help ensure improved communications. The ASSIST Coordinating Committee adopted the recommendations at its next meeting in December 1994.[11]

Although the early efforts of the Multicultural Subcommittee to deal with multicultural issues were challenging, throughout the life of ASSIST the members of this subcommittee became quite adept at pursuing and advocating for their priorities and at utilizing the communication mechanisms available, especially the ASSIST Coordinating Committee structure. The following actions resulted from the formation of the Multicultural Subcommittee:

- Cultural diversity was given higher priority within the ASSIST project.
- The diversity mission of the Multicultural Subcommittee expanded to include tobacco-related issues in gay and lesbian communities.
- Specific multicultural training meetings were held, and more effort was made to identify and disseminate culturally sensitive materials.
- ASSIST training and information exchange conferences devoted more time to multicultural topics.
- NCI staff carefully reviewed state annual action plans to ensure that adequate attention was given to multicultural issues.
- Representation from the Multicultural Subcommittee was included on all standing and ad hoc committees to improve access to and participation in the communication and decision-making processes at all levels.

- The Multicultural Subcommittee participated in the development of the multicultural training module *From Sensitivity to Commitment*.

The events surrounding the formation of the Multicultural Subcommittee also affected communication and decision-making processes within ASSIST. The ASSIST Coordinating Committee structure was reorganized and made more inclusive. A new Project Managers Subcommittee was formed, and each subcommittee had a seat on the committee. Also, an effort was made to recruit staff members other than managers and directors to the subcommittees. This resolution of multicultural issues and the general opening of the lines of communication and decision making for the project could not have occurred had NCI staff not recognized and supported at the national level organizational development that was consistent with the ASSIST assumptions being applied in the individual states.

The Technical Assistance and Training Subcommittee

The role of the Technical Assistance and Training Subcommittee was to plan and review the development of training activities and to make recommendations regarding project-wide technical assistance strategies. All ASSIST staff and coalition members were eligible to serve on this subcommittee. The members selected a chairperson.

The subcommittee provided substantive input to such initiatives as the following:

- Agendas, presenters, and formats for the information exchange conferences and national conferences
- The site trainers' network program and relevant training materials
- Training modules on youth advocacy, policy advocacy, media advocacy, multicultural, and post-ASSIST program continuance issues

In 1996, the Technical Assistance and Training Subcommittee conducted a training needs assessment to revise the original Strategic Training Plan from 1991. Input was sought from health department and ACS project managers regarding training needs, interests, and priorities. Most of the issues identified as priorities concerned building skills and capacity for long-term success after ASSIST funding ended. In addition, throughout the ASSIST project, members of this subcommittee regularly participated in the conference calls and discussions held by the Strategic Planning Subcommittee. As the end of ASSIST drew near, members of the Technical Assistance and Training Subcommittee participated on the advance teams that studied various aspects of resources for building a national tobacco prevention and control program.

The Research and Publications Subcommittee

The role of the Research and Publications Subcommittee was to develop and review project policy regarding scientific publications and presentations about ASSIST. This subcommittee also provided guidance to ASSIST states on the strategic use of data in professional publications to further ASSIST objectives. Members of the subcommittee regularly tracked and reported on the status of commissioned papers covering national

and state issues in ASSIST and maximized opportunities for presentations on ASSIST at important national conferences, such as those of the American Public Health Association. All ASSIST staff and coalition members were eligible to serve on the subcommittee. The members selected the cochairs. The subcommittee conferred regularly via telephone conference calls and also met in conjunction with ASSIST conferences.

In 1999, as ASSIST drew to a close, the Research and Publications Subcommittee responded to a request from the ASSIST Coordinating Committee to propose a role for the committee in the evaluation and dissemination stage of ASSIST. Participation by the committee was an important issue because decision making for the governance, operations, and future of ASSIST had evolved into a highly participatory process. While NCI emphasized that the evaluation must remain objective, the committee favored continuing the participatory process and pushed for an action evaluation that would involve ASSIST staff. The outcome was the formation of the Documentation and Dissemination Workgroup. The ASSIST Coordinating Committee submitted to NCI recommendations for membership of this workgroup.

The responsibilities of the workgroup were to identify conferences and other opportunities at which to present ASSIST findings, to promote and facilitate publication of data from ASSIST studies, and to be a communication link between NCI and the evaluation group.[12] The workgroup was also asked to assist with the development of a monograph that would describe how ASSIST was organized, how it operated, the types of activities it conducted, and the insights gained that were applicable to other tobacco prevention and control efforts. The workgroup developed an outline for the monograph, identified authors and reviewers, developed timelines and work schedules, and determined relevant citations and sources of information. The workgroup sought input from individuals in all the ASSIST states and from members of the various project committees. This culminated in the writing and development of this monograph.

The Project Managers Subcommittee

The Project Managers Subcommittee was established to provide project managers with opportunities to exchange ideas, identify issues of mutual concern, and communicate these to NCI staff. It also provided a means for NCI staff to communicate priorities, policies, and procedures and to obtain feedback on their feasibility and progress in implementation. This exchange was essential because project directors varied greatly in their knowledge of ACS divisions and in their knowledge of and their involvement in specific ASSIST activities and day-to-day issues. Some project directors provided close direction and had detailed knowledge of the project activities; others delegated most of the decision making to project managers and had very little knowledge about the details of the project.

The subcommittee was divided into three groups. The first group consisted of state health department and ACS project managers, who discussed issues relevant to both partners' roles in the

project. The second group included only the state health department project managers, because most of the discussion was related to the responsibilities of state health departments as the prime contractors for the ASSIST project. The third group consisted of ACS project managers, who met periodically to discuss issues related to the administration of state divisions and their relationship with the national ACS. One additional reason for forming separate groups was that both ACS and the state health department project managers felt that there were topics affecting project management that might be more freely discussed among colleagues of the same partner type. The members planned their own agenda to parallel the conference agenda. For example, speakers from the Food and Drug Administration and the Substance Abuse and Mental Health Services Administration presented information to the project managers about implementation of their agencies' regulations, and NCI staff presented an overview of legislative tracking systems. The subcommittee also discussed issues that the managers had to deal with, such as burnout toward the end of the project and how to plan for program continuation after ASSIST.

Communication Vehicles

As the technology of electronic communication advanced, the state partners and subcontractors, following the general trend of business communication, increasingly relied on e-mail, listservs, and Web sites for rapid communication on advocacy-related issues. At the time, the use of electronic communication was forward thinking for a public health program, and the new technology enabled quick response to the states' needs, simultaneous reception of news, and rapid sharing of successful strategies. Most states developed phone and fax trees to reach individuals and organizations that did not have easy access to e-mail. Several states established state Web sites as the project was ending.

All states developed brochures and brief publications—some modest, others quite sophisticated—to describe the ASSIST project and its core assumptions to potential participants, opinion leaders, government officials, the news media, and the general public. All states, except Massachusetts and Wisconsin (which had other mechanisms in place), developed newsletters to communicate information to ASSIST participants within the state and to other interested parties. The newsletters provided information about state and local coalition activities, news, facts and statistics on tobacco and the tobacco industry, types of policy interventions, specific legislation and legislative activities, and advocacy approaches to specific state and local bills and laws.

Formats and editorial policies varied widely. For example, some states, such as North Carolina, used the newsletter to establish the ASSIST "brand name" for their tobacco control activities. Other states chose to identify tobacco control activities with a preexisting state coalition, program effort, or other entity that was already widely recognized, such as Tobacco-Free Indiana and the Coalition for a Tobacco-Free West Virginia. The mix of topics and the emphasis on facts,

educational activities, general news, or specific advocacy-related topics varied considerably among states and over time, especially in light of strategic factors. For example, projects in tobacco-growing states tended to emphasize news, health facts and figures, and neutral descriptions of legislative events in newsletters and relied on ACS or other nongovernmental partners to communicate advocacy issues to the public. In states where governors and the heads of health departments were supportive of, or at least tolerant of, an advocacy approach, ASSIST projects included advocacy content in their newsletters. Controversy did arise; at one point in Missouri, the ASSIST newsletter editor decided not to publish an issue because an attorney from the state's health department censored a large amount of text. The staff subsequently reached a better understanding with the state's public information office and resumed publication.

ASSIST's Electronic Communication System

Through a subcontract from the ASSIST Coordinating Center, the Advocacy Institute developed an electronic communications system (ECS) for ASSIST to facilitate rapid communication and access to information. ECS was modeled on the Advocacy Institute's Smoking Control Advocacy Resource Center Network (SCARCNet), an information exchange service for tobacco control advocates. The ASSIST ECS was a monitoring system for receiving and reporting on the states' progress, and a service for providing current published articles on tobacco control news. All ASSIST sites were required to purchase computers, modems, and software that met specific standards to facilitate communication with NCI and among the states. Periodic upgrades were required to keep pace with the rapid advances in technology. All sites were linked with one another, NCI, and the ASSIST Coordinating Center through ASSIST-only bulletin boards that were attached to SCARCNet. ECS was a critical element in supporting policy issues and countering the tobacco industry.

As ASSIST matured, listservs and e-mail began taking precedence for project-specific communications, and the larger SCARCNet environment was preferred for strategy exchanges. Although such modes of electronic communication were in common use by the end of the 1990s, the systems used in ASSIST represented a forward-thinking approach for public health early in the decade.

Planning for Strategic Communication

Within a short time after the ASSIST states began implementing interventions, the tobacco industry vigorously attempted to thwart the project not only by discrediting the project itself, but also by attacking the credibility of those involved with the project. The industry used the media to challenge the tobacco control policies supported by ASSIST coalitions and to create the impression that more damage than good would be done to the population because of economic implications. For example, a criticism raised in numerous locations was that efforts to decrease youth access to tobacco were clearly antibusiness. More alarming

even were vague implications that the project was somehow illegally using its resources to engage in activities inappropriate to federal and state government agencies. These issues are discussed in depth in chapter 8.

The electronic and other communication mechanisms enabled ASSIST staff members at all levels to communicate with one another and to respond quickly to crises. However, these repeated challenges necessitated a planning process that would enable ASSIST partners to respond strategically and effectively as crises or urgent situations arose and even to take the initiative in placing these issues before the public and decision makers.

Recognizing the ability of the private sector to respond to issues that could affect its credibility and public image, NCI staff sought expertise about applying these methods to a public health program. Accordingly, NCI and the ASSIST Coordinating Center worked with experts in the field of strategic and crisis communication to isolate the elements that are critical to a strategic communication plan. These elements address the need for an appropriate visible leader, the need for quick decision making, and the need to protect credibility: careful consideration of how to respond and what to communicate must occur before the credibility of the program or agency is damaged. Along with other fundamentals depicted in the sidebar, timeliness in responding is critical.

Using these fundamentals, the ASSIST Coordinating Center provided seminars, training workshops, and onsite technical assistance to ASSIST staff and partners to develop strategic communication plans. The resulting plans varied from location to location but generally included the following three elements:

1. Concise, hard-hitting main messages about what the ASSIST project was to accomplish
2. Scenarios in which key, hard-to-answer questions about ASSIST were developed with concise, specific answers to the questions, along with a strategy for delivering them
3. Strategies for transitioning from the crisis response mode to proactively delivering the main messages about ASSIST and the facts of tobacco use

During the training sessions, the states shared experiences and insights, such as successful and unsuccessful methods of coping with or even capitalizing on tobacco industry efforts. (See chapter 8.) The states were prompted to carefully review advocacy activities for compliance with federal and state laws and with policies of their agencies. National-level NCI and ACS staff participated in strategic planning and training to be spokespersons for issues regarding ASSIST at the national level. A Communications Action Team was created to meet crisis needs. The partnership empowered this team to respond very quickly to any accusations against ASSIST and then to disseminate information throughout the ASSIST networks to make everyone aware of what was happening. By authorizing the team to act independently, they successfully circumvented the otherwise cumbersome process of obtaining a series of approvals from various committees.

Readiness to Build Capacity and Capabilities

Throughout the course of ASSIST, coordination, decision making, and communication mechanisms were continually evolving and adapting to changing circumstances and needs. This responsiveness was apparent in the initial redefinition of the role of the ASSIST Coordinating Committee. It was also apparent in certain reforms. These reforms were made to the decision-making process after the staff and local participants told project directors and NCI staff that greater attention should be given to serving the needs of ethnically and culturally diverse communities. The mechanisms in place made it possible for the 17 ASSIST states to implement the interventions and to function as a coordinated tobacco prevention and control program.

Chapter 4 describes the systems and products that were offered to and utilized by the states to build their strength, especially through coalitions, and their skills, through training and practice, to plan for and implement comprehensive tobacco control interventions.

Fundamentals of a Strategic Communication Plan

Purpose

- To respond to urgent program issues
- To take advantage of unique opportunities

Steps of a Strategic Communication Effort

- Define the situation.
- Collect and review available information.
- Identify the messages, strategies, and spokespersons to be used.
- Identify and mobilize resources.
- Evaluate the effort.

Criteria for Identifying Threats and Opportunities

- Time is of the essence.
- The circumstance is not routine; it is out of the ordinary.
- There is a policy issue that must be addressed.
- The circumstance is a one-time advantageous occurrence.

Reactive Strategic Objectives

- To discern issues that need a rapid, public response
- To present the most effective partners as spokespersons
- To use national resources as appropriate
- To monitor the effectiveness of response and shift strategies if necessary

Proactive Communication Objectives

- To maintain a central focus on health
- To legitimize tobacco control as a public health issue
- To present a unified voice for ASSIST
- To maintain solidarity for ASSIST partnerships
- To evaluate and learn from experiences

Appendix 3.A. Memo of Understanding Between the National Cancer Institute and the American Cancer Society

July 20, 1990

Re: The American Stop Smoking Study for Cancer Prevention (ASSIST)

This Memorandum of Understanding defines the respective roles and responsibilities of the National Cancer Institute and the national organization of the American Cancer Society relative to the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST). The Memorandum assumes that the American Cancer Society Divisions will serve as the voluntary health agency collaborating with the local health department in the vast majority of ASSIST sites to be funded in 1991. If the American Cancer Society is not the lead voluntary health agency in at least 75% of the ASSIST sites, this Memorandum will need to be modified to reflect the relative contribution of each organization to the collaborative relationship.

Background

The American Stop Smoking Intervention Study for Cancer Prevention represents a collaborative effort between the National Cancer Institute and the American Cancer Society, along with State and local health departments and other voluntary organizations to develop comprehensive tobacco control programs in up to 20 states and metropolitan areas. The ASSIST intervention model is based on proven smoking prevention and control methods developed within the National Cancer Institute's intervention trials and other smoking and behavioral research. The purpose of ASSIST is to demonstrate that the wide-spread, coordinated application of the best available strategies to prevent and control tobacco use will significantly accelerate the current downward trend in smoking and tobacco use, thereby reducing the number and rate of tobacco-related cancers in the United States.

The primary objective of ASSIST is to demonstrate and evaluate ways to accelerate the decline in smoking prevalence sufficiently in all ASSIST sites to reduce smoking prevalence to less than 15% of adults by the year 2000. Site selection criteria and program planning guidelines have been developed so that populations among whom smoking prevalence rates remain a problem can be emphasized in ASSIST intervention sites. This includes groups in which smoking rates are elevated relative to the majority population or groups which have displayed slower rates of decline (e.g., women, the medically underserved, the less educated, and several ethnic minority populations). Therefore, both the National Cancer Institute and the American Cancer Society will need to be prepared programmatically to address the special needs of these priority populations within ASSIST efforts.

ASSIST is the largest health promotion initiative ever undertaken by the National Institutes of Health. It is anticipated that between 15 and 20 contracts will be awarded to State and local health departments throughout the country. These health departments

will join with American Cancer Society Divisions or other qualified voluntary health agencies to convene state-wide coalitions and/or local coalitions in major metropolitan areas.

These coalitions will consist of community groups and agencies and will work to a) define the smoking problem in each site; b) develop a comprehensive smoking prevention and control intervention plan (Phase I); and c) implement the plan through coalition member groups (Phase II). Each plan will describe the delivery of proven smoking prevention and control interventions through schools, worksites, religious and social groups, professional organizations, health care professionals, and health care institutions in a manner which will reach targeted groups of smokers and potential smokers. During a five-year intervention period between 1993 and 1998, the coalitions in each of the funded sites will initiate, coordinate, and deliver a level of tobacco use prevention and control programs throughout their service areas far in excess of current activities.

To meet these challenges, ASSIST will require a significant collaboration between the National Cancer Institute and the American Cancer Society. Both institutions agree that the shared leadership of this project will be of great benefit:

* The National Cancer Institute has invested over $250 million in research to produce state-of-the-art behavioral strategies and products in smoking prevention and control that are ready for national dissemination to achieve the Institute's Year 2000 goals and objectives.
* The American Cancer Society possesses a vast national network of 57 Divisions, 3400 Units, and 2.5 million volunteers active in cancer (and smoking) control through which the knowledge and products from the National Cancer Institute research can be distributed across the United States.
* ASSIST offers the opportunity to join the unique strengths of the National Cancer Institute and the American Cancer Society to achieve the nation's objectives in smoking prevention and control.

National Cancer Institute Support

As with any project of the federal government, the National Cancer Institute funding of ASSIST depends upon availability of funds. The ASSIST concept was approved by the Division of Cancer Prevention and Control Board of Scientific Counselors at their October 1988 meeting for funding up to $120 million over 10 years.

In addition to its responsibility for the management and support of ASSIST site, coordinating center, and other related contracts, the National Cancer Institute will print and make available to the American Cancer Society certain core materials for the ASSIST intervention effort. These materials will be distributed directly by the American Cancer Society at no cost in ASSIST sites.

American Cancer Society Support

As with any project of the American Cancer Society, the funding of ASSIST depends upon availability of funds. The ASSIST concept was approved by the American Cancer

Society Board of Directors at their October 1988 meeting to support full ACS participation in this effort.

The American Cancer Society will receive no Federal, State, or local public funds for its participation in the project, in keeping with its longstanding national policy. The American Cancer Society will provide programmatic assistance through its staff dedicated to the project and the large network of volunteers.

The American Cancer Society will contribute staff, training, travel, and materials equivalent to a minimum of 15% of total contract funds in each funded site to be distributed annually throughout the project. This contribution will include a minimum of one full-time equivalent (FTE) staff person in each funded site devoted exclusively to the project and does not include in-kind contributions. However, the direct cost of materials, travel, and additional staff time will be used as the basis for the calculation of a Division's required 15% match. The American Cancer Society estimates its support at approximately $16 million, depending on the number of collaborative partnerships established in funded ASSIST sites.

The American Cancer Society will work with the National Cancer Institute to develop improved program materials and/or repackage existing materials for use as core ASSIST intervention support resources. These materials will reflect the current state of the science of smoking cessation and prevention intervention and will be labeled to reflect joint sponsorship of the American Cancer Society and National Cancer Institute.

Local ACS Participation

Federal government procurement regulations require that Justification of Other Than Full and Open Competition (JOFOC) be prepared when competition will be limited. In the case of ASSIST, a JOFOC was developed to restrict competition for awards to state and certain local health departments which will form a partnership with a voluntary health agency meeting a set of criteria, e.g., specified minimal contributions of financial, material, and staff resources, an existing network of volunteers, and a commitment to the long-term institutionalization of the ASSIST intervention after federal funding is completed. This agency will receive no public funds to support participation in the project.

The health department and the qualified voluntary health agency will lead coalition activities through an executive committee structure which also includes representation from the coalition.

The JOFOC does not mandate that the American Cancer Society serve as the only health agency eligible to work in partnership with the health department, and it is possible that other qualified voluntary health agencies may assume that role. The American Cancer Society will urge full partnership and support of ASSIST among American Cancer Society Divisions nationwide, bringing to bear its network of volunteers, its experience in serving as a convener of groups and agencies, and a substantial commitment of financial and in-kind resources dedicated to ASSIST.

Administrative Oversight

ASSIST has been developed and will be conducted as a collaborative effort between the National Cancer Institute and the American Cancer Society. However, because the National Cancer Institute is the lead Federal agency in the National Cancer Program and is responsible for the management of public funds associated with ASSIST, certain decisions must remain the prerogative of the National Cancer Institute alone. Details are provided below on a number of issues related to the shared administration and management of the project:

1. **Institutional Authority:** The Director of the National Cancer Institute shall retain his regular statutory authority over ASSIST. The National Cancer Institute will authorize the release of trial findings and results as appropriate.
2. **Management and Committee Structure:** On the national level, American Cancer Society staff and volunteers will work closely with National Cancer Institute project staff in planning and coordinating the ASSIST intervention effort. American Cancer Society senior staff and national volunteers will be represented on the ASSIST Management Committee, which will serve as the on-going mechanism for the planning and coordination of the ASSIST intervention effort within our respective organizations. Additionally, a Scientific Advisory Committee will be appointed by the National Cancer Institute as the principal external oversight body for ASSIST. This committee will report on policy and scientific issues related to ASSIST planning, timelines, and progress. This committee will be specifically charged with advising on advancing ASSIST from the planning phase (Phase I) to implementation (Phase II). Scientists and others regarded as national experts in cancer prevention and control will be selected to serve on this committee, including representatives of both the National Cancer Institute and American Cancer Society advisory committees and the populations to be targeted in the intervention efforts, particularly ethnic minorities and women.
3. **The Community Intervention Trial for Smoking Cessation (COMMIT) — ASSIST Relationship:** COMMIT is National Cancer Institute's ongoing $45.3 million community intervention trial which is testing models for comprehensive smoking prevention and control intervention in 11 matched pairs of communities. A variety of data from ongoing process evaluation and annual assessments of cohorts of smokers in the 22 COMMIT sites will inform ASSIST planning. The proposed timeline permits emerging data from COMMIT to be carefully monitored and Phase II of ASSIST to be delayed until COMMIT provides statistically significant documentation of the efficacy of community-wide intervention strategies. DCPC Biometry Branch statisticians feel that this finding could emerge in 1991 or 1992 cohort follow-ups and be fully evaluated in the 1993 assessments. Thus, the start of Phase II of ASSIST is now projected for July, 1993.
4. **Periodic Scientific Review of ASSIST Implementation:** Findings from COMMIT as well as other smoking and behavioral research related to the ASSIST intervention

will be reviewed on a regular basis by the ASSIST Scientific Advisory Committee and other National Cancer Institute advisory committees in order to ensure that the plan for ASSIST interventions reflects the consensus of scientific evidence about effective intervention methods. These committees also will review progress in the implementation of these proven methods within sites and across the ASSIST project as a whole to assure that the objectives for the project are being met.

5. **Decision-making Criteria for ASSIST Continuance:** While the National Cancer Institute remains organizationally committed to the ASSIST project, it is only scientifically prudent to consider the potential situations that could bring the justification for continuing ASSIST into question. Specifically, the Scientific Advisory Committee will be charged with developing criteria to judge the scientific appropriateness for advancing ASSIST from Phase I to Phase II. Interim criteria for not continuing ASSIST into Phase II are as follows:
   a) Progress on smoking as measured by change in national prevalence (for both males and females, and for both blacks and whites) from the 1985 Current Population Survey (CPS) to the 1989 CPS and continuing through the 1992 CPS is so positive that the U.S. Public Health Service Year 2000 objectives to reduce tobacco use can be anticipated to be reached without the ASSIST intervention effort.
   b) Results from COMMIT fail to demonstrate that community-wide smoking control efforts lead to significant increases in quit rates. This outcome is most likely to occur if the quit rates in the comparison communities are greater than anticipated due to increased smoking cessation influences occurring on the national level which substantially affect the comparison sites but the increased resources in the intervention sites fail to increase the effect. This finding would suggest that providing additional smoking control resources to individual communities or metropolitan areas would be an inefficient method to increase the national decline in smoking prevalence.
   c) Some combination of a) and b) above, particularly if differences in community quit rates in COMMIT are in the expected direction but show smaller differences between pairs than expected and national smoking prevalence rates are decreasing at an accelerated rate between 1985 and 1989 and continuing through 1992.

Conclusion

ASSIST offers the National Cancer Institute and the American Cancer Society an unique and challenging opportunity. Through ASSIST both our organizations can build on complementary strengths, and through the synergy of our efforts, we can prove true the adage that the whole is greater than the sum of its parts. By working together we have the opportunity to make significant progress toward the attainment of our mutually endorsed objectives to reduce smoking in the United States and thereby save thousands of lives now and in the future.

Appendix 3.B. ASSIST Key Required Resources

Action Handbook for Tobacco Control.

ASSIST: A Guide to Working With the Media.

ASSIST Ad Hoc Advisory Committee Meeting.

ASSIST Coalition Profiles.

ASSIST Coordinating Committee Meeting Materials.

ASSIST Information Resources.

ASSIST Media Kit.

ASSIST Operations Manual. Volume I. Introduction to Contract Administration.

ASSIST Operations Manual. Volume II. Electronic Communications System. Version 1.3.

ASSIST Orientation Guide.

ASSIST Program Guidelines for Tobacco-Free Communities.

ASSIST Scientific Advisory Committee Meeting. 1992.

ASSIST Scientific Advisory Committee Meeting. 1993.

ASSIST Slide Collection: What Is ASSIST?

ASSIST Slide Collection: Why Tobacco Control?

ASSIST State Summaries. Volume I. Demographics and Selected Program Characteristics.

ASSIST Training Materials. Volume I. Orientation.

ASSIST Training Materials. Volume II. Site Analysis and Related Activities.

ASSIST Training Materials. Volume III. Site Analysis and Comprehensive Smoking Control Plan.

ASSIST Training Materials. Volume IV. Planning and Coalition Building.

ASSIST Training Materials. Volume V. Development of the Annual Action Plan.

ASSIST Training Materials. Volume VI. Media Advocacy: A Strategic Tool for Change.

ASSIST Training Materials. Volume VII. From Phase One to Page One: Refining Our Media Skills.

ASSIST Training Materials. Volume VIII. Implementing Policy Advocacy: Steps to Success.

ASSIST Training Materials. Volume IX. Implementing Policy Advocacy: Steps to Success—Part II.

Clean Air Health Care: A Guide to Establish Smoke-Free Health Care Facilities.

Clean Indoor Air: A Guide to Developing Policy.

COMMIT Community Mobilization Experience: Lessons Learned. Summary Report of a Trial-Wide Study.

COMMIT Project: Forming Partnerships With Religious Organizations.

Community-Based Interventions for Smokers: The COMMIT Field Experience.

Community Collaboration Manual.

Curriculum for 'Death in the West.'

Death in the West.

Death or Taxes: A Health Advocate's Guide to Increasing Tobacco Taxes. Draft.

Environmental Tobacco Smoke in the Workplace: Lung Cancer and Other Health Effects.

Essential Elements of School-Based Smoking Prevention Programs.

Essential Elements of Self-Help/Minimal Intervention Strategies for Smoking Cessation.

Evaluation Information Exchange. Tobacco Prevention. The Next Generation.

Federal Trade Commission Report to Congress for 1992: Pursuant to the Federal Cigarette Labeling and Advertising Act.

Group Techniques for Idea Building.

Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youths.

Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans.

Health Promotion at the Community Level.

How to Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians.

How to Help Your Patients Stop Using Tobacco: A National Cancer Institute Manual for the Oral Health Team.

How to Make Meetings Work: The New Interaction Method.

Incentive Programs Workbook.

Information Exchange Conference: Breaking the Grip of Tobacco State by State.

Information Exchange Conference: A Partnership for Building Diverse Community Involvement.

Information Exchange Conference: Tobacco Prevention: The Next Generation. New Approaches to Youth Policies, Secondhand Smoke, and Institutionalization.

Information Exchange Conference: Youth Access.

It's Your Business: Smoking Policies for the Workplace.

Legislative Approaches to a Smoke Free Society. [Narrative and Appendix].

Major Local Tobacco Control Ordinances in the United States.

Making Health Communication Programs Work: A Planner's Guide.

Manual for Training Health Care "Influentials."

Mass Communication and Public Health: Complexities and Conflicts.

Media Advocacy and Public Health: Power for Prevention.

Media Strategies for Smoking Control: Guidelines.

Model Policy for Smoking in the Workplace.

No Smoking: A Board Member's Guide to Nonsmoking Policies for the Schools.

Nurses: Help Your Patients Stop Smoking.

On the Air: A Guide to Creating a Smoke-Free Workplace.

Organizing. A Guide for Grassroots Leaders. Rev. ed.

Physician's Guide to Preventing Tobacco Use During Childhood and Adolescence.

Preventing Tobacco Use Among Young People: A Report of the Surgeon General.

Promoting Smoking Control Through Worksites in the Community Intervention Trial for Smoking Cessation (COMMIT).

Report on Tobacco Advertising: Give Children a Chance.

Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders.

Review and Evaluation of Smoking Cessation Methods: The United States and Canada, 1978-1985.

School Programs to Prevent Smoking: The National Cancer Institute Guide to Strategies That Succeed.

Self-Guided Strategies for Smoking Cessation: A Program Planner's Guide.

Selling the Smokeless Society: Fifty-six Evaluated Mass Media Programs and Campaigns Worldwide.

Site Trainer's Network: Policy Advocacy Module.

Site Trainer's Network: Administrative Handbook.

Site Trainer's Network: Youth Advocacy Module.

Smoke Fighting: A Smoking Control Movement Building Guide.

Smoke Signals: The Smoking Control Media Handbook.

Smokefree Workplace: An Employer's Guide to Nonsmoking Policies.

Smokeless Tobacco or Health: An International Perspective.

Smoking Cessation: What Have We Learned Over the Past Decade?

Smoking Policy: Questions and Answers.

State Legislated Actions on Tobacco Issues.

Stopping Teenage Addiction to Tobacco. A Community Organizer's Manual.

Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's.

Taxing Tobacco.

Tobacco Advertising and Promotion: A Guide to Developing Policy.

Tobacco and the Clinician: Interventions for Medical and Dental Practice.

Tobacco Effects in the Mouth.

Tobacco Free Youth: How to Reduce Sales to Minors in Your Community.

Tobacco Taxation and Economic Effects of Declining Tobacco Consumption.

Tobacco Use: An American Crisis. Final Conference Report and Recommendations from America's Health Community.

Tobacco Use in America Conference: Final Report and Recommendations From the Health Community to the 101st Congress and the Bush Administration.

Tobacco-Free Young America: A Guide for the Busy Practitioner.

Toward a Tobacco-Free California: A Master Plan to Reduce Californians' Use of Tobacco.

Truth and the Consequences of Cigarette Advertising: An Advocate's Guide to Arguments in Support of Banning Cigarette Advertising and Promotions.

What Works? A Guide to School-Based Alcohol and Drug Abuse Prevention Curricula.

Where There's No Smoke: Helping to Create a Smoke-Free Environment. An Advocacy Guide for Public Education Volunteers.

Where There's No Smoke: Helping to Create a Smoke-Free Environment. Scripted Speeches for Primary and Secondary Targets.

Where There's Smoke: Problems and Policies Concerning Smoking in the Workplace. 2nd ed.

Who Profits from Tobacco Sales to Children?

Working with Unions to Reduce Cigarette Smoking.

Youth Access to Cigarettes.

Youth Access to Tobacco: A Guide to Developing Policy.

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4. Building National, State, and Local Capacity and Capability

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4. Building National, State, and Local Capacity and Capability

Once the structural components and communication mechanisms were in place, the process of preparing the states for action began. Throughout the American Stop Smoking Intervention Study (ASSIST), the states' project staff and coalition members were trained to achieve two major goals. First, they sought to create the capacity to implement tobacco control interventions statewide, especially by building and linking strong coalitions in communities throughout the state. Second, they sought to build the capabilities of all coalition members. To do this, they trained them (1) to plan evidence-based interventions that were responsive to each community's needs and that were realistic in terms of the program's readiness and resources and (2) to implement tobacco control interventions, especially policy and media interventions. The substantial investment that ASSIST made in developing the capacity of the states and the capabilities of the state participants is reflected in the effectiveness of their intervention efforts.

Creating the Capacity to Act

At the outset, the National Cancer Institute (NCI) recognized the key role that state and local coalitions play in planning and implementing tobacco control activities. Effective tobacco control occurs with the implementation of community-based strategies by partnerships comprising strong health advocates and community leaders. NCI selected the coalition model as the basic organizational structure for ASSIST because of the potential strength of coalitions to mobilize diverse community organizations and individuals to work together to influence social norms and policies. In the request for proposals for the ASSIST project, each state was required to develop a state coalition. Most states also developed local coalitions.

Coalitions: The Force behind the Interventions

The effectiveness of coalitions in health promotion and disease prevention had been demonstrated in the research studies underlying the rationale for a community-based tobacco control project. (See chapter 1.) Community initiatives designed by a diverse group of citizens are likely to be feasible for that community, supported by that community, and ultimately successful. By joining together around an issue of mutual interest, organizations and agencies reduce competing and duplicative efforts. Also, there is strength in numbers; therefore, coalitions can be especially effective in addressing issues relating to policy changes and the enforcement of existing policies and laws.

Generally, coalitions follow predictable stages and take time to develop and flourish, and ASSIST coalitions were no exception. Typically, the developmental stages are formation, implementation, maintenance, and reaching goals and objectives.[1] During the

formation stage, a coalition defines its mission and goals. A diverse membership that participates in planning, action, and advocacy is essential. During the implementation stage, a coalition initiates activities designed to meet its goals. During the maintenance stage, a coalition builds on its activities and, on occasion, revisits its mission and goals. Process evaluation is important during the implementation and maintenance phases to determine whether plans and interventions have been implemented as designed. Most coalitions have frequent meetings of a steering committee and less frequent meetings of the general membership. Officers and committee chairs need clear job descriptions. A system for regular and clear communication must be in place and must be used. During the final stage, in an ideal model, outcome measures examine a coalition's effectiveness in meeting its mission, goals, and objectives.

Ideally, coalitions reach a state of institutionalization, or permanence, and have a base of substantial long-term funding. Such coalitions are usually respected by policy makers in the jurisdiction that they serve and are seen as authorities on policy issues; often, they are invited to join the efforts of other groups. Coalitions can fail to sustain themselves for a variety of reasons: lack of direction, turf battles, failure to plan or act, dominance of professionals, insufficient community linkage, weak organization, funding problems, leadership problems, inadequate sharing of responsibility and decision making, time and loyalty conflicts, lack of training, and burnout of members or staff.[2]

Guidelines for New Partnerships

During training, the following guidelines were offered to ASSIST staff members to consider as they developed their states' coalition memberships.

- Involve diverse and key players.
- Choose a realistic strategy.
- Establish a shared vision.
- Agree to disagree in the process.
- Make promises you can keep.
- "Keep your eye on the prize."
- Build ownership at all levels.
- Avoid "red herrings."
- Institutionalize change.
- Publicize your success.

Source: Melaville, A. I., and M. J. Blank. 1991. *What it takes: Structuring interagency partnerships to connect children and families with comprehensive services.* Washington, DC: Education and Human Services Consortium.

As the ASSIST coalitions developed, they experienced the growth stages, and many of the predictable issues arose. In meeting the challenges, however, the coalitions became strong internally and forceful externally. The fourfold purpose of the ASSIST coalition design was as follows:

1. To increase the tobacco control capacity for existing community groups and organizations
2. To sustain and enhance the coalitions' role as a tobacco control agent
3. To recruit organizations (including those not related to health) that had not participated in tobacco control efforts
4. To amplify the coalitions' potential to create community change for tobacco control

The relationship of the state coalitions and the local networks of affiliates was

designed to be interactive throughout the project.[3]

Challenges to Working Collaboratively

The elements of coalition development played out in the ASSIST project as changes in coalition leadership and the environment occurred. In the beginning, NCI's imposed structure of contract accountability implied a formalized process from which coalitions should be formed. Some state ASSIST staff members encountered community leaders who would not readily accept the formation of new bodies or committees solely because a new NCI contract prescribed structure and required certain functions. States varied greatly in their ability to mobilize and organize their partners. However, coalitions continued to be formed for several years into the project. Even those coalitions that were developed had mixed success.

Differences in Organizational Culture

During the planning phase of ASSIST, many coalitions were new and were forming organizational cultures. Other tobacco control coalitions, however, had been in existence for years prior to ASSIST and had operated independently from government funding. For those coalitions, issues of ownership and direction surfaced; for example, an existing coalition may have worked collaboratively with state staff members during the ASSIST proposal development process. Afterward, however, the coalition leadership may have changed, with a resulting change of focus to new opportunities. Insistence by state staff members—having been awarded an

On Target, *published by New Mexicans Concerned about Tobacco*

ASSIST contract—that the coalition work on contract deliverables, such as the site assessment, sometimes resulted in friction between the paid contract staff and volunteers.

Another difference in organizational culture that presented a challenge to some coalitions was the ASSIST contract requirement of deliverables—items produced by the state health department contractors and submitted to NCI. In the first 2 years, the contract required the coalitions and staff to work on assessments, environmental analyses, and sound strategic plans for a 5-year implementation phase. Although these tasks may have been agreed to during the proposal process, issues of "why wait for action?" to "we want to spend the funds now" caused splintering among groups within existing and new coalitions. For the action-oriented coalitions, accepting

the strings attached to the ASSIST funds—primarily the requirement to engage in careful long-term planning—was a serious challenge. Some coalitions lost initial members who, though strongly committed to tobacco control, found the process to be too slow, particularly since in the meantime the tobacco industry continued to lobby at the federal and state levels, to work against clean indoor air initiatives, and to market its products very aggressively. Other coalitions, however, were just getting started and wanted to do everything by the book. The value of careful planning became more and more appreciated during the implementation phase, when multifaceted activities were initiated.

Surgeon General David Satcher addresses an ASSIST conference

Planners and Activists

The types of individuals who served best during the planning phase tended to be different from those who served well during the implementation phase. In some states with mature coalitions that were reluctant to perform ASSIST planning, the staff met the challenge by developing small committees to address the deliverables required by the contract. In these situations, some coalition members worked on advocacy issues while others were planning advocacy activities. Early in the third year, planning and implementation merged, and the coalition members worked collaboratively. ASSIST funds could then be turned into full-scale action—even as plans were modified in response to a changing environment.

Participatory Decision Making

The ASSIST project initially had a highly formalized structure and imposed modes of accountability on the coalitions. The coalitions wanted more participation in decision making, which implied changing to a flatter management structure for coalitions, committees, and staffing. As this need became widespread among the coalitions and the program advanced, the formalized structure of ASSIST at the national level was changed to be less rigid and more inclusive. It provided "seats at the table" for field directors and program managers to offer various perspectives of program needs, as described in chapter 3. This evolution from a hierarchical form of management, also experienced to some degree in the Community Intervention Trial for Smoking Cessation (COMMIT), provided many opportunities for better feedback and decision making for program direction and resource allocation by the coalitions.

Laborious Process

Coalition work is demanding and must be done with an understanding of the environment and the stages of development of an alliance. As the ASSIST project evolved, its national leadership became more open to opinions and ideas from the states but also had the responsibility to balance immediate needs with long-term vision. Would it be better to spend more time planning, so that all implementation staff could ponder the process and learn the systems for change? Or would it be better to provide more direction and leadership to achieve immediate outcomes? The challenge was addressed by NCI and the ASSIST Coordinating Center largely through tailored responses to needs for technical assistance and training in the various states.

Case studies 4.1, 4.2, and 4.3 point to some of the challenges that the coalitions addressed in developing collaborative working relationships. To attract coalition members representative of New Mexico's rich diversity of populations, ASSIST staff sought outside professional marketing help. Massachusetts, an ASSIST state with a long history of conducting tobacco control programs, formed regional networks to advance its capacity and capabilities. North Carolina took advantage of an evaluation to identify the most effective elements in forming effective coalitions.

Did the States Build Capacity?

Most states completed the 8-year project period with more local coalitions than were anticipated initially, and five states decreased their number of coalitions. For example, the coalition in Maine's largest city, Portland, was started through ASSIST and is still in operation, as are some small coalitions in small towns and cities, now supported with funds that Maine obtained as a result of the Tobacco Master Settlement Agreement. In contrast, Washington State discontinued its state coalition, as did Maine. Table 4.1 indicates the number of ASSIST coalitions in each state in 1992 (toward the end of the planning phase) and in 1996 (toward the end of the implementation phase). Appendix 4.A provides an example of the diverse

Table 4.1. Number of ASSIST State and Local Coalitions, 1992 and 1996

State	1992	1996
CO	8	13
IN	1	6
ME	3	2
MA	4	20
MI	4	62
MN	3	26
MO	3	19
NJ	3	3
NM	5	8
NY	9	23
NC	11	10
RI	8	8
SC	8	12
VA	6	17
WA	5	10
WV	1	20
WI	13	33
Total	**87**	**285**

Sources: ASSIST Coordinating Center. 1992. ASSIST coalition profiles. Internal document, ASSIST Coordinating Center, Rockville, MD. ASSIST Coordinating Center. 1996. Draft of ASSIST coalition profiles. Internal document, ASSIST Coordinating Center, Rockville, MD.

Case Study 4.1
Albuquerque: A Multicultural Coalition

Situation: New Mexico has a rich mix of cultures and includes some communities that predate the founding of Jamestown. Also, New Mexico is one of the poorer states and, overall, registers low on a list ranking quality of life. Poor, uneducated citizens of New Mexico are targets for tobacco companies. In Albuquerque, a coalition, Tobacco-Free New Mexico, was already in existence when the ASSIST staff determined that a second tobacco control coalition was needed to focus on tobacco use by minority groups.

Strategy: ASSIST supported the development of a coalition known as Multicultural Advocates for Social Change on Tobacco (MASCOT). The ASSIST staff employed an advertising and marketing firm to identify and attract coalition members, especially leaders in the minority communities. The resulting community-based coalition initially had 20 volunteer members and subsequently became a core of 6 to 10 regular members. Members included, among others, coordinators of tobacco education in county and city fire departments, representatives of New Mexico's Department of Substance Abuse and its Office of Indian Affairs, representatives of the Adolescent Social Action Program at the University of New Mexico, a medical doctor, and an American Indian. Progress in enlisting additional American Indians was slow.

MASCOT meetings were held weekly. Initially, the group engaged in a period of self-training, using publications and videos, and of sharing information. The group developed a logo for branding its activities. The members tackled issues of leadership, mission, and goals and objectives. An ASSIST field director chaired meetings until the members elected a chair. The coalition then focused on educating individuals in diverse ethnic communities in Albuquerque about youth access to tobacco, industry promotional tactics, and achieving self-efficacy. At the same time, the coalition secured a fiscal agent (the New Mexico Public Health Association) to manage antitobacco money received through grants, contracts, and donations. Some members tracked tobacco control measures that occurred in the state and attended national ASSIST meetings. Early on, MASCOT planned to become independent of the ASSIST program, eventually applying for nonprofit status.

Source: Adapted from O. S. Harris and M. F. Herrera. 1996. The first year in the life of a multicultural coalition. In *Communities for tobacco-free kids: Drawing the line,* 565–74 (Sessions and case studies of the National Tobacco Conference, May 29–30, 1996). Rockville, MD: ASSIST Coordinating Center.

Case Study 4.2
Regional Networks in the Massachusetts Tobacco Control Program

Situation: In Massachusetts, the contract award of ASSIST energized the American Cancer Society (ACS) and the tobacco control advocacy community. As a result, ACS and the Massachusetts Coalition for a Healthy Future financed the passage of ballot question 1, the Massachusetts tobacco excise tax, and created the Health Protection Fund. The Health Protection Fund provided funding for the Massachusetts Tobacco Control Program (MTCP) of the Massachusetts Department of Public Health. This program development occurred as ASSIST moved from its planning phase to its program implementation phase. In a matter of months, program dollars rose from $1.195 million (ASSIST fiscal year 1993) to an additional $58.1 million (from the department of health funds) for the first year of funding for MTCP.

Although ASSIST funding was a small part of MTCP's overall funding, it played an important role in shaping the program model and providing funds to create a programmatic infrastructure. The Massachusetts legislature initially voted to provide funds for program services but not for administrative infrastructure. Therefore, ASSIST funds were used to support the organizational structures that allowed MTCP to become a successful and comprehensive tobacco prevention and control program.

Strategy: In 1995, a field operations unit replaced program-specific contract managers who were overseeing community-based programs. Regional field directors organized local programs funded by MTCP into regional networks. Small and large regional meetings, convened monthly by MTCP regional field directors, served as forums for regional action planning, information dissemination, provider collaboration, identification of best practices, and training. Each of the six regional networks was guided by a steering committee, composed primarily of program managers from local programs. Steering committees worked on goal alignment, strategic planning, regional public relations campaigns, and quality improvement. This organizational strategy facilitated communication and planning within larger geographic areas and across agency and program boundaries. Linking programs together played an important role in creating a successful social movement in Massachusetts.

—Harriet Robbins, Massachusetts Department of Public Health, and Milly Krakow, Krakow Consulting

Case Study 4.3
Evaluating ASSIST Coalitions in North Carolina

Situation: In North Carolina, the operations of 10 ASSIST coalitions offered an opportunity to compare and contrast the effectiveness of procedures, personnel, and other factors.

Strategy and Results: The North Carolina ASSIST coalitions were evaluated with interviews, surveys, observations of meetings, and a review of documents. A conceptual model of factors that might influence coalition effectiveness was developed. The factors were leadership, decision making, communication, conflict, costs and benefits of participation, organizational climate and structure, staff roles, capacity building, member profiles, recruitment patterns, and community capacity for tobacco control. Coalition effectiveness was measured by observing member satisfaction and participation, the quality of action plans, resource mobilization, and implementation of activities.

The study revealed that coalitions were more effective in implementing activities when they provided a vision for the coalition at the local level, involved members in planning actions, fostered frequent communication among staff, and hired skilled staff who saw their roles as "coaching" the communities in activities rather than taking full responsibility for the activities.

Personal accounts by coalition members revealed insights into the composition of the coalitions and the ability to recruit, as illustrated in the following examples:

> I wanted to get people involved, but, early on, there was so much that was nebulous about the program.
>
> We said, 'Will you be on this task force? Here's what we'll be doing'—but it wasn't specific enough. Now we are a little more directed.
>
> So you sort of have to have something under your belt … to say 'Well look what we have done.' Without that, I don't feel like I can go out [and expand the coalition].
>
> *—Michelle Kegler, then doctoral candidate, University of North Carolina at Chapel Hill, and current Program Specialist/Evaluator, Tobacco Technical Assistance Consortium*

Source: Kegler, M. C., A. Steckler, S. H. Malek, and K. McLeroy. 1998. A multiple case study of implementation in 10 local Project ASSIST coalitions in North Carolina. *Health Education Research* 13 (2): 225–38.

ASSIST Coordinating Center staff

membership of the Rhode Island state-level coalition; the number and diversity of members were typical of the coalitions.

To examine aspects of the coalition approach to implementing tobacco interventions, NCI engaged an independent contractor to conduct a pilot study during the first 6 months of 1995 to assess a number of characteristics of three state coalitions.[4] New Jersey, New York, and South Carolina participated in the pilot study designed to investigate the feasibility of conducting coalition assessments of all ASSIST state-level coalitions. Three types of coalition characteristics—environmental, structural, and functional—were examined as measures that could influence a coalition's effectiveness.

The environmental characteristics were state history of tobacco control, geographical and cultural diversity, and previous collaboration. Pilot study results showed that these characteristics played a role, though not a critical one, in the effectiveness of the statewide coalition networks. Rather, the most important characteristics were the size of the geographic area and the extent of previous collaboration among key individuals and organizations. South Carolina's history as a tobacco-producing state, New York's large geographical area, and the racial and ethnic diversity found in all three states presented challenges that slowed progress but were not insurmountable factors.

In terms of structural characteristics, matters of complexity (numbers of coalitions and bureaucratic processes) and membership of the coalitions related strongly to coalition effectiveness, whereas formalization of policies and procedures was considered relatively unimportant. The evidence showed that managing a large number of coalitions presented major challenges and strained staff resources. At the same time, however, a large network of local coalitions can be very important to defeating tobacco industry legislation. Frustration

was high in all three states regarding extensive bureaucratic red tape and regulations. Regarding membership, all three states found that recruiting members to state and local coalitions was difficult. Broad membership was especially important because different types of coalition members increased the diversity of skills and could play different roles at different times, thereby enhancing a coalition's ability to respond quickly to unexpected events. There was strong evidence that additional training in community outreach skills was needed for coalition organizers, particularly at the local level, in order to broaden coalition membership beyond the public health community.

The results showed that two functional characteristics—leadership and vision—were considered essential for effectiveness; four other functional characteristics—management, communication, resource allocation, and conflict resolution—related strongly to effectiveness but were not easily distinguishable from one another and were merged into a single functional characteristic called management/communication. Vision was defined as "the extent to which coalition members have a clear sense of direction and a common understanding of coalition goals and objectives." ASSIST staff in all three states reported that it took much longer than expected to train coalition members in the new paradigm of tobacco control. The results showed that leadership is a very important factor in moving a coalition forward but that a dynamic leadership style is not required. Low-key, well-respected leaders were adept at motivating the members and advancing their agendas. An unexpected finding that emerged was the importance of two additional but related functional characteristics—strategic planning and community outreach. A major conclusion of the pilot project was that the six functional characteristics—vision, leadership, management/communications, shared decision making, strategic planning, and community outreach—are important for coalitions focusing on policy and media advocacy.[5] Although the assessments were not conducted in all states as originally planned, the pilot project provided valuable information that served the ASSIST Coordinating Center staff in planning technical assistance and training.

A review of the states' final reports provides insight into the opinions of ASSIST state managers about coalitions, the role that coalitions played in their respective states, and the likelihood that coalitions will be maintained in the future. NCI asked the coalitions to comment on the following topics in their final quarterly reports:

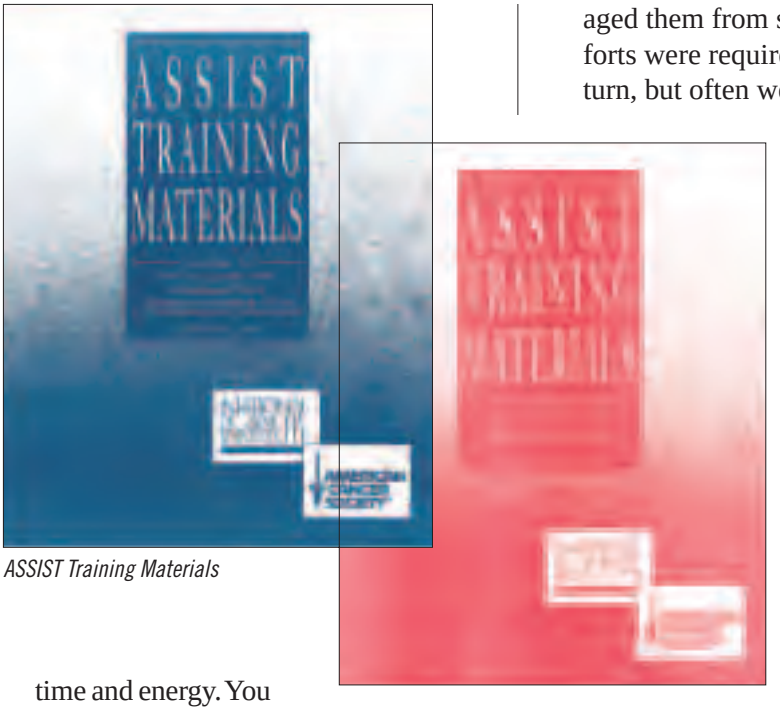
- List several of the most important lessons that have been learned through your ASSIST interventions, and describe how these experiences will guide the development and implementation of future tobacco prevention and control efforts in your state.
- Based on what you learned from other states or national organizations throughout ASSIST, what major tobacco control activities or policies are yet to be achieved in your state? Do you plan to attempt these activities over the next several years?

- What factors or resources contributed most to the success of activities in your state and throughout ASSIST? How? Why?
- Was the coalition model effective in bringing together various partners or organizations in your state? Would you use this model again? Why? Why not?

Fourteen states found the coalition model to be very effective. Most stated that they planned to maintain, if not expand, their support for coalitions with funds from their new cooperative agreement with the Centers for Disease Control and Prevention (CDC). Missouri and Washington State felt that while their state coalitions were not successful, their local coalitions worked well. Maine substituted the coalition model for a partnership model. The following sampling of comments from six of the states illustrates the range of insights from participants.

ASSIST Information Exchange and Training conference materials

- **Colorado**—Key to the success of Colorado ASSIST was the efforts of volunteers from the 12 coalitions throughout the state. They multiplied staff efforts many times. Dedicated (funded positions) staff charged with leading and guiding the coalitions provided a consistency and built on each year's accomplishments within the project. Colorado planned to continue the model within the CDC framework and increase the number of coalitions when tobacco settlement monies become available to the state health department.[6]
- **Minnesota**—The coalition model is a valuable though time-consuming strategy requiring continuous maintenance. In most cases, a full-time local coordinator is needed to provide staff leadership for a coalition. The benefit of a coalition is that it is a means for many community members, organizations, and decision makers to come together for a common cause. Coalitions provide a strong community base of support for policy change and are a means of reaching people at the local level (educating and involving them) and mobilizing them to influence policies to reduce tobacco use.[7]
- **Rhode Island** commented as follows on the challenges of forming a coalition: "It was idealistic to get a large coalition up and running quickly, especially without lots of staff. Coalitions are messy and not always efficient. They can be very costly in terms of staff



ASSIST Training Materials

time and energy. You experience a loss of control. They are slow, and the more ownership they have, the more need there is to consult them and allow them to make decisions. This can hurt, given how fast the tobacco industry is. However, the trade-off is important. Coalitions provide access to community, multiple perspectives, and political clout."[8(p22)] The comments from Rhode Island should not be construed as criticisms of coalitions. Rather, they merely point out that working with a large group of people is time-consuming and that one must be prepared to cede some control to others.

- **Washington State's** experience with coalitions was less positive: "Initial efforts were successful in bringing various partners and organizations in Washington to the table, but two years of site analysis and planning discouraged them from staying. Stronger efforts were required to ensure their return, but often were not undertaken. The coalition model was far more effective at the local level and is being continued."[9] Washington State voted to discontinue its state coalition. However, the problems described reflect administrative challenges more than a belief that coalitions are inherently ill-advised. The loss of volunteers in Washington State was a problem that some of the other ASSIST states encountered.

Creating Capacity during the First 2 Years: Planning for Comprehensive Tobacco Control

To most effectively change people's behavior, and especially to promote policies that would reinforce the behavior change, the ASSIST coalitions needed strategic plans for interventions. An intensive and extensive strategic planning phase was guided by NCI staff and by the departments of health, with assistance from the ASSIST Coordinating Center.

The ASSIST project, funded at a total of about $22 million annually, began on October 1, 1991, with a 2-year planning phase. The 2-year planning phase gave the states—many of which had no tobacco

control resources prior to ASSIST—ample time to plan and build the requisite infrastructure for initiating a comprehensive tobacco control initiative. During that time, each of the 17 states, working with their coalitions, conducted a site analysis (for which the state was defined as the site) and a needs assessment and developed a 5-year comprehensive tobacco control plan, tailored to the needs of the state but within the guidelines provided by NCI. The plans included goals related to public policy and mass media. All states emphasized the opportunities available for working with priority populations.

Site Analyses

The purpose of the site analysis was to provide each state with the baseline information that it needed to develop a comprehensive tobacco control plan. The site analysis documented the distribution of tobacco use by age, gender, and geographical area; the economic burden of tobacco use; and the social and political climate for enacting and enforcing tobacco control policies. The analysis included an assessment of the site's potential resource strengths and weaknesses for implementing ASSIST, including finances, equipment, facilities, personnel, expertise, organizational relationships and structure, existing policies for tobacco control, and media relationships. With the information from the site analysis, the following planning tactics were formulated:

- Each coalition translated the ASSIST primary objectives into site-specific quantitative objectives that expressed the number of persons in the state who would quit smoking as a result of interventions and the number of persons who would not initiate tobacco use. These objectives were also expressed as tobacco prevalence objectives. These quantitative objectives provided the coalition a clear picture of the magnitude of its undertaking.
- Each coalition made final decisions about which populations would be the priority focus of its interventions.
- Each coaliton determined which policy and media intervention strategies would likely be the most effective in influencing the behavior of the priority populations.
- Each coalition reaffirmed or modified its preliminary decisions about geographical regions in the states for interventions. For each intervention region, a local coalition was identified to participate in the process of developing the comprehensive plan.[10]

Comprehensive Tobacco Control Plans and Annual Action Plans

Each state's site analysis was the basis for the state's 5-year comprehensive tobacco control plan to be implemented during the project. (Initially, the plan was referred to as the comprehensive smoking control plan, but later "tobacco" replaced "smoking" to include smokeless tobacco.) Through a series of objectives, strategies, and tactics, each plan set forth initiatives developed and approved by the state's coalition to address the ASSIST program objectives for interventions and channels. (See chapter 2.) Each year, an annual action plan was developed, based on the comprehensive

plan, that charted a yearly course for implementing the interventions in the tobacco control plan. Roles and responsibilities for carrying out the activities in the action plan were specified, along with resource allocations and monitoring procedures. Budgets were allocated for training and support. The annual action plan allowed each coalition to reassess its original plans and define its course yearly based on changing priority populations, channel conditions and opportunities, and other key environmental changes (economic, social, and political factors). The annual action plans afforded the coalitions the opportunity to emphasize specific objectives and related strategies for specified periods in coordination with the goals of the broader plan.[3] (See appendix 4.B for an example of a responsibility tracking form from Minnesota.)

The process of constructing the tobacco control plan and the annual action plans required the coalitions to formulate measurable objectives applicable to the priority populations that they sought to reach.[3] For intervention regions, the objectives, strategies, and tactics had to be specific to the regions. The plans were ambitious yet realistic. The criteria for selecting strategies included the potential reach and influence relative to the priority population, resources available, and the developmental stage and readiness of the program and coalitions. Each strategy listed specific actions or activities that would be implemented to achieve an objective. Over the years, the states became more proficient at expressing the outcomes as quantifiable objectives.

The sample plans in appendices 4.D–4.H were derived from the comprehensive plans and annual action plans of two states. The examples illustrate that different states developed different strategies and a broad range of activities. The strategies developed were for decreasing environmental tobacco smoke (also referred to by advocates as *secondhand smoke*, *passive smoking*, and *involuntary smoking*). The comprehensive plans set forth 5-year objectives. Appendices 4.C and 4.D contain passages from Wisconsin's plans that illustrate objectives and strategies for two channels (community environment and worksite) for 1993–94. The passages from Minnesota's plans in appendices 4.E through 4.G show activities for the same channel in two different periods (1993–94 and 1998–99) and reflect a change from fundamental formative activities to detailed, targeted activities. As is apparent in the 1993 and 1998 annual action plans, the nature of the interventions changed and grew over time in reach and sophistication. The early annual action plans tended to focus on resource development and distribution, whereas the later plans called for media campaigns and interaction with high-priority population groups.

Project Management Plans

To guide the implementation of each state's comprehensive tobacco control plan, the sites were also required to produce a project management plan to cover the same 5-year period as the comprehensive tobacco control plan. In the project management plan, the states explained how they would organize, manage, and monitor their work. Orga-

nizational issues, such as the interrelationships between state and local coalitions, were clarified, along with decision-making roles, lines of communication, and responsibility for various tasks. Monitoring mechanisms were identified to demonstrate how the states would stay on schedule and ensure that activities occurred as planned. Each state outlined a crisis communication plan as well, in an effort to anticipate how information would be transmitted in a crisis and who would serve as spokespersons to the public. Last, the plan included a summary of the budget allocated and a description of how that budget would be allocated and tracked. Appendix 4.H contains a sample plan that was derived from the project management plan of ASSIST in Washington.

Building the Capability to Act

When the ASSIST project began, changing the social environment through media interventions and policy advocacy was a public health strategy to which the states were unaccustomed. The health department personnel, ACS members, and the organizations in the coalitions required technical assistance, support, and training to develop the knowledge and skills that they needed to mobilize their respective local communities to implement tobacco interventions. NCI established the ASSIST Coordinating Center as the project's hub for ongoing technical assistance and training, information coordination, and leadership support. ACS also played a vital role by providing coordination for and participation in training events.

Technical Assistance and Training: The Forces behind the Coalitions

The project's technical assistance and training services, provided throughout both phases of the project, were designed to build the capabilities of ASSIST's participants by developing their general skills and by providing specific information. The needs assessment (see the earlier section on creating capacity) helped to determine which services to provide. The basic technical assistance and training services provided are listed below:

- Customized consultation through site visits, a dedicated electronic communications system (ASSIST ECS), and frequent teleconferences
- Information on specific tobacco issues in packets of materials
- Facilitation of networking and sharing of information among the sites
- Building of linkages and communications among state, federal, and community activities
- Development and dissemination of resource materials, including training manuals, modules, policy guidelines, and fact sheets
- Referrals to experts in tobacco control, policy development, and media relations
- Training events and creation of resource materials focused on:
  - project management and administration;
  - strategic planning;
  - building, developing, and managing coalitions;
  - developing and implementing effective educational programs;

- supporting policies (including voluntary policies) for tobacco control;
- using the media to change the social environment to discourage tobacco use; and
- creating rapid responses (e.g., to promotional actions by the tobacco industry).

The planning phase (October 1991–September 1993) was a critical period for the sites. The expectation during this time was one of "getting everyone oriented," while allowing sufficient time to concentrate on knowledge development, environmental scanning, and planning for the upcoming implementation phase. NCI staff and the ASSIST Coordinating Center's team of technical assistance specialists assisted the states. Generally, team members were public health professionals with experience working in health departments or voluntary agencies. Team members were assigned to specific states to provide rapid response and proactive customized consultation to help the states develop their plans. During this planning phase, the training goals were to build a foundation of skills, to develop a common understanding of ASSIST and its approach to tobacco control, and to help staff develop project plans.

Training during the Planning Phase

As could be expected with a project of this size and scope, experience in environmental tobacco control varied among the states. Overall, the respective state and local staffs had little or no experience in using policy advocacy approaches for tobacco control interventions; instead, most had concentrated on changing individual smoking behavior. Some staffs had already sponsored programs with policy components; few had experience in developing coalitions.

Five training events and information exchange conferences were held in the first year, four in the second. These training workshops were instrumental during the planning phase in bringing the staffs of all 17 states to a level of skill and understanding necessary to plan ASSIST tobacco control interventions. The primary participants of these workshops were the health department and ACS project managers. Tobacco control consultants with expertise in the relevant topics were retained to design and deliver the training, supplemented by NCI, ACS, and ASSIST Coordinating Center staff members. The first training was a project overview. Each of the next four training events was designed to help ASSIST staff develop the required planning documents. The titles, dates, and objectives of each of the five training workshops are presented in the sidebar on planning phase training.

After the first year into the project, the participants were eager to conduct interventions and to start making a difference in their states, and many project managers had the challenge of explaining to coalition members why activities could not begin as quickly as they would like. In retrospect, many participants felt that this planning and training period was essential because it provided the time and resources necessary to establish a solid foundation for each state.

Others believed that this process took too long. Training in partnership with site-specific technical assistance was key in helping the states prepare their plans and strategies. Few, if any, public health projects have the opportunity to give adequate preparation time before implementation—the ASSIST experience was unusual in this regard.

A year into the planning phase of the program, the ASSIST Coordinating Center hired a consultant from Georgetown University to informally assess the technical assistance and training needs of coalitions. This assessment, based on interviews with project managers, ACS staffs, and members of the state-level ASSIST coalitions, found wide differences among them in their training and development.[5] The report listed the following needs (among others):

- Make training diverse so that it reaches, for example, persons who are not close to tobacco control issues
- Make goals and strategies very clear
- Define relationships among and roles of coalition groups
- Identify skills needed for good coalition functioning
- Adapt general planning skills to specific planning requirements
- Provide training on policy advocacy
- Provide training on how to conduct media advocacy

The report also noted that many coalitions had been applying successful training methods, and many managers brought to their training processes sophisticated strategies for addressing the diverse experiences of the members.

Planning Phase Training

ASSIST Orientation—November 8, 1991

- Orient the staff of ASSIST states to the ASSIST conceptual model, goals, and operations

Site Analysis and Related Activities—February 3–5, 1992

- Provide the staff of the 17 ASSIST states with the knowledge and skills that they need to conduct an acceptable coalition-based site analysis, including key informant interviews

Site Analysis and Comprehensive Smoking Control Plan—July 20–21, 1992

- Revise and refine the site analysis
- Understand the relationship among the site analysis, comprehensive smoking control plan, annual action plan, and project management plan
- Understand the components and requirements of the comprehensive smoking control plan
- Address coalition issues

Planning and Coalition-Building—October 14–15, 1992

- Reinforce the understanding of the big picture of ASSIST and how the components fit together
- Brainstorm possible problem-solving strategies for issues occurring in the coalition process
- Expand knowledge and skills in addressing group dynamics, communications, and contract issues
- Enhance the understanding of the requirements of the ASSIST planning process
- Become oriented to and practice specific planning tools in ASSIST (i.e., stakeholder analysis and priority-setting methods)

Development of an Annual Action Plan—January 25–26, 1993

- Present expectations for achieving ASSIST national objectives
- Study the lessons learned from effective tobacco control strategies (e.g., California's experience)
- Develop strategic steps of the annual action plan

Source: ASSIST Coordinating Center training materials.

Transitioning to Implementation

During the planning phase, the assumption underlying the training program was that all states would become capable—more or less simultaneously—of implementing tobacco control interventions. In reality, the staffs had different skill levels, and the policy environments for which they developed their plans varied. While the staff members of some states produced strong annual action plans, others struggled with how to put into practice ASSIST's conceptual framework. (See the "cube" in chapter 2.)

The first intervention year was essentially a transition period during which it became apparent that certain capabilities had to be further developed. Each training event included a process evaluation questionnaire. Feedback from these questionnaires was considered in planning the technical assistance and training for the implementation phase. The training strategy was revised to provide more support for the "how-to" and incorporated the following tactics:

- **A continued explication, illustrating applications, of the policy advocacy model of ASSIST.** Most states were having problems understanding the strategy of changing public policies to create an environment that does not support tobacco use. They also needed a clarification regarding the differences between advocacy activities and lobbying activities.
- **More tailoring to the range of individual state needs in designing training sessions.** Trainings were initially didactic and formatted to include thematic information in plenary presentations. The format was changed to provide specific sessions on media and policy topics and issues as the participants' skills were developed and applied in their states. The participants were given the freedom to attend those sessions that best fit their individual needs. Also, the sessions became more interactive. Plenary session lectures were minimized in number and length, and more sessions were participatory. Training tools included the use of more case studies, interactive role playing, and practice exercises. University professors conducted the trainings, and these progressed to peer trainings. Direct technical assistance supported state personnel after training.
- **Finding new ways of continuously assessing and responding to state needs.** In addition to gathering input from the states about their technical assistance and training needs through written questionnaires and through insights provided by technical assistance staff, a new direct link to the field was established. A new training committee, composed of state staff members representing both management and operations, was established. The committee provided information for needs assessment purposes and recommendations for specific training content. When the ASSIST Multicultural Subcommittee was formed, the members' ethnic-specific expertise was solicited in the development of all subsequent training activities.
- **Using a variety of trainers.** Consultants in policy, media, and coalition development continued to be involved; however, peer-to-peer

training was given more prominence. Selected state staff members were invited to serve as training facilitators and share their experiences in implementing a range of interventions in worksites, schools, and community settings. Efforts were made to incorporate sessions on cultural diversity.

During the implementation phase of the project (October 1993–September 1999), the comprehensive intervention plans were critiqued and revised, and the annual action plans were critiqued, revised, and implemented. Funding levels were increased from a planning level of approximately $400,000 per year per state to more than $1,000,000 per year per state.

During this phase, the principal technical assistance and training goals were to mobilize and build momentum for tobacco control; implement and refine strategies; and institutionalize tobacco control within health departments, voluntary agencies, and community-based organizations.

Technical assistance was much in demand by the states during the implementation phase. Staff members in each state had regular access to their designated liaison at the ASSIST Coordinating Center and their assigned NCI project officer. These resources were responsible for assessing and responding to requests—either personally or by assigning the request to other ASSIST Coordinating Center content specialists or consultants. Technical assistance was provided in a variety of ways—via site visits, conference calls, and meetings during training events between state staff members and their assigned technical assistance specialist. The states and NCI noted that an advantage of having the ASSIST Coordinating Center deliver the technical assistance was that the center provided a collaborative environment in which the states could be frank about their needs. The ASSIST Coordinating Center was not responsible for the states' funding and contractual obligations; thus, the requests and assistance relevant to programmatic issues could occur without concern about seeming weaknesses in the states' programs.

As the implementation phase approached late 1993, the training program began to incorporate opportunities for the states to share their experiences at information exchange conferences. Unlike the earlier training sessions in tobacco interventions, the new approach allowed for more networking and discussion breakout sessions facilitated primarily by conference participants. Many sessions presented a variety of case studies—state experiences that shared successes and lessons learned in implementing policy interventions and media advocacy. In addition to being well received by the ASSIST states, this change of training format also generated interest outside ASSIST and caught the attention of the California Tobacco Control Program. In May 1994, ASSIST and the California program sponsored a cooperative information exchange conference, followed by a conference in Massachusetts in June 1995. Their successes in sharing cutting-edge approaches to tobacco interventions led to the first of four annual national conferences

beginning in May 1996, cosponsored by NCI, ACS, various other federal agencies and voluntary organizations, and national ethnic organizations that provided training. Bringing together all these players was challenging but gave impetus to an emerging national tobacco control movement that continues today.

Process evaluation from these training events was very positive, and the ASSIST Coordinating Center staff and the Technical Assistance and Training Subcommittee closely reviewed the results. Modifications were made to future conferences and training sessions as seemed warranted by the feedback and by observations of field activities. As a result, vast improvement began to appear in the states' annual action plans in addition to a difference in the strategies and activities that they implemented. Appendix 4.I describes the 17 training events offered during the implementation phase.

Building Capabilities Back Home: The Site Trainers Network

During the planning phase, the training workshops brought together all 17 state health department project managers and all 17 ACS project managers. The centralized training reinforced a common approach to tobacco control and linked the states to one another for exchange of experiences. During the implementation phase, the training program addressed the need to build the skills of coalition members and staff members in the communities. A Site Trainers Network (STN) was created. The STN, basically a "train-the-trainers" network, provided the support that states needed to organize and implement their intrastate tobacco control advocacy trainings. Topic-specific modules and materials were developed.

To build their cadre of in-state trainers, each state was expected to send two to four representatives to module training sponsored by the ASSIST Coordinating Center. Each training candidate had to make a commitment to teach the module in his or her home community for at least 1 year. Each state designated a training coordinator to plan and coordinate the intrastate training events and to lead the cadre of state trainers.

Between 1994 and 1999, the following six STN modules were created and presented:

- *Policy Advocacy* and *Administrative Handbook*, December 13, 1994, Washington, DC
- *Youth Advocacy,* September 26–28, 1995, Crystal City (Arlington), Virginia
- *Planning for Durability: Keeping the Vision Alive*, October 20–21, 1996, Arlington, Virginia
- *Multicultural STN Workshop: From Sensitivity to Commitment*, April 13–14, 1997, Washington, DC
- *Advanced Media Advocacy Module Workshop*, April 18–19, 1998, Detroit, Michigan
- *Advanced Policy Advocacy Workshop,* June 11–12, 1999, Bethesda, Maryland

All modules incorporated the following five elements:

1. Objectives, lesson plans, and optional teaching formats
2. A variety of delivery techniques

3. Encouragement for states to develop short- and long-term training plan
4. Options for 1- or 2-day delivery
5. Flexibility for delivery based on a state's needs

Additional technical assistance systems were put into place after STN training was delivered. Quarterly teleconference calls were held from 1994 to 1997 for the training coordinators as a vehicle for problem-sharing, networking, and support. One of the challenges that developed, particularly noticeable during 1997, was state staff turnover, which created a shortage of training coordinators. In response, technical assistance shifted to provide more one-on-one assistance to health department staff members who had been assigned training responsibilities. In addition, some states developed their own training materials, often incorporating and adapting module components.

How well did the STN program work? An evaluation of the project was undertaken in 1998. State training coordinators and project managers participated in a survey, which found that the project was valuable for its usability, flexibility, and utility. Even after the ASSIST project ended, the module materials continued to be used, and a few states had more formalized intrastate training programs than before the inception of the STN. For example, New York used the multicultural module not only within ASSIST, but also within its state office of minority health. NCI, Prospect Associates, and ASSIST's Multicultural Committee received an award of appreciation from the New York City Intercultural Cancer Council in 1999.

Site Trainers Network Modules

Each module was developed with the priority needs of the states at the forefront. For example, an ongoing state multicultural training mechanism was needed to help the states develop and implement interventions that would be responsive to the distinct cultural, social, and religious norms of diverse groups (e.g., ceremonial usage of tobacco in American Indian cultures). The Multicultural Subcommittee of the ASSIST Coordinating Center felt that the site trainers network (STN) approach would be effective in establishing a common base of knowledge and sensitivity among health professionals and advocates in the ASSIST project. In early 1997, a planning group was formed; it consisted of representatives of the subcommittee, editorial consultants, and ASSIST Coordinating Center staff knowledgeable in tobacco control and multicultural issues.

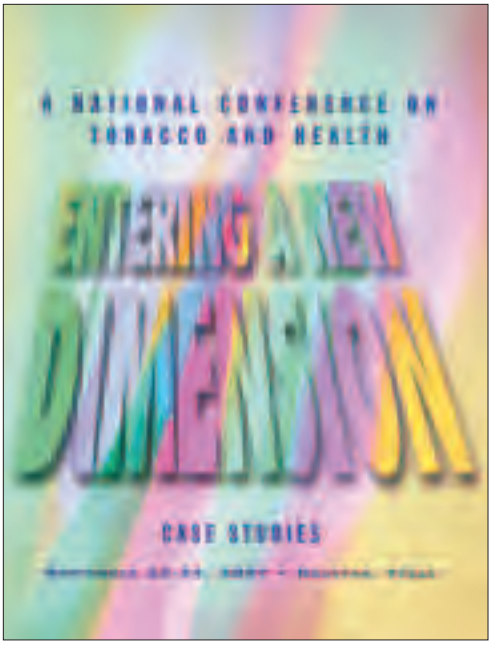
The completed module, From Sensitivity to Commitment, comprised six distinct sections with activities and exercises: developing awareness, community assessment, creating partnerships, building collaborations, developing leadership, and planning for action. The module was designed to be experiential rather than merely didactic. To internalize multicultural awareness, participants needed to experience issues and situations encountered by diverse ethnic groups. Exercises such as the "Iceberg Self-Assessment" and "Create a Culture" were core activities. By mid-1997, 67 new trainers in 15 states were ready to deliver the module.

Willing and Ready

Over the life of the ASSIST project, 17 national training workshops, information exchange conferences, and national tobacco control conferences were held for more than 6,600 participants. It is clear that the technical assistance and

training provided over the years had a positive impact on the outcomes of the project. Over the life of the project, as the ASSIST model became more effectively implemented and as state staff became more skilled, the approach to technical assistance and training evolved to be responsive to the states' needs in the following major ways.

- From a relatively top-down, directed program to one that became more bottom-up, that is, more interactive with the participants in planning and delivery
- From external experts to internal experience, relying less on consultants and more on information exchange and peer-to-peer learning experiences, which allowed for sharing of state experiences
- From a predetermined plan to flexibility in responding to state needs as they developed, including needs for assistance in developing planning reports, intervention plans, media and policy advocacy skills, capabilities in addressing specific issues (e.g., youth access, cultural diversity); in coalition-building; and in planning for the future (program institutionalization)



Case study materials

The capacity and capability developed by the states, combined with the flexibility of the ASSIST Coordinating Center in delivering ongoing technical assistance and training, readied the coalitions to implement the media and policy interventions described in chapters 5 and 6.

Appendix 4.A. Example of Membership in an ASSIST State Coalition: Rhode Island

	ASSIST Program Objective Area				
Coalition Member	**Community Environment**	**Community Groups**	**Health Care**	**Schools**	**Work Sites**
ACS, Rhode Island Division	x	x	x	x	x
American Fed. of State, County and Municipal Employees				x	
American Heart Assoc., Rhode Island Affiliate	x	x	x	x	x
AMICA Mutual Life Insurance Co.	x		x		x
Blue Cross/Blue Shield of Rhode Island	x		x		x
Boys and Girls Clubs of Warwick		x			
Boy Scouts of America, Narragansett Council		x			
Brown University Program in Medicine		x	x		x
Citizens Bank					x
City of Pawtucket		x		x	
Cumberland School Committee				x	
Comm. Coll. of Rhode Island, Allied Health Dept.			x	x	x
Davol Inc.					x
Fleet Bank	x				x
Greater Providence Chamber of Commerce	x				x
Harvard Comm. Health Plan			x		
Healthy Mothers/Healthy Babies		x	x		
Hospital Assoc. of Rhode Island	x		x		x
Institute for Human Development				x	
Kenny Manufacturing Co.					x
Kent County Occupational Health					x
Laboratory/Cancer Prevention Research Consortium			x	x	x
Local 1199 of Service Employees Intl.– New England Health Care Employees			x		x
Manufacturing Jewelers and Silversmiths Assoc.					x
Memorial Hospital of Rhode Island			x		
Miriam Hospital Health Promotion Ctr.			x		
Monam Hospital, Brown Program in Medicine			x		
Narragansett Electric Co.	x				
National Educational Assoc. of Rhode Island				x	x
Newport Hospital			x		
Newport School Committee				x	
New Visions for Newport	x	x			
Occupational and Environmental Health					x
Ocean State Physicians Health Plan			x		
Office of Substance Abuse				x	
Opportunities Industrialization Ctr. of Rhode Island		x			
Pawtucket Heart Health Project	x	x	x	x	x
Planned Parenthood of Rhode Island	x		x		
Portuguese-American Journal	x	x			
Progresso Latino	x	x			
Providence Ambulatory Health Care Fndtn.			x		
Providence College				x	
Providence Fire Dept.					x
Providence Journal Co.	x				

Appendix 4.A (continued)

Coalition Member	ASSIST Program Objective Area				
	Community Environment	Community Groups	Health Care	Schools	Work Sites
Providence School Dept.				x	
PHHP STOP Coordinator					
Raytheon Co.					x
Rhode Island Anti-Drug Coalition				x	
Rhode Island Cancer Prevention Research Consortium			x		
Rhode Island Committee on Safety and Health					x
Rhode Island Hospitality Assoc.	x				x
Rhode Island Human Rights Commission	x				
Rhode Island Interscholastic League		x			
Rhode Island Middle Level Educators				x	
Rhode Island Pharmaceutical Assoc.	x		x		
Rhode Island State Assoc. of Fire Fighters	x				x
Rhode Island Thoracic Society			x		
Rhode Island Assoc. of School Administrators				x	x
Rhode Island Black Ministerial Alliance		x			
Rhode Island Business Group on Health			x		x
Rhode Island Chamber of Commerce Fed.	x				x
Rhode Island Council of Comm. Mental Health Centers			x		
Rhode Island Dental Assoc.			x		
Rhode Island Health Ctr. Assoc.			x		
Rhode Island Hospital	x		x		x
Rhode Island Indian Council		x			
Rhode Island League of Cities and Towns	x	x			
Rhode Island Lung Assoc.	x	x	x	x	x
Rhode Island Medical Society			x		
Rhode Island School Health Assoc.				x	x
Rhode Island State Nurses Assoc.			x		
Rhode Island Women's Health Collective		x	x		
Roger Williams Cancer Ctr.	x		x		x
Rhode Island AFL/CIO					x
Socio-Economic Development Ctr. for Southeast Asians		x			
State Dept. of Elementary and Secondary Educ.				x	x
State Dept. of Health	x	x	x	x	x
State Dept. of Human Services	x	x	x		
St. Joseph Hospital			x		
The Gathering		x			
Tobacco Free Teens				x	
United Black and Brown Fund		x			
United Way of Southeastern New England	x	x	x		
University of Rhode Island Self-Change				x	
Urban League of Rhode Island		x			
University of Rhode Island, Urban Field Ctr.				x	
Warwick Veterans Memorial High School				x	
Westerly Hospital			x		
Women and Infants Hospital			x		x
WCRD AM	x				
WPRO AM and FM	x				

Source: ASSIST Coordinating Center. 1992. ASSIST coalition profiles. Internal document, ASSIST Coordinating Center, Rockville, MD. 112–6.

Appendix 4.B. ASSIST Responsibility Matrix from Minnesota

Name of Organizational Unit: _____

Primary Function of Organizational Unit: _____

TASKS	PARTICIPANTS									
	PD	**PM**	**FD**	**ACS PM**	**Stwd. Coal Mbrs.**	**Local Coal Mbrs.**	**Unit Chr.**	**Unit Mbrs.**	**Stwd. Exec Comm.**	**C&A Comm.**
Develop operating guidelines/ parameters	A	R		R					A	A
Develop work plan and schedule	C	R		R						
Recruit new members		C	R		R	R				
Plan/coordinate training of members		A	R	A/R	I	I			C	C
Prepare meeting agendas—Local/State	A	R	C/I	C/R	I	R			I	R
Chair Meetings	R									R
Take meeting minutes and distribute			R			R				
Hire staff	A	R	C	C	I	I			I	DK
Staff committee		C	R							
Develop & maintain communication protocols	A	A	R							C
Gather information for planning purposes		R	R	R	R					
Determine action priorities		R/C	R/C	R/C	R/C	R/C				R/A
Develop contract reports/ deliverables (CTCP, APP)	A	R	R						A	
Develop public information reports	A	C/A	R	R					A	A/I
Identify resource needs		R	R	R	R	R			C	C
Manage/allocate resources	A	R		R					A	I
Manage purchases/acquisitions/ subcontracts	A	R	C	C						
Maintain program records	A	R	R	R						
Participate on ECS	I	R	R	R	I	I			I	I
Liaison with other networks/ programs		R	R	R	R					
Identify/recruit intermediaries		R	R	R	R	R			R	
Serve as spokesperson		C	C	C	R	R			R	R
Represent site on National Coordinating Committee	R	C	I	I					I	I
Evaluate projects	A	R	R	R	R				A	A
Distribute funds	A	R	C	C	C	I			A	A

A – Approve; R – Responsible; C – Consulted; I – Informed; DK—Don't Know; NA—Blank

Appendix 4.C. Wisconsin ASSIST's Comprehensive Smoking Control Plan: Selected Channels

Community Environment Channel

Objective 1: By 1998, cues and messages supporting nonsmoking will have increased, and prosmoking cues and messages will have decreased.

Strategies

1. Build a corps of skilled advocates at state and local levels to promote, educate, and train volunteers and intermediaries on mass media opportunities for supporting policy initiatives and approaching media gatekeepers (1993–95)
2. Generate media coverage surrounding tobacco policies to generate support for controls, reinforce nonsmoking norms, and increase individual understanding of the health hazards of smoking (1993–98)

Objective 2: By 1998, ASSIST Wisconsin will substantially increase and strengthen public support for policies that mandate clean indoor air; restrict access to tobacco by minors; increase economic incentives and taxation to discourage the use of tobacco products; restrict the advertising and promotion of tobacco; and remove financial barriers to prevention, detection, and remediation of illnesses related to use of tobacco products.

Strategies

1. Educate and inform public authorities and the media through briefings, hearings, and epidemiologic data (1993–98)
2. Develop a rapid communications system to offer a system of communications for and provide current information about tobacco control activities, research, resources, and policy opportunities and to alert tobacco control activists of new policy initiatives (1993–94)
3. Inform the public and policymakers how public and private policies and strengthened policy enforcement can decrease tobacco promoters' access to minors and can decrease the percentage of minors who smoke (1993–95)

Worksite Channel

Objective 1: By 1998, the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace should increase to at least 75%.

Objective 2: By 1998, worksites reaching priority populations will adopt and maintain a tobacco use cessation focus.

(a) By 1998, all employers in Wisconsin, and especially health organizations, should have ongoing smoking cessation programs for their staff and clients.

(b) By 1998, all Wisconsin social service and education organizations should provide or provide access to or identify ongoing smoking cessation programs for their staff.

Objective 3: By 1998, all public and private employees in Wisconsin will have the legal right to not be exposed to environmental tobacco smoke in their places of work.

Source: Wisconsin Department of Health. 1992. *Wisconsin comprehensive smoking control plan,* 10–3. Madison: Wisconsin Department of Health.

Appendix 4.D. Wisconsin ASSIST's 1993–94 Annual Action Plan: Selected Channels

Community Environment Channel

Annual Objective 1: Provide support—technical information and assistance in strategy development—upon request to all local ASSIST coalitions that are engaged in efforts involving local policies (clean indoor air, smoke-free restaurants and workplaces, tobacco promotion and distribution, and youth access issues).

Annual Objective 2: Recruit and train at least 30 state and local coalition members to effectively represent smoking control issues within their constituencies, within their communities, before public policymakers, and in the media.

Annual Objective 3: Develop an alert system to inform state and local coalition members of the latest developments in tobacco-control activities, research, resources, and policy opportunities and to motivate them to take action.

The following state and local activities were designed to support objectives for fiscal year 1993–94.

- Activity 1: Coordinate trainings for state and local coalition members in policy and media advocacy.
- Activity 2: Support the development of state and local coalitions to work effectively in the community environment.
- Activity 3: Distribute action alerts and other rapid communications on tobacco control initiatives to key state and regional coalition contacts.
- Activity 4: Develop local coalition policy guidelines for initiatives to decrease youth access to tobacco products specific to current Wisconsin statutes.
- Activity 5: Support key magnet events that facilitate statewide media attention on tobacco control efforts in local and state coalitions.
- Activity 6: Identify important local, regional, and statewide conferences for key channels and/or priority groups, and integrate tobacco control issues into their agendas.
- Activity 7: Develop a plan to increase the utilization of paid advertising and public service announcements that promote tobacco control in newspapers, and on billboards, television, and radio.
- Activity 8: Promote media coverage of successful smoking control policy implementation in worksites, schools, and other community settings.
- Activity 9: Develop, adapt, and disseminate research findings to provide a continuous stream of information about the health and economic impact of tobacco use in Wisconsin.

Worksite Channel

Annual Objective 1: By October 1994, the proportion of worksites with a moderate smoking policy that includes restrictions of smoking in meeting rooms and other common areas should increase by at least 5%, and the proportion of companies with a strong smoking policy that protects the health of nonsmokers by prohibiting smoking or limiting smoking to separately ventilated "smoking lounges" should increase by at least 5%.

Annual Objective 2: Provide resources to at least 500 employers to assist them in adopting smoke-free worksite policies, in disseminating smoking cessation materials to employees wishing to stop smoking, and/or in maintaining worksite-oriented prevention services (e.g., for young adults at risk for beginning smoking).

Annual Objective 3: Develop and maintain a group of at least 30 individuals trained to serve as smoking control resources on worksite smoking issues.

- Activity 1: Develop a worksite committee for the Tobacco-Free Wisconsin Coalition.
- Activity 2: Adapt and provide smoking control policy models to present to business organizations.
- Activity 3: Provide materials and outreach efforts that show workers how smoking, sidestream smoke, and use of smokeless tobacco affect their individual, co-worker, and family health and economic status.
- Activity 4: Identify key regional and statewide conferences, and integrate tobacco control and prevention education into their agendas.
- Activity 5: Coordinate up to four regional workshops to train a cadre of state and local coalition members, management and labor representatives, health educators, and other influential individuals who will provide models, information, presentations, materials, and training to local coalitions.
- Activity 6: Provide smoking control policy workshops to representatives of business organizations and unions.

Source: Wisconsin Department of Health. 1993. *Wisconsin annual action plan*. Madison: Wisconsin Department of Health.

Appendix 4.E. Minnesota ASSIST's Comprehensive Tobacco Control Plan: Community Environment Channel

Objective 1: By 1998, increase the number of public places in Minnesota that will be tobacco free.

Strategies

- Educate property owners and managers, business owners, and the general public on environmental tobacco smoke hazards and policy issues.
- Promote and enlist public support for tobacco-free environments.
- Encourage public policymakers to take action by providing healthful, smoke-free environments.
- Strengthen the Minnesota Clean Indoor Air Act by removing current exemptions.
- Increase the enforcement of the Minnesota Clean Indoor Air Act.

Source: Minnesota Department of Health. 1992. *Minnesota comprehensive tobacco control plan*. St. Paul: Minnesota Department of Health.

Appendix 4.F. Minnesota ASSIST's 1993–94 Annual Action Plan: Community Environment Channel

Objective: By September 1994, local coalitions will enact policies to reduce environmental tobacco smoke.

- Activity 16: Involve chamber of commerce, restaurants and retail associations, private industry councils, similar business group associations, and community organizations to promote clean indoor air policies.
- Task 1: Coalition staff and members will prepare and compile environmental tobacco smoke information, sample policies, and smoking cessation resources. (December 1993)
- Task 2: Coalition staff and members will identify organizations interested in receiving smoke-free workplace materials and implementing policies. (January 1994)
- Task 3: Coalition staff and members will conduct presentations and incorporate articles in appropriate organizational newsletters. (December 1993–September 1994)
- Task 4: Coalition staff and members will provide ongoing technical assistance and resources to organizations in the community. (December 1993–September 1994)

Source: Minnesota Department of Health. 1993. *Annual action plan*. St. Paul: Minnesota Department of Health.

Appendix 4.G. Minnesota ASSIST's 1998–99 Annual Action Plan: Community Environment Channel

Objective 1: By September 1999, encourage rental property owners and housing developers to provide and promote smoke-free housing.

Activities

- Increase the awareness of landlords and housing developers of the economic and health benefits of providing smoke-free housing.
- Provide information and consultation to property owners and housing developers interested in smoke-free housing.
- Support these activities through media advocacy.

Objective 2: By September 1999, increase awareness of the impact of secondhand smoke.

Activities

- Work with the Minnesota Department of Human Services and with foster care and daycare providers to increase their knowledge of the dangers of secondhand smoke to children, especially children with asthma or other chronic health conditions.
- Increase awareness of secondhand smoke's impact in vehicles.
- Support these activities through media advocacy.

Source: Minnesota Department of Health. 1998. *Minnesota annual action plan.* St. Paul: Minnesota Department of Health.

Appendix 4.H. Washington State ASSIST's Project Management Plan: Selected Components

Management and Coalition Organization

Overall Organization of Washington State ASSIST

ASSIST in Washington is comanaged by the Washington State Department of Health (DOH) and ACS, Washington Division. DOH is responsible for the fiscal and administrative management of the project; all other project decisions are made jointly by DOH and ACS. The project managers from the DOH and ACS staff the state coalition and its committees. Four DOH field directors staff four local coalitions that participate in Washington State ASSIST. Washington State ASSIST is governed by an executive committee composed of three DOH representatives, three ACS representatives, one state coalition representative, and two ex officio members (one each from DOH and ACS). The executive committee reviews and approves all decisions related to ASSIST.

The relationship of Washington State ASSIST to the Tobacco Free Washington Coalition is created through a written agreement between the ASSIST Executive Committee and the Tobacco Free Washington Coalition Steering Committee. This agreement sets forth the responsibilities of each organization in implementing ASSIST in Washington State. The agreement states that the coalition will incorporate the accomplishment of the ASSIST objectives into their goals. The Tobacco Free Washington Coalition created six task forces to coincide with the ASSIST channels.

Monitoring Progress

Fiscally, contractually, and programmatically, each annual objective of the state and local coalitions will be monitored by the ASSIST project manager at DOH and the local field directors, respectively, with input from the appropriate task force. Each task force at the state and local levels will monitor the progress of each annual objective that pertains to the associated channel by conducting progress meetings every month. Subcontractors of the various activities will be required to send a written report or attend these meetings to report on progress. If progress is not adequate, the task forces will make adjustments as necessary. Project managers and field directors will attend task force meetings to assess programmatic progress. Subcontracts will also be monitored by the respective project manager or field director. For objectives not requiring a subcontract, budgets will be monitored closely by the respective project manager or field director. The steering committee of the state coalition will monitor overall progress toward the accomplishment of the annual objectives. At least six steering committee meetings will be held per year to monitor overall statewide progress at both state and local levels.

Communications between Staff, between ACS and DOH, and between State and Local Coalitions

The primary mode of communication between the ASSIST project manager and the ASSIST field directors is the electronic communications system. DOH has its own system called DOHNet to which all ASSIST staff and the project manager are connected. In addition to the use of electronic mail, the staff members, including the ACS project manager, regularly communicate via conference calls.

Project managers from the ACS and DOH communicate on a regular basis by phone. Regular meetings of the project managers are also held to plan for coalition meetings and to strategize coalition activities. The ASSIST project directors, project managers, and the DOH cancer program manager meet on a regular basis to discuss issues that affect the entire project.

At least two members from each of the local coalitions attend all the full coalition meetings of the Tobacco Free Washington Coalition. Each of the local coalition presidents is a member of the state coalition's steering committee and thus receives regular communications about the progress of the coalition and has input into setting the direction for the coalition. Periodically, the chairs of each task force from each of the coalitions (state and local) hold a conference call to discuss strategies within their channels. These conference calls facilitate continuity and collaboration among coalitions at the state and local levels.

Technical Assistance and Training

The ASSIST project manager attends the national ASSIST trainings and periodically attends other tobacco-related conferences and workshops to increase knowledge and skills needed to perform the duties of the position. The ASSIST field directors receive quarterly trainings from the project manager, the cancer control manager, and the project director on the topic of the most previous national training and on other topics identified by the field directors as a training need. Selected coalition members have been and will continue to attend ASSIST national trainings when they relate to the members' respective task force. The Tobacco Free Washington Coalition membership will be surveyed annually to assess the training needs of coalition members.

The ASSIST project manager will assess the technical assistance needs of the field directors with input by the field directors through individual conferences. Coalition members will regularly assess their own technical assistance needs at the task force level.

Source: Washington State Department of Health. 1993. *Washington ASSIST project management plan: October 1, 1993–September 30, 1998*. Olympia: Washington State Department of Health.

Appendix 4.I. Training Events of the Implementation Phase

Date	Place	No. Participants	Training Content
Training Workshop: "Media Advocacy: A Strategic Tool for Change"			
Mar. 1993	Washington, DC	180	■ Developing a working understanding of media advocacy ■ Building effective volunteer and staff teams ■ Fiscal and resource allocation requirements ■ Lessons learned—Uptown Coalition Campaign ■ Developing the project management plan ■ Model policies and their appropriateness ■ Using the electronic communications system to support media advocacy
Training Workshop: "From Phase One to Page One: Refining Our Media Skills"			
July 1993	Washington, DC	180	■ The changing perspective of prevention—how media advocacy supports policy change ■ "Piggybacking" the electronic communications system's local media advocacy activities ■ National stories: creating media advocacy opportunities ■ Developing and defining media skills for advocacy purposes ■ Training spokespersons ■ Accessing multicultural media channels ■ "Pitching" local stories-skills session ■ Translating science into media language ■ Working together in partnership: ACS and state departments of health
Information Exchange Conference: "Youth Access"			
Oct. 1993	Washington, DC	162	■ Forum for sites to discuss ASSIST issues ■ Sharing information and resources ■ Learning from experiences of allied organizations and individuals
Training Workshop: "Implementing Policy Advocacy: Steps to Success—Part One"			
Dec. 1993	Washington, DC	160	■ Utilizing direct and indirect advocacy methods to achieve tobacco control ■ Identifying tools needed to support the following policy areas – Clean indoor air – Youth access – Advertising and promotion ■ Building coalition capacity ■ Applying planning skills to achieve policy objectives

Appendix 4.I (continued)

Date	Place	No. Participants	Training Content
Training Workshop: "Implementing Policy Advocacy: Steps to Success—Part Two"			
Mar. 1994	Washington, DC	162	■ Improving the process for developing annual action plans ■ Increasing sites' knowledge and skills needed for planning pertaining to policy issues on clean indoor air and economic disincentives ■ Identifying tools available to sites in the areas of clean indoor air and economic disincentives and increasing sites' understanding of how to use these tools ■ Building coalition capacity for conducting advocacy activities related to clean indoor air and economic disincentives
Information Exchange Conference: "Breaking the Grip of Tobacco—State by State"			
May 1994	San Francisco, CA	294	■ Providing a forum for the 17 ASSIST sites to discuss issues specific to their work ■ Providing an opportunity for sites to use case studies and other resources to increase their knowledge and helping them meet their ASSIST objectives ■ Learning from California's experience in tobacco control, using case studies and other methods ■ Learning about international tobacco control experiences, using case studies and other resources
Information Exchange Conference: "Building Diverse Community Involvement"			
Dec. 1994	Washington, DC	224	■ Exploring strategies to increase involvement of ethnic and nontraditional groups in ASSIST ■ Increasing coalition-building skills to support tobacco control
Information Exchange Conference: "Tobacco Prevention: The Next Generation"			
June 1995	Boston, MA	616	■ Providing a forum for collaboration among participating organizations ■ Strengthening participants' ability to develop and implement comprehensive youth and secondhand smoke policy initiatives ■ Expanding resource networks among participants ■ Providing resource tools for use "back home" ■ Providing proactive strategies for dealing with the tobacco industry ■ Sharing Massachusetts's and participating organizations' programs and interventions ■ Providing information on national tobacco prevention efforts

Date	Place	No. Participants	Training Content
Information Exchange Conference: "Tobacco Prevention: Connecting for the Future"			
Oct. 1995	Washington, DC	197	■ Identifying methods for durability and institutionalization ■ Enhancing skills for effectively working with coalitions ■ Learning from the experiences of women's and other organizations to build allegiances to develop a sustainable tobacco prevention movement
National Tobacco Control Conference: "Communities for Tobacco-Free Kids: Drawing the Line"			
May 1996	Chicago, IL	712	■ Providing a forum for the sharing of information and tobacco prevention and control methods among conference participants
Information Exchange Conference: "Building Momentum for Tobacco Prevention: Planning for the Future"			
Oct. 1996	Arlington, VA	228	■ Identifying, exploring, and starting to build systems for durability to prepare for project transition ■ Sharing strategies for building and maintaining strong partnerships between ASSIST partners and allied organizations on state and local levels
Information Exchange Conference: "Step by Step: Advancing Toward a Tobacco-Free Nation"			
Apr. 1997	Washington, DC	230	■ Providing a forum for the exchange of information among ASSIST sites ■ Providing learning opportunities on emerging issues in tobacco control ■ Providing opportunities to develop and strengthen federal, state, and local partnerships
National Tobacco Control Conference: "A National Conference on Tobacco and Health: Entering a New Dimension"			
Sept. 1997	Houston, TX	736	■ Providing a collaborative forum for conference participants to strengthen partnerships and to share strategies, technology resources, and information to advance and mobilize communities to reduce tobacco use. Program objectives include the following: – To provide current and accurate information on tobacco issues – To showcase program outcomes – To foster communication and collaboration across various programs and organizations – To provide sessions designed to increase in-depth knowledge and skill-building opportunities.

Appendix 4.1 (continued)

Date	Place	No. Participants	Training Content
Information Exchange Conference: "Affirming Our Commitment to Tobacco-Free Communities"			
Apr. 1998	Detroit, MI	246	■ Providing a collaborative forum for conference participants to develop skills and to share strategies, resources, and information to further reduce tobacco use. Program objectives include the following: – To provide opportunities to increase knowledge and skills – To provide current information on national and international tobacco control efforts – To acknowledge the success of the ASSIST project – To reaffirm the commitment to tobacco control to prepare for a new era
National Conference on Tobacco and Health: "No More Lies—Truth and the Consequences for Tobacco"			
Oct. 1998	St. Paul, MN	972	■ Providing a collaborative forum to strengthen partnerships and share strategies, technology resources, and information to advance and mobilize communities to reduce tobacco use. Program objectives include the following: – To provide current and accurate information on tobacco control issues – To showcase program outcomes and best practices – To foster communication and collaboration across various programs, communities, and cultural groups – To provide sessions to increase in-depth knowledge and develop and enhance skill-building opportunities to prepare for new and emerging challenges
Information Exchange Conference: "ASSIST Success: A Foundation for the Future"			
Mar. 1999	Bethesda, MD	231	■ Providing a collaborative forum for the conference participants to develop skills; to share strategies, resources, and information to further reduce tobacco use; and to acknowledge the success of the ASSIST project.

Date	Place	No. Participants	Training Content
National Conference on Tobacco and Health: "Tobacco-Free Future: Shining the Light"			
Aug. 1999	Orlando, FL	1,040	■ Providing current and accurate information on tobacco control issues ■ Showcasing program outcomes and best practices ■ Fostering communication and collaboration across various programs, communities, and cultural groups ■ Providing sessions to increase in-depth knowledge and develop and enhance skill-building opportunities to prepare for new and emerging challenges

Note: Shading indicates training events that were information exchange conferences.

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5. Media Interventions to Promote Tobacco Control Policies

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5. Media Interventions to Promote Tobacco Control Policies

The overall strategy of the American Stop Smoking Intervention Study (ASSIST) was to reduce the prevalence and effects of tobacco use by promoting a tobacco-free social norm and environment. State health departments, voluntary health agencies, and other partners came together in coalitions to advocate for state and local tobacco prevention and control policies, such as cigarette excise tax increases, restrictions on tobacco advertising and promotion, youth access laws, and clean indoor air ordinances. Getting these policies accepted and enacted required a broad base of support from the public and from policymakers. This chapter describes a strategic approach to using a variety of media interventions to promote public health policies and illustrates how media advocacy was used in ASSIST to promote policies for a tobacco-free environment. In particular, a principal strategy was to leverage earned media coverage to advance policy issues. The strategies described in this chapter are especially relevant to states and communities with small mass media budgets. Several case studies are presented to illustrate the processes and effectiveness of the interventions. While ASSIST's comprehensive approach used several types of media interventions, it was the strategic application of the interventions to effect policy change that made them powerful and that distinguished ASSIST in the tobacco control movement.

The Power of the Media

The power of the media is widely acknowledged. Broadcast media—television and radio—reach nearly every person in this country at home and at work. Print media—newspapers and magazines—also have a wide reach, especially among adults, decision makers, and highly educated individuals. The Internet is an electronic medium of mass communication rapidly increasing in reach worldwide. The tobacco industry gives testimony to the influence and reach of the media by the billions of dollars that this industry has invested in advertising campaigns to promote tobacco use, specific brands, and pro-tobacco social norms. At the end of the 1980s, U.S. cigarette manufacturers were spending almost $4 billion annually on advertising and promotion; in 2002, the six largest cigarette manufacturers spent $12.5 billion, an 11% increase from 2001, while the total number of cigarettes sold or given away *decreased* by nearly 4% from the previous year.[1] In 1998, the tobacco industry spent $40 million on a television advertising campaign to defeat the proposed McCain bill to control tobacco products.[2(p223)] This bill would have given the Food and Drug Administration authority to regulate the sale, manufacturing, labeling, and marketing of tobacco products and to use a tobacco tax to fund antismoking campaigns, research, and health-related activities.

Billboard featuring R. J. Reynolds, a private citizen, of Washington State

Decades of advertisements positioned cigarette images, such as the Marlboro Man, as central figures in American life and promoted the perception of smoking as an acceptable, even desirable, social behavior, associated with healthy, vibrant lifestyles. A study of formerly confidential tobacco industry documents has revealed that the industry, despite voluntary restrictions on such practices, continues to use the power of film to promote social acceptability of tobacco use, particularly among young people.[3] In addition, the tobacco industry was able to influence the kind and amount of coverage of tobacco and health issues in other types of media because they depended on the substantial revenue from tobacco advertising.[4,5]

At the time that ASSIST started, research had begun to establish the effectiveness of mass media interventions in influencing health behaviors, including tobacco use.[6–8] (Also see chapter 1.) Tobacco control activities had used media interventions to accomplish two objectives:

1. To increase the public's exposure to prohealth, antitobacco messages
2. To limit the public's exposure to protobacco messages

Media coverage of the tobacco and health issue was credited with improving public awareness of the health hazards of smoking, with changing attitudes about smoking, and with contributing to declines in the prevalence of smoking in the general population.[7] For tobacco control programs, five specific functions of mass media interventions had been identified. Mass media interventions

1. provided information to the public about health facts and issues related to tobacco use,
2. alerted citizens and policymakers to injurious public policies that promoted tobacco use,
3. motivated people to stop or to refrain from initiating tobacco use,
4. recruited smokers into treatment programs, and
5. offered smoking cessation advice and programs.[9]

ASSIST contributed to the state of the art an important sixth function: the strategic use of the media on a large scale to advocate for tobacco prevention and control policies.

Preparing for Media Interventions

Effective use of media interventions is critical to advocacy efforts. The media can reach large numbers of people

ASSIST-produced video, Up in Smoke: The Transformation of America's Billboards

with persuasive messages and can play a powerful role in establishing the legitimacy of tobacco prevention and control interventions. Conversely, if criticisms in the media of tobacco prevention and control efforts are not skillfully countered, these criticisms can drastically undermine support among the public and key decision makers. The tobacco industry has been very effective in using the media to sell its products and to undermine the major messages of the tobacco prevention and control movement.[10,11] Early in ASSIST, it became apparent that there was a need to quickly build the capabilities of ASSIST partners at the national, state, and local levels not only to implement media interventions, but also to react effectively to media coverage and advocacy opportunities.

System Prerequisites

For ASSIST to conduct media interventions successfully, three elements had to be in place:

1. An infrastructure of organizational units clearly responsible for the interventions
2. A system of communication throughout the infrastructure that would enable timely implementation of media interventions
3. Technical assistance to equip ASSIST personnel and coalition volunteers with needed skills and to provide them continued support in planning and implementing media interventions

These three elements were developed and established during ASSIST's 2-year planning phase. Each ASSIST state was

Tips on Media Relations from Virginia ASSIST

The media can bring many resources to a small campaign and can cause it to become prominent in the community. The media can offer public service time or space to a project or can give value-added service to a paid campaign. If a media channel or personality becomes interested in the topic, additional coverage may be provided in the form of news features or commentary. In planning for media relations, consider the following strategies:

- Make the best connection. When looking for a contact at a media channel, first review the staff structure. The easiest person to approach is a public service director, but he or she may not be the best contact for your purposes. Think strategically. Determine who would be the most valuable connection, and approach that person directly, whether it be the editor of a publication, a public service director, a journalist, an account executive (for paid campaigns) who can assist with added value, a radio personality, a television anchor or reporter, or a community relations director.
- Explore existing connections. Look at existing relationships with organizations, and identify their media connections. Get these organizations involved in an activity, and let them reach the media.
- Show the media channel how the media will benefit. Find a way to link your message to something that the channel values. For example, look at the channel's past community relations efforts, staff make-up, or editorial policy statement to find common ground.
- Get a commitment from the media channel. Getting a commitment from the newspaper or the radio or television station, not just from an individual, is critical. For example, after the second year of Virginia's Sack the Pack campaign, the sportscaster left the station's employment. Although many of the station's staff members were involved in the campaign, the station had not committed itself to the project. The station's lack of commitment meant that the coalition had to approach the new sports anchor and the station director to regain involvement.
- Get media buy-in. Media channels that "buy in" to a project will focus on it to ensure its success. They can offer valuable public service time and space, known personalities who will commit themselves to the cause, and matching funds for project materials.

Source: Adapted from M. White. 1998. Institutionalizing tobacco use control into the media's agenda. In *No more lies: Truth and the consequences for tobacco* (Case Studies of the Fourth Annual National Conference on Tobacco and Health, October 26–28, 1998). Rockville, MD: ASSIST Coordinating Center.

required to include a staff position dedicated to media interventions by the end of the planning phase. This requirement emphasized the critical importance of media activities to the success of ASSIST interventions. By mid-1993, the 17 states were ready to implement media intervention strategies described in their annual action plans. (These are described in chapters 3 and 4.)

Nevertheless, while the advantages of using mass media interventions were clear, the states faced a major challenge—the high cost of paid mass media—at the outset and throughout the project. Recognizing that purchasing only a few media spots could exhaust a state's budget, ASSIST contracts limited the use of funds to purchase mass media to no more than 15% of the states' total budgets. In practice, the states spent even less than the amount allowed. The ASSIST guidelines directed the states to use media advocacy techniques to generate "earned" media coverage of tobacco and health issues, that is, coverage that is not purchased but is achieved through

Success Factors behind ASSIST's Effective Communications

Over the course of the project, several key success factors emerged concerning effectively engaging the media.

- *Develop hard-hitting, clear messages to explain ASSIST.* ASSIST was a complex project, difficult to describe for the media, which require simple, short, and straightforward messages, readily grasped by the public.
- *Identify and prepare all spokespersons to deliver the same messages.* The 17 ASSIST states had numerous coalitions with many partners at the national, state, and local levels, and all spokespersons had to describe the project in a consistent way.
- *Be ready to respond to the media quickly when asked.* The media require a response on a very short deadline with virtually no time to prepare. If there is no response within a single news cycle, the opportunity is very likely lost. Being ready and effective requires having a strategic communication plan in place.
- *Be ready to counter tobacco industry arguments.* ASSIST staff members, aware that the tobacco industry would oppose their efforts, were trained to stand their ground.
- *Stay focused.* ASSIST staff members and partners were confronted with many media-related distractions during the project. When crises arose, they responded quickly to the issues raised, but they also knew how to determine which issues would advance their goals and which would deter them.

Answer Quickly, and Get Back to Your Point

Question: Won't increasing the price of tobacco products drive people out of state and hurt our convenience stores and gas stations?

Answer: There's a good reason tobacco companies make this argument: They know that raising prices prevents children 7, 8, and 9 years old from smoking. The industry fights price increases across the board because they know that higher prices will encourage smokers to quit and will discourage kids from starting.

Question: Restaurants are private businesses. Shouldn't the government stay out and let these private business people accommodate customers as they see fit?

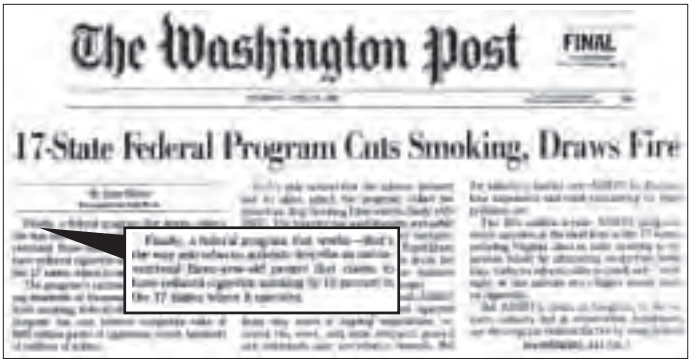
Answer: We wouldn't dream of letting these private businesses determine how many rats run through their kitchens, whether or not they should have sneeze guards over the salad bar, or whether they can serve meat that has been sitting on the counter for 2 days. These businesses thrive only because the public has confidence that the government has regulated them well enough to dramatically reduce the potential health and safety risks.

Source: ASSIST Coordinating Center. 1998. Advanced media advocacy module trainer's manual. Training manual, ASSIST Coordinating Center, Rockville, MD.

the strategic efforts of advocates.[12] Thus, media advocacy became the principal media intervention.

Media Relations

Before implementing any media interventions, ASSIST staff had to understand the importance of cultivating positive relationships with members of the media. To succeed in dealing with the media, individuals had to establish their credibility and the credibility of the project with media gatekeepers. Advocates had to be trusted as sources of truthful and useful information, and they had to be known as reliable and responsive contacts for the media. To begin


The Washington Post FINAL

17-State Federal Program Cuts Smoking, Draws Fire

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Collage of headlines from The Charlotte Observer, *January 22, 1997. Reprinted with permission.*

establishing media relations, ASSIST personnel were taught the following approaches:

- Watch how the media work in the community—who reports on the tobacco issue, and how frequently? How do the media cover it—the whole story or certain parts of the story?
- Develop a list of media professionals interested in the issue for later contact.
- Build relationships with those professionals by providing useful information about tobacco issues or by commenting on stories that they have already done.
- Be proactive about making media contacts. The media need timely, relevant, newsworthy ideas as much as advocates need the coverage.

Training Spokespersons

Tobacco control can be adversarial, most notably when the tobacco industry challenges some aspect of the program or opposes a policy intervention. When the momentum builds around tobacco news and events, the right individual, or spokesperson, must be available to keep decision makers and the public clear about the real issue at hand. Speaking effectively to members of the media or to the public requires preparation, coaching, and practice. While celebrities or content experts, such as the former tobacco industry researcher Victor DeNoble or the president of a local oncology medical society, are often desired spokespersons, ASSIST staff also had to be prepared to speak to their media contacts.

People in the tobacco control movement generally have backgrounds in the health professions and may not have been trained to function in highly charged or adversarial circumstances. Therefore, spokesperson training workshops were provided to ASSIST staff members. Participants in the training workshops were taught skills around four techniques to use for an interview with a representative of the media:

1. Establish rapport and a conversational approach in the interview; this

technique will enable the spokesperson to bring up important information that might not be asked for in a question-and-answer format.
2. Find out as much as possible about the story beforehand, and provide the interviewer with materials on the topic for use as background information.
3. Develop three or four key messages relevant to the topic. Stay on track by returning quickly and authoritatively to the key messages when tobacco industry spokespersons or reporters frame the debate away from the policy issues.
4. Suggest visuals for television appearances. Provide photo opportunities.

Media Strategies and Tactics

Media Advocacy

"Media advocacy is the strategic use of mass media as a resource for advancing a social or public policy initiative."[13(p8)] Media advocacy stimulates community involvement in defining policy initiatives that influence the social environment in which individuals make choices—for example, choices about tobacco use. Media advocates react to unexpected events and breaking news and create events to draw media attention and coverage to an issue.[14] When traditional media relations and interventions—for example, publicizing special events, marking health observances, and publicizing research results—are used strategically, not just informatively, they are tactics in the approach of media advocacy. In all the ASSIST states, ASSIST staff and volunteers were trained to use all media interventions in ways that were strategic and community based. In this way, ASSIST advanced the state of the art in media advocacy for tobacco control.

Media advocates must know the relevant policy issues, know how to frame an issue for public debate, and know how the media function—what types of stories are deemed newsworthy, how editors decide what stories get covered, and what deadlines and logistic issues might influence coverage. Therefore, ASSIST conducted media advocacy training to impart knowledge and skills to advocates and to encourage and empower their involvement in tobacco control. A communication network among advocates for sharing information on local and national activities helped ASSIST advocates implement media advocacy efforts. Newsletters, listservs, and

A Definition of Media Advocacy

"Strategic media approaches can help deliver the visibility necessary to enhance power in this media-driven age. Media advocacy is one such strategy: It is the strategic use of news media and, when appropriate, paid advertising, to support community organizing to advance a public policy initiative. It gives visibility to and 'certifies' the existence of those demanding change. It adds an exclamation point to the demand."

Source: Wallack, L., K. Woodruff, L. Dorfman, and I. Diaz. 1999. *News for a change: An advocate's guide to working with the media.* Thousand Oaks, CA: Sage Publications (p. ix).

Strategy Development: Nine Key Questions to Consider in the Development of an Advocacy Strategy

Looking Outward

Objectives: What do you want?

Any advocacy effort must begin with a sense of its goals. Among these goals some distinctions are important. What are the long-term goals and what are the short-term goals? What are the content goals (e.g., policy change) and what are the process goals (e.g., building community among participants)? These goals need to be defined at the start, in a way that can launch an effort, draw people to it, and sustain it over time.

Audiences: Who can give it to you?

Who are the people and institutions you need to move? This includes those who have the actual formal authority to deliver the goods (i.e., legislators). This also includes those who have the capacity to influence those with formal authority (i.e., the media and key constituencies, both allied and opposed). In both cases, an effective advocacy effort requires a clear sense of who these audiences are and what access or pressure points are available to move them.

Message: What do they need to hear?

Reaching these different audiences requires crafting and framing a set of messages that will be persuasive. Although these messages must always be rooted in the same basic truth, they also need to be tailored differently to different audiences depending on what they are ready to hear. In most cases, advocacy messages will have two basic components: an appeal to what is right and an appeal to the audience's self-interest.

Messengers: Whom do they need to hear it from?

The same message has a very different impact depending on who communicates it. Who are the most credible messengers for different audiences? In some cases, these messengers are "experts" whose credibility is largely technical. In other cases, we need to engage the "authentic voices" who can speak from personal experience. What do we need to do to equip these messengers, both in terms of information and to increase their comfort level as advocates?

Delivery: How can we get them to hear it?

There is a wide continuum of ways to deliver an advocacy message. These range from the genteel (e.g., lobbying) to the in-your-face (e.g., direct action). Which means is most effective varies from situation to situation. The key is to evaluate them and apply them appropriately, weaving them together in a winning mix.

Looking Inward

Resources: What have we got?

An effective advocacy effort takes careful stock of the advocacy resources that are already there to be built on. This includes past advocacy work that is related, alliances already in place, staff and other people's capacity, information and political intelligence. In short, you don't start from scratch, you start from building on what you've got.

Gaps: What do we need to develop?

After taking stock of the advocacy resources you have, the next step is to identify the advocacy resources you need that aren't there yet. This means looking at alliances that need to be built and capacities such as outreach, media, and research, which are crucial to any effort.

First efforts: How do we begin?

What would be an effective way to begin to move the strategy forward? What are some potential short-term goals or projects that would bring the right people together, symbolize the larger work ahead and create something achievable that lays the groundwork for the next step?

Evaluation: How do we tell if it's working?

As with any long journey, the course needs to be checked along the way. Strategy needs to be evaluated revisiting each of the questions above (i.e., are we aiming at the right audiences, are we reaching them, etc.). It is important to be able to make midcourse corrections and to discard those elements of a strategy that don't work once they are actually put into practice.

Source: Shultz, J. 1995. *Strategy development: Key questions for developing an advocacy strategy.* Washington, DC: Advocacy Institute. http://www.democracyctr.org/resources/strategy.html.

computer newsgroups supported timely communication and creativity among the national, state, and local advocates.

When ASSIST became an object of scrutiny in hearings of the House Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, funding for ASSIST was threatened. Tobacco control advocates mounted an intensive media advocacy effort about ASSIST with a reporter from the *Washington Post*. This effort paid off in a front-page *Post* story on April 19, 1997, by J. Mintz, with the lead sentence, "Finally, a federal program that works."

Planning for Media Advocacy

Planning for media advocacy typically occurs in two stages: the broad, strategic stage of preparing for readiness and the focused, tactical stage of responding to or creating a specific opportunity. A good strategic plan identifies the policy issue to be promoted through the media and the methods for obtaining favorable media coverage—in other words, the plan assesses where the advocate wants to go and how to get there. A good strategic plan also puts in place the tools and skills that the advocate will need when the moment comes for specific media advocacy activities. The plan must include "damage control" strategies; that is, advocates need to anticipate and prepare for challenges to their messages and credibility. (Chapter 3 describes the fundamentals of strategic communication that should be considered.)

In brief, planning for media advocacy should include deciding which policy objectives will be advanced; gathering accurate information on the relevant issues; making contacts with journalists to win or support their interest in the

ASSIST training materials for media advocacy

issues; defining the audience to reach with the media intervention and tailoring a clear message for that audience; choosing appropriate media channels for the message (e.g., newspaper, television, radio); and anticipating how to deal with negative responses. After the plan has been implemented, it is important to determine which elements of the plan succeeded and which elements did not. Feedback from the field to improve the plan should indicate whether the message should change, whether the priority audience has shifted, and whether the media contacts list is still appropriate.[15] For example, instead of a message originally designed for women, the strategy might require a more specific focus on teenage women, and this focus would require media contacts who relate to that audience.

ASSIST media advocacy kit

Training for Media Advocacy

As ASSIST was moving from the planning phase to the implementation phase, two of the early national meetings were dedicated to media advocacy training. On March 17–19, 1993, a workshop entitled "Media Advocacy: A Strategic Tool for Change" was held in Washington, DC. This training event, attended by staff from all the ASSIST sites, laid the groundwork for doing media advocacy at the state and local levels. The training event launched a new media document created jointly by the American Cancer Society (ACS) and the National Cancer Institute (NCI): *ASSIST: A Guide to Working with the Media*.[15]

A second media advocacy training event—"From Phase One to Page One: Refining Our Media Skills"—was held on July 22–23, 1993. This training event included nationally recognized media advocacy speakers, a panel of media professionals, and on-camera spokesperson training.

Together, these two training events helped prepare ASSIST staffs and coalitions to use media advocacy as an effec-

A Strategy Checklist

"The critical element of an effective media advocacy effort is that it is strategic. This means that you always need to assess your use of media in relation to and in support of, rather than instead of or isolated from, other approaches."

Questions for Strategy Development

1. What is the problem?
2. What is the solution?
3. Who has the power to make the necessary change?
4. Who must be mobilized to apply pressure for change?
5. What message would convince those with the power to act for change?

Source: Wallack, L., K. Woodruff, L. Dorfman, and I. Diaz. 1999. *News for a change: An advocate's guide to working with the media.* Thousand Oaks, CA: Sage Publications (pp. 9, 13).

tive approach in the ASSIST model. The strategic focus on framing policy initiatives to obtain earned media coverage became a hallmark of the overall strategies in ASSIST states. Media advocates also met in ancillary meetings at each ASSIST information exchange conference and at national conferences. The ASSIST Coordinating Center typically arranged for a guest speaker at those meetings—a member of the media or a representative of the advertising industry—who provided insights on an aspect of media advocacy. Toward the end of the project, in 1998, the ASSIST Coordinating Center developed and presented the train-the-trainer module Advanced Media Advocacy. The focus was on how to meet the new challenges brought about by success—in some cases, intensified opposition by the tobacco industry; in other cases, a waning interest by the media. Spokesperson training was an important component of the workshop.

Benefits of the Newspaper Channel in North Carolina

1. Newspapers have the space to give in-depth explanations of complicated issues.
2. Because they have editorial pages, newspapers can offer policy issue support by printing positive editorials and editorial cartoons and can provide a forum for citizens to write letters supporting an issue.
3. Newspaper articles can be "recycled"—they can be copied and circulated to inform decision makers and to show editorial board and community support for a policy change.
4. It is important to allow a reporter to maintain objectivity. Though the reporter may already be concerned about the problem, the media advocate should treat the reporter as an objective observer of a real community problem—not as a tobacco control advocate.
5. Awards and appreciation should be expressed for thorough and fair coverage—not for advocacy work in tobacco control.
6. It is the man biting a dog that makes the news, not the dog biting a man; shocking, extreme stories draw reporters' and readers' interest.
7. The timing of articles or a series of articles is important. Coverage that gives the rationale behind a bill under consideration, for example, is critical during the debate about a proposed bill.

Following these national workshops, most of the ASSIST states held media advocacy training events with presentations and on-site technical assistance from NCI and ASSIST Coordinating Center staff and from other national media advocacy experts.

Evolving Limitations on the Right to Lobby

Although the use of federal money to lobby the U.S. Congress has long been restricted, when the ASSIST interventions began in the early 1990s, federal money could be used to advocate for policies to state governments and local policymaking bodies. However, the laws and regulations changed during the course of the 8-year ASSIST project.

The Federal Acquisition Streamlining Act (FASA) also was enacted during the course of ASSIST. The final rules implementing FASA were published on August 16, 1995, and the law became effective on October 1, 1995. Under FASA, "Costs incurred to influence (directly or indirectly) legislative action on any matter pending before Congress, a State legislature, or a legislative body of a political subdivision of a State" were deemed unallowable under federal contracts P.L.103-355, section 306[e][B].

By its own terms, FASA applied only to government contracts based on solicitations issued after October 1, 1995. Since the original ASSIST contracts preceded that date, they were not affected by it. Later, FASA's total prohibition against using federal money to lobby at any level of government did apply to the 1-year extension contracts issued to ASSIST states beginning on October 1, 1998, because these contracts were considered new contracts. The law that appropriated fiscal year 1997 money for the Department of Health and Human Services—the Omnibus Consolidated Appropriations Act—broadened the ban on using that money for lobbying and prohibited lobbying to state legislatures.

—Anne Marie O'Keefe, former Policy and Media Advocacy Manager, ASSIST Coordinating Center

Acting Locally: The ASSIST Media Network

Because the policy changes at the core of ASSIST were designed to occur at the local level for the greatest effect, most media advocacy activities also were conducted at the local level. Local media are likely to cover an issue or policy when it has a local angle and is represented by a community spokesperson. To support effective local media advocacy interventions, ASSIST staff established the ASSIST Media Network, a network of trained media advocates who would receive information and manage media advocacy activities in their ASSIST sites.

The ASSIST Media Network, which became the basic infrastructure for communications on media advocacy, was composed of one or more individuals from each state whose primary responsibility was to work with the media. The network was a critical element of the media advocacy strategy. ASSIST's media and policy achievements would not have been possible without empowering the field staffs with time, resources, and skills sufficient to conduct effective media advocacy. For example, in North Carolina, the Philip Morris "Think. Don't Smoke" campaign was covered by two different newspapers, each of which framed the story very differently. A contact person of the North Carolina ASSIST Media Network worked with the reporter of the *Charlotte Observer* story, which presented the Philip Morris campaign as a disingenuous attempt by the tobacco company to gain credibility

by funding what was in fact a weak and ineffective youth antismoking message. She quoted local spokespersons. The Associated Press, on the other hand, wrote a story that was carried in the *Winston-Salem Journal*. The Associated Press reporter, who had not been contacted by a tobacco control staff member, presented the Philip Morris campaign as the company's effort to turn over a new leaf and prevent underage smoking.

As the ASSIST project matured, so did the network. Early in the implementation phase, the ASSIST Media Network served as a resource for staff members who were developing media capabilities and media relations—they shared information on and experience in gaining the media's attention through special events, research results, and other means. In the later years of the project, as local tobacco policy initiatives gained prominence, the ASSIST Media Network responded through increasingly sophisticated applications of media advocacy. Many ASSIST Media Network representatives established their own intrastate networks of community media advocates who could adapt information and frame messages for community newspapers and local television stations in ways that would succeed locally. These networks fostered creativity as a result of the information sharing and group brainstorming. For example, in tobacco-producing states, the media and the public were not always open to stories criticizing the tobacco industry. Understanding this predisposition, local advocates found alternative spokespersons or framed messages as prohealth. In this way, they made messages more acceptable to the media. (See case study 5.1.)

In some situations, it was not possible for state or local health department staffs to disseminate a particular tobacco control story. Some events and stories were considered too controversial within the state's political environment. In these cases, the advantage of the partnership model became evident: the nongovernmental partners, such as ACS and other voluntary health groups, took the lead as media spokespersons.

National Backup for Media Advocacy

ASSIST staff members monitored trends and activities at the national level and disseminated information to the ASSIST Media Network with suggestions on how to frame the information for the local media. The information was provided in a rapid manner that facilitated quick action by the local sites. Many suggestions focused on how to piggyback local coverage on national stories and events. The media materials distributed by ASSIST staff made the practice of media advocacy easier for state-level personnel and provided consistent messages across ASSIST states.

Project staff members at NCI and the ASSIST Coordinating Center provided ongoing technical assistance to the ASSIST Media Network

- at monthly teleconferences;
- by telephone and e-mail on an as-needed basis; and
- in the form of mailings of materials (including sample press releases, sample letters to the editor, detailed information on topics for op-eds, and updates on tobacco issues and research) and recommendations for media activities.

Case Study 5.1
Tobacco State Turns Opinion Around

Situation: When ASSIST first started in North Carolina, key informant interviews with journalists and analyses of newspaper coverage revealed that the North Carolina press usually covered tobacco as a business issue, not as a health issue.

Strategy: ASSIST leaders planned to change the type of coverage by training advocates in communities around the state to create news stories, coordinate news coverage, and orchestrate opinion writing on tobacco as a health issue. The project tracked progress through the news analyses of print coverage of tobacco provided by the ASSIST Coordinating Center, which tracked and analyzed tobacco coverage in every daily newspaper in the United States. ASSIST staff looked particularly at newspaper editorials, which not only reflect the opinions of a community, but also often change policy opinions and lie at the cutting edge of social norm changes.

Media Intervention: North Carolina ASSIST worked to change the editorial slant about tobacco and to make it a health issue. It focused on building the capabilities of local communities in the following four areas:

1. Strategic communication, which means being prepared to respond to opportunities and threats in the media
2. Spokesperson preparation, which involves ensuring that staff, key leaders, youths, adult volunteers, and community activists know how to frame tobacco issues for the news media and how to prepare for news interviews
3. Media advocacy, which entails planning for changes in policy and social norms by embedding media communication as part of the overall plan
4. Editorial board advocacy, which involves monitoring local editorial boards and using the data collected to plan a successful editorial board visit, op-ed piece, or letter to the editor

Results: While no attempt has been made to assess a specific outcome relationship between ASSIST's media advocacy efforts from 1994 to 1997, North Carolina newspaper editorials on tobacco policy issues did become more supportive of the health issue. Prohealth editorials increased and even exceeded the number of protobacco editorials. (See table 5.1.)

—Sally Herndon Malek, former ASSIST Project Manager, North Carolina Department of Health and Human Services and current Head, North Carolina Tobacco Prevention and Control Branch

Table 5.1. Number of Newspaper Editorials in North Carolina, 1993–98

Year	Prohealth	Protobacco	Neutral
1993	16	38	28
1994	51	73	31
1995	49	35	13
1996	53	42	16
1997	97	42	8
1998	52	63	9

Source: ASSIST newspaper clippings database.

The monthly teleconferences and the biannual meetings provided opportunities for ASSIST Media Network members to learn from one another. Peer-to-peer sharing of strategies, materials, and messages was one of the most valuable resources of the ASSIST Media Network.

ASSIST relied on national experts for advice to provide the ASSIST Media Network with the most up-to-date and accurate information with which to frame stories in the local media. For example, when a U.S. District Court judge in North Carolina ruled on July 17, 1998, that the assessment of relevant scientific studies for the Environmental Protection Agency's 1992 report, *Respiratory Health Effects of Passive Smoking,*[16] was selective, misrepresentative, and procedurally faulty,[17] the national project staff convened an emergency ASSIST Media Network conference call with legal experts, media advocacy experts, and an author of the report to explain the situation from all perspectives. The tobacco industry's allegations about the report were effectively countered by the experts, who explained them to the ASSIST Media Network representatives, who, in turn, framed stories in their local media with a favorable tobacco control perspective.

Among the types of materials that the ASSIST Coordinating Center sent to network members to support their efforts were "swiss cheese" press releases. These press releases were referred to as swiss cheese because they had "holes" for inserting local information. These releases became a staple that local media advocates relied on to do their jobs. From 1997 to 1999, a release was included in a packet of materials sent monthly to network members.

ASSIST states used several types of media tactics in their media advocacy strategies, such as news coverage of activities, events, and antitobacco educational campaigns. Ensuring that the news was covered strategically set the context for additional media tactics that would promote specific public policies. The combination of media interventions raised the public's consciousness of the problem and supported a tobacco-free social norm. Case studies 5.2–5.4 illustrate how media networks identified an advocacy opportunity, planned a strategy and tactics, and mobilized the necessary individuals to conduct activities and to influence the media in framing and covering the stories.

News Coverage of Tobacco Issues

Straightforward news coverage of tobacco-related events adds importance to those events, helps keep tobacco issues in the public's mind, and reinforces a tobacco-free social norm. In particular,

Case Study 5.2
Strengthening Youth Access to Tobacco Laws: North Carolina

Situation: The North Carolina ASSIST media contact person received a call from a general assignment reporter regarding an expected bill that would strengthen the state law on youth access to tobacco by increasing penalties to violators. The bill would require a photo identification check, signage, and removal of the word *knowingly* from the law's text (which had made the law difficult to enforce). The reporter planned to do a brief background story.

Strategy: The media contact person saw this situation as an opportunity to do more and pitched to the reporter the idea of an investigative series on tobacco use by minors in North Carolina.

Media Intervention: The ASSIST media contact person orchestrated an exclusive weeklong series of articles in the *Charlotte Observer* regarding underage tobacco use across the state. A state-level media contact person worked behind the scenes with the reporter and helped to shape a comprehensive story.

In a telephone background interview, the media contact person made a list of documents to copy for the reporter and provided statistics, stories, and names of local and state contacts. After more than an hour on the phone, the reporter decided that a visit to the tobacco control office was in order. At the meeting, the media contact person provided documents, fact sheets, names of more contacts, and stories.

Months later, the reporter was asked what about this story compelled her to pursue it as an investigative series and not just as a single news story. She noted that the media contact person had told her how health educators in mountain counties learned that smokeless tobacco use was being encouraged for very young boys—as young as 3 or 4—by parents who believed that chewing tobacco is harmless. Health educators also knew of parents and grandparents rubbing snuff onto the gums of infants to ease teething pain. The thought of educating the public about such shocking practices compelled the reporter to talk to more sources; the result was a comprehensive series on teen tobacco use.

Results: A four-part series, "Carolina's Youth: Sold on Smoking," was published. The series covered the history of the youth access to tobacco law, smoking in schools, smokeless tobacco use, health effects of smoking, and reasons that teens smoke. The series, which ran January 12–15, 1997, included sidebars, photographs, graphics, an editorial supporting the proposed law change, and an editorial cartoon drawing attention to the problems of underage smoking.

While the series was running, the media contact person asked the reporter whether the series could be offered as a reprint, with all the related articles, editorial, cartoon, and letters to the editor printed together for distribution to interested citizens. The

newspaper publisher not only agreed to do so, but also offered to send a copy of the reprint, along with a cover letter, to each member of the North Carolina General Assembly.

When debate began on the bill in the spring, multiple copies of the *Charlotte Observer* series were circulated at the legislative building. Although the efforts of many groups and individuals contributed to the eventual passing of Senate Bill 143, which strengthened the state law and made it enforceable, the *Charlotte Observer* series and reprint had a significant effect. The new law went into effect on December 1, 1997.

—C. Ann Houston, Director of Public Education and Communication, Tobacco Prevention and Control Branch, North Carolina Department of Health and Human Services

Case Study 5.3
The Media Network of the Tobacco-Free Michigan Action Coalition

Situation: On Christmas Eve 1993, during final negotiations on a tobacco tax bill, the legislative leadership in Michigan added a local preemption clause and pushed it through without public notification or debate. This preemption issue raised awareness of the need to increase tobacco control media efforts.

Strategy: The Tobacco-Free Michigan Action Coalition established a network of media advocates at the community level who could conduct effective media advocacy with local media on tobacco control issues. Local tobacco control coalition coordinators were responsible for media advocacy in their areas. They established relationships with local reporters, forwarded background information, pitched stories, and either acted as the tobacco expert or as a referral source to another local expert. Michigan Department of Health staff members summarized events and information and communicated summaries to the network by telephone, mail, and fax.

State health department staff members organized formal training sessions to enhance the skills of media network members. In an initial full-day training event, national media experts, a panel of local reporters, and a media consultant addressed media relations and media advocacy. The network meetings included training on how to convey messages effectively at meetings with editorial boards. Communication was an essential part of the program and included a summary of events relevant to the policy issue; suggestions for framing the issues; media bites; and sample materials, such as swiss cheese press releases, op-ed pieces, and sample letters to the editor.

Media Intervention: In 1994, during a legislative battle seeking to repeal local preemption, media network members spoke on radio and appeared on television in their

Case Study 5.3 (continued)

local areas. In each interview, outlining the issues and keeping the repeal before their audience, they turned the discussion to preemption. When a legislator emerged as the primary roadblock to repeal, the media network coordinator in the legislator's district mobilized coalition members and launched a local media strategy primarily using the print media, but also including television and radio. Although the legislator did not change his position, he clearly felt the pressure.

The chief medical officer for the county wrote several letters to the editor and op-ed pieces. The network coordinator organized individuals to write letters to the editor, resulting in even more letters from the general public. The network coordinator provided information to a local newspaper, which then, in an editorial in the Sunday edition, criticized the legislator for his role in blocking repeal. The coordinator then provided questions about preemption to reporters covering a debate between gubernatorial candidates.

Results: Although the repeal effort failed (the lame-duck legislature did not act on the bill), Michigan's media network members gained experience and confidence. They successfully gained access to the media and engaged the community and editorial staff in their efforts. Time and again, they reported that it was easy for them to do media advocacy when tools were provided. Had staff members been required to do the research and draft their own press materials, they would have been less likely to do it, but they almost always followed through when they received everything that they needed to do the job.

The training for and the experience with the repeal laid the groundwork for future successful media advocacy efforts in Michigan.

Source: Adapted from D. May. 1995. Care and feeding of the media network. In *Tobacco prevention: The next generation* (New approaches to youth policies, secondhand smoke, and institutionalization, June 4–6, 1995). Rockville, MD: ASSIST Coordinating Center.

Case Study 5.4
Winston Additive-Free Media Advocacy Campaign

Situation: In 1997, R.J. Reynolds Tobacco Company (RJR) repositioned its Winston brand as an additive-free cigarette with the theme "No additives. 100% tobacco. No bull." The ASSIST Coordinating Center recognized the campaign as an effort to convince smokers that an additive-free cigarette is less hazardous than other cigarettes. This effort might discourage smokers from quitting or might convince nonsmokers to initiate smoking.

Strategy: By piggybacking on national events, three voluntary organizations mobilized a local grassroots countercampaign to terminate the misleading and deceptive nature of the ad campaign for RJR's new additive-free Winston cigarette.

At the national level, the American Cancer Society, the American Lung Association, and the American Heart Association filed a joint petition with the Federal Trade Commission (FTC), the federal agency charged with enforcing fair and truthful advertising. The petition urged an investigation of the campaign, especially the implied health claim contained in the no-additive assertion. The petition asked the FTC to enjoin the campaign based on the deception inherent in this implied health claim and on the lack of scientific evidence to substantiate it.

For local media advocacy activities, the ASSIST Coordinating Center produced and disseminated a packet containing media advocacy materials and provided networking opportunities and technical assistance on how to use the materials most effectively.

Media Intervention: At the national level, the three voluntary health associations decided to provide exclusive breaking stories to CNN and the *Wall Street Journal*, which ran the story of the FTC petition on the front page of the business section. Further national broadcast and print coverage followed, including feature stories, editorials, and letters to the editor.

At the local level, numerous activities kept the story alive. For example, in Rhode Island, at a news conference in front of a Winston billboard near a school, a group of high school students held a sign that read "100% bull." The story was carried on the front page of the *Pawtucket Times* and was the lead news story on two local television network affiliates. One of the television reporters contacted the billboard company from the site and informed the company that the billboard was in violation of an ordinance restricting tobacco advertisements near schools. Within 30 minutes of that phone call, the Winston additive-free billboard was removed.

Results: There was broad and well-placed national and local coverage of the opposition to the Winston campaign and of the resulting action taken by the FTC. In 1999, the FTC ruled that RJR's campaign deceptively implied a health claim and that RJR had to run corrective advertising to the effect that not putting additives in the cigarettes did not mean that the cigarettes were safe or less harmful. It was the first time that the FTC required such a disclosure in an ongoing ad campaign. The *Washington Post* reported that the petition filed by the health groups spurred the action by the agency.[a]

Source: Adapted from C. Hall-Walker and M. Thomas. 1998. Taking advantage of an opportunity: The Winston Billboard Youth Demonstration. In *No more lies: Truth and the consequences for tobacco* (Case studies of the Fourth Annual National Conference on Tobacco and Health, October 26–28, 1998), 83–6. Rockville, MD: ASSIST Coordinating Center.

[a]Schwartz, J. "FTC has a beef with 'no bull' ads." *Washington Post*, March 4, 1999.

three types of news coverage brought attention to the need for tobacco control: special events, breaking tobacco news, and publication of research results.

Special Events

Events that are of interest to large segments of the population are opportunities for earned media coverage of tobacco control issues. The ASSIST Coordinating Center alerted ASSIST Media Network members about non-ASSIST events on which they could piggyback media messages. For example, the best-known national smoking cessation event is ACS's Great American Smokeout (GASO), which has been held annually since 1977. The Smokeout is a multimedia event occurring each November throughout the United States. In some communities it includes an 8-day media blitz leading up to Smokeout day, when smokers are urged to stop smoking for at least 24 hours. Public awareness of and participation in the Smokeout have been high for years.[9] In 1998, an estimated 9 million persons (nearly 20% of all U.S. smokers) participated in the GASO community activities either by smoking less or by not smoking at all for 24 hours. Of those participants, 10% reported smoking less or not smoking at all for 1–5 days after the event.[6,18]

In 1987, the American Lung Association began sponsoring Non-Dependence Day on the 5th of July to focus attention on the problem of nicotine addiction and to offer assistance to smokers wanting to quit smoking. National events, such as the Smokeout and Non-Dependence Day, can be used to trigger media events, such as television and radio cessation clinics,[6] newspaper stories profiling former smokers,[19] and community-wide stop-smoking contests.[20–22]

News coverage also is generated when government agencies designate specific times of the year to highlight specific prevention initiatives (e.g., High Blood Pressure Control Week). The state of New York designated the first week of January 1990 as Tobacco Awareness

Piggybacking on Special Events

Missouri local coalitions conducted media-worthy events to publicize ACS's Great American Smokeout, including radio station interviews, Dixieland funerals, cessation programs, "screamouts," and Teens Against Tobacco Use training events. These activities generated 11 newspaper, radio, and television stories.

New Jersey held a statewide rally of 750 students for the Great American Smokeout. The students—from all parts of the state—marched from a park to the New Jersey State House, where they delivered pledges from friends and family members promising not to smoke. The students listened to motivational speeches by the commissioner of health, physicians, and peers. The event received public television and local newspaper coverage.

North Carolina worked with partners, including ACS, to promote a U.S. Women's Soccer game in Davidson, North Carolina, on March 16, 1996. Two commercials with tobacco use prevention messages for youths aired in the Charlotte area during the days surrounding the game. About 3,000 people attended the game and received a poster of the team with a no-smoking message.

Source: Adapted from ASSIST site quarterly reports, 1996–99. Internal documents, ASSIST Coordinating Center, Rockville, MD.

Week and provided $5,000 to each county health department across the state to create local tobacco control events. The events varied from poster contests to smoking policy workshops for businesses to training programs for healthcare providers. Because the local events were conducted as part of a statewide initiative, local media coverage of the events was heightened.

In addition to the training and technical assistance provided to the states for local media advocacy activities, ASSIST staff arranged media events for the project at the national level. The national tobacco control conferences usually

More Piggybacking

To reach African Americans in Milwaukee, Wisconsin's ACS conducted an educational outreach campaign to kick off a cessation program and the Great American Smokeout in late 1997. A T-shirt exchange was also a component of the program. A news story and an ad promoting the event appeared in the local newspaper.

Rhode Island made a special effort to involve Hispanic/Latino youths in planning and coordinating a variety of tobacco control activities; these activities included Kick Butts Day in 1998, presentations on smoking policies at schools, participation in the World No Tobacco Day collaborative event with other youths, a spring health fair, attendance at a state forum to learn about a pending smoke-free restaurant policy, and participation in a peer-counseling retreat.

Seven of South Carolina's local coalitions conducted educational and awareness activities to piggyback on Kick Butts Day and World No Tobacco Day. A few of these activities drew media attention. Activities included an event for youths featuring a jazz band, student presentations, and door prizes; sending out a press release recognizing smoke-free restaurants in the area; letters to the editor to publicize the day; events at a baseball stadium; and airing 25 tobacco facts during the course of the day.

Source: Adapted from ASSIST site quarterly reports, 1996–99. Internal documents, ASSIST Coordinating Center, Rockville, MD.

And More Piggybacking

In April 1999, four local Colorado coalitions planned and conducted prevention activities and media activities for Kick Butts Day. Approximately 300 youths participated in events in Denver, 100 in Boulder, 1,500 in Larimer, and 150 in La Plata; the total was 2,050 youths. Youths from local schools delivered speeches, and other youths created a large collage of tobacco advertisements and arranged a media event featuring youths kicking soccer balls through the collage to demonstrate eliminating tobacco advertising. Media coverage was strong and enhanced the reach of these activities.

In a sixth county in Colorado, working with key community groups, including the State University's Men's Soccer Team, coalition volunteers and student interns delivered presentations on tobacco-related topics at local middle schools reaching 1,500 students. A local newspaper featured the Kick Butts Day events with a lead story, and a local affiliate of a national network covered the event in its evening news.

Also in 1999, in recognition of Kick Butts Day, students from a New York school went on a scavenger hunt for smoking messages in their community. They subsequently wrote letters to newspapers and community leaders about their findings. Participating youths and local organizations were quoted on local television and in newspapers.

Source: Adapted from ASSIST site quarterly reports, 1996–99. Internal documents, ASSIST Coordinating Center, Rockville, MD.

generated considerable local coverage in the city where the conference was being held and several stories in the national media. To prepare for these annual conferences, ASSIST project staff at NCI convened a media task force composed of members of each partner organization. The task force determined the main media messages and managed the media advocacy activities at all five National Conferences on Tobacco or Health held during ASSIST.

Case study 5.5 about West Virginia illustrates how strategic thinking can create a tobacco news event at an already scheduled event likely to receive coverage.

Tobacco News

Tailoring information for the local news media can effectively extend the life of a national news story or create a new media hook. For example, after a news release on the medical costs associated with treating smoking-related diseases in the United States, several state health departments released cost information specific to their individual states. A new wave of media coverage on the local burdens of smoking ensued.[13,23] Case studies 5.6 and 5.7 show how to bring local attention to a national event and national attention to a local issue.

Research Results

The release of research results also can be newsworthy. The public's interest in health stories is so strong that even familiar health information can be presented in new ways to capture attention. A good example is the release of the U.S. surgeon general's reports on smoking and health. Even though the reports summarize previously released scientific information, presentation by the surgeon general in a high-profile news conference generates extensive media coverage. For state and local programs to prepare for this media opportunity and localize health news, it is important for the sponsoring national agency to work with them, for example, to send embargoed publications and press releases far enough in advance to enable the states to plan for the official release of a document or other event. Having a highly visible and credible spokesperson or group deliver the information will often generate media coverage, even when the message is familiar—such as health consequences of smoking during pregnancy.[13,24,25] (For a bibliography of articles written about ASSIST, see appendix 5.A; for a discussion of dissemination of research results in Wisconsin, see case study 5.8.)

Mass Media and Countermarketing Campaigns

Mass media educational and antitobacco campaigns work by creating awareness and support in the community, but the process can be complex—advocates must work to address competing interests (including official constraints) and must learn to apportion competing resources. Considerable effort typically is spent achieving consensus about the messages of a campaign, and considerably more effort is required to implement a campaign that will achieve the desired outcome.

A review of 56 evaluated antitobacco campaigns concluded that a key element

Case Study 5.5
Charleston, West Virginia, Bids So Long to the Marlboro Man

Situation: In the fall of 1996, the Charleston City Council adopted a resolution prohibiting tobacco product advertising on city property. One council member thought the 20-foot sign advertising cigarettes in the outfield of a minor league ballpark sent the wrong message to children. Members of the local tobacco control coalition agreed.

Strategy: Complementing the city council members, the coalition reached out to establish a partnership between the local coalition's smoking workgroup and the Charleston Alley Cats baseball team to promote a tobacco-free message at the baseball park.

Media Intervention: A coalition representative approached the baseball team's community relations director to discuss partnering on tobacco prevention activities. To draw media attention, a news conference was planned around the removal of the tobacco advertising sign and the announcement that members of Teens Against Tobacco would raise funds to replace the Marlboro Man sign.

Next, the coalition sponsored a contest for high school students to design a tobacco-free sign. The design contest drew more than 30 entries. A pregame ceremony for Teens Against Tobacco Day was planned to unveil the winning sign; the ceremony featured the mayor, a council member, teens, and a representative from the coalition. A photo session was held at the end of the pregame ceremony with the teen who designed the winning sign, elected officials, and a representative of the minor league baseball team.

Results: The events received excellent media coverage, including a positive slant in a column of the morning newspaper. The Charleston City Government became interested in working with the coalition on other tobacco prevention initiatives.

Tips from West Virginia

- **Acknowledge community leaders.** Elected officials appreciate the public recognition and positive media coverage.
- **Seek to develop partnerships with nontraditional allies** within the community, such as a minor league baseball team.
- **Look for win-win situations.** All partners should benefit from the events.
- **Maintain the momentum.** After a positive experience, continue to build a working relationship with the new partners.

—Brenda Grant, Charleston Area Medical Center, and Helen Matheny, formerly with the Kanawha Coalition for Community Health Improvement and current Director of Communications and Health Programs,West Virginia State Medical Association

Case Study 5.6
The Tobacco Master Settlement Agreement—A National Event Covered Locally

The removal of tobacco billboards nationwide is an example of a national event used by ASSIST to generate earned media coverage at the local level.

Situation: As part of the November 1998 Tobacco Master Settlement Agreement, the tobacco companies agreed to remove all billboard advertising by April 23, 1999, and to turn over remaining leases for this space to the state attorneys general.

Intervention: The National Cancer Institute, the Centers for Disease Control and Prevention, the Food and Drug Administration, and Arnold Communications (an advertising agency) collaborated to provide information to the ASSIST Media Network on how to work with outdoor advertising companies to replace the tobacco billboards with prohealth messages. In addition, the ASSIST Coordinating Center directed an effective earned media campaign. In teleconferences and mailings, the ASSIST Media Network received suggestions for holding and promoting media events at the billboard sites, obtaining video coverage of the Marlboro Man coming down, and developing talking points that framed the issue not as a gift from the tobacco industry but as a chance to rid the landscape of deceptive, antihealth messages.

Results: The effort paid off in an abundance of local television and print coverage featuring several state attorneys general and other high-profile spokespersons. The ASSIST Coordinating Center created a videotape documenting this historic event.

—Lynn C. Cook, former Media Relations Specialist, ASSIST Coordinating Center, and current Prevention Project Director, Danya International, Inc.

Case Study 5.7
The Indiana Countercampaign—A Local Event Covered Nationally

A media countercampaign in Indiana is an example of a local story that resulted in national coverage.

Situation: A local convenience store chain began advertising discount cigarette prices in direct violation of the Master Settlement Agreement.

Intervention: The Indiana ASSIST Media Network representative mounted a local countercampaign on television and radio.

Results: These broadcast countermarketing spots caught the attention of an ABC evening news producer and became the subject of an *Eye on America* segment. Some local stations pulled the cigarette advertisements. The chain revised the ads, but they soon disappeared completely.

—Johnny Kincaid, Smokefree Indiana

Case Study 5.8
ASSIST–Wisconsin State Medical Society Partnership for Publishing Tobacco Research

Situation: In the early 1990s, the Wisconsin Division of Public Health published limited health information through its vital and health statistics reports and its periodic special reports. However, these reports rarely contained policy-oriented health information. The production of a tobacco-specific report was costly and required substantial resources for staff and distribution. The State Medical Society of Wisconsin published a monthly medical journal for its nearly 7,000 physician members and health policymakers throughout the state; hence, an opportunity existed to partner with that organization.

Media Intervention: Staff members from the Wisconsin Division of Public Health approached the medical society to discuss their interest in finding a better way to disseminate tobacco and health information. The medical society was interested in gaining positive recognition and in increasing its stature among its members and in the community. The public health staff proposed publishing reports periodically on tobacco, an arrangement that seemed beneficial to all. Subsequently, ASSIST staff coauthored 25 articles in the *Wisconsin Medical Journal* on a variety of tobacco control issues, including the health and economic burdens of smoking, the prevalence of tobacco use, youth access to tobacco products, environmental tobacco smoke, and smoking cessation. In addition, several journal covers were dedicated to the tobacco topic.

Results: This public health series of articles provided a low-cost and credible method for the health department to disseminate information about tobacco use and enhanced the medical society's ability to improve health and to increase its visibility in the community and among policymakers. (Appendix 5.A includes tobacco-related articles published in the *Wisconsin Medical Journal*, 1992–97.) These articles led to numerous newspaper and media stories and were frequently cited by policymakers throughout the duration of ASSIST. These articles were used in conjunction with state-driven data that enhanced and expanded media coverage on numerous tobacco control issues. These efforts also furthered the new approach of community and social environment change.

—Patrick L. Remington, former Wisconsin ASSIST Department of Health Project Director and current Professor of Population Health Sciences, University of Wisconsin Medical School

in the success or failure of a campaign is its intensity.[6] The more intensive the campaign—that is, the greater its reach, frequency, and duration—the greater is its effect on behavior. The success of interventions depends on the intended audience receiving an adequate "dose" of the message.[6,26] The disappointing results of many health promotion campaigns delivered through the mass media can be

traced directly to inadequate exposure to campaign messages, especially in campaigns relying solely on public service announcements that are infrequent and aired during times of low viewership.[6] In an evaluation of a 6-month antismoking television campaign conducted in media markets in New York and Pennsylvania from August 1988 to January 1999, only two of the television stations kept records of when the messages were aired, and those two reported that half of the donated airtime was between 12 midnight and 7 a.m. Purchasing time to air the same messages in better time slots significantly improved response, as measured in calls to a hotline.[27] Nevertheless, because of budget constraints, ASSIST used very little paid airtime and instead focused on earned media coverage.

Perhaps the most visible mass media intervention for tobacco control prior to ASSIST was the tobacco counteradvertising campaign that aired between 1967 and 1970 and that was sponsored primarily by the major voluntary health organizations and government agencies.[6–8] For the most part, the campaign relied on donated airtime and advertising space for public service announcements. When the Federal Communications Commission ruled that, under the Fairness Doctrine, television and radio broadcasters were required to donate airtime for countertobacco messages as a balance to cigarette commercials, a significant amount of antismoking advertising aired. The free time provided for the counteradvertising spots was valued at approximately $75 million (in 1970 dollars) per year from 1968 through 1970.[28] Several studies support the conclusion that the antismoking messages aired during the Fairness Doctrine era were very effective.[8,29] Cigarette consumption declined each year during the campaign and rose again when cigarette advertising and antismoking messages were removed from the air in 1970.

By 1990, Minnesota, Michigan, and California had funded countertobacco media campaigns with revenue earmarked from cigarette excise tax increases. Minnesota and Michigan had limited funds

South Carolina Takes on the Tobacco Industry

In 1998, South Carolina ASSIST created and implemented a hard-hitting antitobacco media campaign. The 6-month, sequential, multimedia counteradvertising campaign targeted four messages disseminated by the tobacco industry:

1. Nicotine is not addictive.
2. Secondhand smoke is not dangerous.
3. The industry does not market to youths.
4. Preemption is in the best interest of communities.

Aptly launched on April Fool's Day and designed to reach South Carolina's registered voters in three media markets, the series of informative billboards and radio and print ads was designed to create outrage and to raise the public's awareness about youths and tobacco, nicotine addiction, secondhand smoke, and the repeal of preemption of local clean indoor air ordinances. Each advertising medium featured a toll-free number for public questions, comments, and information about participation in the Partners Working for a Smoke-free South Carolina group.

Source: Adapted from ASSIST Coordinating Center. 1998. South Carolina ASSIST quarterly reports. Internal documents, ASSIST Coordinating Center, Rockville, MD.

(Also see case study 5.4.)

Selected Results from the 1999 Massachusetts Adult Tobacco Survey

- 96% of nonsmokers and 92% of smokers believe that secondhand smoke can harm children.
- 89% of nonsmokers and 79% of smokers believe that secondhand smoke can cause lung cancer.
- 98% of the adults surveyed expressed support for restricting smoking in public buildings and for some form of restriction on smoking in restaurants. (More than half prefer a complete ban.)

Source: Robbins, H., M. Krakow, and D. Warner. 2002. Adult smoking intervention programmes in Massachusetts: A comprehensive approach with promising results. *Tobacco Control* 11 Suppl. no. 2: ii4–ii7.

for this purpose, but in California, excise taxes funded a $28.6-million, 18-month antismoking advertisement campaign launched in April 1990 as part of a larger comprehensive tobacco control program that spent $1.3 billion over 10 years. The campaign included paid advertisements in newspapers and magazines, on billboards, and during prime time on television and radio. A 14% decrease in lung and bronchus cancers between 1988 and 1997 is attributed in part to the comprehensive program.[30]

"Let's Make Smoking History"

Massachusetts was an ASSIST state but also had other sources of funding for major tobacco control efforts. Independent of ASSIST funding, but simultaneous with the project, Massachusetts began a $14-million media campaign in October 1993 designed to reduce the acceptability of smoking, to personalize health risk, and to expose the behavior of the tobacco industry. The Massachusetts Tobacco Media Education Campaign produced television, radio, newspaper, and billboard advertising and conducted public relations events throughout the state.[31] Partnering with its advertising agency, Arnold Communications, a full-service marketing communications agency, the Massachusetts Tobacco Control Program (MTCP) media campaign has garnered significant national and international attention and numerous awards. The MTCP was a leader in developing campaigns that were unique, creative, and powerful and served as a model for other states. Therefore, NCI made arrangements with Massachusetts and Arnold Communications to air some of their advertisements in other states at no cost to Massachusetts or the other states.

The Massachusetts media campaign used a three-segment approach of youth prevention, adult cessation, and public education and public opinion. Each segment was directed to a particular audience and was aimed at achieving a designated outcome, with the general goal being to raise awareness and influence behavior. For example, *youth prevention* messages were designed to decrease the demand for cigarettes among minors. *Adult cessation* messages focused on populations over 18 years of age and were designed to motivate and support a quit attempt. *Public education and public opinion* campaigns were aimed at the entire population and raised awareness about the hazards of secondhand smoke and the tobacco industry's practice of targeting advertising to children.

Massachusetts is well known for its tag line "Let's make smoking history," which accompanied numerous strong media messages. Massachusetts launched the first of three tobacco control campaigns called Truth; the other notable Truth campaigns were developed by Florida and the American Legacy Foundation. These were among the first ads aimed at changing public opinion toward the tobacco industry, without a specific behavioral change goal (e.g., cessation or prevention).

The Massachusetts Truth Campaign utilized spokespersons such as Janet Sackman, who began smoking when she was modeling for cigarette ads in the 1950s and was later diagnosed with throat cancer. In her advertisement, she talks about how sorry she is that she helped persuade young people to smoke. In another advertisement, Victor De Noble, who was a tobacco industry scientist, talks about what he refers to as the tobacco industry's deception. The Truth Campaign presents people on camera who talk about the unglamorous health consequences of smoking from their experiences. Pam Laffin—a young mother, a lung transplant recipient, and a victim of smoking—tells about the physical and emotional pain that she and her children have experienced. Rick Stoddard shares the experience of watching his beloved wife die at age 46 of lung cancer. Ronaldo Martinez, who has had a laryngectomy due to throat cancer, talks about how "cigarettes take everything." Another notable Massachusetts media campaign is the Get Outraged campaign (www.getoutraged.com); this campaign educates the public with compelling facts that should outrage them about the hazards of cigarettes, the tobacco industry's lack of accountability, and deaths related to smoking.

Massachusetts Campaign Visibility

Recognition of the tag line "Let's make smoking history" remained high and consistent throughout the campaign. Annual estimates of the proportion of adults who recognized the tag line varied between 76% and 80% from 1995 to 1998.

Source: Biener, L. 2000. Adult and youth response to the Massachusetts Anti-Tobacco Television Campaign. *Journal of Public Health Management and Practice* 6 (3): 40–4.

The MTCP was very successful in reaching Massachusetts youths with more than 40 separate youth-oriented television spots between 1993 and 1999, designed for many different segments of the youth audience in Massachusetts. Many youths also saw the approximately 70 MTCP ads that were part of the general audience campaign. The ads used various approaches to deliver the messages, including graphic depiction of health consequences, dramatic presentation of personal histories, explanations of tobacco industry strategies, frequent use of humor and sarcasm, and the power of celebrity. One recent television spot features former Boston Red Sox star pitcher Pedro Martinez teaching hopeful teenagers how to throw a curveball. Noticing that one boy has cigarettes, Martinez looks at him with surprise and says, "You can't pitch with these. You gotta throw them away!" The advertisement ends with the pack of cig-

arettes, pitched as a fastball, bursting into flame in the catcher's mitt. Related images of Martinez have appeared in print and outdoor advertising, much of it in Spanish.[32] A scientific study found that adolescents aged 12 to 13 who were exposed to the media campaign were significantly less likely to become established smokers than those who had not been exposed to the media campaign.[33]

Campaigns in ASSIST States

Case study 5.9 illustrates the effectiveness of an integrated, multimedia approach during an intense campaign period in one ASSIST state. In Rhode Island, community-based organizations worked with the Spanish-language radio station to reach teenagers through a multiple-format radio campaign conducted by youths.

Monitoring Newspaper Coverage

The ASSIST states worked strategically and with great determination to increase media coverage of the health issues related to tobacco use and of the policies that would promote a tobacco-free environment. Some measurement of their progress toward this objective was important to ASSIST staff members and coalitions. Knowing that their efforts were making a difference motivated the staff and coalitions.

Newspaper Clippings Database

The ASSIST Coordinating Center conducted ongoing tracking and periodic assessments of newspaper coverage of tobacco issues. Beginning October 1, 1993, and continuing through March 2001, a database was maintained of newspaper clippings on tobacco topics from more than 1,800 domestic daily newspapers from all 50 states and the District of Columbia. The clippings included news and feature articles, letters to the editor, and editorials about tobacco control policies. Trained staff at the ASSIST Coordinating Center coded the clippings and added them to the newspaper clippings database. The four ASSIST policy areas were tracked and then coded according to whether they

Media Coverage of Published Research Results

West Virginia conducted a county-by-county analysis of the cost and morbidity associated with tobacco use and released the results to the media early in 1999.

In Virginia on November 7, 1996, the Shenandoah Coalition Against Tobacco conducted a merchant education assessment of 70 merchants in 2 counties, Winchester and Frederick. The results were released at a press conference on November 21, the Great American Smokeout day. The story received favorable media coverage and amplified the educational effort through a wider audience.

Maine released data collected from conducting Operation Storefront in 1997, in which community groups assessed the amount of storefront advertising for tobacco products. Displays and data from the program were released in a media event featuring the governor declaring May to be Tobacco Awareness Month. Local press conferences for media outlets were conducted throughout the state.

Sources: Adapted from ASSIST Coordinating Center. various dates. West Virginia, Virginia, and Maine ASSIST quarterly reports. Internal documents, ASSIST Coordinating Center. Rockville, MD.

Case Study 5.9
Todo a Pulmón ("With Full Breath"): A Rhode Island Radio Campaign for Hispanic Youths

Situation: Tobacco companies have successfully used advertising and promotional techniques to sell their products to minority members of their market, particularly youths. Reaching culturally diverse youths with a culturally sensitive message is a challenge.

Strategy: Two Rhode Island community-based organizations, Progreso Latino and Channel One, worked collaboratively with Latino youths and the personnel of the Spanish-language radio station WRIB to reach 12- to 17-year-old Hispanics/Latinos through a radio campaign. Youths from the two organizations were trained in countertobacco advocacy at workshops. Through ASSIST, they conducted a survey of racial/ethnic neighborhood billboard advertising.

Media Intervention: WRIB broadcasts *Generación X*, a program for teens airing from 4 p.m. to 6 p.m. each Saturday. Between mid-December 1997 and mid-January 1998, youth tobacco control advocates and staff from Progreso Latino and Channel One met with *Generación X* personnel to work intensively on designing a statewide campaign. The campaign ran January–February 1998. The youths developed ideas, wrote and prerecorded their public service announcements to be played between music cuts, and created antismoking messages to be broadcast live from the studio. The youths determined that both English and Spanish would be used on the program in an effort to reach a wider audience and to allow bilingual youths to use the language with which they were most comfortable.

Youth participants rotated responsibilities for recording messages and going to the radio studio for broadcasts. Their prerecorded messages were broadcast 40 times during the week. The youths wrote and developed new messages, which aired every week of the campaign.

With the support of the radio station staff, Latino youths assumed ownership of the first half-hour of *Generación X*. By the third Saturday broadcast, Latino youths had renamed their segment of the program *Todo a Pulmón*. Youth-created don't-smoke messages were delivered live from the studio. These antismoking messages were interspersed with tobacco facts contests; notices of local school and community events; calls from the youth audience; and talk about current music, movies, and videos. During the 2 months of broadcasting *Todo a Pulmón*, the participating youths became more proficient, and the program improved in quality and popularity. This experience provided young Hispanic tobacco control advocates in Rhode Island with a bilingual radio forum to reach other youths in the state and gave them ownership of their campaign.

Results: In addition to the airtime devoted to the program, an unanticipated payoff of the campaign occurred: Other tobacco control coalition partners began using Spanish-language ads in their radio campaigns.

Source: Adapted from G. S. Dennaker. 1998. Todo a Pulmón: A radio campaign targeting Hispanic youth. In *No More Lies: Truth and the Consequences for Tobacco* (Case Studies of the Fourth Annual National Conference on Tobacco and Health, October 26–28, 1998). Rockville, MD: ASSIST Coordinating Center.

were in favor of, against, or neutral with respect to tobacco control.[34] (To simplify discussion, the terms used in this section to describe the type of slant are pro-health, protobacco, and neutral.)

To get a broad picture of whether there were changes in the general newspaper environment, the ASSIST Coordinating Center conducted a study to determine whether newspaper coverage of tobacco issues increased during several years of ASSIST. The study analyzed 95,911 articles collected in the newspaper clippings database during calendar years 1994 through 1998 to determine the rate of print media coverage on local tobacco control issues and to compare the amount of coverage in newspapers in ASSIST states with non-ASSIST states. The analysis showed that the amount of tobacco coverage in newspapers was greater in ASSIST states than in non-ASSIST states in analyses that controlled for differences in states' initial tobacco control conditions. Because ASSIST states had lower baseline scores on these conditions, it was predicted that fewer articles would be found in ASSIST states. Just the opposite was observed; thus, focusing on media interventions and media advocacy may have influenced the amount of coverage.[34]

Reports to the States on Their Newspaper Coverage

Media analysis quarterly reports derived from the database served to compare ASSIST state newspaper coverage with non-ASSIST state coverage of tobacco in the four ASSIST policy areas. On a quarterly basis, the ASSIST Coordinating Center sent to each state reports summarizing the data on newspaper articles specific to that state. Clipping tallies and percentages of coverage were calculated for each state and compared with national and ASSIST state percentages. States also received tables illustrating the number of articles clipped over the course of the quarter and a pie chart denoting the percentage of articles by policy type for that quarter. For example, a report to Michigan covering January 1 to March 31, 1994, highlighted the following two observations:

1. There was a 2.6-fold increase in the number of clips between February and March of 1994, in part as a result of the Day One report on tobacco and the tobacco workers' march on Washington. . . .
2. Press attention to Michigan's Prop A and the tobacco workers' march on Washington resulted in ASSIST sites having a higher percentage of articles focusing on economic

disincentives than the national average.[35]

The data presented in figures 5.1 and 5.2 are from the ASSIST newspaper clippings database.

Time segment reports on newspaper coverage, such as those illustrated in table 5.2, can further be compared with significant events, legislation, and media interventions stimulated by either the tobacco companies or tobacco control advocates. The case study about North Carolina (case study 5.1) describes media intervention efforts by ASSIST from 1994 to 1997 to move tobacco coverage from the business page to the news and editorial pages. In this tobacco-growing state, it was important for public health professionals to bring attention to tobacco use as a health issue, not only as an economic issue. During those years, the number of editorials supporting tobacco control measures increased. During three of those years (1995–97), the number of editorials supporting tobacco control exceeded the number of editorials that were opposed to tobacco control measures. This kind of feedback to the tobacco control practitioners reinforced their motivation and confidence in the effectiveness of their media intervention efforts.

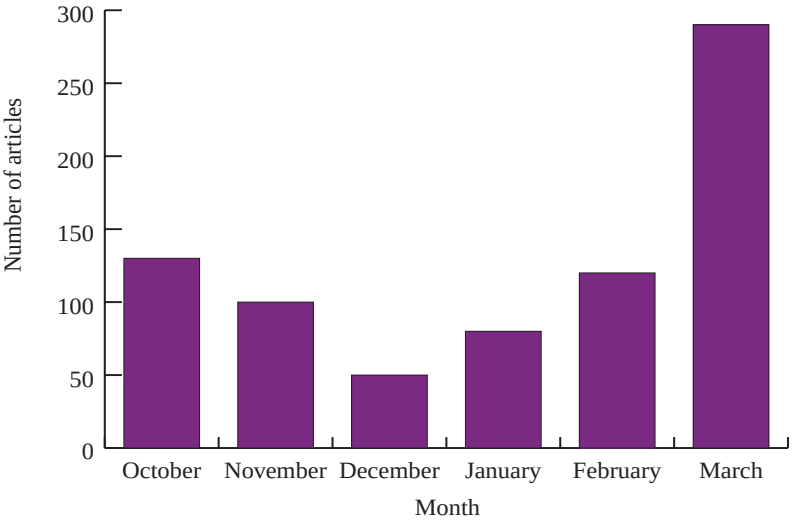
From Media to Policy Change

Through media advocacy and other media interventions, ASSIST brought public attention to tobacco policy issues. Although no single strategy worked in every state, the following important elements were in place throughout the project and contributed to the success of the media interventions:

- Technical assistance and training in media communications
- Strategic communication plans
- Mechanisms for sharing information, ideas, and successes
- Communications with the ASSIST Coordinating Center, which provided a national perspective on tobacco issues
- A dedicated media staff person at the state level
- Access to national experts
- Access to materials that could be adapted locally for news stories, editorials, press releases, and other formats
- A clear understanding of the audiences to be reached
- Familiarity with the media markets
- Well-established media relations
- Skills in media advocacy

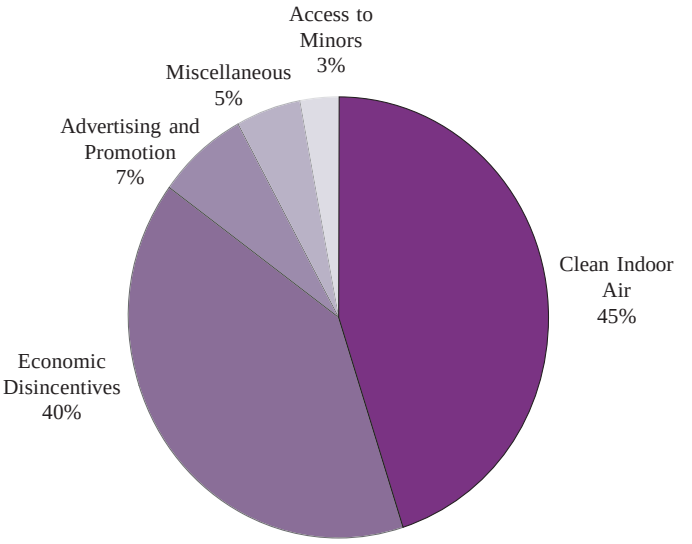
The interventions of the 17 ASSIST states made tobacco and health an issue of public priority. The media interventions described in this chapter were applied to, and brought media attention to, the four policy areas described in chapter 6: clean indoor air, youth access to tobacco, cigarette excise tax increases, and tobacco advertising and promotion.

Figure 5.1. Number of Policy-Related Tobacco Articles: Michigan, October 1, 1993, to March 31, 1994



Source: ASSIST newspaper clippings database.

Figure 5.2. Percentage of Articles by Policy Type: Michigan, January 1 to March 31, 1994



Source: ASSIST newspaper clippings database.

Table 5.2. Media Analysis Quarterly Report for Michigan: October 1, 1993, to March 31, 1994

	Michigan		National	ASSIST States
	N	%	%	%
By month				
October	130	17	14	18
November	101	13	12	13
December	54	7	9	8
January	78	10	13	12
February	116	15	17	16
March	290	38	36	33
Total	**769**	**100**	**100**	**100**
By policy type				
Clean indoor air	220	45	64	59
Youth access to tobacco	12	2	7	6
Economic disincentives	194	40	6	6
Advertising and promotion	35	7	6	6
Miscellaneous	23	5	18	23
Total	**484**	**100**	**100**	**100**
By type of article				
Cartoon	8	2	1	1
Editorial	94	19	17	17
Hard news	259	54	62	61
Letter to the editor	123	25	20	21
Total	**484**	**100**	**100**	**100**
By point of view				
Protobacco	77	16	16	16
Neutral	251	52	58	55
Prohealth	156	32	27	29
Total	**484**	**100**	**100**	**100**
By circulation				
< 10,000	47	10	14	12
10,000–49,999	198	41	43	41
50,000–99,999	115	24	16	21
> 100,000	124	26	26	26
Total	**484**	**100**	**100**	**100**
By number of front-page articles	59	12	11	12

Source: ASSIST Coordinating Center, Rockville, MD.

Appendix 5.A. ASSIST Bibliography

Bibliography Criteria

These criteria were determined by the ASSIST Research and Publications Subcommittee. To be included in the ASSIST bibliography,

- articles should relate to ASSIST and be authored after 10/91,
- author/coauthor should be ASSIST staff or persons funded by ASSIST, and
- articles should have appeared in peer-reviewed publications and/or should be official DOH publications that are available upon request.

Asterisks indicate titles that were added since July 2003.

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6. Public and Private Policy Interventions

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6. Public and Private Policy Interventions

At the center of the American Stop Smoking Intervention Study (ASSIST) model is the use of policy to alter the environment in which people live and change the social norm from one that tolerates smoking to one that actively discourages the use of tobacco in any form. This chapter presents the ASSIST states' intervention strategies to achieve policies that advance objectives in four tobacco control areas: eliminating exposure to environmental tobacco smoke, increasing the price of tobacco products, restricting tobacco advertising and promotions, and reducing youth access to tobacco products. All 17 ASSIST states made progress in these four areas, but not without overcoming formidable challenges. Through policy advocacy interventions, ASSIST educated policymakers, organizations, businesses, and individuals about the benefits of mandatory and voluntary tobacco control policies. In this chapter, case studies of interventions and insights of staff and coalition members illustrate the process of mobilizing ordinary citizens to effect major policy change despite opposition from a powerful, determined tobacco industry.

Policy as an Intervention

Changes in public and private policies are formal reflections of changes in community norms and as such, predictors of behavioral change. Providing leadership for policy development is a core function of governmental public health agencies.[1,2(pp6–7),3] State and local health departments have a long history of using policy interventions (requiring immunizations and restaurant inspections, etc.) to prevent and control infectious diseases. However, using a policy advocacy approach to prevent chronic disease caused by tobacco use was a major change in the public health approach to tobacco prevention and control at the time ASSIST began.

Shaping community norms about tobacco use and building support for public and private policies through the mass media and social networks are at the heart of the ASSIST model. Policy interventions must convince decision makers that the public perceives a proposed policy to be in the best interest of the community as a whole. Media advocacy helps bring about public and private policy changes, which in turn increase the demand for and use of program services. The three types of intervention—mass media, policy, and program services—can be likened to a three-legged stool: all three support behavioral change and without any one of the legs, the stool will not stand.

As all ASSIST contractors and subcontractors knew, federal money carries a variety of contractual, regulatory, and legislative restrictions. In 1991, at the start of the project, these restrictions were identified, explained, and widely disseminated in the

White Paper entitled *Restrictions on Lobbying and Public Policy Advocacy by Government Contractors: The ASSIST Contract.*[4] It was revised, updated, and redistributed to all ASSIST project directors, project managers, and the ASSIST Coordinating Center by the National Cancer Institute (NCI) ASSIST contracting officer on July 23, 1997.[5] The restrictions were also the subject of numerous trainings.[6] Throughout the ASSIST intervention phase, additional restrictions in regard to lobbying were attached to federal funding, especially through the annual appropriations process. Beginning October 1, 1998, none of the federal funding for ASSIST could be used by any partners for lobbying at any level, including the local level. The provisions of the Federal Acquisition Streamlining Act of 1994[7] applied to the ASSIST contract extensions for the last year of ASSIST, in 1998, because they were considered "new contracts." Encumbrances on the use of federal and foundation funding were one of the important reasons that ASSIST coalitions included different partners. Charitable organizations—called 501(c)(3)s in the Internal Revenue Code—including the American Cancer Society (ACS), are allowed to make substantial expenditures on lobbying.[8,9] Most of the public education that precedes policy and all of the enforcement that follows policy do not constitute lobbying. Partners like ACS and the many volunteers who participated in ASSIST coalitions could lobby and perform other functions that could not be financed with federal funds. (See section on Understanding the Regulations on Lobbying, chapter 8, part 2).

Interventions in Four Policy Areas

Following the ASSIST framework described in chapter 2, the 17 states promoted interventions in four policy areas, expressed as objectives in the "ASSIST Program Guidelines for Tobacco-free Communities":

> Eliminate environmental tobacco smoke in all areas where others may face involuntary exposure and the serious health risks associated with inhalation of other people's tobacco smoke.
>
> Eliminate all tobacco product advertising and promotion, other than point of sale price and objective product information advertising.
>
> Reduce access to and availability of tobacco products, particularly to persons under the legal age of purchase.
>
> Reduce consumption of cigarettes and other tobacco products through price increases using increased taxes and other costs imposed on tobacco products.[10(p12)]

Ordinances Passed during ASSIST Years

Tobacco control efforts by the ASSIST coalitions stimulated the passage of state and local laws and also private policies. Between 1992 and 1999, municipalities enacted local ordinances in the ASSIST states in the four policy areas: clean indoor air (506), excise taxes (7), youth access (688), and advertising (74).

Source: ANR Foundation Local Tobacco Control Ordinance Database(c), 9/18/03.

These objectives guided ASSIST's tobacco control advocates in developing their strategies to reduce tobacco use by influencing social norms through policy. See appendices 6.A–6.C for excerpts from the ASSIST policy guides on youth access to tobacco, clean indoor air, and tobacco advertising and promotion.

Eliminating Exposure to Environmental Tobacco Smoke

The purpose of environmental tobacco smoke (ETS) policies is to protect people from involuntary exposure to other people's tobacco smoke and from the serious health risks associated with inhaling it. For most people, tobacco smoke is the most widespread and harmful indoor pollutant that they will encounter. The harmful effects of ETS or secondhand smoke are well documented and are described in numerous reports:

- Centers for Disease Control and Prevention's 1986 *Health Consequences of Involuntary Smoking: A Report of the Surgeon General*[11]
- U.S. Environmental Protection Agency's (EPA) 1992 *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*[12]
- California EPA's 1997 *Health Effects of Exposure to Environmental Tobacco Smoke: Final Report and Appendices*[13]
- National Toxicology Program's 2000 *Ninth Report on Carcinogens*[14]
- International Agency for Research on Cancer's 2004 monograph, *Tobacco Smoke and Involuntary Smoking*[15]

Terms for Environmental Tobacco Smoke

> "ETS, or 'secondhand smoke,' is the complex mixture formed from the escaping smoke of a burning tobacco product and smoke exhaled by the smoker. The characteristics of ETS change as it ages and combines with other constituents in the ambient air. Exposure to ETS is also frequently referred to as 'passive smoking,' or 'involuntary tobacco smoke' exposure. Although all exposures of the fetus are 'passive' and 'involuntary,' . . . in utero exposure resulting from maternal smoking during pregnancy is not considered to be ETS exposure."[a]

The ASSIST project originally used the term *clean indoor air* to refer to policies but later expanded the concept to include outdoor environments as well and used the term *environmental tobacco smoke*.

[a]National Cancer Institute. 1999. *Health effects of exposure to environmental tobacco smoke: The report of the California Environmental Protection Agency* (Smoking and tobacco control monograph no. 10, NIH publication no. 99-4645). Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health (p. ES1).

The U.S. Environmental Protection Agency designated ETS as a Class A (known human) lung carcinogen in 1993.[12(p1)] The National Institutes of Health's National Toxicology Program has determined that ETS is a known human carcinogen. NIH's *Ninth Report on Carcinogens* concluded that ETS exposure is causally related to lung cancer. The report notes that secondhand smoke contains at least 250 chemicals that are known to be toxic or carcinogenic.[14] Each year in the United States, ETS is

responsible for at least 3,000 deaths from lung cancer and about 47,000 deaths from ischemic heart disease.[16–19] In addition to causing these diseases in adults, ETS has been found to cause a number of health problems in children, including bronchitis, pneumonia, asthma, middle ear infections, and sudden infant death syndrome.[16] The Surgeon General has concluded that, compared with children of nonsmoking parents, children of parents who smoke have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly lower rates of increase in lung function.[11] The evidence that ETS poses serious health risks has become even stronger since the end of ASSIST.

While the primary purpose of smoking restrictions is to protect nonsmokers from the carcinogens and toxins found in ETS, recent evidence points to a second benefit—ETS policies help reduce smoking prevalence:

> Research clearly shows that smoke-free public places, especially workplaces, provide a more supportive environment for smokers to quit. Even the tobacco industry's own internal research has shown this. For example, a Philip Morris study that followed some 25,000 smokers over time found that those working in a smoke-free work environment experienced an 84 percent higher quit rate than those facing no or minimal smoking restrictions.[20(piii)]

A 1990 study of nearly 12,000 California residents found that employees in smoke-free workplaces had a lower smoking prevalence and, among continuing smokers, lower cigarette consumption than individuals working where smoking was permitted.[21] A review of 26 studies conducted between 1984 and 1993 on the effects of smoke-free workplaces found that totally smoke-free workplaces were associated with reductions in smoking prevalence of 3.8% and of 3.1 fewer cigarettes smoked per day per continuing smoker.[22]

When the ASSIST project started, a few states or localities had restrictions on public smoking; however, many of these had been enacted for fire prevention or nuisance purposes rather than for health protection purposes. By 1991, the adverse health effects of tobacco use and ETS

1999 ASSIST conference materials

Mecklenburg County (NC) Health Department guide to smoke-free restaurants

exposure were well documented, and a mounting body of scientific evidence supported the effectiveness of certain policies for reducing tobacco use. For example, in 1989, Congress prohibited smoking on all domestic commercial flights up to 6 hours in duration to protect airline workers and passengers from health risks associated with ETS. NCI, through its systematic research approach that led to ASSIST, was ready in 1991 to greatly increase the use of policy interventions to reduce and prevent tobacco use.

The ASSIST program objectives for smoke-free environments sought the following four outcomes:

1. State and municipal regulations creating smoke-free environments
2. Substantial and progressive voluntary action by employers, property owners, commercial enterprises, university and school officials, healthcare providers, municipal and transportation authorities, day care centers, media gatekeepers, parents, and others to support and adopt smoke-free policies
3. Broader and more intense public and policymaker support for implementation of smoke-free policies in worksites, public places, schools, and other locations
4. Increased levels of citizen awareness of the harmful nature of ETS

The primary policy intervention strategy was direct policy advocacy aimed at increasing the public's and policymakers' awareness of the issues. Coalition members informed public regulatory authorities about legislative steps taken in other jurisdictions to create smoke-free environments; encouraged property owners and managers, business owners, employers, and healthcare providers to voluntarily implement smoke-free policies on their premises; and provided media contacts with the evidence and rationale to support a smoke-free position in articles and editorials. (See chapter 5.)

ASSIST state and local coalitions recognized the strategic advantages of focusing efforts for smoke-free policies on a variety of public settings. In many communities, protecting children from ETS exposure was the first and most obvious choice. For some indoor commercial settings (e.g., restaurants, hotels, and theaters) advocates could present clear evidence of financial benefits to the businesses in addition to the health benefits of smoke-free environments. For other settings, such as bars, the evidence became available only in the later ASSIST years.[23,24] After reviewing all 97 studies on the economic impact of smoke-free policies on the hospitality industry, Scollo and colleagues concluded, "All of the best designed studies report no impact or a positive impact of smoke-free restaurant and bar laws on sales or employment."[25(p13)] The tobacco industry circulated anecdotal information that led restaurant and bar proprietors to believe that smoking restrictions would negatively affect their business.[25] However, the tobacco industry's internal documents make clear that its real concern was the economic impact that these policies were having on the industry itself by motivating smokers to quit or reduce their consumption. In the tobacco industry's own words, "Total prohibition of smoking in the workplace strongly affects industry volume. Smokers facing

these restrictions consume 11%–15% less than average and quit at a rate that is 84% higher than average."[26] Table 6.1 contains a breakout of the clean indoor air ordinances enacted as of August 25, 2003. The tables in this chapter include data for all states, to put the ASSIST states in context. For more current data, contact the Americans for Nonsmokers' Rights at www.no-smoke.org.

As the ASSIST states succeeded in securing adoption of clean indoor air policies, they also sought to eliminate exposure in all public settings in which a large number of people could be exposed to environmental tobacco smoke. Outdoor settings for sports and entertainment events were also of particular concern to ASSIST coalitions because children and adolescents tend to be present at these settings.

Promoting Higher Taxes for Tobacco

An increase in the price of cigarettes results in a decrease in cigarette consumption. The substantial evidence for the relationship between price (including increases by taxation) and consumption has been summarized in numerous reports: the 1992 report of the surgeon general, *Smoking and Health in the Americas*;[27] a 1993 summary report of a National Cancer Institute Expert Panel;[28] the 1994 Institute of Medicine report, *Growing Up Tobacco Free*;[1] the 2000 Institute of Medicine report, *State Programs Can Reduce Tobacco Use*;[29] and the 1999 World Bank report, *Curbing the Epidemic*.[30]

Studies show a range of estimates for the price elasticity of demand for cigarettes, but most fall in the range from –0.25 to –0.50. The range indicates that if cigarette prices rise by 10%, overall cigarette smoking will fall by between 2.5% and 5%. The long-term response to a permanent change in cigarette prices will be larger than the initial short-run response.[31] Another finding is that young smokers are up to three times more sensitive to price than are adult smokers.[32] The relationship between price and consumption is also noted in internal tobacco industry documents:

> In the opinion of PM Inc. and Philip Morris International, past increases in excise and similar taxes have had an adverse impact on sales of cigarettes. Any future increases, the extent of which cannot be predicted, could result in volume declines for the cigarette industry, including PM Inc. and Philip Morris International.[33(p165)]

Many major health and medical organizations in the United States and the

Long-standing Benefits of Tobaco Excise Taxes

The benefits of excise taxes have long been recognized. In a report on the economics of tobacco control, the World Bank refers to Adam Smith's reasoning regarding the advantages of tobacco taxes. Because tobacco taxes would lessen the need for other excise taxes, for example, on necessities and other manufactured goods, he promoted excise taxes as benefiting the poor. Smith argued that with tobacco excise taxes, poor people would "live better, work cheaper, and . . . send their goods cheaper to market."

Source: World Bank. 1999. *Curbing the epidemic: Governments and the economics of tobacco control*. Washington, DC: World Bank (p. 37). www1.worldbank.org/tobacco/book/html/chapter4.htm.

Table 6.1. Number of Municipalities per State with Clean Indoor Air Ordinances, as of August 25, 2003
(Shading indicates ASSIST states.)

State	Total	Workplaces	Restaurants	Bars	Public Places
California	332	293	272	22	304
Massachusetts	227	173	211	76	211
Missouri	108	95	39	3	105
New Jersey	91	39	6	0	52
Texas	74	46	61	7	73
Alabama	68	62	18	1	65
Wisconsin	58	47	23	1	54
West Virginia	54	53	53	2	54
New York	52	48	18	4	47
North Carolina	51	43	32	5	50
Kansas	50	44	7	1	47
Colorado	47	42	38	6	46
Georgia	38	33	21	1	35
Louisiana	38	31	6	0	37
Mississippi	34	33	1	1	33
Arizona	30	28	25	2	29
Illinois	30	20	19	0	28
Ohio	23	21	20	2	23
Oregon	21	20	16	3	20
Virginia	20	9	17	0	20
Florida	15	5	0	0	6
South Carolina	15	8	3	0	14
Michigan	14	10	1	0	12
New Mexico	14	11	8	1	13
Maryland	12	10	7	1	11
Minnesota	12	4	4	0	6
Indiana	9	8	3	2	9
Pennsylvania	9	5	5	0	8
Rhode Island	9	1	1	0	1
Tennessee	9	8	3	0	9
Alaska	7	5	6	0	5
Washington	7	4	3	0	5
Hawaii	5	3	5	0	5
Montana	5	5	4	1	5
Nebraska	5	4	0	0	4
North Dakota	5	4	2	0	5
Arkansas	4	3	2	0	4
Maine	4	3	2	0	3
New Hampshire	4	0	3	0	0
Iowa	3	3	0	0	3
Wyoming	3	3	2	0	3
Delaware	2	2	2	0	2
Oklahoma	2	1	0	0	2
Utah	2	1	0	0	1
Kentucky	1	1	1	1	1
District of Columbia	1	1	1	0	1
Vermont	1	1	1	0	1
Connecticut	1	1	0	0	1
South Dakota	1	1	0	0	1
Idaho	0	0	0	0	0
Nevada	0	0	0	0	0

Source: ANR Foundation Local Tobacco Control Ordinance Database©, 9/18/03. Copyright 1998–2003 American Nonsmokers' Rights Foundation. All rights reserved.

Note: Because some municipalities have coverage in more than one category, the numbers are not mutually exclusive.

ASSIST States Increase Tobacco Taxes

During the ASSIST project, 12 of the 17 ASSIST states increased tobacco taxes. Increases ranged from 1–71¢ and averaged 14¢. After the ASSIST project ended, the capacity built by the project helped facilitate a number of states to pass tobacco tax increases.

Sources: American Lung Association. 2001. *State legislated actions on tobacco issues*, ed. E. M. Schilling and C. E. Welch. Washington, DC: American Lung Association; The Tobacco Institute. 1998. *The tax burden on tobacco. Historical compilation*, vol. 33. Washington, DC: The Tobacco Institute.

World Health Organization, in its publication *Guidelines for Controlling and Monitoring the Tobacco Epidemic*,[34] identify increasing tobacco taxes as a key strategy for reducing tobacco use.[35] The most common means available to the public for raising the price is to increase the excise tax on tobacco products.

The public tends to support increases in tobacco taxes in part because they favor funding tobacco prevention programs.[36] Reporting the results of a 1997 telephone poll paid for by the Abell Foundation and the Maryland Teachers Association, the *Baltimore Sun* stated,

> Anti-smoking activists released a poll yesterday showing Maryland voters favor by nearly 2-to-1 a $1.50-a-pack increase in the state's cigarette tax and said teen smoking has become so potent a political issue that it can outweigh party loyalty.[37]

More recently, a 2003 synthesis (by the Campaign for Tobacco-Free Kids) of polls conducted in 28 states in 2002 and 2003 shows that there is broad public and voter support for cigarette-tax increases.[36] In most states, voters favor the proposed cigarette-tax increase by a 2-to-1 margin. They prefer cigarette-tax increases to other tax increases or to budget cuts but also strongly believe that at least some tobacco-tax revenues should be used for programs to prevent and reduce smoking, especially by children and adolescents.[36] A second reason that the public supports tobacco tax increases may be the exposure of the tobacco industry's culpability in deceiving the public and its diminished credibility resulting from the litigation of the 1990s and the internal industry documents that were consequently made public.

The ASSIST objective for the tobacco-pricing policy area was to reduce consumption of cigarettes and other tobacco products through price, and especially tax, increases. The objective can be best achieved by gaining the support of the public and of policymakers; therefore, a public-private partnership, such as that of NCI with ACS, is fundamental to the strategy. To increase the public's and policymakers' awareness of the need for higher taxes on tobacco products, the ASSIST coalitions disseminated data on the effectiveness of substantial tobacco-tax increases in reducing tobacco consumption and on public support for such measures. Coalition members met with community and business leaders and with media contact persons to encourage them to write editorials supporting substantial tax increases. Table 6.2 shows the state tax excise rate increases during the ASSIST years. (See NCI Monograph 17 for a comparative evaluation of

Table 6.2. State Tax Rates for 2000 and Rate Increases, 1991–99 (per pack)

(Shading indicates ASSIST states.)

State	2000 Rate	Rate Change	Date of Change
New York	$1.110	39 to 56¢ 56¢ to $1.11	6/1/93 3/1/00
Alaska	$1.000	29¢ to $1.00	1/29/97
Hawaii	$1.000	60¢ 60 to 80¢ 80¢ to $1.00	7/1/93 9/1/97 7/1/98
California	$0.870	35 to 37¢ 37 to 87¢	1/1/94 1/1/99
Washington	$0.825	43 to 54¢ 54 to 56.5¢ 56.5 to 81.5¢ 81.5 to 82.5¢	7/1/93 7/1/94 7/1/95 7/1/96
New Jersey	$0.800	40 to 80¢	1/1/98
Massachusetts	$0.760	26 to 51¢ 51 to 76¢	1/1/93 10/1/96
Michigan	$0.750	25 to 75¢	5/1/94
Maine	$0.740	31 to 33¢ 33 to 37¢ 37 to 74¢	1/1/91 7/1/91 11/1/97
Rhode Island	$0.710	37 to 44¢ 44 to 56¢ 56 to 61¢ 61 to 71¢	7/1/93 7/1/94 7/1/95 7/1/97
Oregon	$0.680	28 to 33¢ 33 to 38¢ 38 to 68¢	11/1/93 1/1/94 2/1/97
Maryland	$0.660	13 to 16¢ 16 to 36¢ 36 to 66¢	6/1/91 5/1/92 7/99
District of Columbia	$0.650	17 to 30¢ 30 to 50¢ 50 to 65¢	7/1/91 6/1/92 7/1/93
Wisconsin	$0.590	30 to 38¢ 38 to 44¢ 44 to 59¢	5/1/92 9/1/95 11/1/97
Arizona	$0.580	15 to 58¢	1/29/94
Illinois	$0.580	30 to 44¢ 44 to 58¢	7/14/93 12/16/97
New Hampshire	$0.520	25 to 37¢ 37 to 52¢	7/1/97 7/6/99
Utah	$0.515	23 to 26.5¢ 26.5 to 51.5¢	7/1/91 7/1/97
Connecticut	$0.500	40 to 45¢ 45 to 47¢ 47 to 50¢	10/1/91 7/1/93 7/1/94
Minnesota	$0.480	38 to 43¢ 43 to 48¢	6/1/91 7/1/92

Table 6.2. (continued)

State	2000 Rate	Rate Change	Date of Change
North Dakota	$0.440	30 to 39¢	7/1/91
		29 to 44¢	7/1/93
Vermont	$0.440	17 to 18¢	7/1/91
		18 to 19¢	1/1/92
		19 to 20¢	7/1/92
		20 to 44¢	7/1/95
Texas	$0.410	No rate change during this period.	
Iowa	$0.360	31 to 36¢	6/1/91
Nevada	$0.350	No rate change during this period.	
Arkansas	$0.345	21 to 22¢	7/1/91
		22 to 34.5¢	2/1/93
		34.5 to 31.5¢	7/1/93
Nebraska	$0.340	27 to 34¢	7/1/93
South Dakota	$0.340	22 to 33¢	7/1/95
Florida	$0.339	No rate change during this period.	
Pennsylvania	$0.310	18 to 31¢	8/19/91
Idaho	$0.280	18 to 28¢	7/1/94
Delaware	$0.240	19 to 24¢	1/1/91
Kansas	$0.240	No rate change during this period.	
Louisiana	$0.240	No rate change during this period.	
Ohio	$0.240	18 to 24¢	1/1/93
Oklahoma	$0.230	No rate change during this period.	
New Mexico	$0.210	15 to 21¢	7/1/93
Colorado	$0.200	No rate change during this period.	
Mississippi	$0.180	No rate change during this period.	
Montana	$0.180	18 to 19.26¢	8/15/92
		19.26 to 18¢	8/15/93
Missouri	$0.170	13 to 17¢	10/1/93
West Virginia	$0.170	No rate change during this period.	
Alabama	$0.165	No rate change during this period.	
Indiana	$0.155	No rate change during this period.	
Tennessee	$0.130	No rate change during this period.	
Georgia	$0.120	No rate change during this period.	
Wyoming	$0.120	No rate change during this period.	
South Carolina	$0.070	No rate change during this period.	
North Carolina	$0.050	2 to 5¢	8/1/91
Kentucky	$0.030	No rate change during this period.	
Virginia	$0.025	No rate change during this period.	

Sources: American Lung Association. 2001. *State legislated actions on tobacco issues,* ed. E. M. Schilling and C. E. Welch. Washington, DC: American Lung Association; The Tobacco Institute. 1998. *The tax burden on tobacco. Historical compilation,* vol. 33. Washington, DC: The Tobacco Institute.

ASSIST and non-ASSIST states.) Some municipalities also passed local ordinances levying excise taxes on tobacco products. During the ASSIST years (1991–99), cigarette excise taxes levied by municipalities in the ASSIST states ranged from 3 to 36¢ per pack. For cigars, the range was 3 to 4¢ per cigar, and for smokeless tobacco, it was 4 to 36¢ per smokeless tobacco container.[38]

Limiting Tobacco Advertising and Promotions

Cigarette advertising and promotions by the tobacco industry depict and reinforce social norms that support smoking, contribute to the social pressures on young people to start smoking, and weaken the resolve of smokers to quit. Advertising and promotions help create the impression, especially among young people, that smoking is more pervasive than it is and create misleading images of social rewards and healthfulness of smoking. The tobacco industry has systematically marketed its products to youths.[39–42] A study of 1,752 adolescents in California, from 1993 to 1996, found that 34% of teen smoking experimentation was attributable to tobacco advertising and promotional activities.[43] The tobacco industry spends billions of dollars each year on advertisements and promotions. During the ASSIST years and directly thereafter, those expenditures increased from $4.6 billion in 1991 to $8.24 billion in 1999 and $12.5 billion in 2002.[44(p1)]

There is strong evidence that advertising targeted at youth influences youth attitudes and behavior. In an *Advertising Age* survey conducted in April 1992, 325 children (8 to 13 years of age) were asked to name familiar cigarette brands; 90% named Camel.[45] Having a favorite advertisement and having a promotional item are each predictive of cigarette experimentation.[43] As Fischer and colleagues noted, "Approximately 30% of 3-year-old children correctly matched Old Joe with a picture of a cigarette compared with 91.3% of 6-year-old children."[46(p3145)] ("Old Joe" was a cartoon character featured prominently in a Camel cigarette ad campaign.)

Strategies to Limit Tobacco Advertising and Promotions

The states implemented the following types of strategies to counter tobacco advertising and promotions:

- Petition and persuade public authorities with regulatory powers to restrict or ban advertising and promotion within their scope of authority (e.g., on public transportation).
- Persuade property and business owners and managers to voluntarily reject cigarette advertising and tobacco promotion on their premises.
- Persuade civic, sports, arts, and other event sponsors, especially those events appealing to priority population audiences, to reject cigarette advertising and promotional sponsorship of such events.
- Persuade media owners and advertising managers to refuse cigarette advertising and to write editorials in support of advertising and promotion bans.
- Provide the media with evidence about the tobacco industry's advertising and promotion strategies, especially as they appeal to youth; public attitudes and actions supportive of advertising control policies; and financial ties and conflicts of interest of organizations that accept tobacco industry business and support.

Restrictions on advertising and promotions at the state or local level are difficult to achieve because of First Amendment concerns, federal preemption under the 1965 Federal Cigarette Labeling and Advertising Act, and the economic self-interest of the media in preserving advertising revenue. Fear of losing those revenues severely inhibits publishers from printing articles that openly present the hazards of tobacco use.[47] When ASSIST began, it was not entirely clear what policy actions could be implemented within the legal limits of the Constitution to restrict advertising of tobacco products. Case law on cigarette advertising and promotion has evolved over time. For some actions the states could build on precedent, but for others they had to chart new territory. For example, states and communities could bar certain forms of advertising and promotion, such as the distribution of free samples, advertising on state or municipally owned or operated subways and buses, and billboards in municipal stadiums. However, no state can ban cigarette advertising in magazines that are sold through interstate commerce. The authority of states and municipalities to bar intrastate forms of advertising, such as billboards or tobacco-sponsored music or sports events, had not been adequately tested in the courts. See table 6.3 for a listing by state of the number of municipalities that had enacted ordinances restricting tobacco advertising, as of August 25, 2003.

The ASSIST program objectives for restricting tobacco advertising and promotions sought the following four outcomes:

1. Permissible state and municipal restrictions on cigarette advertising and promotion (e.g., bans on advertising on mass transit vehicles and in municipal stadiums, billboard restrictions, bans on free samples, and action to prosecute "unfair or deceptive" cigarette advertising under state laws)
2. Substantial and progressive voluntary action by media owners and advertising managers and by sports, cultural, music, and other event managers to refuse cigarette advertising and promotion
3. Broader and more intense public and policymaker support for restraints on tobacco advertising and promotion
4. Increased levels of citizen awareness of the nature and role of cigarette advertising and promotion[1,10(p2),40]

ASSIST pursued a number of strategies to limit tobacco industry advertising and promotions. The following are some examples of direct advocacy efforts:

- Persuading property owners to prohibit tobacco advertising on billboards in ballparks and on posters at convenience stores near schools
- Persuading sponsors of cultural and sports events to reject tobacco advertising opportunities

With respect to media advocacy, ASSIST staff worked to expose and draw attention to factual omissions and distortions in tobacco advertising and media coverage. Though lacking the resources for an effective paid countermarketing campaign, ASSIST staff did respond opportunistically to tobacco media ads by seeking and gaining media coverage that highlighted the health

Table 6.3. Number of Municipalities per State with Advertising Ordinances, as of August 25, 2003
(Shading indicates ASSIST states.)

State	Total	Location/ Zoning	Public Transit	Retailer Restrictions	Tombstone Exemption
California	48	45	6	36	22
Massachusetts	29	6	25	2	0
New York	20	13	7	14	4
New Jersey	6	5	0	5	1
Oregon	6	0	0	6	0
Florida	4	0	1	2	0
Michigan	4	3	1	0	1
Washington	4	4	2	1	2
Colorado	2	2	0	2	0
Connecticut	2	2	1	2	1
Hawaii	2	2	0	1	0
Maryland	2	2	0	0	1
Minnesota	2	2	0	2	2
Missouri	2	1	1	0	0
Ohio	2	2	1	1	1
West Virginia	2	2	0	0	0
Wisconsin	2	2	0	1	1
Alaska	1	0	1	0	0
Arkansas	1	1	0	1	0
Illinois	1	0	1	0	0
Indiana	1	1	0	0	0
Maine	1	0	0	0	0
Oklahoma	1	1	0	0	0
Pennsylvania	1	1	0	0	1
Rhode Island	1	1	0	0	0
Texas	1	1	0	0	0
Alabama	0	0	0	0	0
Arizona	0	0	0	0	0
Delaware	0	0	0	0	0
District of Columbia	0	0	0	0	0
Georgia	0	0	0	0	0
Idaho	0	0	0	0	0
Iowa	0	0	0	0	0
Kansas	0	0	0	0	0
Kentucky	0	0	0	0	0
Louisiana	0	0	0	0	0
Mississippi	0	0	0	0	0
Montana	0	0	0	0	0
Nebraska	0	0	0	0	0
Nevada	0	0	0	0	0
New Hampshire	0	0	0	0	0
New Mexico	0	0	0	0	0
North Carolina	0	0	0	0	0
North Dakota	0	0	0	0	0
South Carolina	0	0	0	0	0
South Dakota	0	0	0	0	0
Tennessee	0	0	0	0	0
Utah	0	0	0	0	0
Vermont	0	0	0	0	0
Virginia	0	0	0	0	0
Wyoming	0	0	0	0	0

Source: ANR Foundation Local Tobacco Control Ordinance Database©, 9/18/03. Copyright 1998–2003. American Nonsmokers' Rights Foundation. All rights reserved.

Note: Because some municipalities have coverage in more than one category, the numbers are not mutually exclusive.

Access, Availability, and Restriction

The terms *access, availability,* and *restriction* are defined as follows for the purposes of this discussion of policy interventions for tobacco control.

Access refers to the ease or difficulty with which an individual can obtain tobacco products. ASSIST sought to make it more difficult for individuals, especially minors, to purchase tobacco in the community.

Availability refers to where tobacco products can be purchased or acquired in the community and where they are placed with stores. ASSIST sought to limit the locations where tobacco products can be obtained.

A *restriction* is any public or private policy, mandatory or voluntary, that reduces the use, possession, promotion, access, or availability of tobacco products in a given location.

consequences of tobacco use. The literature on the effectiveness of mass media campaigns suggests that this type of countermarketing increases awareness of the health consequences of tobacco use but does not result in behavior change.[48] The goal of ASSIST staff efforts in this context was simply to increase awareness.

Reducing Minors' Access to Tobacco Products

The main purpose of establishing and effectively enforcing restrictions on minors' access to tobacco products is to decrease the number of adolescents who initiate smoking. Almost 90% of all adult smokers started smoking before age 18.[49] As of 1989, more than 3 million American children under the age of 18 consumed an estimated 947 million packs of cigarettes and 26 million containers of smokeless tobacco yearly.[41] Policies that reduce the access of minors to tobacco products, especially the purchase of those products, create barriers to early experimentation and reinforce a social norm that disapproves of smoking by children and adolescents.

When ASSIST began, 49 states and the District of Columbia had laws that made it illegal to sell tobacco products to minors, but few, if any, of these laws were being enforced. A 1990 report of the inspector general of the Department of Health and Human Services found that these laws were ineffective in preventing the sale of tobacco to minors, as confirmed by studies demonstrating the ease with which minors obtained tobacco.[50]

Restrictions on youth access work best when they are introduced as part of a multifaceted, comprehensive strategy that includes interventions designed to address the appeal of tobacco to minors. These include interventions addressing tobacco advertising and promotion, adult modeling of smoking in public places, smoking by adult role models, and other environmental cues and social norms that youths encounter daily in adult society. In one study, the authors considered the very process of intensive community organizing as an important context for the effects of local policies and their enforcement.[51]

The ASSIST program objectives for tobacco access and availability policy sought the following four outcomes:

1. State, municipal, and private action restricting the access and availability of tobacco products, such as eliminating the sale of tobacco in

smoke-free areas (e.g., hospitals, pharmacies) or on municipal property and moving all tobacco products behind the counter
2. Substantial and progressive voluntary action by retailers to observe existing restrictions on the access to and availability of tobacco products
3. Broader and more intense public and policymaker support for restrictions on, enforcement of, and improvement in regulations on the access to and availability of tobacco products
4. Increased levels of citizen awareness of the access to and availability of tobacco products

The ASSIST states implemented a broad array of strategies to reduce minors' access to tobacco. The states promoted strengthening access laws, adopting laws that require tobacco retailers to obtain licenses, and restricting sales—for example, requiring that retailers move tobacco products from self-service displays to vendor-assisted displays, prohibiting the sale of single cigarettes, and prohibiting point-of-purchase displays. (See table 6.4.) The strategies included persuading hospitals, pharmacies, and public places frequented by minors (e.g., schools, sports arenas, movie theaters) to voluntarily limit or eliminate the sale or free distribution of tobacco on their premises. Also, as with all policy interventions, the coalitions provided the media with information supporting the effectiveness of access restrictions.

More important, the coalitions took actions to ensure compliance with these laws. For example, in cooperation with law enforcement and regulatory agencies, minors participated in compliance checks. The coalitions also implemented programs to educate vendors about the restrictions. The ASSIST states were able to intensify their efforts in this policy area because of efforts by two other federal agencies—the Food and Drug Administration and the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration—to reduce youth access to tobacco. (See chapter 9.)

Challenges to Public Policy Interventions

Throughout the process of advocating for tobacco control policies, ASSIST advocates encountered opposing efforts by the tobacco industry, some major and some minor. The strength of that opposition reflected the high stakes at risk for the tobacco industry. As noted by Tina Walls of Philip Morris, "Financial impact of smoking bans will be tremendous. Three to five fewer cigarettes per day per smoker will reduce annual manufacturer profits a billion dollars plus per year."[52(p4)] The chief barriers posed by the tobacco industry to the ASSIST efforts, as identified in monograph 11 of NCI's monograph series on smoking and tobacco control, were discrediting research; enlisting front groups for smokers' rights; and promoting ineffective alternatives, legal challenges, and preemptive legislation.[20] (See chapter 8 of this monograph for a recent analysis of the tobacco industry's documents and a categorization of eight strategies to interfere with the ASSIST project.)

Table 6.4. Number of Municipalities per State with Youth Access Ordinances, as of August 25, 2003

(Shading indicates ASSIST states.)

State	Total	Vending Machine	Sampling	Licensing	Self-Service Displays	Single Cigarette Sales	Use/ Possession/ Purchase
Massachusetts	225	218	180	199	174	174	18
New Jersey	222	196	2	16	87	2	53
California	197	185	47	34	123	48	5
Minnesota	192	172	11	161	127	72	105
Illinois	138	62	59	68	11	11	124
Missouri	61	17	12	7	6	8	28
Colorado	42	20	2	3	13	6	35
Florida	42	26	0	0	40	0	2
Wisconsin	35	14	4	11	1	11	23
Ohio	23	16	5	6	5	5	15
Oregon	22	11	0	8	22	1	0
New York	21	17	5	3	16	1	2
Pennsylvania	18	14	0	1	2	1	3
Michigan	15	11	1	4	1	0	5
Texas	14	10	3	0	3	1	6
Connecticut	13	11	0	1	3	0	0
North Dakota	13	13	0	10	7	0	11
Arizona	11	11	0	1	7	0	1
North Carolina	11	2	0	0	0	0	0
Kansas	9	4	2	1	3	3	5
Maryland	9	9	2	0	7	1	0
Rhode Island	7	2	0	3	1	1	4
Utah	7	6	0	0	7	0	0
Alabama	6	5	0	0	0	0	1
Maine	6	4	1	1	5	0	0
Nebraska	6	2	1	1	2	1	4
Georgia	3	1	1	0	0	0	1
West Virginia	3	2	0	0	0	0	2
Hawaii	2	0	2	0	0	0	0
Indiana	2	0	2	2	0	0	0
Iowa	2	0	0	1	0	0	0
Louisiana	2	1	0	0	0	0	0
Mississippi	2	0	0	0	0	0	1
Oklahoma	2	0	1	0	0	1	2
Wyoming	2	1	0	0	0	0	2
Alaska	1	1	0	1	1	1	1
Arkansas	1	1	1	0	0	0	1
District of Columbia	1	1	1	1	0	0	0
Montana	1	1	1	0	0	0	1
Vermont	1	1	1	0	1	0	0
New Hampshire	1	1	0	0	0	0	0
Delaware	1	0	0	0	0	1	0
Idaho	0	0	0	0	0	0	0
Kentucky	0	0	0	0	0	0	0
Nevada	0	0	0	0	0	0	0
South Carolina	0	0	0	0	0	0	0
South Dakota	0	0	0	0	0	0	0
Tennessee	0	0	0	0	0	0	0
Virginia	0	0	0	0	0	0	0

Source: ANR Foundation Local Tobacco Control Ordinance Database©, 9/18/03. Copyright 1998–2003 American Non-smokers' Rights Foundation. All rights reserved.

Note: Because some municipalities have coverage in more than one category, the numbers are not mutually exclusive.

Discrediting the Science

The tobacco industry's efforts to discredit research are evident in its opposition to the U.S. Environmental Protection Agency's (EPA's) report on the respiratory and other health effects of passive smoking.[53] The EPA report presented a meta-analysis of studies on the health effects of environmental tobacco smoke.

The tobacco industry objected to the scientific analysis the EPA conducted[54] and referred to the EPA report as "junk science."[55,56] Tobacco industry documents that became public in the late 1990s during litigation indicate the industry's intent:

> OBJECTIVES
>
> Our overriding objective is to discredit the EPA report and to get the EPA to adopt a standard for risk assessment of all products. Concurrently, it is our objective to prevent states and cities, as well as businesses from passing smoking bans. And finally, where possible we will proactively seek to pass accommodation legislation with preemption.
>
> STRATEGIES
>
> To form local coalitions to help us educate the local media, legislators and the public at large about the dangers of "junk science" and to caution them from taking regulatory steps before fully understanding the costs in both economic and human terms.[57(Bates no. 2021183916)]

—Memo from Ellen Merlo (VP, Philip Morris USA Corporate Affairs) to William Campbell (Chairman, Philip Morris USA)

During the public comment period on the EPA report, 71% of submissions claiming the conclusions to be invalid were from individuals affiliated with the tobacco industry.[58] Immediately, after the report was released by the EPA, six tobacco-related organizations filed a lawsuit against the EPA[59] in the U.S. Court of the Middle District of North Carolina Winston-Salem Division. The tobacco industry groups argued that the EPA had exceeded its authority, had violated administrative law procedure, and that the risk assessment was flawed and not the result of reasoned decision making. The lower court ruled in favor of the industry, but a federal appeals court reversed the decision in December 2002. Nevertheless, ASSIST staff found that the publicity given to the industry's claims about the science behind tobacco use confused the public, making it more difficult to promote clean indoor air legislation.

Ineffective Alternatives

The tobacco industry continues to promote its own alternatives to the public health community's tobacco prevention and control programs. Past tobacco industry alternative programs include "Accommodation" and "Red Light-Green Light," which supported smoking in designated public areas; "Helping Youth Say No" and "Right Decisions, Right Now," designed for parents and schools; and Philip Morris's 1998 youth smoking prevention campaign, "Think. Don't Smoke."

These alternatives stimulated research into their efficacy. A limited, but growing body of evidence suggests that these tobacco industry programs were ineffective. For example, focus group research conducted by Teenage Research

Unlimited,[60] a marketing firm that specializes in the teenage market, concluded that the "Think. Don't Smoke." campaign "does not appear to offer any compelling reason for [at-risk] teens not to smoke. Therefore, campaigns should not be developed with a 'choice' theme as a key foundation."[60,61]

Preemption

Preemption is a mechanism by which a higher level of government asserts exclusive jurisdiction over an area of policy. Preemption clauses remove or limit the authority of lower levels of government to enact or enforce legislation that is stronger than the state law in the policy area preempted. Preemptive legislation is perhaps the strongest challenge to effective public policy intervention and can lead to unanticipated and costly litigation.

In the mid-1980s, faced with an increasing number of effective local tobacco control ordinances, especially in the area of ETS and clean indoor air, the tobacco industry launched a major effort to pass preemptive laws aimed at legislatures at the state level.[62–64] Later, after the 1992 EPA report (*Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders*) was released, some boards of health banned smoking in public places, and the industry used preemption to challenge the authority of the boards and other local governing bodies to enact smoking regulations.[65] By 1998, a total of 30 states—12 of which were ASSIST states—had enacted some form of preemptive legislation, including 14 laws preempting local ordinances on clean indoor air, 22 laws preempting local ordinances on youth access to tobacco, and 17 laws preempting some or all types of local restriction on tobacco advertising and promotion.

Internal Tobacco Industry Documents Confirm the Power of Local Measures

"By introducing pre-emptive statewide legislation we can shift the battle away from the community level back to the state legislatures where we are on stronger ground."

—Tina Walls

Source: Walls, T. CAC presentation #4, draft. Philip Morris. July 8, 1994. http://legacy.library.ucsf.edu/tid/vnf77e00. Bates no. 2041183751–3790.

The threat of preemption drew varied responses from different communities. In North Carolina, the threat of preemption in the summer of 1993, when ASSIST was to enter its intervention phase, prompted 89 communities to hold public hearings and fast-track smoking control rules passed mostly by local boards of health over a 3-month period. A legal challenge to the authority of the boards of health to regulate smoking in public places subsequently invalidated the enforcement of 88 of the 89 local rules. The issue was that the ordinances exceeded the authority of the boards of health, which were appointed rather than elected. The only rule that withstood the challenge was in Durham County. In Durham County, not only the board of health but also the Durham City Council and the Durham County Commissioners passed the ordinance during the 3-month interval before the preemption law took effect.[66] The first state to repeal preemp-

tion of tobacco control was Maine (an ASSIST state), which restored local control over tobacco displays, placement, and time of sale provisions in 1996 (the preemptive language was included in a youth access bill passed a year earlier).[67] In 2002, Delaware became the first state to repeal preemption of local clean indoor air ordinances, simultaneously adopting a comprehensive smoke-free state law.

Insights from Policy Advocacy Experiences

The overall experience of the 17 ASSIST states was that policy change—resulting from community education, grassroots mobilization, and media advocacy—is a powerful tool in reducing tobacco use and tobacco-related disease. Stillman et al., in their evaluation of ASSIST, concluded that "investment in building state-level tobacco control capacity and promoting changes in tobacco control policies are effective strategies for reducing tobacco use."[35(p1681)]

The enactment of new policies or changes in existing policies regarding any issue typically result from advocacy processes that involve challenges from those with opposing views. In the case of advancing tobacco control policies, these challenges are almost always strong and well organized. To be successful in bringing about tobacco control policies, advocates must be prepared not only to propose the policies, but also to endure substantial opposition. Furthermore, as described in chapters 3–5, not only the advocates but also the community must be involved and ready to support and defend the policies. Advocates must have a clear concept of the specific policy desired, the ability to present persuasive reasons for supporting the policy, messages and approaches tailored to specific individuals and population groups, and a realistic strategic plan that pulls together community resources.

Presented in this chapter are 14 insights that the authors derived from the experiences of ASSIST staff and coalition members working in the field to promote tobacco control policies. Many of those insights are illustrated with case studies shared over the ASSIST years and from formal presentations at conferences. These insights are told in the words of those who were personally involved and reflect their experience. The case studies illustrate how, through persistence and with creative strategies, the ASSIST staff and coalitions met many of the challenges to their policy intervention efforts. As historical experiences, the case studies reflect the environment at the time, especially the legal environment, which has changed during the past several years. The insights are sequenced from broad principles of policy advocacy, to specific tactics, to implications for the future.

Insight 1: Most Policymakers Want to Do the Right Thing for the Public's Health, but the Right Thing Must Be Explained and Promoted to Them by Their Constituents

> They don't see the light until they feel the heat.
>
> *—A lobbyist's insight*

A Leadership Taxonomy*

It takes more than one leader, or one type of leader, for a community to achieve its goals.

The *Visionary* challenges conventional views of the possible, aims high, takes risks, and rethinks priorities.

The *Strategist* thinks backward from the goals to the means to achieve the goals, sorts out what is realistically attainable, and develops the road map to get there.

The *Statesperson* carries the movement's flag, is the "bigger than life" public figure who embodies authority and respect, lends credibility, and is widely known and respected beyond the movement.

The *Expert* provides a solid foundation of science and makes it known through peer-reviewed writings and authoritative public statements.

The *Inside Advocate* knows the most effective intervention points: how to open doors, to confront decision makers, to feel out the arguments that resonate with them, to press them in ways that cannot be dismissed, and to negotiate the tribute that must be paid.

The *Strategic Communicator* is the public teacher, the master of the sound bite, and translates complex scientific data, public policy, or basic concepts of truth and justice, into powerful metaphorical messages.

The *Movement Builder* successfully resolves conflict, bridges ego and turf, opens up lines of communication, and squashes rumor and innuendo. Movement builders are facilitators; they bring people, especially the "insiders" and "outsiders," together, to explore differences through civil discourse and debate.

The *Outside Sparkplug* is an agitator, an unabashed teller of truth, a leader outside the conventional, political establishments, free of the ties that bind "inside" players, and capable of holding governments and organizations to their own rhetoric of mission and commitment.

Source: Pertschuk, M. 1999. *A leadership taxonomy.* Washington, DC: Advocacy Institute.

*See Insight #5, page 196.

Reversing the social acceptance of tobacco use requires educating the public and policymakers about tobacco's serious health and economic threats not only to the individuals who use tobacco, but also to their families, friends, and communities. That educational process must be ongoing because new generations must also understand the health and economic issues associated with tobacco use.

Educating the public and policymakers about why policies should be enacted to protect the public health was a major undertaking of the ASSIST coalitions. Policymakers, especially at the local level, care about the opinions of their constituents. In numerous communities, ASSIST coalitions presented to their city councils the scientific evidence of the health consequences of smoking. The council members listened, and some passed ordinances restricting environmental tobacco smoke.

One must make some educational efforts in person to be effective with policymakers, but the media can also attract policymakers' attention. Many policymakers regularly rely on the editorial pages to take the pulse of the community. Editorials can make an appealing case

by presenting a solution and by making a practical policy appeal. Other types of media coverage can also attract attention. For example, in 1995, a social studies teacher introduced her fifth-grade class to a fact that she learned from ASSIST. As a class project, the class took out a classified ad in *USA Today* asking, "Each year, what kills more people than AIDS, alcohol abuse, car accidents, murders, suicides, illegal drugs, and fires combined?" The answer—cigarette smoking—drew nationwide media coverage about the hazards of tobacco use and earned attention for the class that conducted this media experiment.

Case study 6.1 shows how knowledgeable teenagers made a direct appeal to policymakers for their own health and won over the county council.

Insight 2: The Process of Laying the Groundwork for Policy Change Can Be as Important as the Policy Itself

Critical to success in passing tobacco control policies, especially at the local level, is laying the groundwork for change through a well-planned process of community education and mobilization. The elements of the process are raising the community's awareness about the issues involved, educating residents about the benefits of the policy, changing community norms, and paving the way for smooth implementation and enforcement of the policy. When community support for a policy is ensured, a campaign for policy change can be launched, and it can be strengthened with media advocacy for the policy. Media coverage of an issue is important when advocating for policies that depend on changes in a population's attitudes and, eventually, in the social norm. Media coverage can build community support for a policy initiative; it can influence the way that individuals think about an issue, which eventually influences social norms.

Laying this groundwork is time consuming and requires patience; however, without the groundwork, the proposed policy is not likely to move forward or be well received even if it is passed. In fact, the groundwork may be even more important than the policy outcome. The very process of debating a proposed policy influences social norms by drawing attention to the issue. Thus, even if the proposed policy is defeated, the effort put into advocating for it will not have been wasted, since community attitudes and norms will have been influenced. In a way, the adoption of the policy is the ratification of an already-occurring change in attitude and possibly norms. Without community support, if a policy is somehow enacted, it may be ignored or resisted as well as difficult to enforce.

A mistake that well-meaning individuals might make is to push prematurely for policy change. For example, a legislative sponsor or individual advocate might independently introduce a policy, anticipating little or no opposition. If opposition arises from the tobacco industry and its allies, the sponsor and other policymakers might quickly back off. Without the visible support of the community and the media, the policymakers are not likely to withstand the opposition. The net result is that not only is the policy initiative defeated, but it also becomes

Case Study 6.1
Kids Make Crucial Appeal to Policymakers in St. Louis County

Situation: In 1995, 75% of the tobacco retailers in St. Louis County, Missouri, were selling tobacco products to children younger than 17 and were not asking for proof of age. The St. Louis ASSIST Coalition wanted to curb teen smoking by taking a stand on youth access to tobacco.

Strategy: The coalition sought to persuade the county council to pass a countywide ordinance covering all 92 municipalities. The only way to avoid a public vote in each municipality was to give the St. Louis County Department of Health and its health inspectors the authority to collect the license fees and enforce the ordinance throughout St. Louis County.

Intervention: The first step toward passing this ordinance involved raising the awareness of the legislators and educating them about how tobacco affects the health of children. In September 1995, six coalition members explained the magnitude of the tobacco problem in St. Louis County to four members of the St. Louis County Council. They reported that the legislators appeared startled by their presentation.

The coalition members proposed a youth access ordinance that would require licensing every retail tobacco vendor in St. Louis County. That week, a council member agreed to be the principal sponsor and began writing an ordinance. The coalition furnished him with sample ordinances from other cities. From that council member, the coalition learned which council members would likely oppose the ordinance. The coalition's allies—the American Cancer Society, American Heart Association, American Lung Association, National Council on Alcoholism and Drug Dependence, and the St. Louis Clergy Coalition—then conducted a letter-writing and telephone campaign in the ZIP-code areas of the resistant council members to urge them to support the youth access ordinance.

Two public hearings were held in January 1996. Anticipating strong opposition to the ordinance from retailers and their tobacco industry associates, the coalition leaders invited people who were knowledgeable about tobacco issues and could maintain a focus on children's health to testify. Most important, the American Cancer Society van picked up students at the various high schools for their "day in court."

Testimonies, discussions, and arguments continued for 2 hours before the first youth advocate took the podium. He was a 13-year-old who had participated in compliance checks and eloquently explained how easy it was for underage youth to purchase cigarettes from gas stations, convenience stores, bowling alleys, and, especially, vending machines. A healthy-looking 17-year-old smoker who wanted to quit smoking was called next. His story of addiction began at age 14 when a friend gave him a cigarette. At that time, he wanted only to look cool, but now he was hooked on cigarettes. A 16-year-old girl explained how the tobacco industry confused younger

children through its advertising on the numerous billboards in residential areas, in grocery stores, and in gas stations. She said that it seemed to her that children were receiving the message "smoking can't be that bad if it is sold legally in stores everywhere."

Only these students spoke, but they were supported by the presence of dozens of other students in the room. When they spoke, the room was silent. Two months of revisions and amendments to the ordinance followed. In the meantime, the nonprofit organizations wrote letters and made phone calls to the most resistant council member.

Results: On April 4, 1996, the St. Louis County Council approved the toughest youth access ordinance in Missouri. The resistant council member made a 180-degree turn and became the cosponsor of the ordinance. That afternoon, the St. Louis county executive signed the ordinance into law, which became effective on July 1, 1996. After the St. Louis County youth access ordinance was passed, many municipalities and school districts strengthened their existing tobacco policies. Tobacco and children's health had finally become a serious issue worthy of discussion at city council meetings throughout the area. Again and again, it was the children who made the policymakers understand what was the right thing to do.

Source: Adapted from P. Lindsey. 1997. Kids are crucial for local ordinances. In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 79–82. Rockville, MD: ASSIST Coordinating Center.

much more difficult to revisit it in the future. Policymakers may be reluctant to get involved again on the same issue later on.

Laying the groundwork by increasing awareness is illustrated in case study 6.2. The purchase of counteradvertising opened the doors of the sports stadiums to a community and closed them to smoking.

Insight 3: Policy Change Is Political; Therefore, Boundaries Must Be Defined and Redefined

> You don't need a weatherman to know which way the wind blows.
>
> —*Bob Dylan*

Policy is made within complex social and political contexts. Policy advocacates must be aware of the agendas and missions of all relevant individuals and organizations. In a state tobacco prevention initiative, it is very important to establish a clear division of tasks among partner organizations and to obtain consensus among the partners on this arrangement. As part of this process, individuals and organizations should be assigned roles that are within their competence and legal capacity, including any real or perceived restrictions that are attached to their sources of funding. One should also take care to avoid inadvertently doing anything to restrict these individuals and organizations' freedom of

Case Study 6.2
Tobacco and Sports Don't Mix in Virginia!

Situation: In its initial tobacco control plan, Virginia's ASSIST staff and coalitions set an objective to change smoking policies in stadiums. The campaigns were to be designed by the state coalition's media committee with a focus on preventing tobacco use by youths. Focusing the message on youths rather than on the total population was an acceptable approach in a tobacco-growing and -manufacturing state.

Strategy: The approach was to identify partners within existing sports programs and organizations through which the coalition could channel tobacco control messages.

Interventions and Results: In 1995, the coalition approached seven minor league baseball stadiums in Virginia to discuss advertising within the stadiums as a mechanism to counter tobacco use messages. None of the stadiums was willing to donate ad space, but all seven accepted paid counteradvertising; two required that the ads focus strictly on prevention of tobacco use by youths. At several stadiums, counteradvertising in event programs and billboards was expanded to include sponsoring a youth tobacco prevention day at the ballpark. The community response was overwhelmingly positive.

In 1996, coalitions leveraged their status as advertisers to work on policy change. They offered to help the management develop no-smoking policies and presented a comprehensive package for implementation. The package included cards and buttons for ushers; messages for scoreboards, message centers, and announcements; signs for seating areas; and a message to be printed on tickets and/or ticket envelopes to promote the new policy.

The managers were receptive to policy change, and by 1997, three stadiums adopted 100% smoke-free seating polices, and the other four adopted smoke-free family sections.

The early successes with minor league stadiums led coalitions to focus on developing similar projects in high school stadiums. They worked with students to develop advertisements that were placed in sports programs for football and basketball games and wrestling matches. Students who had been through advocacy training encouraged their schools to expand smoke-free policies to include athletic stadiums. Several groups had success and held celebrations to inform the community of the change. One such activity, Sack the Pack, occurred as a partnership with a local television sports department.

Over the next several years, coalitions throughout the state expanded their sports initiatives. In one region, a coalition recruited the general manager of a minor league baseball team to become active in the coalition's efforts. His involvement led to a decision to remove a lifesize advertisement of the Marlboro Man from the team's

stadium when the contract expired. In another region, the department of parks and recreation was instrumental in persuading regional and national youth baseball events to be tobacco free.

The state coalition created a partnership with the Hampton Roads Mariners, a semiprofessional soccer franchise. Coalition members worked with the management to ensure that the team's new stadium opened smoke free. The team was pleased with the support that they had received and asked for assistance to promote a tobacco-free message through its Kids' Club packets and autograph day.

Source: Adapted from M. White. 1999. Tobacco and sports don't mix! In *Tobacco free future: Shining the light* (Case studies of the fifth annual national conference on tobacco and health, August 23–25, 1999), 29–32. Rockville, MD: ASSIST Coordinating Center.

action. Partners should not accept funds that restrict their ability to use a wide range of advocacy tools.

Advocates working for policy change are almost invariably called upon to make adjustments or compromises to get their policies adopted. Advocates must determine which concessions are and are not acceptable. Tension may arise on this point between the perspectives of leaders at the state or community level and those of experienced national tobacco control advocates. For example, a community that lacks any smoking regulations might perceive a proposed clean indoor air ordinance that contains numerous exemptions as taking a significant step forward, whereas national advocates might view the measure as setting a bad precedent for other communities.

There is no easy resolution to this issue. However, general principles that should be followed include advocating for the maximum degree of policy change possible, never accepting a measure that actually weakens existing policy, never accepting preemptive legislation, and balancing the lessons learned in other communities against the unique circumstances of the community in question and the perception by community members of what is possible. Veteran advocates should help the local coalition or advocacy group understand the potential implications and pitfalls under consideration so that they can make an informed decision. This is especially true because provisions in fine print that look innocuous on paper can severely undermine a policy in practice. For this reason, legal expertise early in the planning stage is very important. It is important that people at the local level consider input but make the final decision. When sharing policy case studies and model policies, one should take care to highlight the local context and potential risks, pitfalls, and loopholes. Perhaps most important, the coalition or an advocacy organization should discuss and reach consensus from the start about which concessions it is and is not willing to accept—in other words, its nonnegotiable bottom line.

Insight 4: United, We Succeed

> When spider webs unite, they can tie up a lion.
>
> —*Ethiopian proverb*

The combined assets of a public-private partnership and the ability to activate a range of state and local coalitions were strengths of the ASSIST model. The public sector partners (state health departments) have the legitimacy and expertise associated with government programs. Their public policy responsibilities include the presentation of information and statistics about the health problem being addressed, educating the public about evidence-based interventions and how public policies affect the public's health, policy analysis and scientific review of various policy options, and policy development (in some states and in some policy arenas, the authority of policy enforcement). In addition, state agencies have organizational or contractual relationships with local educational agencies.

ASSIST's formal partner from the private, voluntary health sector—the ACS—has a compatible mission to recognize and promote cancer prevention and control. In 1991, ACS had a local volunteer network of approximately 1 volunteer per 1,000 population.[68,69] ACS and all public charities—501(c)(3) organizations—are allowed by the Internal Revenue Code to expend significant portions of their operating budgets on lobbying.[7]

Mobilization of these grassroots networks toward a priority policy goal can be a powerful tool. However, this was not always easy to achieve. In some states, other voluntaries were more committed and better prepared than ACS. Moreover, dissension among the voluntaries and between the voluntaries and the state health departments sometimes inhibited collaboration. Nongovernmental partners became quite frustrated from their dealings with the bureaucratic constraints and restrictions on the use of federal funds.

State and local tobacco control coalitions played a crucial role in the policy successes of the ASSIST states. In fact, community coalitions probably made the single most important contribution to policy change in these states. In addition to successfully spearheading local policy initiatives, they were also instrumental in mobilizing grassroots support for beneficial state legislation (e.g., increases in state cigarette excise taxes, retailer licensing, and allocation of Tobacco Master Settlement Agreement funds to tobacco control) and in opposing harmful state legislation (e.g., bills preempting local authority to enact clean indoor air, youth access, and advertising ordinances). Working in tandem, though not always without tension, these diverse partners drew on their complementary strengths to win a series of significant policy victories at the local and state levels and, in the process, to dramatically influence social norms.

Case study 6.3 shows how bonds of trust among organizations and community members serve all involved when the right issue or moment arrives. Involving the African American clergy of St. Louis in an effort to eliminate tobacco billboard advertising from all neighborhoods especially benefited African Americans,

Case Study 6.3
ASSIST Unites with Faith Leaders to Ban Tobacco Advertising in St. Louis

Situation: A strong bond of trust had been established between ASSIST staff in Missouri and the St. Louis Clergy Coalition, a network of African American ministers and priests who represent 47,000 congregation members from 13 religious denominations in 109 churches in St. Louis. They had worked together successfully on tobacco control initiatives. With that trust in mind, the St. Louis ASSIST coalition invited the clergy coalition to collaborate on a project to eliminate tobacco advertising from all residential areas in St. Louis.

Strategy: The strategy was for the clergy coalition to add its influence to a proposed ordinance to ban tobacco billboard advertising and to draw media attention to the initiative.

Intervention: A press conference kicked off the campaign to ban tobacco billboards. World No Tobacco Day was on a Sunday, so the press conference was held in an inner-city African American church at 3 p.m., after church services and before the 5 p.m. television news deadline. Representatives from the St. Louis Clergy Coalition, the Mound City Medical Forum, the American Cancer Society, the St. Louis Catholic Archdiocese, and ASSIST staff, as well as a teenage boy, spoke at the press conference. The St. Louis ASSIST media consultant assisted in preparing speeches for them, which covered different facts and emphasized how often children are exposed to tobacco advertising in neighborhoods. As in other cities, tobacco billboards were far more common in poor African American neighborhoods than in white neighborhoods.

The media arrived in full force, and the story of the ministers' commitment to getting an ordinance passed became the lead news story on three major television stations at 5 p.m. and 10 p.m. The visuals on the television newscasts were the billboards located on almost every corner on the streets surrounding the church. The next day, the faith leaders' commitment to ban tobacco billboards in St. Louis City made the front page of the *St. Louis Post-Dispatch*, and the day after that, it was the subject of a *Post-Dispatch* column. The story was also covered several times on radio stations KMOX-AM and KTRS-AM.

Without delay, the faith leaders contacted an African American member of the Board of Aldermen and asked her to sponsor the ordinance to ban tobacco billboards. She willingly agreed, and a meeting was set to discuss the language of the ordinance and to plan the strategy for getting the ordinance passed. The proposed ordinance stated that tobacco advertising could remain on interstate highways but would be eliminated from all residential areas. The sponsor said that she would introduce the bill in committee the following week and get the bill passed before the legislative session ended in 5 weeks.

Case Study 6.3 (continued)

On the day that the ordinance was read in the Legislation Committee, members of the local coalition showed up at city hall in large numbers to show community support and to testify. Radio and television reporters covered the hearing. The committee approved the bill 7–0. Following the vote, several other committee members quickly approached the sponsor of the bill and asked to sign on as cosponsors.

Results and Insights: On Friday, July 17, 1998, the bill was debated before the full membership of the Board of Aldermen. On the final day of the legislative session, the 24 aldermen who were present gave their final vote on the tobacco-advertising ordinance. It passed 24–0.

The faith leaders' involvement strengthened the St. Louis coalition. The faith leaders knew that they had powerful influence in their communities, and they were pleased to learn another way they could wield that power. The mutual effort for tobacco control demonstrates what coalition really means—a union for a common purpose.

Much of the success of this project was the result of some excellent advice from a credible political consultant and a skilled attorney, the ability of the ASSIST coalition members to do much of the background for the faith leaders, and good timing.

Source: Adapted from P. Lindsey. 1998. Faith leaders ban tobacco advertising. In *No more lies: Truth and the consequences for tobacco* (Case studies of the fourth annual national conference on tobacco and health, October 26–28, 1998), 77–81. Rockville, MD: ASSIST Coordinating Center.

whose neighborhoods had a disproportionate share of undesired tobacco billboard advertising.

Insight 5: Develop the Necessary Skills among Various Leaders to Advance a Winning Combination of Activism, Advocacy, and Diplomacy

Leadership is not one-dimensional or static in the ASSIST model. The most effective coalitions used a synergistic and well-timed combination of activism, advocacy, and diplomacy. The Advocacy Institute's *A Leadership Taxonomy* (see sidebar, page 188) reflects the types of leaders required by a movement to achieve its goals, and these were present among the tobacco control practitioners working with ASSIST. The organizational affiliations of the individuals who fill these roles may vary, as long as the organizations' restrictions do not prevent these individuals from performing the functions necessary to their roles. The important consideration is whether the right person is in the right role at the right time. An individual's role should match his or her actual skills (not self-perceived skills) and comfort level. Finally, the individuals involved must commit adequate time to fulfill the responsibilities of their roles. Case study 6.4 illustrates how the commitment by the right people in the right roles made it possible to lead the Las Cruces, New Mexico, community

Case Study 6.4
Filling the Roles in Las Cruces, New Mexico

Situation: In 1995, when the first comprehensive clean indoor air ordinance in New Mexico—the Las Cruces Clean Indoor Air Ordinance—was under consideration, the Las Cruces tobacco control coalition was cochaired by two individuals. One, a health educator and member of the regional health department's health promotion team, was a native of Las Cruces who knew the community very well and was respected by community residents. The other, a retired pharmacologist and toxicologist whose research had focused on tobacco and who had recently moved to Las Cruces, brought a different kind of credibility to the table: the credibility that derived from his technical expertise. He conveyed this expertise powerfully in his testimony before the city council at key junctures in the debate about the ordinance.

Strategy: These two individuals complemented each other well. The retired academician was essentially irrefutable in his presentation of the scientific evidence about the health risks posed by environmental tobacco smoke and was not afraid to be confrontational when necessary. The health educator, in contrast, was adept at community outreach and drew on his community organizing skills, knowledge of the community, and acceptance within the community to identify and recruit potential allies.

Intervention: Both these individuals were fully committed to the cause and were able to work full-time on the ordinance campaign for long stretches. The health educator, though not in a categorical tobacco control position, recognized the importance of this opportunity to protect the public's health, while the academician, having retired, had time available to devote to the effort.

Results: The contributions of several other key figures further complemented those of the retired academician and the health educator. The director of a local public-housing-authority youth program recruited, trained, and mobilized a cadre of youth tobacco control advocates who had a major impact on the city council. Several other core coalition leaders, working as a team, set the overall strategy for the efforts to pass, defend, and strengthen the ordinance. The regional ASSIST field director and the New Mexico ASSIST program staff as a whole also played a number of important roles by providing the coalition with staff support and technical assistance that linked the coalition to external resources; coordinating its media advocacy efforts; providing education and testimony about the health risks posed by exposure to secondhand smoke; and overseeing the development, maintenance, and evolution of the coalition (including recruiting new members and facilitating leadership transitions). Without capable, appropriate persons to fill these essential, complementary roles, the ordinance could not have been adopted and sustained.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

in successful efforts to pass a clean air ordinance.

Insight 6: Shining Light on the Tobacco Industry's Tactics Can Help Advocates Achieve Policy Goals

> Sunlight is the best disinfectant.
> —*U.S. Supreme Court Justice Louis Brandeis*

Introducing or changing policies, whether government regulations or private sector guidelines, is a political process, and stakeholders with opposing views are likely to challenge those policies. As detailed in chapter 8, internal tobacco industry documents that came to light during lawsuits in the 1990s reveal a number of political tactics used by the industry, including strong lobbying of key policymakers, campaign contributions, and support of allies to make its case. Shining light on these tactics can help to effectively counter or prevent the industry's opposition.

In countering the tobacco industry's advertising and promotions, the ASSIST states had to navigate the legal issues imposed by the first amendment and by the preemption provision of the Federal Cigarette Labeling and Advertising Act enacted by Congress in 1965 (as amended in 1970): "No requirement or prohibition based on smoking and health shall be imposed under State law with respect to the advertising or promotion of any cigarettes the packages of which are labeled in conformity with the provisions of this chapter. . . ."[70] Although preemption laws prevented a number of ASSIST states from changing public policies on advertising tobacco products, they could, and did, develop strategies to influence private policies in an effort to reduce tobacco advertising in their communities. Many volunteers rallied to oppose advertising that targeted youths and other vulnerable populations, as illustrated in case study 6.5.

Insight 7: Effective Social Movements Engage Many Segments of the Community

> If there is a problem within a community, one must go within that community and solve the problem from the inside out.
> —*Adage*

Social norms reflect the values of a community. Thus, to promote and strengthen the social norm of a tobacco-free society, the ASSIST model relied on community coalitions. The ASSIST coalitions set the priorities for policy interventions in the communities and the strategies for conducting policy advocacy. First, however, the coalitions ensured that their memberships and outreach were comprehensive in involving as many segments of the population as possible. The coalition membership represented health organizations, social service agencies, community groups, and private citizens of diverse ages and socioeconomic and ethnic characteristics. In advocating for policy, there is strength not only in numbers but also in the degree to which the entire community is represented. Case study 6.6 illustrates how 70 organizations worked together to achieve mutual goals.

Case Study 6.5
Shining the Light on Tobacco Advertising and Promotions

- **Reducing Point-of-Purchase Advertising.** Exposure to point-of-purchase advertising influences youths to purchase and experiment with cigarettes. In 1999, a 4-month study of 3,031 retail outlets in 163 communities nationwide found that some form of tobacco point-of-purchase marketing (interior or exterior advertising, self-service pack placement, multipack discounts, tobacco-branded functional objects, or vending machines) was observable in 92% of the stores.[a(p185)]
  - Operation Storefront, developed by the California Tobacco Control Program, was adopted by many ASSIST states as an intervention to reduce the amount of storefront and in-store tobacco advertising in convenience stores, especially in neighborhoods with schools and other vulnerable populations. (See insight 9 for examples.)
- **Exposing Advertising Targeted to Specific Populations.** Advocates in several ASSIST states exposed the tobacco marketing technique of targeting youths by concentrating advertising in convenience stores and on billboards near middle schools and high schools and in African American, Hispanic/Latino, and American Indian communities.[b]
- **Exposing Advertising and Giveaways in Family Settings.** ASSIST volunteers brought attention to the advertising and marketing techniques used in family venues, such as tobacco product giveaways at NASCAR races and at sports and entertainment events. Some states countered the advertising by introducing an alternative, such as entering a tobacco-free car in a NASCAR race, at the event.
  - Tobacco industry giveaways such as Marlboro Miles and Camel Cash were countered by paid and earned media events. For example, a popular event encouraged teens to bring in cigarettes, lighters, or any item with a cigarette logo on it and drop them off in exchange for an item with a health message.
  - A local coordinator in Minnesota organized a tobacco merchandise "buyback" during a lunch hour at a local high school. Teens turned in tobacco merchandise in exchange for antitobacco items.
  - Twenty-six New Jersey middle school students attended a workshop on tobacco advertising. Their antitobacco advertising designs were reproduced on T-shirts and tote bags for fundraising purposes.
  - Youths from a Wisconsin antitobacco group monitored outdoor tobacco advertising throughout one county. In another county, 1,000 youths from 16 schools throughout the county collected and exchanged tobacco industry paraphernalia for prizes.
  - Piggybacking on the national Kick Butts Day, a Virginia high school held a gear exchange in which more than 50 students exchanged tobacco promotion

Case Study 6.5 (continued)

items for health promotion materials. More than 200 students who professed to have never used tobacco signed a pledge to remain tobacco free for life. This event gained local television news coverage.

- Two Indiana middle schools conducted a T-shirt trade-in, where tobacco T-shirts were exchanged for T-shirts with a tobacco-free message.[b]

- **Placing Tobacco Counteradvertising.** New Mexico placed tobacco counterads in programs for boys' and girls' basketball and soccer championships. For the latter event, antitobacco announcements were read over the loudspeaker during 12 games.
  - Indiana produced press releases and counterads for an annual riverfront event that traditionally has some tobacco industry sponsorship, reaching potentially 100,000 participants.
  - New Mexico helped sponsor a "Play It Tobacco Free" state championship tournament. The tournament featured a number of antitobacco advertising and promotion techniques, including statements by high school and university athletes about the importance of remaining tobacco free and a banner displaying photos of people who had died from smoking-related diseases. The event involved 60 students and was covered by the local public television station.[b]
- **Protesting Tobacco Advertising.** A Ticketmaster/Joe Camel ad protest was held by local coalitions in Washington State against the advertising tactics that provided discount tickets with Camel proof of purchase.[b]

[a]Data on reducing point-of-purchase from Terry-McElrath, Y., M. Wakefield, G. Giovino, A. Hyland, D. Barker, F. Chaloupka, S. Slater, P. Clark, M. Schooley, L. Pederson, et al. 2002. Point-of-purchase tobacco environments and variation by store type—United States, 1999. *Morbidity and Mortality Weekly Report* 51 (9): 184–7.

[b]ASSIST state quarterly reports, 1996–99.

Insight 8: Youth Are Effective Change Agents

Youths are the leaders of today!
—Donna Grande, Director, Office of Program Development, American Medical Association

Involving teens in policy interventions in a meaningful way develops their skills in the areas of leadership, public speaking, policy advocacy, and media advocacy; enhances their self-confidence; and puts them on the public record as opposing tobacco use. The more meaningful the role teens are given in planning a policy initiative, the more likely it is that they will assume ownership of the intervention, that they will be highly motivated to implement the intervention, and that they will do an exceptional job. Furthermore, teens are effective advocates. For example, in the

Case Study 6.6
Massachusetts Increases Tobacco Tax to Fund Healthcare for Children

Situation: Chapter 47 of the Acts of 1997, An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth (Health Care Access Act) was under consideration in Massachusetts in 1996. One part of the bill proposed to expand children's eligibility for Medicaid and a special Massachusetts program that offers health insurance for non-Medicaid eligible children. Passing the bill depended partly on a plan to fund the program. Knowing that any significant increase in the price of tobacco is an effective tobacco control measure, the tobacco control advocacy network saw an opportunity to combine forces with children's health advocates toward complementary goals.

Strategy: Tobacco prevention advocates joined forces with supporters of the Health Care Access Act to communicate a simple message to the public about raising the cigarette tax: Fund children's healthcare by taxing tobacco. Linking children's healthcare and cigarette taxes was the way to reach congruent public health goals.

Intervention: Seventy organizations joined the coalition to fight for passage of the Health Care Access Act, to be funded in part by a 25¢ increase in cigarette taxes. Organized by Health Care for All, the coalition included the following five categories of members:

1. The medical community, including physicians and hospitals
2. Tobacco control advocate groups
3. Public health organizations lobbying for children and healthcare reform
4. Associations representing seniors
5. Insurance companies and business leaders

The broad membership of the coalition allowed for both a traditional statewide grassroots campaign and insider, relationship-based lobbying. This combination created a political will that was impossible to stop despite public opposition by the governor and the tobacco industry's 6-month lobbying expenditures of about half a million dollars.[a]

Grassroots lobbying efforts included rallies in communities across the state and lobby days at the state house. The American Cancer Society mobilized 1,000 members of its tobacco control advocacy network to phone, write, and meet with legislators. Coalition organizations called their members and asked them to call their elected officials and express their support.

A poll of registered voters in Massachusetts found that 78% favored and 20% opposed a bill "that would raise the cigarette tax by 25 cents . . . to buy health insurance for children who don't have it and help buy prescription drugs for senior

Case Study 6.6 (continued)

citizens who can't afford them."[b] The coalition took advantage of the popular support by integrating an aggressive statewide media campaign into its efforts, including hard-hitting radio ads addressing Governor William Weld about his opposition, newspaper ads in small local newspapers of swing legislators, and an op-ed column by former Senator Paul Tsongas. Equally critical to passing the bill was support from the chairs of the House and Senate Health Care Committees, Representative John McDonough and Senator Mark Montigny, as sponsors of the bill.

Opposition to the bill came from retailers who claimed that Massachusetts smokers would flock to neighboring states to purchase cigarettes and from the governor, who was running for the U.S. Senate and tried to use this bill to underscore his reputation as a no-tax governor. Governor Weld had opposed all new taxes since he took office in 1991.[c] His opponent in the race, Senator John Kerry, held press events and ran political ads blasting the governor for his position.

Results[d] and Insights: Before the 4th of July holiday, the tobacco bill passed the Senate by a vote of 30 to 2. The governor vetoed the bill shortly afterward. On July 24th, both the House and Senate overrode the governor's veto with more than the two-thirds vote necessary, and the bill became law. Massachusetts disproved the notion that state legislatures will never pass a tax increase opposed by the tobacco lobby. Coalitions that form around expanded access to healthcare are potentially much stronger than the public health coalitions that have fought for tobacco use prevention and control.

Sources: Adapted from K. Adami and L. Fresina. 1997. Funding health care for children through an increase in the tobacco tax—The Massachusetts experience. In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 1–4. Rockville, MD: ASSIST Coordinating Center.

[a]Massachusetts Lobbyist and Employer Statistics database, Division of Public Records, Massachusetts Ethics Commission. http://db.state.ma.us/sec/pre/stat_search.asp.

[b]Knox, R. A. 1996. Health plan for youths, elders eyed cigarette-tax hike included in state bill; Backing uncertain. *Boston Globe*, March 27, 1996, city ed.

[c]Vaillancourt, M., and D. S. Wong. 1996. Weld may try to stall health bill to stop tobacco levy, he risks triggering business payroll tax. *Boston Globe,* July 9, 1996, city ed.

[d]In 2001, Massachusetts increased the tax another 75¢, for a current total tax of $1.51.

case of the St. Louis County youth access ordinance that went into effect on July 1, 1996, several young people who testified at the public hearings made more of an impact on the county council members than dozens of physicians and adult tobacco control experts. Teens who had participated in compliance checks were able to convince the St. Louis County Council that youth access to tobacco and the subsequent increase in teen tobacco use are community health

problems that must be addressed through local legislation. (See insight 1.)

Case study 6.7 about Grand Rapids, Michigan, and case study 6.8 about Silver City, New Mexico, illustrate that, with training and adult supervision, teens can be entrusted with significant responsibility and can have a significant influence on policymakers.

Insight 9: Framing the Issue and Using the Science Help to Put You in Control

> If you don't like the news, go out and make some of your own.
>
> —*Scoop Nisker*

Success or failure in advocating for a policy may well depend on which side does a better job of framing the issue in the media and in public debate. A policy is more likely to be adopted if public health advocates succeed in framing the issue as a public health problem. On the other hand, a policy may well be defeated if opponents succeed in framing the issue in terms of the rights of businesses or smokers, or of economic impact. In other words, present the issue in a way that will appeal to the public at large, and keep that message in the forefront of the debate.

An important skill for media advocates to develop is the ability to translate research findings and national policy debates into terms that are relevant to local residents. This translation can be done by using simple, common-sense-language; citing concrete local examples and anecdotes; and highlighting the key implications for local policy—the bottom line. The new information can be used to reinforce the central message—the key issue at stake in the ongoing policy debate is public health. This skill is especially valuable in media advocacy. Advocates must clearly know how they wish to frame that information before they participate in an interview or some other opportunity to speak about the issue. They must be well prepared so that when challenged they will not lose the framing. (See chapter 5.)

The ability to frame the issue by using the science is powerful in refuting an opponent's claims. For example, public health advocates might rebut opposition claims that a proposed clean indoor air ordinance violates smokers' rights by making the following points.

- The right to breathe clean air takes precedence over the right to smoke.
- Smokers are not barred from patronizing smoke-free restaurants; they just may not smoke there. On the other hand, persons with respiratory conditions cannot patronize restaurants that allow smoking without placing their health in immediate jeopardy.

Similarly, public health advocates may refute opponents' claims that the passage of such an ordinance will result in restaurants losing business. For example, they could respond to such a claim regarding lost business by asserting, "Every independent, scientific study that has been done on this issue using sales tax data has shown that clean indoor air ordinances do not negatively affect restaurant sales." In both cases, the public health advocates should immediately link back to their main point, their frame: "However, the issue here isn't

Case Study 6.7
Youth Advocates Make Michigan Arena Tobacco Free

Situation: The project director of the Smoke-Free Class of 2000: Education, Action, and Celebration of Grand Rapids, Michigan, was gathering ideas for writing advocacy letters as an exercise in the smoke-free curriculum of Grand Rapids middle schools. She investigated whether the nearly completed Van Andel Arena had a smoking policy. This 12,000-seat sports and entertainment facility is the nucleus of the downtown revitalization. A conversation with the deputy city manager, also chair of the Downtown Development Authority (DDA), revealed that the DDA had not even considered smoking an issue. This information became part of a lesson on advocacy.

Strategy: Eighth graders from six Grand Rapids middle schools involved in the Smoke-Free Class of 2000 used their new skills to advocate for a tobacco-free policy for their community's new sports arena. Through a grant, ASSIST supported an integrated curriculum built on the materials of the Smoke-Free Class of 2000.

Policy Intervention: Seventy students wrote letters requesting a tobacco-free policy for the arena to the mayor, to the chair of the DDA, and to the local newspaper (as letters to the editor). Subsequently, a teacher and a dozen students met with the chair of the DDA. Students read their letters regarding a tobacco-free policy for the arena and answered the chair's question: "Why a tobacco-free arena and not a smoke-free arena?" Students explained that the issue covered tobacco sales, advertising, and even smokeless tobacco. The chair explained the DDA's decision-making process: after the necessary committee meetings, a policy is recommended to the full committee for final determination.

Near the end of the school year, a group representing the Smoke-Free Class of 2000 was in the crowd that attended a DDA meeting. During the public comment period, a student addressed the mayor and the DDA, urging them to approve the tobacco-free policy. A classmate distributed Smoke-Free Class of 2000 bumper stickers and gave a logo T-shirt to the deputy city manager in appreciation of his help in their efforts.

Results and Follow-Up: The DDA vote unanimously supported a tobacco-free policy. The advocacy effort was successful.

They celebrated their success. A front-page news story included quotations from members of the Smoke-Free Class of 2000. To draw attention to the new policy and commend the DDA for its decision, an ad was placed in the Grand Rapids Press. These three full-page ads ran prior to the grand opening activities for the sports arena. They read:

> The SMOKE-FREE CLASS OF 2000 Salutes the City of Grand Rapids' Downtown Development Authority for choosing to put the health of West Michigan first by making the Van Andel Arena tobacco free!

May 9, 1996

Zoar Planning Commission

I am a eighth grade student at Creston-Hayfield Christian School, and a member of the Smoke Free Class of 2000.* Our class has been working hard to inform everyone of the dangers of smoking, and how addictive and habit forming it actually is. We have also been talking about how terrible smoking smells, and how it distracts those around someone who smokes. That brings me to why I have written this letter. A decision has not been made as to if the Pikaboki Arena will be smoke-free or not, and I hope my letter, as well as the others, can influence your decision to make this new arena completely smoke free. Many other arenas and stadiums around the country are being built smoke free, or are changing into smoke free facilities. Joe Louis arena is smoke free, and a good majority of Old Kent Park is smoke free as well. The new ice in Grand Rapids, Michigan National Ice Center is smoke free as well. So please consider the fans, and the lungs of other people who will be enjoying the Griffins this next season. My family has season tickets, so I will be attending many if not all home games, and I would hate to have to leave just to get away from fans who are smoking. Please make the new arena's air be as clean as the arena itself, and make it a smoke free environment. I really am looking forward to this season, and seriously hope that everything will be perfect with the arena, and it would be perfect if it is a no-smoking environment. Thank you for your time

Examples of students' letters that helped convince the Grand Rapids (MI) Downtown Development Authority to adopt a 100% tobacco-free policy for the new Van Andel Arena. Letters provided courtesy of Krista Schaafsma.

These lines preceded a list of the 400 students in the Smoke-Free Class of 2000 and the individuals, agencies, and groups who supported their advocacy efforts. Framed ads were presented to the DDA, the Van Andel Arena, the Kent County Board of Health, the American Lung Association, and the Grand Rapids Christian High School.

Members of the ninth-grade class arranged a winter social event at the Van Andel Arena during a Harlem Globetrotters basketball game. Students presented the framed ad to the arena general manager and then received a surprise of their own. The front patio of the arena was being paved with engraved bricks, and the Smoke-Free Air for Everyone Coalition purchased a brick honoring the students. Television reporters filmed the event, including an interview that appeared as a feature on the evening news.

Insights:

- **Give the students a choice regarding advocacy topics.** This helps prevent accusations of using youths to address your agenda.
- **Students love the attention.** The media publicity and attention make them feel empowered, and this empowerment also works to help bridge the gap into a very adult world while it imparts important civic lessons.

Case Study 6.7 (continued)

- **Prepare the youths.** The thought of preparing comments for formal events can discourage youth participants, so provide the students with sample statements and invite them to reword them.
- **Include incentives.** Youths appreciate refreshments or food at meetings. In addition, T-shirts, articles about the youths in school newspapers or school newsletters, and certificates for their school portfolio can all be used to encourage and recognize their work.

Source: Adapted from K. V. Schaafsma. 1997. Youth advocacy in action: Absolutely amazing! In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 23–8. Rockville, MD: ASSIST Coordinating Center.

Case Study 6.8
Teens Lead the Way in Silver City, New Mexico

Situation: A local contractor in the community of Silver City, New Mexico, recruited a team of about 20 peer educators and youth advocates from three local high schools. The students were trained in tobacco control, peer education, youth advocacy, media advocacy, and policy advocacy. Adult supervisors on the staff of the three schools coordinated the training and activities.

Strategy: The students decided to form a community tobacco control coalition. Their initial efforts to recruit adults, including representatives from local public health and youth agencies and other community leaders, met resistance. The adults felt that existing local coalitions that dealt with broader public health issues were already adequately addressing tobacco issues. However, the students persisted and ultimately succeeded in recruiting a strong core of committed adult tobacco control activists. Working together, the teens and adults formed a coalition, with teens filling several of the coalition officer positions and playing an important role in setting the coalition's priorities.

Intervention: The coalition set an objective of a strong municipal clean indoor air ordinance and laid the groundwork for this ordinance by educating the community about the health risks posed by ETS. The coalition's teen members made presentations to a variety of community organizations. They wrote a weekly teen column in a local newspaper that discussed the adverse health effects of ETS, the benefits of clean indoor air policies, and other tobacco issues. The coalition also worked with a professor of journalism at a local university and the ACS state chapter to conduct a poll, which found that an overwhelming majority of Silver City residents supported a clean indoor air ordinance. In addition, the coalition conducted a campaign to recognize local restaurants that adopted voluntary smoke-free policies. Finally, the coalition's teen members held a series of meetings with Chamber of Commerce

officials, other business and community leaders, and city councilors to explore their level of support for an ordinance. A survey conducted among Chamber of Commerce members found a majority of them to be open to the idea of an ordinance making restaurants smoke free. The teen coalition members considered restaurants a priority because many teens worked in or patronized restaurants.

Results and Insights: This careful groundwork ultimately led to an ordinance that (1) made Silver City restaurants smoke free, (2) required that bar areas in restaurants be either smoke free or separately enclosed and ventilated, and (3) banned or restricted smoking in a number of other public places. The coalition's teen chairperson played a leading role in presenting city officials with a model ordinance, negotiating the proposed ordinance's provisions with the city council, and addressing councilors' concerns. The council viewed her as an expert on clean indoor air policy issues and repeatedly deferred to her recommendations. Under her leadership, the coalition was successful in mobilizing more than 30 Silver City residents to testify in favor of the ordinance, including the mayor's own teenage daughter. The mayor, who was a smoker, publicly stated that he did not believe that smoking was a right when it affected other people. The city council adopted the ordinance by a unanimous vote.

The Silver City story illustrates that, when properly trained and supervised by adults, teens can have significant influence on policymakers because the latter are unaccustomed to hearing from teens and are often open to their ideas. Many policymakers are becoming aware that teens offer good advice on addressing teen problems, such as teen smoking and teen exposure to ETS. A major argument used effectively by the teen coalition members was that, in addition to protecting restaurant employees and patrons from the health risks posed by ETS, the ordinance would also set a good example for youths by removing the environmental cue of seeing adults smoking in restaurants.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

rights or economics. It's the serious, documented health risks posed by secondhand smoke, and the right of the public and employees to be protected from these risks."[25,71]

Case study 6.9 on the cigarette excise tax in New York demonstrates that scientific studies can be used to support policy decisions. The data showed that a pro-health policy would not have a harmful economic impact on most communities. Case study 6.10 from North Carolina and case study 6.11 on Operation Storefront illustrate how local coalitions gathered their own observational data on cigarette sales to minors and protobacco advertising in storefronts in their communities. Although the information was not collected

Case Study 6.9
New York Counters Tobacco Industry Claims with Data

Situation: The tobacco industry argued that increasing the cigarette excise tax would damage the economy by causing job loss, reduced productivity, and lost profits on the part of those involved in the distribution and sale of cigarettes. To address these arguments, tobacco control advocates needed scientific evidence that increasing cigarette excise taxes would not hurt the economy.

Strategy: In New York, the American Lung Association of New York State commissioned a study (with funding from a Robert Wood Johnson Foundation SmokeLess States grant) to determine whether New York would suffer economically from a $1 increase in the state's cigarette excise tax. The study showed that a $1 increase in the cigarette excise tax would result in economic benefits to New York. The results of this study, "Estimating the Economic Impact of Increased Cigarette Excise Taxes: A Tool for the State Tax Analyst," were used to support a tax increase of $1.[a] The study—coupled with existing data on medical costs, insurance costs, loss of job productivity, and work absenteeism related to tobacco use—provided data needed to convince policymakers and businesses that they have a vested interest in reducing tobacco consumption.

Insights: The tobacco industry has sponsored economic studies by well-known consulting groups, including Chase Econometrics, Price Waterhouse, and Wharton Applied Research Center; these studies calculate the economic impact of reduced cigarette consumption.[b,c,d] However, these studies are critically flawed: they are based on the assumption that the resources devoted to tobacco product production and distribution would disappear if sales were to decline. In fact, the economic activity associated with tobacco sales does not disappear as consumption falls but rather is redistributed to other sectors of the economy as consumers use money previously spent on tobacco to purchase other goods and services. This alternative spending generates economic activity and employment in the same way that spending on cigarettes does.

In 1996, Kenneth E. Warner and his colleagues published a groundbreaking report that concluded that most states and regions of the country would benefit economically from a reduction in tobacco product sales.[e] Warner and his colleagues found that at that time only the tobacco states of the Southeast would suffer economically from reduced cigarette consumption. For states outside the Southeast, Warner's findings contradicted the tobacco industry's long-standing claim that a drop in tobacco sales is detrimental to the economy.

—Russell Sciandra, Director of the Center for a Tobacco Free New York, and Tim Nichols, Director of Governmental Affairs for the American Lung Association of New York State

[a]Nauenberg E., and J. Nie. 1999. Estimating the economic impact of increased cigarette excise taxes: A tool for the state tax analyst. In *State tax notes* (V17#20), 1313–18.

[b]Chase Econometrics. 1985. *The economic impact of the tobacco industry on the United States economy in 1983.* Bala Cynwyd, PA: Chase Econometrics, v–3.

[c]Price Waterhouse. 1992. *The economic impact of the tobacco industry on the United States economy: Update of 1990 study.* New York: Price Waterhouse.

[d]Wharton Applied Research Center and Wharton Econometric Forecasting Associates Inc. 1979. *A study of the tobacco industry's economic contribution to the nation, its fifty states, and the District of Columbia.* Philadelphia: Univ. of Pennsylvania.

[e]Warner, K. E., G. A. Fulton, P. Nicolas, and D. R. Grimes. 1996. Employment implications of declining tobacco products sales for regional economies of the United States. *Journal of the American Medical Association* 275:1241–6.

Case Study 6.10
Collecting Local Numbers in North Carolina

Situation: Since media coverage is mostly local in North Carolina, a clear strategy was to build the capacity of local communities to develop messages that they could take to the news media.

Strategy and Intervention: In North Carolina, ASSIST sought to build support for an enforceable policy to reduce youth access to tobacco. A policy restricting sales of tobacco to minors had been on the books for almost 100 years but was never enforced. Members of the coalition supervised teens who bought Marlboro cigarettes in randomly selected stores in each of the state's media markets. Ten highly successful press conferences were held on the same day in 1994 to provide the relevant communities with data on tobacco purchases that the youths had made in the local stores. Half of the stores had sold to the teens. The teens told their stories at the press conferences, and the coverage was excellent.

Seeing local people present actual numbers on a local issue on the evening news, hearing the issue debated on talk radio, or reading an editorial that supports a policy to address the local issue can help the public and policymakers realize that the problem is real in their community. This intervention opened the doors to a larger public policy debate on youth access to tobacco that resulted in the adoption of an enforceable youth access law and the governor's appointment of the Alcohol Law Enforcement Division to enforce the youth access to tobacco law. Buy rates in North Carolina dropped from 51% in 1994[a] to 20.8% in 2000[b] and to 14.8% by 2004.[c] Media coverage of the easy access that youth had to tobacco in 1994 also opened

Case Study 6.10 (continued)

doors to a broader public discussion of tobacco prevention and control public policies such as clean indoor air and 100% tobacco-free schools.

—C. Ann Houston, former North Carolina ASSIST field director and current Director for Public Education and Communications, Tobacco Prevention and Control Branch, North Carolina Department of Health and Human Services, and Jim D. Martin, former North Carolina ASSIST field director and current State Advisor on Preventing Teen Tobacco Use, Tobacco Prevention and Control Branch, North Carolina Department of Health and Human Services

[a]North Carolina Department of Health and Human Services, Project ASSIST. 1994. *Project ASSIST bulletin.* Raleigh, NC: Division of Adult Health Promotion.

[b]North Carolina Department of Health and Human Services, Substance Abuse Services Section. 2000. *Annual Synar Report.* Raleigh, NC: North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

[c]North Carolina Department of Health and Human Services, Substance Abuse Services Section. 2004. *Annual Synar Report.* Raleigh, NC: North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

Case Study 6.11
Point of Purchase: Operation Storefront

Operation Storefront was a two-phase campaign. First, participants documented the nature and scope of storefront tobacco advertising. Second, they educated decision makers about the effects of advertising on youths and promoted private and public policy changes. They documented the changes that resulted. This intervention was conducted from 1996 to the end of ASSIST in Maine, Massachusetts, Michigan, Missouri, New Jersey, New York, Rhode Island, Washington State, West Virginia, and Wisconsin. Below are a few excerpts from states' experiences described in their quarterly reports.

- *Maine* developed and distributed a working manual on Operation Storefront. This manual was distributed to participants in a skills-building train-the-trainer workshop. Displays and data from Operation Storefront were released in a media event, which featured the governor declaring May as Tobacco Awareness Month. Local press conferences for local media outlets were conducted throughout the state.
- *Maine* conducted 248 tobacco advertisement assessments statewide with 102 youths and adult volunteers.
- *Massachusetts's* local providers completed phase 1 of Operation Storefront. Phase 1 entailed assessing tobacco advertising visible from the outside of 3,000

tobacco merchandisers in 125 cities and towns (whose combined population was greater than 3.5 million) throughout the state. Tobacco advertisements made up 52% of more than 2,000 advertisements visible to youths on storefronts. Phase 2 involved educating decision makers and advocating for policy change.

- One of *Michigan's* local coalitions trained 200 students via teleconference on the tobacco industry's advertising tactics and on how to advocate for the removal of tobacco advertising and replacement with countertobacco messages. This event was covered by the local media.
- *Missouri* coalitions conducted Operation Storefront activities, including training and press events. One coalition held a press conference to report the results of its assessment. As a result, the city prosecutor considered strengthening a policy regarding signage for smoking and advertising. Missouri developed a database for community groups participating in the Operation Storefront project, for which more than 60 groups signed up.
- One of *Missouri's* local coalitions held a news conference to release the results of Operation Storefront and the billboard assessment. The coalition also kicked off their countertobacco billboard campaign, which entailed posting prohealth messages on 12 billboards in the Kansas City area. This event was covered by two print and two broadcast media outlets and was also picked up by the Associated Press.
- A *New Jersey* local coalition conducted training on tobacco control issues and Operation Storefront for Eagle Scout candidates.
- Twelve *New York* students conducted Operation Storefront throughout one region of the state. They found an average of 128 tobacco ads in the stores that they visited; this average was significantly higher than for the preceding years. The biggest increase was for cigar products. The students presented their findings on a local radio station talk show.
- *New York* sponsored several activities to raise awareness of tobacco advertising. The activities included a conference on women and tobacco for 70 participants, a conference for 1,200 sixth graders, and a news conference and protest rally on *Marlboro Man's* induction to the Advertising Hall of Fame.
- *Rhode Island* local coalitions and youths conducted outdoor and point-of-purchase tobacco advertising assessments. Rhode Island students assessed tobacco billboard advertisements, took photographs, and documented six sites. Youths also approached an advertising firm to donate billboard space for their posting of antitobacco messages.
- In *Washington* State, a county health department—in collaboration with the local coalition, the Korean Women's Association, and the local Girl Scouts—conducted Operation Storefront. They surveyed 177 stores and awarded certificates of compliance to those retailers who had complied with the tobacco outdoor ad limitation, the yellow warning stickers, and the year-of-birth signs.

Case Study 6.11 (continued)

- Nineteen of 39 *Washington* counties completed Operation Storefront activities in which youths visited tobacco retail outlets in their communities to assess the amount and placement of tobacco advertising.
- Local coalition members in *West Virginia* took photos of tobacco advertising displays in storefronts for media advocacy efforts of the state coalition regarding the effects of advertising on youths.
- *Wisconsin* local coalitions worked with ACS to recruit youth for Operation Storefront activities.

Source: ASSIST state quarterly reports, 1996–99.

with a scientific study design, it did document what was happening in the communities and was useful in media advocacy efforts.

Insight 10: Policy Change Requires a Flexible Strategy and the Ability to Respond Rapidly to Opportunity

> Opportunity is missed by most people because it is dressed in overalls and looks like work.
>
> —*Thomas A. Edison*

Strategies and tactics used in ASSIST were defined as planned or opportunistic. Planned strategies were based on the body of scientific evidence supporting tobacco control, and ASSIST guidelines called for focusing on the policies that would have the greatest effect on the population. Planned strategies were described at the outset of each fiscal year and were implemented as a part of an annual action plan. As states entered the intervention phase, staff realized that the action plans had to be flexible to respond to opportunities that were not known when the plans were written, especially when those opportunities were related to a development in the political climate favorable to achieving policy changes.

Opportunistic strategies are quick responses to breaking news, media events, or other unanticipated opportunities for policy advocacy—a member of a local governing body agrees to sponsor a tobacco control ordinance, a political shift occurs in a governing body that suddenly makes possible the adoption of a proposed ordinance that previously had been stymied, or there is a local hook to a breaking national news story. In ASSIST, opportunistic strategies arose from the resourcefulness of staff and coalitions. For example, when billboards advertising tobacco products were brought down in compliance with a provision in the Tobacco Master Settlement Agreement, the coalitions promoted media events around the dismantling to bring attention to the health issues of tobacco use. The Tobacco Master Settlement Agreement of 1998 was an opportunity for states to seek funding for tobacco control programs.

Key informant interviews were used to examine the worth of responding to opportunities because action might require a redirection of resources, time, and energy. Coalitions were challenged to show that these strategies would lead them to their policy goals more rapidly and with fewer negative repercussions than the previously planned activities. For example, as described in case study 6.12, when the South Carolina state house was declared a historic site, the ASSIST coalition seized the opportunity and advocated successfully to pass a policy that prohibited smoking in the building.

Insight 11: Make Gains Where Possible—Small Changes Add Up

> If you can't do A, then do B, C, and D, but never lose track of A because it may come around again.
>
> *—John M. Garcia, former Project Director, ASSIST Coordinating Center*

Changing social norms requires taking incremental steps that over time add up to arriving at a larger, long-term policy goal. Changing tobacco control policies requires an investment of time. For example, increasing state tobacco taxes may take 6 years from the time a well-thought-out strategy is designed. Numerous smaller victories will be needed on the way to the ultimate goal of increasing tobacco taxes, for example, increasing public awareness in the geographical areas of key legislators who have leadership positions. Advocates should never underestimate the significance of these smaller victories and should never lose track of strategies that may not have been effective at a particular time—because an opportunity to apply the strategies may occur later.

A measure that ASSIST program managers often used to help decide if an activity was worth the effort was to ask "What is it going to get us?" If the answer did not reveal that the activity would lay groundwork or build support for evidence-based policy change, the activity was reconsidered. On the other hand, an activity that could help build community support for an evidence-based policy change in one of the four policy areas would be well worth the effort.

Case study 6.13 illustrates how helping North Carolina public schools solve a school-based problem was a step toward building support for an important tobacco control initiative later.

Insight 12: Keep Policy Advocacy Local and Loud

> Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has.
>
> *—Margaret Mead*

> We could never win at the local level. The reason is, all the health advocates . . . they're all local activists who run the little political organizations. They may live next door to the mayor, or the city councilman may be his or her brother-in-law, and they say "Who's this big-time lobbyist coming here to tell us what to do?" When they've got their friends and neighbors out there in the audience who want this bill, we get killed. So the Tobacco Institute and tobacco companies' first priority has always been to preempt the field, preferably to put it all on the federal

Case Study 6.12
An Historic Opportunity: South Carolina Bans Smoking in Its State House

Situation: South Carolina's 1991 Clean Air Act required that government buildings become smoke-free environments, but legislators exempted the state house from the law. During the next 7 years, health advocates attempted three times to make this historic building smoke free. Finally, in 1998, a 3-year, $68 million historical renovation project provided an opportunity to revive the issue.

Strategy: A grassroots advocacy plan that included the media and the distribution of a postcard was quickly developed to bring the following three key messages to the attention of the House-Senate Oversight Committee:

- The historical significance of the State House makes it appropriate to make the building smoke free. Tobacco smoke would harm historical artifacts, furnishings, and carpet.
- Visitors to the State Capitol are exposed to harmful chemicals in secondhand smoke. Specifically, hundreds of South Carolina school students visit the state house daily.
- The taxpayers of South Carolina are spending $68 million on the historical renovation of the State House. If tobacco use continues, taxpayers will incur additional costs for cleaning and maintaining the building.

Intervention: A 40-member coalition of traditional and nontraditional partners, including ASSIST, collaborated on an initiative for a smoke-free state house. Three of the partners—the American Cancer Society, the American Lung Association, and the American Heart Association—had a working relationship with South Carolina state senator Darrell Jackson and sought his support. He agreed to join this effort (for the third time). Also during this time (June–July 1998), a reporter from the state's largest daily newspaper began to follow the oversight committee's agenda. The oversight committee was charged with developing rules and regulations regarding special events and food consumption inside the state house. The reporter, and a representative of the American Cancer Society, contacted Senator Jackson for comments regarding tobacco use and smoking in the state house. The story, which became the official kickoff of the campaign, was published on July 8, 1998, and became a front-page issue. The Associated Press picked up the story, as did television and radio outlets from all parts of the state.

The grassroots movement also distributed 15,000 postcards with the simple message that smoking does not belong in the House or Senate. Within 2 weeks, all 15,000 postcards were distributed and mailed to the clerk of the senate. Editorials and news articles supporting the smoking ban began to appear in newspapers.

Senator Jackson placed the item on the oversight committee's agenda before the August committee meeting. At the meeting, the senator, along with health advocates

and 75 members of the Young People's Division of the African Methodist Episcopal Church, a community-funded partner of ASSIST, presented the case for a smoke-free state house.

Results: After 45 minutes of discussion, with media representatives present from around the state, the committee voted unanimously to make all public areas of the state house smoke free. The same afternoon, the governor and lieutenant governor banned tobacco use in their offices. The total cost of this campaign was less than $300, which covered printing the postcards.

What had been an issue in South Carolina for many years was now legislative policy in just 22 days. This successful effort to ban smoking in the state house was the lead story that night on television stations across the state and was covered extensively in print the next morning.

Source: Adapted from P. Cobb and G. White. 1999. It's a state house, not a smoke house! In *Tobacco free future: Shining the light* (Case studies of the fifth annual national conference on tobacco and health, August 23–25, 1999), 135–8. Rockville, MD: ASSIST Coordinating Center.

Case Study 6.13
Twice North Carolina Makes Gains for a Smoke-free School Environment

In 1994, the U.S. Congress passed the Pro-Children Act, which required that all education, health, and library institutions that receive federal funds become smoke free.[a] Therefore, the school buildings in North Carolina had to become smoke free; however, the schools were not interested in tobacco prevention and control—the curricula were overburdened already, and North Carolina produces tobacco. Tobacco control advocates learned that schools were under pressure to improve their standardized test scores, but scores do not improve if students are repeatedly suspended for smoking. Thus, an alternative-to-suspension program was created jointly to address the related needs. This alternative program provided a win-win approach and a means to recruit support from school leaders for a tobacco and health initiative.

Three years later, concerned by the data on tobacco use by North Carolina school children, North Carolina's governor, James B. Hunt, called a governor's "Summit to Prevent Teen Tobacco Use" and listened to what the teens had to say. They asked the governor to help make schools in North Carolina 100% tobacco free, not just for students, but also for teachers and visitors campus-wide. The governor responded; he understood that to have good schools, teachers and staff had to be good role models, and he asked every school board in the state to adopt such a policy.

Advocacy continued for 100%-tobacco-free schools in 2001–02 with the North Carolina State Board of Education adopting a resolution endorsing 100%-tobacco-free schools.

Case Study 6.13 (continued)

The Tobacco Prevention and Control Branch (staffed with former ASSIST personnel) wrote grants to the American Legacy Foundation and secured a staff person to be dedicated to this policy change. Intensive training events and earned media have resulted in a new surge in school districts adopting 100%-tobacco-free school policies, including districts that have strong historic ties to the tobacco industry.

—Sally Herndon Malek, former ASSIST Project Manager, and current Head, Tobacco Prevention and Control Branch, North Carolina Department of Health and Human Services

[a]Pro-Children Act. U.S. Code 20 (1994), § 6083. Available at http://www.unf.edu/dept/fie/sdfs/legislation/pca.pdf and at http://thomas.loc.gov.

> level, but if they can't do that, at least on the state level, because the health advocates can't compete with me on a state level.[72]
>
> *—Victor Crawford, former Tobacco Institute lobbyist who shared insights before his death from tobacco-induced cancer*

All 17 ASSIST states found that most effective tobacco control policy change took place or was initiated at the local level. Policymaking is generally more transparent and responsive to citizen input at the local level than at the state or national level. During the ASSIST era, as illustrated in the Victor Crawford quotation, the tobacco industry was far less effective at fighting a series of local efforts than state and national efforts, where their money and resources invariably outweigh the resources of tobacco control advocates. Moreover, the process of advocating for local policies educates the community about the rationales, benefits, and requirements of these policies and thereby reinforces changes in social norms and facilitates policy implementation and enforcement. Tobacco control policies that are effective at the local level can become the experience and evidence that advocates can point to when promoting state-level policies. The tobacco industry's intensive lobbying for state preemption laws—a goal that, for much of the 1990s, was at the forefront of the industry's state-level legislative agenda[57,58]—seems to be an acknowledgment of the effectiveness of local policy change (see case study 6.14). In some states, the lack of local policies was a key factor in unsuccessful fights against preemption.

Insight 13: It's Not Over 'Til It's Over, or Never Give Up, Never Give Up, NEVER GIVE UP!

> If you are building a house and the nail breaks, do you stop building or do you change the nail?
>
> *—Zimbabwean proverb*

Sometimes it takes years for a community or a state to adopt sweeping policy change. Even when strong public support exists for such change, powerful interests may resist it and create an impasse.

Case Study 6.14
Indiana's Battle against Preemption

Situation: The Indiana General Assembly passed a bill that preempted all local jurisdictions on the sale, distribution, and promotion of tobacco products.

Strategy: The Indiana Campaign for Tobacco Free Communities spearheaded a campaign to bring about a veto of the bill by the governor. The campaign was funded by the National Center for Tobacco-Free Kids and received technical assistance from the Center, the American Cancer Society, and Americans for Nonsmokers' Rights.

Intervention: News coverage of the issue in the *Indianapolis Star* was excellent, with almost daily coverage. The *Star*, which had previously shown little editorial support for tobacco control, published two editorials supporting a veto by the governor; one of the editorials ran on the day of the crucial vote. After the General Assembly overrode the governor's veto of the original bill that had been passed by the General Assembly in 1995, the *Star* ran an in-depth article on the tobacco industry's influence in the state house. The article was a culmination of a year of work by coalition members with reporters who had covered a "state house sellout" series published in 1996. The result was a front-page story outlining the tobacco industry's ties with retailers' groups and the subsequent impact on the vote to overturn the governor's veto.

Results: Indiana's governor vetoed the bill in March 1996. As part of his veto message, he pointed to the lack of local tobacco ordinances as a weakness in Indiana's ability to effectively fight preemption. The governor noted:

> Supporters argue this legislation is necessary to preempt local ordinances that, at present, are virtually nonexistent in Indiana; opponents defend the right of localities to enact measures which, to date, they have shown little or no inclination to enact.

Epilogue and Insight: In 1997, the Indiana legislature removed the right of local communities to regulate youth access to tobacco by a single vote, thereby overturning a veto by Governor Evan Bayh. Though the veto failed, key victories were scored in this hard battle. Tobacco advocates were successful in limiting the preemption coverage to the sale, display, and promotion of tobacco products; thus, clean indoor air laws were excluded from the exemption. Also, the battle became a litmus test for commitment to tobacco control and laid the groundwork for future policy battles.

Source: Adapted from K. Sneegas. 1997. Lessons from Indiana: The battle against preemption. In *Entering a new dimension: A national conference on tobacco and health case studies* (September 22–24, 1997), 159–65. Rockville, MD: ASSIST Coordinating Center.

However, by refusing to become discouraged and by continuing to lay the groundwork for change through ongoing community education and mobilization, advocates can prepare themselves for opportunities that suddenly create an opening for the long-sought change to occur. (See case studies 6.15 and 6.16.)

Insight 14: It's Never Over!: The Importance of Vigilance after a Policy Takes Effect

Often, getting a policy adopted is only the start of the battle. Advocates cannot afford to relax once they have achieved that goal. In many cases, opponents of the policy will not give up once the policy is passed. Instead, they may seek to reverse it through various means. Advocates must publicize the positive impact of policy change through data and testimonials as well as anticipate and prepare to respond to opposition tactics. One helpful approach is for advocates to "put themselves in their opponents' shoes" and then ask what they would do and what options are open to them. (See case study 6.17.)

Educating Local Store Owners about Tobacco Displays and Placement Fees

The smaller the town, the greater the effect. Many operators of stores in smaller towns and cities live in the same area as their stores. These owners are known by the community and feel more responsibility toward their neighbors than the big-city chains with large, absentee corporate owners. Most small-town retailers are not aware of the tobacco industry's true agenda behind contracts for placement of tobacco products and ads. They simply do what the tobacco representatives tell them to do and take the money. The act of simply educating a retailer about how tobacco displays facilitate shoplifting by children and explaining that the community is aware that he takes placement fees to perpetuate the situation can be quite powerful with some individuals. Several concerned citizens making this point to a storeowner in person is an effective approach and might be enough to change the practice within a chain of stores.

—Anne Landman, former Regional Program Coordinator for the American Lung Association of Colorado

The Influence of Policy

Public policy affects everyone and reflects and reinforces social norms and behaviors. Some policies provide guidance; others mandate adherence to regulations. The role of public health policy is to protect the population from unnecessary health risks and dangers, to promote public knowledge about healthful and preventive behaviors, and to provide opportunities and access to health care. As evidence unfolds about beneficial and harmful environmental factors, scientists and the public health community have a responsibility to disseminate that information to the public. When challenges deter dissemination and application, public health policy is an effective recourse, but it is not an easy process. Enacting new policies requires (1) the support of the community for a policymaker who has introduced a policy or (2) advocacy by the community to introduce a policy.

Policy advocacy was the very core of the ASSIST project, and its focus on interventions in four policy areas proven to be effective in promoting health and

Case Study 6.15
Persistence Pays Off in Mesilla, New Mexico

Situation: In 1995, the small, traditional, predominantly Hispanic/Latino community of Mesilla in south central New Mexico considered adopting a comprehensive clean indoor air ordinance covering all workplaces, including restaurants, along the lines of an ordinance passed earlier in neighboring Las Cruces. However, the board of trustees (the town's governing body) lacked the votes to pass a strong ordinance and settled for a weaker ordinance that allowed smoking in up to 40% of the seating in restaurants. The main obstacle to the ordinance was vigorous opposition by two local restaurants that were among the town's largest employers; the owners were concerned about potential loss of revenues, especially from tourists.

In 1998, Mesilla revisited its ordinance but again was unable to muster a majority for an ordinance requiring restaurants to go 100% smoke free. Finally, in 2000, a key member of the board of trustees shifted his stance on the ordinance from opposition to support. This trustee's change of position was influenced by information on health and economic issues provided to him by the Las Cruces tobacco control coalition (which included a number of Mesilla residents), as well as by personal and political factors. This shift made it possible to amend the original ordinance to ban smoking in restaurants and to require bar areas of restaurants to be either smoke free or separately enclosed and ventilated.

Insight: At each of the three stages of this process, and in the interim between them, the Las Cruces coalition consistently educated Mesilla residents and leaders, as well as the members of the board of trustees, and advocated for smoke-free restaurants. However, the coalition was careful to take a low-key approach that avoided burning bridges with opponents and that was respectful of the tight-knit community's norms of civility and consensus decision making. This steady perseverance ultimately paid off, with the two previous "failures" laying the foundation for the final victory.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

in decreasing premature death and disease related to tobacco use: clean indoor air, restricted tobacco advertising and promotion, reduced youth access to tobacco products, and price increases on tobacco products. The ASSIST staff and coalitions met a variety of challenges in promoting policies in those areas. They met the challenge of developing the personal skills necessary to conduct policy advocacy successfully, of mobilizing community support for policy campaigns, and of responding to tobacco industry opposition. Their strategies and tactics were varied and met the particular needs of their communities, but the coalitions

Case Study 6.16
Changing Policy on Public Transportation: Smoke-free Washington State Ferries

Situation: The Washington State Ferry System serves daily commuters and thousands of tourists. Because smoking was allowed on the ferries, virtually all 23 million passengers and 1,500 employees were exposed to secondhand smoke. A member of the Tobacco Free Coalition of Sno-King was embarrassed that her visitor had to walk through tobacco smoke to enjoy the scenic beauty and breathe in the fresh sea air. The visitor asked, "So what are you going to do about it?" With that question, the wheels of change were put in motion.

Strategy: The Sno-King coalition led multiple efforts to achieve a policy banning smoking on the ferries: volume postcard mailings, peaceful protests, public education events, and persistent contact with state authorities.

Intervention: A series of interventions from June 1997 through July 1998 were necessary to achieve results. First, the Sno-King coalition wrote 15 letters to the chief executive officer of the Washington State Ferry System asking for 100%-smoke-free ferries and wrote several letters to the editors of local newspapers.

Response: No policy change.

Next, the Sno-King coalition collaborated with the Tobacco-Free Kitsap County Coalition and conducted a smoke-free rally at the ferry terminal. This hour-long rally received coverage from two local television stations and the daily newspaper, and positive comments from ferry passengers.

Response: No policy change.

September 1997: The Tobacco-Free Washington Coalition became involved. Hundreds of postcards urging the Washington State Transportation Commission to change its smoking policy were sent to the commission.

Response: No policy change.

October 1997: A smoke-free walking tour was coordinated with a regional youth tobacco conference, "Tobacco in 3-D." Participants held "We want smoke-free ferries" signs or handed out flyers about the smoke-free ferry issue. About 30 participants chanting "secondhand smoke makes us choke" walked all over downtown Seattle, through the Washington State ferry terminal, and past the CEO's office. National Public Radio interviewed participants.

Response: No policy change.

December 1997: It was time to get on the agenda of the Washington State Transportation Commission's meeting. The Department of Transportation's ombudsman was a critical element in this process. Letters and postcards, many from youths, were sent

to the State Transportation Commission, and at the commission's meeting, seven volunteers provided public comment on the smoke-free ferry issue.

Response: The commission decided that because a 1988 law prohibited smoking in state facilities, there was a need to reopen discussion regarding the State Ferry System's smoking policy. The Transportation Commission charged the State Ferry System to evaluate its smoking policy.

January 1998: Representatives from the various coalitions attended six regional meetings of the Ferry Advisory Committee.

Results and Insights: On June 21, 1998, the State Ferry System announced a policy change: smoking would be permitted only in designated areas at the back section of the ferries. Although the policy change was not a 100% ban, it was a step in the right direction, and the Transportation Commission has stated that a total ban will occur sometime in the future.

It is important to determine who has the authority to make policy change in a large state system and to anticipate who might pose barriers. For example, there are 13 unions representing 1,500 ferry employees. Smoking breaks were written into the collective bargaining contracts between the ferry system and the ferry system employees.

Source: Adapted from S. Vermeulen. 1998. Campaign to change policy on public transportation: Smoke free Washington State ferries. In *No more lies: Truth and the consequences for tobacco* (Case studies of the fourth annual national conference on tobacco and health, October 26–28, 1998), 113–6. Rockville, MD: ASSIST Coordinating Center.

all used media interventions and media advocacy to bring attention to the health issues inherent in tobacco use and to the proposed policies.

Once in effect, policies have an impact on the daily lives of many people. Policies protecting workers from environmental tobacco smoke impose rules in the workplace but also liberate those workers from exposure to thousands of secondhand smoke chemicals and poisons. Cigarette taxes raise the price of a pack of cigarettes but also decrease the prevalence of smoking and of the resulting diseases and premature deaths. Advertising restrictions limit the placement of billboard ads and other signage but thereby remove unwanted protobacco messages from the view of children. Restrictions on selling to minors increase the responsibility and culpability of retailers but thereby decrease the ease with which children could have access to cigarettes leading to addiction.

In short, tobacco control policies are experienced in some form by everyone in society and reinforce a tobacco-free way of life. As policies take effect, positive outcomes occur—people quit smoking, employers implement smoke-free work environments, and retailers learn how to refuse to sell tobacco products to minors.

Case Study 6.17
Protecting the Gain in Las Cruces, New Mexico

Situation: In 1995, Las Cruces became the first community in New Mexico to enact a comprehensive clean indoor air ordinance. Before the ordinance had even taken effect, opponents launched a referendum drive. If successful, the drive would have forced the Las Cruces City Council to either repeal the ordinance or place it on a ballot for a public vote. Although the Las Cruces tobacco control coalition was confident that the ordinance would have prevailed in a referendum (a poll conducted by the New Mexico State University Journalism Department and the *Las Cruces Sun-News* found that 73% of the residents surveyed supported the ordinance),[a] the campaign would have consumed enormous energy and resources and would have opened the door to further tobacco industry interference. The drive failed when the opposition gathered fewer than half of the signatures required.

However, the referendum drive was succeeded by a series of other opposition tactics, including the following six tactics:

1. Two lawsuits by local restaurants seeking to block enforcement of the ordinance and to have it struck down
2. The formation of a regional restaurant association created in response to the ordinance
3. A media and public relations offensive against the ordinance by a new restaurant that was refusing to comply with the ordinance in coordination with a local radio talk show host
4. Personal attacks in the media on members of the local tobacco control coalition and, in some cases, legal harassment of these advocates
5. An effort to unseat a mayor who had come to support the ordinance by channeling $10,000 in campaign contributions to his opponent in an election
6. An attempt to invalidate the ordinance through the passage of a preemptive law at the state level

Strategy: Through prompt responses, sound strategic thinking, and effective community mobilization and media advocacy, the Las Cruces coalition, working closely with partners at the local, state, and national levels, was able to turn back each of these challenges.

Intervention: The coalition countered the opposition through a series of its own coordinated tactics: numerous letters to the editor and op-ed columns (which included scientific findings, presented in nontechnical language, with explanations of their policy implications), press conferences, sponsorship of community forums and candidate debates, broad community outreach and cultivation of allies (including proprietors of restaurants that had adopted voluntary smoke-free policies), petition

drives in support of the ordinance, delegation visits to newly elected and incumbent city council members, and ongoing consultation with the ordinance sponsor.

Results: The coalition was able to defeat each of the opposition's attempts to roll back the ordinance. In addition, the coalition was able to achieve passage of several amendments progressively strengthening the ordinance. The Las Cruces experience also helped inspire several other communities in the region (including the New Mexico communities of Carlsbad, Mesilla, and Silver City and the nearby Texas city of El Paso) to adopt ordinances similar to that in Las Cruces. In January 2002, Doña Ana County (the county in which Las Cruces sits) adopted an ordinance that was even more comprehensive than the Las Cruces one.

In October 2002, the Las Cruces City Council, at the request of the Las Cruces coalition, rescinded the original ordinance and replaced it with a new one that contained almost no exemptions. Opponents once more launched a petition drive to force a referendum on the new ordinance, and this time succeeded in collecting enough signatures to do so. The opposition, led by the local Chamber of Commerce, conducted a well-funded, well-organized campaign against the ordinance; the coalition once more waged a vigorous campaign in its defense. The vote was held in March 2003, and the new ordinance lost, 56% to 44%. Technically, the vote was on just the new provisions in this ordinance, which extended the ordinance's coverage to free-standing bars, truck stops, private clubs, parks, and areas within 50 feet of the entrances of buildings where smoking is banned. With the defeat of the new ordinance, Las Cruces reverted to the previous ordinance, which still required most enclosed workplaces and public places to be smoke free, including restaurants.

Throughout the series of events that followed the passage of the original ordinance, the coalition was forced to expend effort on defending the ordinance that could have otherwise been devoted to other policy interventions. The coalition had not anticipated the amount of energy that it would have to spend on sustaining its initial policy victory.

—Stephen Babb, former ASSIST Field Director, New Mexico Department of Health in Las Cruces, and current Program Consultant at the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC

[a]Giles, M. 1997. Poll shows most residents support smoking ban. *Las Cruces Sun-News*, May 7, 1995.

Program services are needed to respond to the increased demand that are created by these outcomes, whether smoking cessation clinics, management training events, or retailer education programs. Chapter 7 describes how ASSIST staff worked with their coalition partners to encourage them to offer the services, congruent with their organizations' missions, that would help individuals and communities embrace a tobacco-free norm in daily life.

Appendix 6.A. Excerpts from *Youth Access to Tobacco: A Guide to Developing Policy*

Youth Access To Tobacco

A Guide To Developing Policy

Number one in a series of four policy guides

ASSIST
The American Stop Smoking Intervention Study

National Cancer Institute
National Institutes of Health
US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prepared by:
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*Page numbers in this Table of Contents are from the original document and do not correspond to page numbers in this monograph.

Background

Tobacco use is the leading cause of preventable disease and death in the United States (US DHHS, 1989). Primary smoking claims an estimated 419,000 lives per year (CDC, 1993a), secondary smoking another 53,000 (Glantz and Parmley, 1991). Tobacco addiction typically begins during childhood or adolescence. Approximately 75 percent of cigarette smokers tried their first cigarette before their 18th birthday (CDC, 1991a). Initiation of daily smoking generally occurs during sixth through ninth grade (Johnston et al., 1992).

Surveys conducted throughout the U.S. show increasingly high rates of smokeless tobacco use, concentrated among young males. Estimates of use range from 10 to 39 percent (US DHHS, 1992).

These young tobacco users underestimate the addictive nature of nicotine. According to a 1986 survey, only five percent of high school smokers believed they would be smoking five years later; in fact, an estimated 75 percent continued to smoke seven to nine years later (Johnston et al., 1992).

Tobacco use among youth has failed to show a significant decline over the past ten years. Although the daily smoking rate for high school seniors decreased from 29 percent to 20 percent between 1977 and 1981, the smoking rate decreased only an additional 1.8 percent through 1991 (Johnston et al., 1992). This trend is in sharp contrast to the greater declines observed for other drug use among youth during the same time period.

Despite the fact that almost all states prohibit the sale and distribution of tobacco products to minors, tobacco is easily accessible to youth. Studies indicate that underage youth can purchase tobacco products 70 to 100 percent of the time from merchants and through vending machines (Altman et al., 1989). Youth themselves report that it is easy for them to purchase tobacco; the majority buy their own cigarettes (Cummings et al., 1992).

The tobacco industry, including manufacturers and retailers, profit from these illegal sales. Researchers estimate that 947 million packs of cigarettes are sold annually to underage youth in the United States, representing total sales worth $1.23 billion and a net profit of $221 million (DiFranza and Tye, 1990).

Overview: Policy Options To Reduce Youth Access to Tobacco

Strategies to reduce youth consumption of tobacco products focus on either the demand or the supply side of the problem. Counter-advertising campaigns and school-based tobacco prevention curricula seek to reduce youth *demand* for tobacco products. Policy options regarding the advertising and promotion of tobacco products will be explored in a future paper in this series. Youth access policies are designed to reduce the *supply* of tobacco products available to youth.

Youth access policies are based on the premise that reducing access will lead to a reduction in youth consumption and addiction. The effectiveness of these policies cannot be measured simply in terms of achieved reduction in tobacco sales to minors. The ultimate goals of all of these policies are to reduce youth consumption of tobacco products and reduce childhood addiction, ultimately reducing adult consumption.

Preliminary results from three studies indicate that youth access legislation may reduce youth consumption. Following enactment and enforcement of a youth access ordinance in Woodridge, Illinois, student surveys showed over a 50 percent reduction in rates of cigarette experimentation and regular use of cigarettes (Jason et al., 1991). A youth access ordinance in Everett, Washington, reduced tobacco use among girls from 26.4 percent to 11.5 percent (Hinds, 1992). In Leominster, Massachusetts, active local enforcement of a state sales to minors law was followed by a significant decrease in the number of youth identifying themselves as cigarette smokers (DiFranza et al., 1992).

Policies to reduce youth access to tobacco can be enacted at the Federal, state and local levels. A recent Federal initiative, the Synar Amendment, requires states to adopt and enforce laws prohibiting tobacco sales and distribution to youth less than 18 years of age. States which fail to achieve specified reductions in the rate of youth sales risk losing a percentage of their Federal funding for drug and alcohol prevention and treatment.

The majority of existing state laws focus on establishing a minimum age for purchase of tobacco products; some states have restricted placement of vending machines, banned free distribution of tobacco product samples, or licensed tobacco retailers (US DHHS, 1993b). State legislation has been largely unenforced and ineffective in reducing youth access (US OIG, 1992). Florida and Vermont are the only two states which currently provide for statewide enforcement of their youth access laws (US OIG, 1992). This situation may change, as the Synar Amendment offers significant incentives for states to achieve reduction in rates of tobacco sales to minors.

Although it is not strictly speaking a youth access policy, increasing state tobacco excise taxes does reduce youth access by placing the product out of financial reach of many youth. An increase in the excise tax will lead to a reduction in tobacco consumption among youth (US GAO, 1989). The issue of excise taxes will be explored in greater depth in a future paper in this series.

To date, the greatest successes in reducing youth access have been achieved at the local level (US DHHS, 1993b). Provisions that have been enacted at the local level include:

- Licensing tobacco retailers, providing for suspension/revocation for repeated sales to minors.
- Banning or restricting tobacco vending machines.
- Banning self-service displays of tobacco products.

- Banning distribution of free samples or coupons for free samples of tobacco products.
- Banning sale of single cigarettes.
- Requiring point-of-purchase warning signs.

The provisions listed above are also appropriate for adoption at the state level. Several of the options (vending machines, licensure, point-of-purchase signs) are included in the Model Sale of Tobacco Products to Minors Control Act for States developed by the Department of Health and Human Services (US DHHS, 1990).

Studies consistently show strong public support for stronger laws and better enforcement to reduce youth access (CDC, 1991b; US OIG, 1992; Burns and Pierce, 1992). The only substantial opposition to reducing youth access comes from the tobacco industry and merchants, both of whom profit from sales to minors.

Policy Options

MINIMUM AGE OF PURCHASE FOR TOBACCO PRODUCTS

Forty-nine states have established a minimum age of purchase for tobacco products; the majority set the minimum age at 18 years of age (US DHHS, 1993b; US OIG, 1992). Under the Synar Amendment, states are required to prohibit the sale or distribution of tobacco products to persons under the age of 18 (US DHHS, 1993a).

Legislation should avoid vague language stating that it is a violation to "knowingly sell tobacco products to minors." This provides a loophole for merchants, who can claim they were not aware the customer was underage (US OIG, 1992). Stronger language requires merchants to request photographic identification if a customer appears to be under a specified age, before concluding the sale.

Options

- Prohibit the sale or distribution of tobacco products to persons under 18 years of age.
- Require merchants to request photographic proof of age for customers who appear to be under 21 years of age.

Passing a law which simply prohibits the sale and distribution of tobacco products to minors will not automatically decrease youth access to tobacco. In order to achieve a true reduction in access, policies must also address the locations and manner in which tobacco is sold or otherwise made available (Reynolds and Woodward, 1993). Policies must also include clear enforcement mechanisms and be actively enforced if they are to achieve their potential to reduce youth access. Policy provisions and enforcement

mechanisms to achieve compliance with minimum age requirements are discussed in this paper.

TOBACCO RETAILER LICENSING

Tobacco retailer licensing legislation requires merchants to obtain a license to sell tobacco products *and* provides for the suspension or revocation of the license if the merchant sells tobacco to a minor. This scheme, similar to that used to control alcoholic beverage sales to minors, creates a significant financial incentive for retailers to avoid illegal sales to minors. The profits lost by forfeiting the right to sell tobacco to adults exceed the typical $100 to $500 fine exacted for violations under most youth access legislation. License fees can be earmarked to fund enforcement activities.

Licensing ordinances are a relatively new development, and there is only preliminary research documenting their effects. Researchers report that a licensing ordinance in Woodridge, Illinois, has reduced the rate of illegal sales to minors, from 70 percent at baseline to less than five percent 18 months after initiating enforcement (Jason et al., 1991). King County, Washington, reduced sales to minors to 27 percent following enactment of a licensing ordinance (Spokane County Health District, 1992).

These licensing ordinances include strong enforcement provisions. Both Woodridge and King County have used underage "inspectors" who, under adult supervision, spot check retailer compliance. The license fee is set at a level sufficient to cover the cost of enforcement efforts. The King County ordinance was recently superceded by preemptive state legislation passed to satisfy the Synar Amendment, and the local enforcment activities have been dismantled. (See sections on Preemption and the Synar Amendment.)

Most licensing ordinances contain a graduated schedule of fines and penalties; suspension or revocation of a license is the last resort, after the retailer has shown a consistent pattern of illegal sales to minors. Under some ordinances, the retailer may appeal suspension or revocation of the license at a public hearing. To avoid frivolous appeals, the retailer may be required to bear the costs of the appeal process.

Options

- Require a license for the retail sale of tobacco products. Earmark fees to fund enforcement efforts.
- Establish a graduated penalty system which culminates in suspension or revocation of the tobacco retail license for repeated sales to minors.
- Establish a public appeal process for suspension or revocation of license. The retailer may be required to pay the costs of the appeals process.
- Enforcement: Systematic, unannounced spot checks of all retailers by underage "inspectors."

TOBACCO VENDING MACHINES

A study commissioned by the vending machine industry found that 23 percent of youth that smoke use vending machines "often" or "occasionally" (NAMA, 1989). A recent study found an even higher percentage (37.8 percent) of youth that smoke who reported using vending machines "often" or "sometimes" (Cummings et al., 1992). Younger children rely more heavily on vending machines as a source of cigarettes (US DHHS, 1989). The NAMA study found that 13-year-olds reported using a vending machine "often" 11 times more frequently than did 17-year-olds (NAMA, 1989).

Option One: A Complete Ban on the Sale of Tobacco Products Through Vending Machines

Former Secretary of Health and Human Services Louis Sullivan and former Surgeon General C. Everett Koop both have called for a total ban on cigarette vending machines. Unlike over-the-counter sales, vending machine sales to minors don't respond to merchant education programs (Altman et al., 1989) or to increased penalties and fines for sales to minors (Forster et al., 1992b).

Complete bans are relatively easy to enforce; the simple presence of a tobacco vending machine indicates a violation. A study of two cities with tobacco vending machines bans found complete compliance two years after the bans were enacted (Forster et al., 1992a).

Options

- Ban the sale of tobacco products through vending machines in all locations.
- Enforcement: If a tobacco vending machine is present, the owner is in violation of the law.

Option Two: A Partial Ban on the Sale of Tobacco Products Through Vending Machines, Restricting Their Placement to Adult Locations

A partial ban provides an exemption for tobacco vending machines placed in bars or other "adult-only" locations, such as employee cafeterias or adult social clubs. These policies are less effective than total bans in preventing illegal sales to minors. Researchers from the University of Minnesota have demonstrated that underage youth experience high rates of success (78 percent) in purchasing cigarettes from vending machines placed in establishments characterized as adult locations (Forster et al., 1992b).

The effectiveness of a partial ban may increase if machines are required to be placed at least 25 feet from any entrance. This prevents placement of the machines in unattended lobbies and entrances. Defining adult-only locations should be done carefully.

For instance, exempting the bar area of a restaurant may fail to prevent sales to minors; 47 percent of youth using tobacco vending machines report that the machine was placed in a restaurant (NAMA, 1989).

Options

- Ban the sale of tobacco products through vending machines, providing an exemption for adult-only locations.
- Require that tobacco vending machines be placed at least 25 feet away from any entrance in an exempted location.
- Enforcement: If a tobacco vending machine is present, verify that it is in an exempted location. Verify that the machine is 25 feet from any entrance. Periodic purchase attempts by underage "inspectors."

Option Three: Require Installation of Locking Devices on all Tobacco Vending Machines

This option is often promoted by vending machine trade associations and the tobacco industry as an alternative to full or partial bans. This is the least effective means of curtailing illegal sales to minors through vending machines.

The state of Utah, which required their use until 1988, found that locking devices were rarely installed, and, where installed, seldom operating. In St. Paul, Minnesota, one year after a locking device ordinance was passed, 30 percent of the machines were not equipped with a locking device. Of those machines with a locking device, compliance deteriorated during the first year after the law was passed, from 30 percent sales to minors at three months to 48 percent at one year (Forster et al., 1992a).

Locking device requirements entail a greater enforcement burden than complete bans (Forster et al., 1992a). Even when installed and operating, attendants may continue to sell cigarettes to underage youth. However, in areas where a full or partial tobacco vending machine ban is politically infeasible, some researchers feel that a locking device requirement accompanied by strong enforcement to ensure installation and operation is better than nothing.

Options

- Require installation of a locking device on all tobacco vending machines.
- Enforcement: Site visits to verify locking device installation and operation. Periodic purchase attempts by underage "inspectors."

SELF-SERVICE DISPLAYS

Self-service displays allow customers to acquire tobacco products without the intervention of a store employee. Tobacco companies offer retailers "slotting fees" for favorable placement of their products in the store, including placement of self-service displays.

Banning self-service displays may reduce youth access in two ways: (1) youth may be less likely to attempt purchase when they must request tobacco from a store employee, rather than handing the product to a sales clerk for checkout, and (2) the absence of displays makes it more difficult to steal tobacco products. This is a relatively new policy development; there is no research to date which indicates whether banning self-service displays reduces youth access to tobacco.

Options

- Prohibit open displays of tobacco products which can be reached without the intervention of a store employee.

DISTRIBUTION OF FREE TOBACCO PRODUCT SAMPLES

Distribution of free tobacco samples is a popular form of promotion for both cigarette and chewing tobacco manufacturers. Free tobacco samples frequently are distributed in locations where underage youth are likely to congregate: music festivals, rock concerts, sports events, zoos, and fairs (Davis and Jason, 1988; Chudy et al., 1993).

Most states prohibit the distribution of tobacco samples to underage youth. In addition, the tobacco industry has a voluntary code addressing product sampling which prohibits the distribution of tobacco products to "any person whom they know to be under 21 years of age or who, without reasonable identification to the contrary, appears to be less than 21 years of age" (Tobacco Institute).

Despite these state laws, and the industry's voluntary code, free sampling of tobacco products in public areas and through the mail is a source of tobacco products for underage youth. A survey of underage youth found that 50 percent reported witnessing other people their age receiving free samples (Davis and Jason, 1988). The same study found that 20 percent of high school students and four percent of elementary students surveyed reported that they themselves had received free samples of tobacco products.

Options

- Ban distribution of free tobacco samples or coupons for free samples in publicly and privately owned property accessible to the general public.
- Ban the distribution of free tobacco samples through the mail.

SINGLE CIGARETTE SALES

Although the Federal Cigarette Labeling and Advertising Act prohibits the sale or distribution of cigarettes without the mandated warning label, some stores sell single cigarettes which are taken out of their packages and stored in cups and trays. This practice is illegal, unless the cigarettes are removed from their packages by the customer or in the presence of the customer (Manfreda, 1989). A study of stores in a southern California community found that almost half sold single cigarettes and that youth were able to purchase them almost twice as often as adults (Leary, 1993). This despite the fact that California prohibits all sales of single cigarettes.

Options

- Prohibit the sale or distribution of one or more cigarettes, other than in a sealed package which conforms to the Federal labeling requirements, including the Federal warning label.

POINT-OF-PURCHASE WARNING SIGNS

Requiring warning signs stating that sales to minors are illegal does not lead to a reduction in sales to minors. A merchant education project in New York found that posting signs had no effect on the rate of sales. Although the intervention led to an increase in the number of stores posting warning signs (40 percent), those stores showed no significant reduction in sales to minors when compared to control stores which did not receive the intervention (Skretny et al., 1990). Posting of signs is the major component in the Tobacco Institute's program "It's the Law." Researchers have shown that this program does not reduce merchants' illegal sales to minors (DiFranza and Brown, 1992). Studies conducted in Missouri and Texas also found that the likelihood of success was not significantly different for stores with and without warning signs (CDC, 1993b).

A study of stores in Massachusetts found that stores which posted signs were less likely to sell to minors; however, the majority (32 of 36) of the signs were not visible to the customers (DiFranza et al., 1987). The warning signs may have served as a cue to the clerks, reminding them to avoid selling tobacco products to minors.

Some tobacco control professionals are concerned that posting warning signs where they are visible to minors presents tobacco as a "forbidden fruit" reserved for adults and may encourage teen rebellion against adult rules (Carol, 1992; DuMelle, 1991). A study of youth susceptibility to smoking found that rebellious attitudes were associated with an increased susceptibility to smoking among adolescents (Pierce et al., 1993). This dilemma may be solved by posting a warning sign so as to be visible to the clerk, but not to underage youth.

Options

- Require warning signs to be posted at point-of-purchase in view of the sales clerk.

Appendix 6.B. Excerpts from *Clean Indoor Air: A Guide to Developing Policy*

Clean Indoor Air

A Guide to Developing Policy

Number two in a series of four policy guides

ASSIST
The American Stop Smoking Intervention Study

National Cancer Institute
National Institutes of Health
US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prepared by:
Americans for Nonsmokers' Rights
Berkeley, California
with
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Rockville, Maryland

June 1994

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Background

THE HEALTH EFFECTS OF ENVIRONMENTAL TOBACCO SMOKE

Environmental tobacco smoke (ETS), also called secondhand smoke, is a combination of smoke exhaled by the smoker and sidestream smoke emitted from a burning cigarette. Exposure to ETS is often referred to as involuntary smoking. The adverse health effects of ETS on the nonsmoker are no longer in question. Environmental tobacco smoke is a cause of respiratory disease, including lung cancer, and may also cause heart disease in nonsmokers (US DHHS, 1986; US EPA, 1992; Glantz & Parmley, 1991; Taylor et al., 1992).

The 1986 Surgeon General's Report was devoted to the health effects of involuntary smoking on the nonsmoker. Based on a comprehensive review of the scientific research, the report reached three major conclusions (US DHHS, 1986):

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers.
2. Children of parents who smoke, compared with children of nonsmoking parents, have an increased frequency of respiratory infections, increased respiratory symptoms and slightly smaller rates of increase in lung function as the lung matures.
3. Simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, exposure of nonsmokers to environmental tobacco smoke.

The findings of the Surgeon General's Report were seconded by the National Academy of Sciences, which also reviewed the scientific evidence regarding secondhand smoke in 1986 (NAS, 1986).

In 1990, the Environmental Protection Agency convened a scientific advisory board to review research on the respiratory effects of ETS on nonsmokers. The final report, Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders, was released in 1992 and included the following conclusions (US EPA, 1992):

In adults:

1. ETS is a Group A (known human) carcinogen.

In children, ETS exposure is causally associated with:

1. Increased prevalence of lower respiratory tract infections;
2. Increased prevalence of middle-ear effusion, symptoms of upper respiratory tract irritation, and a small but statistically significant reduction in lung function;
3. Additional episodes and increased severity of symptoms in children with asthma; and,
4. Exposure to ETS is a risk factor for new cases of asthma in children who have not previously displayed symptoms.

The EPA did not issue any findings regarding the link between heart disease and ETS exposure. However, the American Heart Association's Scientific Council has concluded that ETS increases the risk of heart disease (Taylor, et al., 1992). Some research indicated that the public health burden caused by ETS may be greater for heart disease than lung cancer (Steenland, 1992; Taylor, et al., 1992; Glantz & Parmley, 1991). Researchers have estimated that in addition to the cancer deaths attributable to ETS exposure (up to 3,700 to lung cancer and up to 12,000 to other cancers), up to an additional 37,000 nonsmokers die from heart disease caused by ETS exposure (Glantz & Parmley, 1991).

In addition to the EPA's classification of ETS as a Group A carcinogen, the National Institute for Occupational Safety and Health (NIOSH) has determined that ETS meets OSHA's criteria for classifying substances as potential occupational carcinogens (NIOSH, 1991). NIOSH also concludes that exposure to ETS poses an increased risk of heart disease among occupationally exposed workers (NIOSH, 1991).

CONSTITUENTS OF ENVIRONMENTAL TOBACCO SMOKE

Environmental tobacco smoke is a combination of mainstream smoke exhaled by the smoker and sidestream smoke emitted by the burning tip of a cigarette. The major source of ETS is sidestream smoke. Because of a lower burning temperature, sidestream smoke actually contains higher amounts of toxins and carcinogenic agents per gram of tobacco burned than mainstream smoke (US DHHS, 1986).

Nonsmokers' exposure to ETS can be measured by cotinine levels in body fluids. Cotinine, a metabolic by-product of nicotine, is an accurate marker for ETS exposure because of nicotine's specificity to tobacco smoke (US DHHS 1986). Many people who report no exposure to ETS have measurable levels of cotinine in their body fluids (NIOSH, 1991). The tobacco industry has claimed that cotinine levels in nonsmokers are caused by eating vegetables from the solanecae family (e.g., eggplant). However, a nonsmoker would have to eat several pounds daily to produce measurable levels of cotinine (Perez-Stable, et al., 1992; Repace, 1994). Although a metabolized by-product of nicotine is the biological marker of ETS exposure, nonsmokers are exposed to far more than just nicotine when they are exposed to ETS.

Four thousand seven hundred (4,700) chemical compounds have been identified in ETS, including carbon monoxide, nicotine, carcinogenic tars, ammonia, hydrogen cyanide, formaldehyde, benzene, and arsenic (US EPA, 1989). Many of these compounds are treated as hazardous when released into outdoor air by industrial plants (US EPA, 1989). Forty-three chemicals in tobacco smoke are identified carcinogenic compounds (US DHHS, 1989).

EFFECTS ON INDOOR AIR QUALITY

The EPA considers ETS the most widespread and harmful indoor air pollutant and a major contributor to indoor air pollution (US EPA, 1990). A 1980 study found that every indoor environment where smoking was permitted had air pollution levels of respirable suspended particles above the standards for outdoor air, while all smokefree areas met Federal standards for outdoor air (Repace & Lowrey, 1980). Exposure to ETS is high because most people spend approximately 90 pecent of their time indoors (US EPA, 1993).

RECOMMENDATIONS TO ELIMINATE EXPOSURE TO ETS

Both the Environmental Protection Agency and the National Institute for Occupational Safety and Health (NIOSH) recommend that nonsmokers should not be exposed to ETS (US EPA, 1989; NIOSH, 1991). Both agencies recommend two methods by which nonsmokers' ETS exposure can be eliminated (US EPA, 1989; NIOSH, 1991):

1. **Complete elimination of smoking in the building; or**
2. **Establishment of separate, enclosed smoking areas that are separately ventilated and directly exhausted to the outside.**

Overview: Clean Indoor Air Policy Options

Clean indoor air policies to reduce nonsmokers' exposure to environmental tobacco smoke (ETS) have historically treated public places, workplaces, restaurants, and bars as separate entities (Hanauer, et al., 1986; Pertschuk & Shopland, 1989; US DHHS, 1993). At a minimum, these policies set nonsmoking as the norm and restrict smoking to designated areas. A more recent trend is to prohibit smoking altogether (US DHHS, 1993).

Clean indoor air policies have been adopted in both the private and the public sectors. In the private sector, voluntary clean indoor air policies generally have been adopted by private employers, although public venues such as hospitals, hotels/motels, airports, and shopping malls have also adopted voluntary policies.

In the public sector, clean indoor air policies take either the form of legislation passed by elected legislative bodies or regulations adopted by public agencies. State laws are often referred to as clean indoor air laws, while local laws are called smoking ordinances (Pertschuk & Shopland, 1989).

Although the chief purpose of clean indoor air policy is to protect nonsmokers from the hazards of ETS exposure, restrictions on smoking have been shown to reduce both smoking prevalence and, among continuing smokers, cigarette consumption (Woodruff, et al., 1993; Emont, et al., 1992; Borland, et al., 1990; Stillman et al., 1990, Brigham, et al., 1994).

VOLUNTARY CLEAN INDOOR AIR POLICIES

Voluntary smoking policies have generally been the purview of private workplaces. The earliest workplace smoking policies were developed as safety measures to prevent fires, protect machinery, avoid product contamination, and improve workplace safety and were more commonly found among blue-collar (i.e., manufacturing) workplaces (US DHHS, 1986). Not until the 1970s did the nature and scope of voluntary workplace policies begin to change (US DHHS, 1986).

During the 1980s, smoking restrictions began shifting from workplace safety to employee health, and more nonmanufacturing workplaces began adopting policies (US DHHS, 1986). The policies themselves became more stringent, restricting smoking to even smaller designated areas.

Since the late 1980s, a growing trend to eliminate smoking in the workplace has emerged. A 1991 survey by the Bureau of National Affairs found that 34 percent of companies had eliminated smoking in the workplace, compared with 7 percent in 1987 and 2 percent in 1986 (BNA, 1991). In 1992, 52 percent of facilities managers surveyed reported that their facility had a smokefree workplace policy (Ward, 1992).

CLEAN INDOOR AIR LEGISLATION

Clean indoor air legislation has shown a bottom-up trend, with the strongest and most comprehensive policies concentrated at the local level, followed by state legislation, and, lastly policy established at the Federal level.

FEDERAL CLEAN INDOOR AIR POLICY

Federal clean indoor air policy focuses on smoking in Federal facilities and on public transportation (US DHHS, 1989). Both the U.S. Department of Health and Human Services and the U.S. Postal Service have adopted policies eliminating smoking in all of their facilities. Other Federal agencies have implemented policies that prohibit smoking except in designated smoking areas.

Amtrak, a quasi-governmental agency, has adopted a policy that eliminates smoking completely on trains traveling less than 4½ hours such as the metroliner between Washington and New York. The ban also covers all trains in California and other selected trains. To date, congressional action on clean indoor air has been limited to the airline smoking ban. Smoking is banned on all airline flights within the continental United States and overseas domestic flights of 6 hours or less.

STATE CLEAN INDOOR AIR POLICY

Early state legislation restricting smoking was intended to reduce fire and other safety hazards or treated tobacco use as a moral wrong (US DHHS, 1986). This trend

continued until the 1970s. With the first reports that smoking's ill effects were not limited to the smoker, state legislation began to shift its concern from fire safety to protecting nonsmokers (US DHHS, 1986).

In 1975, Minnesota passed its Clean Indoor Air Act, the first comprehensive state legislation to set nonsmoking as the norm. This landmark legislation restricted smoking except in designated areas in many public places, including restaurants and public and private worksites. In 1993, Vermont passed the most restrictive state clean indoor air legislation. Vermont is the first state to completely ban smoking in public places, restaurants, and all government buildings.

As of 1993, 46 states and the District of Columbia had passed some form of clean indoor air legislation dealing with public places. Forty-two restrict smoking in the public workplace and 22 include restrictions in private workplaces (Nobel, 1994).

LOCAL CLEAN INDOOR AIR POLICY

As with state legislation, the first local clean indoor ordinances were passed in the 1970s (US DHHS, 1993). As of September 1992, 543 local smoking ordinances were on the books (US DHHS, 1993).

Local ordinances are almost always stronger and more comprehensive than their corresponding state laws (US DHHS, 1989). The recent trend to completely eliminate smoking in public places, workplaces, and restaurants began and continues to flourish at the local level. In 1985, Aspen, Colorado was the first municipality to ban smoking in restaurants. Following the release of the draft EPA risk assessment in 1990, an increasing number of local 100 percent smokefree ordinances were enacted. As of May 1994, 87 smokefree ordinances completely eliminate smoking in public places, workplaces, and restaurants; 35 eliminate smoking in public places and restaurants; and 16 eliminate smoking in public places and workplaces (ANR, 1994).

Local ordinances have been adopted at a much faster rate than state legislation. A 1993 status report for the Tobacco Institute tracked a total of 388 local clean indoor air ordinances. Of these, 215 had been adopted, 147 were pending, and only 26 had been defeated (Tobacco Institute, 1993a). In contrast, of the clean indoor air bills introduced in 43 state legislatures in 1993, 20 were defeated (including an attempt to repeal preemption in Iowa) and only 16 were adopted (at least two of which include preemption of local ordinances) (Tobacco Institute, 1993b).

The tobacco industry has been largely unsuccessful in defeating clean indoor air policy at the local level. For this reason, preemption of local ordinances by state legislation has emerged as the tobacco industry's primary strategy to prevent the passage of clean indoor air legislation. (See section on Opposition to Clean Indoor Air Policy for more information on preemption.)

LOCATIONS COVERED BY CLEAN INDOOR AIR LEGISLATION

Locations that are generally covered by clean indoor air policies (legislative or regulatory), at both the local and the state level include:

- Workplaces, both public and private
- Enclosed public places, which include most areas open to the general public or to which the public is invited (e.g., retail stores, banks, theatres, museums, and public transit)
- Restaurants, and in some instances, bars (particularly those attached to restaurants)
- Schools
- Child care centers
- Health care settings
- Public transportation
- Prisons
- Recreation facilities such as sports stadiums, bowling centers, and bingo parlors

PUBLIC SUPPORT FOR CLEAN INDOOR AIR POLICIES

As early as 1964, a majority (52 percent) of adults thought smoking should be allowed in fewer places than it was at the time (US DHHS, 1989). Years before the 1986 Surgeon General's report on involuntary smoking, nonsmokers believed that exposure to secondhand smoke was harmful. A 1978 survey completed for the tobacco industry found that 58 percent of Americans believed that being exposed to other's cigarette smoke was hazardous to their health (The Roper Organization, 1978).

A 1988 Gallup survey found that the percentage favoring a total ban on smoking in public places was 60 percent (75 percent of nonsmokers) (Gallup, 1988). In 1994, that percentage had increased to 67 percent (78 percent of nonsmokers), according to a New York Times/CBS NEWS poll (Janofsky, 1994). The public has also shown a consistent trend in support of restrictions on smoking in the workplace (US DHHS, 1989).

Adoption of smokefree policies may actually lead to an increase in support for smoking bans in certain environments. In 1984, a Field poll in California found that only 38 percent of the state's residents favored a complete ban on smoking in airplanes. In 1993, a few years after the congressional ban of smoking on domestic flights, that number had more than doubled to 81 percent (The Field Poll, 1993).

Policy Options

Given the serious health risks associated with secondhand smoke exposure, it is imperative that nonsmokers be provided with smokefree public places and workplaces to the greatest extent possible. In some instances, it is not judged to be politically possible to immediately enact smokefree legislation; this may be particularly true in jurisdictions that are adopting restrictions on smoking for the first time. To be effective, it

is essential that the legislation be supported by the community. Policy development should always begin with community education, including media advocacy, before any legislation is introduced.

The options listed below contain several provisions that can be incorporated into a piece of clean indoor air legislation. Each list begins with the total elimination of smoking; recommendations for partial restrictions are located at the end of each options list. Although these options specifically focus on enacted legislation, many of the options are appropriate guidelines to develop voluntary policies.

WORKPLACES

Approximately 80 percent of the average nonsmoker's exposure to secondhand smoke occurs at work (Repace & Lowrey, 1985). In addition to reducing secondhand smoke exposure, worksite restrictions and bans help some smokers reduce or quit smoking (Borland, et al., 1990; Stillman, et al., 1990). A recent study estimates that if every California workplace went smokefree, consumption among employees would drop 41 percent below that if there were no workplace smoking policies (Woodruff, et al., 1993). The effect of a workplace policy on smoker behavior is reduced when the workplace is only partially smokefree (Woodruff, et al., 1993).

Many workplaces voluntarily restrict or eliminate smoking. A 1991 survey by the Bureau of National Affairs found that 85 percent of responding firms adopted policies restricting smoking, with 34 percent completely eliminating smoking at work. Although many of these were adopted voluntarily, 36 percent of the respondents reported that their policies were adopted as a result of state or local legislation (BNA, 1991). (See section on Voluntary Worksite Programs for more information.)

Many local jurisdictions and state legislatures first adopt policies that cover only governmental workplaces, restricting or eliminating smoking in all government facilities. These restrictions are often adopted through administrative policies or resolutions, although some are put in place through enacted legislation. The next phase is to extend these restrictions to private workplaces. The majority of state and local laws partially restrict smoking in public and private workplaces, although a growing number of local ordinances completely eliminate smoking in all workplaces.

Smokefree workplace legislation prohibits smoking in all enclosed areas of the workplace. Some legislation has allowed the construction of smoking areas, which are enclosed and separately ventilated from the rest of the building. (See section on Common Exemptions for more information.)

Partial bans on smoking in the workplace generally prohibit smoking in all common areas, particularly restrooms, hallways, common work areas, and meeting rooms. In addition, many allow employees to designate their own immediate work areas as nonsmoking (Pertschuk & Shopland, 1989; US DHHS, 1993). Partial restrictions often include a "nonsmoker's preference" clause, specifying that in the event of a dispute over

a smoking policy, the right of the nonsmoker to a smokefree workplace prevails (US DHHS, 1993). Partial restrictions almost always specify that the proprietor of any regulated area has the right to designate the entire facility smokefree (US DHHS, 1993).

Most workplace legislation, smokefree or partial restrictions, includes a "nonretaliation clause" protecting employees and job applicants who seek their rights under the law (US DHHS, 1993). Many clean indoor air laws also require employers to develop a written policy for the workplace, which conforms with the requirements of the law (US DHHS, 1993).

Options

* Prohibit smoking in all enclosed workplaces.
* Prohibit smoking in all enclosed workplaces, except for a designated smoking area that is enclosed, separately ventilated, and directly exhausted to the outside.
* Include a nonretaliation clause protecting nonsmokers who assert their rights under the law from retaliation by an employer.
* Require the employer to develop a written workplace policy whose provisions comply with requirements established by the law. Copies shall be provided on request.
* If smoking is allowed in designated areas, prohibit smoking in all commonly used areas of the workplace, allow employees to designate their immediate work area as nonsmoking, specify that the nonsmoking employee's rights prevail when disputes arise over smoking in the workplace, and specify that any regulated area may designate the entire facility as smokefree.

ENCLOSED PUBLIC PLACES

Legislation restricting smoking in public places typically prohibits smoking completely rather than mandating separate smoking and nonsmoking areas. "Public places" includes any enclosed area open to the public such as retail stores, businesses open to the public, theatres, museums, and reception areas (Pertschuk & Shopland, 1989; US DHHS, 1993). Some of the newest local ordinances regulate smoking in the common areas of apartment buildings such as lobbies, stairways, common laundry facilities, and hallways between apartments (ANR, 1994).

Most clean indoor air legislation lists various venues covered under the law to clarify the intent and coverage of the law. When such lists are present, it is important to include language stating that the list "includes, but is not limited to" the listed areas.

Options

* Prohibit smoking in all enclosed public places, specifying that all enclosed public places, unless specifically exempt, are included.
* List specific environments (e.g., elevators and restrooms, service lines, retail stores, office areas where the public is allowed, and theatres) that are covered by the ban.

RESTAURANTS AND BARS

Although restaurants and bars serve as both public places and workplaces, they have historically been treated separately in clean indoor air legislation (Pertschuk & Shopland, 1989; US DHHS, 1993; Hanauer, et al., 1986). However, the debate has begun to focus on restaurants and bars as workplaces. This is important, as secondhand smoke levels in both restaurants and bars are higher than those found in most other workplaces.

The level of environmental tobacco smoke in restaurants is about 1.6 to 2 times higher than that found in an office. In bars, exposure to ETS is 3.9 to 6.1 times higher than office exposure. This increased exposure to secondhand smoke results in a 50 percent greater risk of contracting lung cancer for restaurant and bar workers (Siegel, 1993b).

Many clean indoor air laws require restaurants to establish smoking and nonsmoking sections. A move to completely eliminate smoking in restaurants began in the mid-1980s and has accelerated in the 1990s with the release of the Environmental Protection Agency's risk assessment classifying secondhand smoke as a Group A carcinogen (US DHHS, 1993; US EPA, 1992). A report released by an Attorneys General Working Group on Tobacco, recommending that fast food restaurants go smokefree, has provided additional impetus to the restaurant industry to adopt voluntary smokefree policies (Attorneys General, 1993).

Policymakers have been reluctant to restrict smoking in free-standing bars and taverns. A handful of local laws require separate smoking sections in bars, but by early 1994, only 10 local ordinances completely banned smoking in all bars (ANR, 1994). Smoking is more commonly regulated in bars that are attached to restaurants. Thirty-six local ordinances that prohibit smoking in restaurants have also covered smoking in bars attached to restaurants (ANR, 1994). Generally, these laws either prohibit smoking in restaurant cocktail lounges and bars or allow smoking only if the bar area is separately

enclosed and ventilated in a manner that prevents secondhand smoke from recirculating into the rest of the restaurant.

Options

* Eliminate smoking completely in all restaurants and bars.
* Permit smoking in free-standing bars, but eliminate smoking in bars attached to restaurants unless the bar: (1) is in a separate room from the dining room; (2) has a separate ventilation system; (3) is not the sole entrance or waiting area for dining; and (4) prohibits minors from entering.
* If smoking sections are established, set the maximum allowable size of the smoking area at a percentage that is no larger than the percentage of smokers in the community.

SCHOOLS

A growing number of public schools completely prohibit tobacco use on school grounds, by students, faculty, staff, and visitors. Some of these restrictions follow state or local law, others have been adopted by the local school district. By the end of 1992, nine states and the District of Columbia prohibited smoking on school grounds. A survey by the National School Board Association found that in the 1991-92 school year, 40 percent of school districts totally prohibited tobacco use by both students and adults (NSBA, 1992).

Fourteen states ban tobacco use by students on school grounds (O'Connor, 1992). Because these policies still allow smoking by faculty, staff, and visitors, they may fail to adequately protect nonsmokers. Smokefree policies that include faculty and staff receive greater support among students (Phillips & McCoy-Simandle, 1993). A policy that applies to both students and adults promotes "a consistent message — tobacco use is hazardous for adults as well as students and therefore unacceptable in the school setting" (Griffin, et al., 1988).

Options

* Prohibit the use of tobacco products by students, faculty, staff, and visitors within all public school buildings and on school grounds during and after school hours.
* Prohibit tobacco use at all off-campus school functions by students, faculty, staff, and visitors.

CHILD CARE CENTERS

Child care centers have begun prohibiting smoking as a result of their own voluntary policies or state or local laws. These policies are the result of increased awareness of the health risks of secondhand smoke, especially for children.

By the end of 1993, 14 states prohibited smoking in child care centers, while many others restricted smoking (Nobel, 1994; ANR, 1994). Many local ordinances ban smoking in all day care centers, covering facilities serving both children and adults (ANR, 1994).

Options

* Prohibit smoking in all child care centers.
* In child care centers that are operated in private homes, allow smoking only after hours in areas where clients are not permitted.

HEALTH CARE SETTINGS

Smoking restrictions in hospitals are fairly common. A 1987 survey by the American College of Healthcare Executives found that 96 percent of responding hospitals had some type of restrictions on smoking (American Medical News, 1991). As a result of standards established by the Joint Commission on Accreditation of Healthcare Organizations, hospitals, including long-term care and mental health care programs housed within a hospital, must be virtually smokefree. The standards permit smoking only for patients with a physician's prescription that permits smoking based on criteria developed by medical staff. Hospitals that were not already smokefree must at least have a plan for going smokefree by December 31, 1993 (JCAHO, 1991).

Under revisions of the JCAHO standards, hospitals may also designate certain smoking areas for patients who do not have patient-specific permission to smoke, providing that the smoking areas are designed in a way to protect nonsmokers and providing that the areas are only for the use of chronically mentally ill patients, long-term/intermediate care and skilled nursing patients, forensic psychiatry patients, and post-acute head trauma (social rehabilitation) patients (Sachs, 1993).

There is little information about smoking policies in non-hospital health care settings. An area that generates controversy is long-term care facilities. Because patients reside in these types of facilities for long periods of time, staff are reluctant to adopt complete bans on smoking. In some states, only the state can regulate smoking in these facilities. In California, for example, the Department of Health Services, rather than counties or municipalities, has regulatory jurisdiction over skilled nursing facilities and intermediate care facilities (Cal DHS, 1992).

Options

* Prohibit smoking completely in hospitals and other health care facilities, including private homes when used as a health care facility.
* Allow exemptions for chronically mentally ill patients, long-term/intermediate care and skilled nursing patients, forensic psychiatry patients, and post-acute head trauma (social rehabilitation) patients, if they have written, patient-specific permission from their attending physician based on standards established by the medical staff and smoking is allowed only in areas that are enclosed, separately ventilated, and directly exhausted to the outside.

PUBLIC TRANSPORTATION

Today, smoking is rarely permitted on public transportation vehicles. Numerous Federal, state, and local laws eliminate smoking on public transportation vehicles and transit depots (US DHHS, 1993). In 1989, Congress banned smoking on all airline flights within the continental United States. The airline smoking ban also extends to overseas domestic flights of 6 hours or less (e.g., California to Hawaii).

Smoking policies covering local public transportation systems, such as buses or light rail, are typically adopted in one of two ways. The first is through inclusion in a local smoking ordinance. The second is adoption of a smoking policy by the local policymaking body with jurisdiction over the system. A total of 391 local ordinances regulate smoking on public transportation. In addition, 39 state clean indoor air laws ban smoking on public transportation (US DHHS, 1993).

Options

- Prohibit smoking in all vehicles of public transportation, including buses and taxicabs.
- Prohibit smoking in all transit depots such as airports and train platforms.

PRISONS

Although prisoners smoke at rates significantly higher than the general population (Duggan, 1990), an increasing number of prisons and jails are eliminating smoking. The American Jailers Association adopted a resolution in May 1990 urging jails to ban smoking (Skolnick, 1990), and about 10 million prison inmates are currently covered by some sort of smoking restrictions (CDC, 1992a).

Some prison policies prohibit smoking in jail cells but permit it in prison yards, while others prohibit smoking by inmates entirely, and the strongest do so for prison staff as well. Some of these policies are put in place by administrators, while others are the result of state or local legislation and regulation.

A recent court case has increased the incentives for prisons and jails to establish smoking policies. In Helling v. McKinney, the U.S. Supreme Court opened the door to potential lawsuits brought by nonsmoking prison inmates on the theory that exposure to secondhand smoke constitutes cruel and unusual punishment, prohibited by the 8th Amendment to the U.S. Constitution.

Although many jails are adopting smokefree policies, larger prisons are responding more slowly (Skolnick, 1990). Nearly two-thirds of inmates are housed in prisons rather than jails (CDC, 1992a), leaving a substantial number of inmates and prison staff exposed to secondhand smoke.

Options

* Prohibit smoking in enclosed areas of jails and prisons by both inmates and staff.
* Establish a nonsmoking area in prison yards.

RECREATIONAL FACILITIES

Although recreational facilities are considered public places, they are often treated separately in clean indoor air legislation. Recreational facilities, including sports arenas, bingo parlors, bowling alleys, and card rooms often seek exemptions from restrictions covering public places.

SPORTS ARENAS AND STADIUMS

Many sports arenas and stadiums, including open-air stadiums, have voluntarily implemented smokefree policies. By mid-1993, 12 open air stadiums and the two enclosed stadiums for Major League baseball teams eliminated smoking in seating areas, compared with 12 open-air stadiums that permitted smoking. Of the 12 that permitted smoking, 6 had nonsmoking seating sections (SES, 1993).

Options

* Prohibit smoking in all seating sections, concourses, and restrooms. If the facility is open air, permit smoking only in a designated area away from the seating sections and restrooms.
* Prohibit smoking in all concourses and restrooms. Establish nonsmoking and smoking seating sections.

BINGO PARLORS

Many lawmakers are reluctant to confront churches, schools, and other non-profit organizations that operate bingo parlors as fundraisers. As a result, bingo parlors are often exempt from provisions regulating smoking in public places. Exemptions for bingo parlors are particularly troubling because some of the highest levels of indoor air pollution ever measured were in bingo parlors (Repace & Lowrey, 1980; Repace & Lowrey, 1982). More recent clean indoor air legislation is beginning to drop the exemption for bingo parlors. The state of Vermont and numerous local ordinances prohibit smoking at bingo games, while others require the establishment of smoking and nonsmoking sections or rooms (Rau, 1993; ALA, 1993b; ANR, 1994; Sullivan, 1992).

Options

* Prohibit smoking at all bingo games.
* Require separate rooms for nonsmoking and smoking patrons.

BOWLING CENTERS

Although bowling centers market themselves as "family entertainment" and are frequented by children, bowling centers have historically been exempted from clean indoor air legislation. As with bingo parlors, new legislation is beginning to drop this exemption. The state of Vermont and numerous local ordinances now include bowling centers under provisions regulating smoking in public places (Rau, 1993; ANR, 1994; ALA, 1993a).

Many bowling centers have restaurants or bars located on the premises. These restaurants and bars must comply with whatever requirements have been established for these venues under state or local legislation.

Options

* Prohibit smoking in bowling centers.
* Prohibit smoking except for a designated area on the concourse.

ENFORCEMENT ISSUES

Clean indoor air legislation has historically required relatively little enforcement activity. Most laws are "self-enforcing;" enforcement is activated by complaint, rather than through active surveillence.

DESIGNATING AN ENFORCEMENT AGENCY

At the state level, the state health department is the most commonly designated enforcement agency (US DHHS, 1989). Most local ordinances designate either the city manager or local health department as the primary enforcement agency (US DHHS, 1993; Hanauer, et al., 1986). Fewer jurisdictions have designated the police department as the enforcement agency (US DHHS, 1989). As a supplement to enforcement activities by the primary agency, environmental health officers and fire officials may be required to inspect facilities for compliance with clean indoor air legislation during the course of other mandated inspections.

VIOLATIONS AND PENALTIES

Compliance with clean indoor air legislation is required of smokers, employers, and proprietors of public places covered by the legislation. Language should be included specifying that each of these parties must comply with the provisions of the law.

Violations should be civil rather than criminal. Many laws classify violations as an infraction. As has been observed in the youth access to tobacco arena, the criminal justice system is already overburdened, and violations of clean indoor air legislation are not likely to be a high priority with law enforcement officials or the courts.

Most legislation establishes a graduated fine structure that increases with multiple violations.

IMPLEMENTATION

One of the chief means of achieving compliance is the posting of "No Smoking" signs and the removal of ashtrays and other smoking paraphernalia from areas in which smoking is prohibited (Hanauer, et al., 1986). Posting of signs informs the public about the law and provides a mechanism for employers and proprietors to request compliance. A study examining the compliance level of retail stores under a local ordinance found that employees and patrons in stores that posted signs were more likely to comply with the prohibition against smoking (Rigotti, 1993).

Because the majority of clean indoor air legislation is "self enforcing," it is important to inform the general public and the business community about the requirements of the law (Rigotti, 1993). Some legislation includes a public education component, requiring the health department or other enforcing agency to develop a program or mechanism to educate the community.

Enforcing laws protecting nonsmokers does not require vast amounts of resources. In Minnesota, the Department of Health spent about $4,600 per year for the first 3 years in which their statewide Clean Indoor Air Act was in effect (Kahn, 1983). San Luis Obispo, California, spent $3,000 on educational materials to help implement their ordinance (Reiss, 1992). Several local jurisdictions have found that enforcement activities required a decreasing amount of attention over time, with the majority of complaints received during the first few months after enactment (Martin, 1988).

Although enforcement activities largely rely on community education and adequate signage to achieve compliance, resources should be available to follow up on complaints and, if necessary, issue citations.

Options

* Designate an enforcement agency.
* Require proprietors and employers to post "No Smoking" signs and remove all ashtrays and smoking paraphernalia in all areas where smoking is prohibited.
* Define violations by smokers, proprietors, and employers who are out of compliance.
* Create a graduated civil fine structure for violations.
* Require the enforcement agency to engage in a public education program to inform the public and the business community about the law.
* Require Health and Fire Department officials to inspect an establishment for compliance during the course of any other mandated inspections.

Appendix 6.C. Excerpts from *Tobacco Advertising and Promotion: A Guide to Developing Policy*

Tobacco Advertising and Promotion

A Guide to Developing Policy

Number three in a series of four policy guides

ASSIST
The American Stop Smoking Intervention Study

National Cancer Institute
National Institutes of Health
US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prepared by:
Americans for Nonsmokers' Rights
Berkeley, California
with
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Rockville, Maryland

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*Page numbers in this Table of Contents are from the original document and do not correspond to page numbers in this monograph.

Background

INTRODUCTION

"Advertising, in the hands of manufacturers of tobacco products, has become a powerful tool for the construction of the massive edifice of this industry."

"There is no obstacle to large-scale sales of tobacco products that cannot be surmounted by aggressive selling."

Although these statements from the *United States Tobacco Journal* were made in 1953 and 1955, respectively, they document the tobacco industry's early recognition of the impact and value of advertising and promotion to increase and maintain the consumption of cigarettes and other tobacco products (US DHHS, 1994). The magnitude and scope of tobacco advertising and promotion have increased to such a great extent that many localities, states, and the Federal Government have enacted or are considering policy remedies to curb tobacco advertising and promotion as a complement to other tobacco control activities such as the adoption of smoking ordinances and restrictions on youth access to tobacco products.

ADVERTISING VS. PROMOTION

With approximately 400,000 people dying each year from tobacco-related diseases as well as smokers who die of other causes and 1.5 million Americans who quit smoking, the tobacco industry must attract more than 2 million new smokers each year to maintain its market (Myers & Hollar, 1989).

Two major forms of tobacco marketing exist: advertising and promotion. "Advertising" is the use of advertisements in the paid media, which is comprised of newspapers, magazines, billboards and other outdoor venues, and transit system vehicles. Advertising entails direct targeting of current or prospective consumers of tobacco products to initiate or maintain cigarette consumption. The tobacco industry argues that advertising functions strictly as a means to encourage brand switching or maintain brand loyalty. Other evidence indicates that advertising serves to foster new and expanded consumption.

"Promotion" encompasses efforts to influence consumers beyond advertising. One prominent form of promotion is sponsorship of artistic, athletic, and cultural events. Other promotions include point-of-purchase displays that publicize the location of tobacco products and increase brand recognition. Retail stores are filled with clocks, grocery cart signs, in/out decals on doors, and banners (Cummings, 1991). Other promotions include coupons, retail value-added items (such as free cigarette lighters and T-shirts), and free samples. Another promotional device that has been extremely successful, but expensive, is the distribution of merchandise that displays tobacco logos (US DHHS, 1994; Warner et at, 1992). The names and addresses of those requesting

merchandise, often along with survey data, are entered into databases that are used for additional marketing efforts as well as political organizing efforts.

TOBACCO INDUSTRY EXPENDITURES

In 1992, according to the Federal Trade Commission, tobacco advertising and promotion expenditures had reached $5.23 billion (FTC, 1994). These expenditures have been increasing dramatically, with the industry spending $361 million in 1970 and $1.2 billion in 1980 (US DHHS, 1994).

By the mid-1980's, *advertising* expenditures had decreased relative to *promotional* activities, primarily as a result of decreased reliance on print advertisements in newspapers and magazines (US DHHS, 1994). In addition, the number of newspapers and magazines that have voluntarily instituted policies banning tobacco advertising continues to grow, although many are more narrowly read journals rather than major publications such as *Time* and *People* magazines. Use of outdoor advertising (billboards) and transit posters remains high (US DHHS, 1994).

In 1992, promotional activities such as coupons, merchandise, and sponsored events accounted for approximately 80 percent of overall advertising and promotion expenditures, up from 12 percent in 1970 (Butler, 1993; FTC, 1994). The largest category of promotional spending includes coupons and retail value-added promotions such as free shirts and lighters, totaling $2.17 billion in 1992, or more than 40 percent of all cigarette advertising and promotional expenditures (FTC, 1994). This is a stunning figure, up from $960 million in 1988 (FTC, 1994).

Promotional allowances are another growth area for tobacco promotion. Promotional allowances are designed to provide incentives to wholesalers and retailers to promote a company's products and include free goods or price reductions, slotting allowances, contests, and training programs. Cigarette companies spent $1.5 billion on promotional allowances in 1992, accounting for nearly 29 percent of the total spent on advertising and promotion (FTC, 1994).

THE IMPACT OF ADVERTISING AND PROMOTION ON TOBACCO CONSUMPTION

Research has demonstrated that a connection exists between advertising, promotion, and tobacco consumption. The tie between tobacco marketing and consumption is confirmed by the following findings:

- Advertising and promotion may encourage children or young adults to experiment with tobacco, and regular use may be initiated with repeated exposure to positive images associated with tobacco use (US DHHS, 1989).
- Advertising and promotion may influence former smokers to resume smoking.
- The paid media's dependence on revenue from tobacco advertising decreases coverage of the risks and consequences of tobacco use (Warner & Goldenhar, 1989; Warner, 1992).

- Organizations such as professional sports teams, cultural and charitable organizations, and groups that serve populations targeted by the tobacco industry (e.g., communities of color and women) have become dependent on tobacco company resources. These groups may be less likely to publicize the negative impact of tobacco use and possibly mute opposition to the tobacco industry's political agenda (Robinson et al., 1992).
- Tobacco advertising and promotion encourages the social acceptability of tobacco products, sometimes diminishing the smokers' perception of the danger of tobacco use (US DHHS, 1989; Myers & Hollar, 1989).

THE IMPACT OF ADVERTISING ON CHILDREN

The *Surgeon General's Report on Preventing Tobacco Use Among Young People,* released in February 1994, documents the problem of underage smoking. Although the report acknowledges that many factors contribute to the initiation and maintenance of tobacco use by children and adolescents, considerable attention is given to the strong influence of advertising and promotion (US DHHS, 1994).

Tobacco industry marketing researchers have successfully produced tobacco-related themes and images that appeal to teenagers. Youth of both genders are enticed with images that associate tobacco use with independence, popularity, and relaxation. Boys are influenced by the ties between smoking and masculinity, athleticism, and adventure, but girls are conditioned to associate tobacco use with thinness, romance, and liberation (US DHHS, 1994).

More than 90 percent of all new smokers are under age 20. During the past decade, the smoking rate for adults has steadily declined, but the teenage rate has remained virtually constant (McKenna & Williams, 1993).

Evidence of the association between tobacco advertising, promotion, and underage smoking is found in a number of studies:

- Approximately 86 percent of adolescent smokers prefer either Marlboro, Newport, or Camel, which are the brands that spend the most on advertising (CDC, 1994).
- In an analysis of tobacco advertising, a study showed that as tobacco expenditures targeting women rapidly increased from 1967 to 1974, a corresponding rise in the annual rates of initiation for 11- to 17-year-old girls was found (Pierce et al., 1994).
- One-half of the adolescents in a Gallup survey could associate brand names with cigarette slogans (US DHHS, 1994).

To counter concerns about tobacco advertising's appeal to children, the tobacco industry adopted a voluntary code of advertising ethics (CigaretAdvertising Code, 1964). The industry's code, for example, purports to prohibit tobacco advertisements in publications intended for persons under age 21 and admonishes against the use of models

who are or appear to be under age 25. The existence of the code has resulted in little, if any, reduction in tobacco advertising's impact on children. In some cases, the guidelines are insignificantly weak. In other cases, the guidelines are apparently ignored, as in the case of the rule against young-looking models. Indeed, the most egregious example of advertising that targets children, the Joe Camel campaign, appeared long after the code had been adopted.

The Joe Camel Campaign

In 1988, R.J. Reynolds began one of the most successful advertising campaigns in history with its "Smooth Character" campaign, featuring a cartoon character named Joe Camel. The mischievous Joe Camel appears in numerous daring, adventurous, and of course, cool situations. The campaign was also among the first to offer products with brand logos in exchange for proofs-of-purchase.

Critics charge that this campaign targets children. Not only is the Joe Camel character well recognized by children, but Camel cigarettes have improved Reynolds' market share among underage smokers (Pierce et al., 1991).

Several indicators substantiate the campaign's youth appeal:

- Camel's share of the under age 18 market increased from 0.5 percent in 1988, when Joe Camel was introduced, to 32.8 percent in 1991 (DiFranza et al., 1991).
- Camel was identified as the most advertised brand of cigarettes by 28.5 percent of teenagers. This brand was preferred by 24.5 percent of males age 12 to 17 and 21.7 percent of females in the same age group (Pierce et al., 1991).
- Approximately 30 percent of 3-year-olds could match the Old Joe character with a cigarette, and 6-year-olds could accomplish this task 91 percent of the time. In addition, the 6-year-old children identified Joe Camel as often as the Mickey Mouse ears of the Disney channel (Fischer et al., 1991).

TARGETED ADVERTISING AND PROMOTION BY RACE AND SEX

Particular attention has been paid to advertising and promotion that targets ethnic groups and women (US DHHS, 1989). The tobacco industry has a long history of courting ethnic populations. The most obvious example of this is a history of extensive financial contributions to political, social, and artistic organizations. Examples include the Congressional Black Caucus, the National Women's Political Caucus, the Kool Jazz Festival, and various Cinco de Mayo celebrations.

The introduction of population-specific brands of cigarettes is one of the more recent avenues that the tobacco industry has taken to target its marketing efforts to particular groups. One of the most notorious examples was the "Uptown" cigarette brand, targeted at African Americans. After a community coalition in Philadelphia mobilized opposition to this marketing strategy by R.J. Reynolds, Uptown was *not* introduced as

part of a planned test market (US DHHS, 1994; *Advertising Age,* 1990). In another case, the tobacco industry enraged women's groups with the introduction of the "Dakota" brand, which targeted young "virile" females (Cotton, 1990).

There are numerous examples of tobacco industry targeting, and the best can often be found in one's own backyard. However, some examples follow:

- Targeting of African Americans includes sponsorship of cultural activities such as the Kool Jazz Festival and the Alvin Ailey Dance Theater. Other activities include the Kool Achiever Awards and image advertisements featuring Martin Luther King. African-American newspapers and magazines receive about $6 million per year in tobacco advertising revenues (Williams, 1986).
- Targeting of the Latino/Hispanic community includes sponsorship of cultural events such as Cinco de Mayo celebrations. Philip Morris is the largest advertiser in Latino magazines, and 20 percent of all Latino newspaper advertising revenue comes from alcohol and tobacco companies (Maxwell & Jacobson, 1992).
- There is growing evidence of targeting of Asian/Pacific Islanders. Several California surveys indicate that Asian/Pacific Islander neighborhoods suffer the highest concentrations of tobacco billboards (Le, 1994). One survey indicated that Asian-American neighborhoods have 17 times more cigarette billboards than white neighborhoods (McLaughlin, 1993).
- One notorious example of a promotion targeting women is Philip Morris' Virginia Slims tennis sponsorship. Virginia Slims has sponsored the women's tennis tour since 1971 (Robinson et al., 1992).
- Native Americans, a group with high use of cigarettes and smokeless tobacco in adults and youth, are also targeted by the tobacco industry, although little if any research on tobacco advertising and promotion has been conducted around this population.
- There is growing evidence that the tobacco industry may be targeting lesbians and gays. Philip Morris ran advertisements for Benson and Hedges' Special Kings in the gay fashion magazine *Genre* and other magazines with a high gay readership as well as for Parliament cigarettes in *OUT* magazine, the largest circulation gay magazine in the United States (Lipman, 1992; CLASH, 1994). Recent advertisements for Virginia Slims may target lesbians, and advertisements for American Brand's Montclair cigarettes feature stereotypically effeminate gay men (Goebel, 1994).

The argument that tobacco industry advertising targets people of color has been validated by numerous surveys of billboard placement. Tobacco billboards are predominantly found in neighborhoods where African Americans and other people of color are more highly concentrated. Some survey results, reported by the Center for Science in the Public Interest (1990), include:

- Seventy percent of the 2,015 billboards in Baltimore advertised alcohol and tobacco; three-quarters of billboards were in predominately African-American neighborhoods.
- In low-income neighborhoods in Detroit, 55 to 58 percent of billboards advertised alcohol or tobacco.
- More than one-third of New Orleans' billboards are located within one-half mile of the city's low-income Federal housing projects.
- Sixty-two percent of billboards in black neighborhoods in St. Louis advertised alcohol and tobacco, compared with 36 percent in white neighborhoods; three times as many billboards were found in black neighborhoods as white.

PUBLIC OPINION ON ADVERTISING RESTRICTIONS

Recent public opinion polls suggest that there is growing support for restrictions on tobacco advertising and promotion. A sample of some of the most recent polls include:

- In a Gallup survey conducted in February 1994, 68 percent of Americans believe that cigarette advertisements influence children and teens to smoke; 66 percent believe that some cigarette advertisements are specially designed to appeal to young people; 53 percent want a total ban on tobacco advertising (Colford, 1994).
- In a 1993 Gallup survey, 53 percent favored a complete ban on tobacco advertising, 76 percent of adults favor restrictions on cigarette advertising that appeals to children, 66 percent favor restrictions on advertising that encourages people to smoke, 64 percent favor restrictions on advertisements that make smoking appear glamorous, and a majority of people in the largest tobacco-growing states also favor the restrictions listed above (Coalition on Smoking OR Health, 1993).
- Ten communities participating in NCI's Community Intervention Trial for Smoking Cessation (COMMIT Program) were surveyed, and 60.5 percent agreed that all tobacco advertising should be banned (CDC, 1991).
- A 1990 survey in California found that 54 percent support a ban on billboard tobacco advertisements, 49 percent support a ban on tobacco advertisements in newspapers and magazines, 67 percent supported a ban on the distribution of free tobacco samples or coupons to obtain free samples by mail, and 75 percent support a ban on the distribution of free tobacco samples on public property.

For a detailed discussion of answers to tobacco industry arguments against regulating tobacco advertising, see the ASSIST Key Required Resource *Truth and the Consequences of Cigarette Advertising: An Advocate's Guide to Arguments in Support of Banning Cigarette Advertising and Promotions.*

Overview of Policy Options

Tobacco advertising and promotion constitute one of the greatest obstacles to tobacco control in the United States. Advertising and promotion encourage children and young people to use tobacco, reduce smokers' motivation to quit, and legitimize the tobacco industry (US DHHS, 1989).

Numerous options are available to the public health community to counter tobacco industry advertising and promotion, ranging from a total ban on advertising and promotion to various voluntary approaches.

Before considering how to approach the problem of tobacco advertising and promotion, public health professionals should first understand the role of tobacco advertising in their specific community. The tobacco industry's activities in each community are different, and it is vital to identify those activities of greatest concern in a specific community before crafting a response.

Pro-health interests must also understand the acceptable limits of policy change in a given community. Although some regions may support a complete ban on advertising and promotion, others such as those in tobacco-producing states may be more limited in what the community is prepared to accept.

The following issues should be considered in assessing a particular community:

- How receptive is the community to tobacco control policy? For example, have ordinances that limit smoking or reduce youth access to tobacco products already been adopted? How strong are those policies?
- To what extent does the tobacco industry target particular populations with their advertising and promotion?
- How are tobacco billboards distributed in the community?
- To what extent does the tobacco industry sponsor cultural, artistic, or athletic events?
- Does tobacco advertising appear on public transportation vehicles or transit depots?
- Do tobacco billboards appear in sports facilities such as stadiums?
- What types of point-of-purchase advertising and promotion are found in the community? Promotional displays? Sales or free distribution of logo-branded gear?
- Does the tobacco industry engage in free sampling of tobacco products?

By answering these questions, public health professionals can develop a sense of both the needs of the community and any practical limits on policy change.

After assessing the needs of the community, the next step is considering options. Although many of these policy options may be implemented at the Federal level through either legislative or regulatory mechanisms, this discussion is intended to provide practical information to those working at the local and state levels.

The following are options available to state and local public health professionals and policymakers. It should be noted that the first two categories represent options for policy change, but the latter four categories provide other options for countering the effects of tobacco advertising and promotion and supporting policy change.

Restrictions on Tobacco Advertising

— Banning or limiting tobacco billboards
— Banning or limiting tobacco advertising on public transportation
— Banning or limiting advertising in public facilities
— Banning or limiting advertising in athletic facilities
— Eliminating the tax deductibility of tobacco advertising expenses
— Barring the use of cartoon characters in tobacco advertising

Restrictions on Promotional Activities

— Prohibiting tobacco industry sponsorship of events
— Prohibiting free sampling of tobacco products
— Banning or limiting point-of-purchase displays

Counteradvertising

— Paid counteradvertising
— Mandatory counteradvertising
— Public service announcements (PSA's)

Counterpromotions

— Alternative sponsorship
— Countersponsorship
— Other counterpromotions

Voluntary Approaches

— Community advertising surveys
— Poster contests
— Voluntary advertising restrictions
— Voluntary point-of-purchase advertising bans

Media Advocacy

Policy Options

RESTRICTIONS ON TOBACCO ADVERTISING

The most direct and comprehensive solution to the problem of tobacco advertising is to ban it. In spite of significant legal issues, there are a number of actions that State and local governments and public health professionals can undertake to eliminate or limit tobacco advertising.

Federal law prohibits television and radio advertisement of tobacco products, effective January 1,1972. Under current Federal law, however, billboard, magazine, and newspaper advertising of tobacco products is permitted. Numerous bills have been introduced in Congress to ban or limit tobacco advertisement and promotion, but to date none have passed.

Tobacco Billboards

The Federal Cigarette Labeling and Advertising Act contains a preemption clause that limits the authority of State and local governments to ban tobacco advertising (see Legal Issues). However, the state of Utah banned tobacco billboards in 1929 (Utah Criminal Code). The Utah law bans all types of billboards, public transportation displays, and point-of-purchase advertisements for tobacco products, including in/out signs, clocks, and merchandise racks (Van Dam, 1989).

The tobacco industry has determined that the Utah ban is either legally valid or that a legal challenge would result in undesirable public relations or political consequences. In either case, the Utah approach should be considered an option. Other states have considered adopting laws banning tobacco billboards, including California, Oregon, Massachusetts, Minnesota, and New Jersey.

The potential for local restrictions on tobacco billboards has generated a significant amount of interest. In 1990, Richmond, California considered an ordinance banning tobacco (and alcohol) advertising within 500 feet of any school. Although this approach is not ideal, a large percentage of the billboards in a given community are affected, especially if the distance is increased to 1,000 feet or even 1 mile. This approach may also have a greater chance of surviving a tobacco industry legal challenge than a complete ban because it is so closely tied to protecting children, which is acknowledged as a legitimate function of State and local government (see Legal Issues).

On February 24, 1994, the city of Baltimore adopted a ban on tobacco and alcohol billboards (City of Baltimore, 1993). In June 1994, Cincinnati, Ohio adopted a law prohibiting all tobacco billboards effective June 1, 1996. Signs within 500 feet of schools or other facilities frequented by children are banned immediately. Cincinnati's law also extends to tobacco advertisements on public transportation vehicles. Another city that has considered, but not adopted, tobacco billboard bans is Philadelphia (Bird, 1994).

Options

- Prohibit all tobacco billboards and other outdoor tobacco advertising signs.
- Prohibit all tobacco billboards within 1 mile of schools and other facilities (such as churches or parks), which are frequented by children.

Public Transportation

The most common type of restriction on tobacco advertising affects public transportation. Transportation depots, such as bus shelters and airports, and public transit vehicles, such as buses and subway cars, have traditionally played host to tobacco (and alcohol) advertisements. These advertisements are of special concern because they are observed by children, often in transit to school.

Bans on public transportation tobacco advertisements are also a sound option because they have not been challenged on the Federal preemption issue. They do not appear to be preempted by the Federal Cigarette Labeling Act (see Federal preemption discussion, Legal Issues). Their legal basis is strong because transportation systems are usually public or quasi-public, and their policies are not treated as broad regulations of advertising in the private sector. Indeed, such policies are often adopted as administrative measures or crafted merely as "preferences" for hiring advertising agencies that refuse tobacco advertising.

Transportation systems that have eliminated tobacco advertising include **New York City's** MTA, **San Francisco's** BART and AC Transit bus system, the **Minnesota Valley's** Transit Authority, **Portland's** bus system, **Denver, Boston, Syracuse,** and **Madison** (WI) (Scenic America, 1993). **Utah's** ban on all tobacco billboards extends to public transportation. The **New York** and **New Jersey** Port Authority has banned all tobacco advertising in facilities under its jurisdiction, including LaGuardia, Kennedy, and Newark airports, the World Trade Center bus terminal, and marine terminals (Weigum, 1993).

The primary argument made against transportation-based policies is the potential loss of advertising revenues. None of the systems or facilities that have implemented such bans have reported any net loss of revenues, however, and other advertisers appear to replace the tobacco companies.

Options

- Ban tobacco advertising on all public transit vehicles, shelters, and in transit depots.
- Ban tobacco advertising in airports.
- Ban tobacco advertising in and on public transit shelters such as train stations and bus shelters.

Public Facilities

In addition to eliminating tobacco advertisements on public transportation, some local governments have banned such advertisements in all publicly owned facilities.

In July 1992, King County, Washington adopted the broadest local policy on advertising to date. King County's ordinance covers all county-owned facilities, including the King Dome, Seattle's stadium (King County, 1992).

Option

- Eliminate tobacco advertising in all facilities owned by a given county or city, including sports facilities, fairgrounds, and public transportation vehicles and depots.

Athletic Facilities

Perhaps the single most important local action that can be taken to reduce tobacco advertising is eliminating billboards and other advertisements in stadiums and other athletic facilities. This includes both professional sports facilities and college stadiums. Addressing this advertising is important for two reasons. First, children are present in large numbers at many athletic events. Second, major sporting events are often televised. Tobacco advertisements in stadiums are usually positioned to be picked up on television cameras (Smokefree Educational Services, Inc., 1991).

Tobacco advertising bans in athletic facilities may be adopted by various governing agencies, including a stadium authority, county board of supervisors, or university. In some cases, sports facilities are privately owned and may be approached to voluntarily eliminate tobacco advertisements (see Voluntary Approaches). In some cases, more than one agency will have the jurisdiction to limit tobacco advertisements in an athletic facility. King County, Washington's ordinance banning all tobacco advertisements in county facilities covers athletic facilities (King County Ordinance, 1992).

Many advertisement bans have been adopted voluntarily by stadium management. Sports facilities that prohibit tobacco advertisements include the Minnesota Metrodome, Dodger Stadium (Los Angeles), Wrigley Field (Chicago), Jack Murphy Stadium (San Diego), and the Oakland Coliseum (Hwang, 1992; Smokefree Educational Services, Inc., 1991).

Option

- Prohibit tobacco advertising in all athletic facilities under the jurisdiction of a public agency.

Tobacco Advertising Deductibility

One approach to tobacco advertising that has recently received a great deal of attention relates to the tax deductibility of such advertising. Proposals have been introduced at both the Federal and State levels to remove tobacco advertising from the class of business expenses that are tax deductible (Colford, 1993; Stark, 1986).

Proponents of eliminating the deductibility of tobacco advertisements point out that such deductions amount to a subsidy for cigarette advertisements, a so-called tax subsidy. It should be noted that indirect restrictions on tobacco advertising face the same first amendment challenges as direct bans. In some cases, partial restrictions may be harder to defend legally than a complete on all tobacco advertising (see Legal Issues). Connecticut and California have both considered legislation.

The same arguments in favor of eliminating the tax deductibility of tobacco advertising apply to promotions as well. However, no specific proposal has yet been propounded on the deductibility of tobacco promotional expenses.

Options

- Eliminate the deductibility of tobacco industry advertising expenses under State corporate income tax laws.
- Eliminate the deductibility of tobacco industry promotional expenses under State corporate income tax laws.

Cartoon Characters

Some states have considered prohibiting the use of cartoon figures in tobacco advertising. These proposals represent a reaction not only to Joe Camel but other cartoon figures as well such as the Kool penguin.

The public health impact of the Joe Camel cartoon advertising campaign for Camel cigarettes is well documented (Pierce et al., 1991; DiFranza et al., 1991; Fischer et al., 1991). The campaign clearly targets children and has been extremely successful in attracting them to Camel cigarettes. Therefore, eliminating the use of cartoons in tobacco advertising can be easily justified.

Although the Federal Government would have the authority to prohibit cartoon characters in all tobacco advertisements, states' jurisdiction is probably limited to advertising signs such as billboards. States are not permitted to place significant burdens on interstate commerce, and magazines normally fall into this category. This is also true of newspapers if at any time even a single copy enters interstate commerce.

As in the case of advertising deductibility, selective bans on particular types of tobacco advertising may raise more serious constitutional issues than a complete ban (see Legal Issues).

Although proposals to date have focused on advertising, it would also be possible to eliminate the use of cartoon figures in promotional activities and materials. This could be accomplished by defining advertising broadly in any proposed legislation. The phrase "other display advertising" is an example of such language.

Option

- Prohibit the use of cartoon characters in tobacco billboards and other display advertising.

RESTRICTIONS ON PROMOTIONAL ACTIVITIES

Although tobacco advertising remains the most obvious marketing tool for cigarettes and other tobacco products, other promotional activities are playing an increasingly important role. During the past 25 years, expenditures on promotional activities other than advertising have increased dramatically relative to advertising expenditures themselves (Butler, 1993). Therefore, an effective strategy to counter tobacco marketing must address promotional activities as well as advertising. The most direct approach to tobacco industry promotional activities is to simply prohibit them by law or by voluntary policy.

Tobacco Industry Sponsorship

A number of organizations and governing bodies have adopted bans on tobacco (and alcohol) promotions at community events such as county fairs, college gatherings, Cinco de Mayo celebrations, and rodeos. Much of this activity has occurred in California under Proposition 99, the state's tobacco tax/tobacco education program. Although no State or local government has yet taken this action, it is within their authority to do so.

Options

- Prohibit tobacco industry sponsorship of all athletic, artistic, cultural, or musical events.
- Prohibit tobacco sponsorship of a specific athletic, artistic, cultural, or musical event.

Free Sampling

Distribution of free tobacco product samples is a popular form of promotion of tobacco products (Hobart & Goebel, 1994). Of greatest concern is the fact that free samples are often distributed at events and locations popular with children such as rock concerts, music festivals, sports events, and fairs (Davis & Jason, 1988).

Although most states prohibit the distribution of free tobacco samples to underage youth, free samples are a source of tobacco products for children (Davis & Jason, 1988). Only the elimination of free tobacco sampling will ensure that samples do not end up in the hands of underage youth. The States of Utah, Minnesota, and California ban or significantly restrict the free sampling of tobacco products. These bans may also prohibit free sampling by mail. More than 103 cities and counties prohibit free sampling as well (ANR, 1994).

Options

- Prohibit the distribution of free tobacco samples in all private and publicly owned facilities and grounds accessible to the public.
- Prohibit the distribution of free tobacco samples through the mail.

Point-of-Purchase Displays

In-store advertising is among the most prevalent forms of tobacco promotion. One study of tobacco advertising in stores found that 87 percent of retail stores carry some promotional items advertising tobacco products (Cummings et al., 1991). Two-thirds of stores displayed tobacco posters, and 80 percent of all tobacco displays were for cigarettes.

Point-of-purchase advertising can be especially damaging to public health efforts. This type of advertising encourages impulse shopping and can undermine the resolve of those who are attempting to quit (Weigum, 1993). Such advertising is also perfectly situated to impact children in stores and gives the impression that cigarettes and other tobacco products are merely ordinary consumer goods like candy or food, rather than

deadly and addictive drugs. Additionally, countertop displays make it easier to shoplift cigarettes. Because the tobacco companies provide financial incentives for retailers to use these displays, shoplifting is less of a financial burden.

The past 5 years have seen a flurry of activity addressing various forms of point-of-purchase tobacco promotion (Weigum, 1993; ANSR PA, 1991). Several communities have campaigned successfully against cigarette advertisements on handbaskets in grocery stores, including New York City and North Carolina (ANSR PA, 1991). More recently, an effort was undertaken in Minnesota to promote ordinances that prohibit all point-of-purchase tobacco promotions.

In Minnesota, the city of Preston adopted a law banning point-of-purchase advertising (see Appendix B). Brooklyn Center (MN) adopted an ordinance on first reading that limits in-store advertising to "tombstone" listings of cigarette brands and prices. Tombstone advertisements consist exclusively of black-on-white lettering listing the brands and their prices. The threat of tobacco industry legal challenge, however, held up the final passage of this ordinance on second reading.

Options

- Prohibit all in-store advertising and promotion of tobacco products, including banners and signs, basket or cart advertisements, in/out decals, separator bars, clocks, and logo merchandise.
- Prohibit all point-of-purchase advertising except tombstone advertisements listing the brands and their prices, which may not be disguised advertisements for particular brands.
- Prohibit self-service displays for tobacco products, requiring all tobacco products to be kept behind the counter (thereby eliminating counter displays).

COUNTERADVERTISING

One way to counter tobacco industry advertising is to purchase anti-tobacco advertisements. Three types of counteradvertising exist: paid counteradvertising, mandatory counteradvertising, and public service announcements (PSA's).

Paid Counteradvertising

One strategy for countering the tobacco industry and promoting an anti-tobacco message is the use of paid media campaigns. Although traditional PSA's tend to focus on individual behavior (i.e., "you should quit"), counteradvertisements tend to focus on

social and political issues as well as environmental change (Dorfman & Wallack, 1993).

Until recently, the use of paid media to counter the tobacco industry in the United States has been limited. Since 1989, California has implemented a massive anti-tobacco campaign under Proposition 99, the tobacco tax initiative passed by the voters in 1988. California's campaign is funded by a tobacco excise tax. There is strong evidence that Proposition 99's media campaign has been successful, at last in promoting cessation among smokers (Popham et al., 1993). California's advertisements have ranged from strong messages about the health effects of passive smoking to direct attacks on the tobacco industry. Minnesota and Massachusetts have also undertaken anti-tobacco media campaigns.

Options

- Conduct a sophisticated, well-funded anti-tobacco media campaign, which is funded by a tobacco excise tax increase.
- Conduct limited anti-tobacco media campaigns, focusing on one media market and/or one particular issue.

Mandatory Counteradvertising

Another approach to counteradvertising is requiring broadcasters, billboard companies, and others who carry tobacco advertisements to run a certain number of anti-tobacco advertisements, thereby balancing their pro-tobacco promotions. This strategy was effective on a wide scale in the late 1960's, before the congressional ban on television and radio advertising that took effect in 1972.

During the late 1960's, the Federal Communications Commission (FCC) required broadcasters to run free anti-tobacco advertisements to balance the tobacco advertisements that then appeared on television and radio. The FCC did so by applying the so-called Fairness Doctrine, which has since been abandoned. Many of the most effective television advertisements that ran under the Fairness Doctrine were produced by the acclaimed public interest media consultant, Tony Schwartz (Bird, 1991). The advertisements were so effective that the tobacco industry ultimately embraced the 1972 ban on radio and television advertisements, which eliminated both the tobacco industry's own advertisements *and* the effective counteradvertisements.

More recently, the New York City Council adopted an ordinance in 1992 requiring billboard companies to post one anti-tobacco advertisement for every four tobacco advertisements on city property. The law applies to advertisements on ferries, baseball stadiums, telephone kiosks, taxis, bus shelters, and some billboards (McKinley, 1992). The New York ordinance is currently in litigation.

Options

- Require free counteradvertisements to balance tobacco advertising on public property, including public transportation, sports facilities, and taxis.
- Require free counteradvertisements on billboards.
- Advertisements should be produced by pro-health organizations rather than the tobacco industry.

Public Service Announcements

Traditional PSA's are another option for countering tobacco advertising and promotion. PSA's, however, have several disadvantages relative to paid or mandatory counteradvertisements. PSA's are most often carried for free, and television and radio stations rarely show or play them during the most popular times. PSA's may also not be placed on the air enough to have a major impact. In addition, PSA's tend to be general in scope rather than targeted to specific groups. Some researchers have even suggested that some PSA's may actually cause harm by focusing the media's attention on individual behavior and away from "more effective socially based health promotion strategies" (Dorfman & Wallack, 1993).

PSA's may have more promise when they are associated with a paid media campaign. Under California's Proposition 99, the state negotiated with media outlets for additional free placement of advertisements beyond the substantial paid media buy. Also, these hard-hitting television and radio advertisements will be made available as PSA's after their use as paid advertisements.

Options

- Extend the impact of paid counteradvertising campaigns by negotiating for free additional time for PSA's.
- Fund high quality production of PSA's, equivalent to tobacco industry efforts.
- Focus PSA's on social, political, and environmental change rather than personal behavior.

COUNTERPROMOTIONS

As the tobacco industry invests more of its resources in sophisticated promotional activities rather than advertising, it is important for the public health community to counter such activities. Although the most effective policy alternative is the elimination

of tobacco promotional activities, there are other strategies available for countering such promotions.

Alternative Sponsorship

Perhaps the most insidious form of tobacco promotion is the sponsorship of athletic, cultural, and artistic events. The identification of alternative sponsors for events, which are currently sponsored by tobacco firms, is a relatively new strategy that shows great promise.

In one early example of alternative sponsorship, Doctors Ought to Care (DOC) arranged an alternative sponsor for the "U.S. Boomerang Team." The team was heading for the Boomerang championships in Australia, with sponsorship and funding from Philip Morris. As part of the deal, the team was required to wear Marlboro shirts and hats and promote Marlboro cigarettes in media interviews. After being contacted by a member of the team, DOC contributed funds, solicited additional funds from the anti-tobacco community, and the team rejected Philip Morris' sponsorship in favor of DOC's (Raeburn, 1988; Wolinsky, 1988).

In Victoria, Australia, the government instituted a broad alternative sponsorship program (Powles & Gifford, 1993; Scollo, 1991). In 1987, the Victorian parliament passed legislation that, among other things, raised the tobacco excise tax by 5 percent and allocated the proceeds to a new Victorian Health Promotion Foundation. The Foundation's mission includes buying out tobacco sponsorship and initiating public health sponsorship of artistic, sports, and community organizations. During 1990-91, the Foundation sponsored 128 athletic and 134 cultural organizations (Powles & Gifford, 1993).

Under California's Proposition 99 anti-tobacco program, a program was funded to investigate and promote alternative sponsorship (Alternative Sponsorship Project, 1993). The project provided assistance to groups seeking alternatives to tobacco and alcohol sponsorship for events, with a focus on ethnic events such as Cinco de Mayo. The project also sought to educate those in the business community such as banks about the advantages of marketing to particular ethnic groups with growing economic resources (a lesson that the tobacco industry learned long ago). The project also brought together event organizers and public health professionals to share their perspectives on tobacco industry sponsorship.

Options

- Encourage organizations receiving tobacco funding to reject that funding and seek alternative donors.
- Provide alternative funding to organizations that conduct athletic, cultural, and artistic events.
- Educate event organizers about the availability of alternatives to tobacco sponsorship. Educate them on marketing the benefits of event sponsorship to alternative sponsors.
- Educate potential nontobacco providers of funds about the benefits of sponsoring sports, cultural, and artistic events.

Countersponsorship

A number of activities are available to counter tobacco industry sponsorship of events and organizations. For many years, DOC, the national health advocacy group for medical care practitioners, has pioneered this endeavor. DOC's activities range from protests of tobacco- and alcohol-funded events such as Virginia Slims tournaments to sponsorship of their own events (e.g., "Emphysema Slims") (*Providence Journal-Bulletin,* 1990). At a minimum, these activities appear to decrease the promotional value of tobacco industry sponsorships.

California's Proposition 99 has funded several pro-health athletic programs or events. Among these are a Tobacco Free Challenge racing car and a ski racing program for children. Such activities often draw attention because they place pro-health messages in events traditionally dominated by the tobacco and alcohol industries.

Option

- Fund and organize artistic, cultural, and athletic events with a pro-health message.

Other Counterpromotions

Other examples of counterpromotions include a T-shirt exchange organized by the National Association of African Americans for Positive Imagery (NAAAPI). The project encouraged smokers (and others) to turn in tobacco- and alcohol-branded items in exchange for a T-shirt or cap bearing a pro-health message. In another example, youth in New Jersey surrounded a tobacco van that was giving away promotional items. The youth-led protest cut short the van's promotional mission.

Options

- Organize a tobacco-branded merchandise exchange project.
- Implement a protest, preferably organized by and for young people, against a specific tobacco industry promotional event.

VOLUNTARY APPROACHES TO TOBACCO ADVERTISING AND PROMOTION

A number of voluntary approaches can be developed to counter tobacco advertising and promotion. In some cases, advertising and promotion can be limited by the voluntary action of businesses such as billboard companies.

Community Advertising Surveys

One strategy that effectively combines youth education with efforts to counter tobacco advertising is tobacco advertising surveys. In a community advertising survey, a group of school-age youth would organize to survey the type and location of tobacco advertisements in a given community. Such a survey has several positive outcomes:

- Young people learn about tobacco industry targeting and other advertising-related issues by studying them directly.
- Public health professionals gain knowledge of the quantity and placement of tobacco advertisements in their own community.
- The information gained in the survey can assist young people and activists in achieving limits on tobacco advertising in the community.

Of course, tobacco advertising surveys may also be conducted by adults. In some cases, such surveys have also been conducted by college students or public health graduate students as part of their course work.

Options

- Organize a project to survey the quantity, type, and location of tobacco advertisements in the community. Involve young people in your survey project.
- Publicize the results of your tobacco advertising survey to increase public knowledge of the impact of tobacco advertising in the community.
- Use the results of your advertising survey to urge businesses such as billboard companies to voluntarily ban or limit tobacco advertisements.

Poster Contests

Another common community response to tobacco advertising is a poster contest for children. In these contests, young participants create their own anti-tobacco posters. Often, the most powerful of these posters satirize the tobacco industry's own advertisements.

Many such contests have been conducted around the country, but the most well known has been organized in New York City by Smoke-Free Educational Services (Bird, 1991). The winners of the contest receive substantial prizes, their posters appear in a nationally distributed book and are prominently displayed in 6,000 New York subway cars (Coalition for a Smoke-Free City, 1993; Tobias, 1991).

Option

- Conduct an anti-tobacco poster contest among children in your community. Provide significant awards for participants and winners. Encourage business owners to donate awards. Display winning posters prominently in the community.

Voluntary Tobacco Advertising Restrictions

One successful approach to limiting advertising involves encouraging business to voluntarily limit tobacco advertising. This strategy has been particularly successful in the case of newspaper and billboard companies (Guy, 1993; Horovitz, 1991).

Unlike many magazines, newspapers typically receive a very small percentage of their advertising revenues from tobacco advertising. At least 12 U.S. daily newspapers have eliminated tobacco advertisements, including the *Seattle Times* (Bischoff, 1993; Guy, 1993).

Billboard companies are concerned about the negative publicity associated with tobacco advertising, especially the accusation that tobacco billboards target poor neighborhoods and communities of color. Community activists, in many cases local clergy, have succeeded in limiting tobacco billboards in some communities (Horovitz, 1991).

Recently, pressure has been increased on magazine publishers to remove tobacco advertising. Many magazines receive a large percentage of their advertising revenue from tobacco and represent a particularly insidious form of targeted advertising. Of greatest concern are magazines with a large audience of young people such as *Spin* and *Rolling Stone*. More responsible publications such as *Sassy* have never accepted tobacco advertising. Groups ranging from the Women and Girls Against Tobacco (WAGAT) project and the Interfaith Center on Corporate Responsibility have called on magazines to drop tobacco advertisements (Teinowitz & Kelly, 1994).

Options

- Call on local billboard companies to voluntarily eliminate or limit tobacco advertisements.
- Encourage local, privately owned athletic facilities to eliminate tobacco advertising.
- Organize a meeting with your local newspaper to encourage them to drop tobacco advertising.
- Urge magazine publishers to stop accepting tobacco advertising. This is especially important for those publications such as Vogue, which have a large audience of young people.

Voluntary Point-of-Purchase Advertising Bans

Although legislation that prohibits point-of-purchase advertising is one response to this form of promotion, another is to encourage businesses to eliminate such promotions voluntarily. Because point-of-purchase advertising is so lucrative, voluntary actions by businesses may not be practical unless there is a groundswell of opposition from the community.

Options

- Encourage businesses to stop all in-store advertising and promotion of tobacco products, including banners and signs, basket or cart advertisements, in/out decals, separator bars, clocks, and logo merchandise.
- Encourage businesses to stop particular types of point-of-purchase promotions such as grocery cart advertisements.

MEDIA ADVOCACY

Anti-tobacco activists have successfully countered tobacco industry promotional activities through the strategic use of the media, known as *media advocacy*. Media advocacy not only can support the other categories of advertising and promotion policy but also can serve as a freestanding educational strategy.

One successful example of media advocacy in tobacco control was a campaign initiated by DOC to counter a national Philip Morris Bill of Rights tour that began in 1990. The national tour marked the 200th anniversary of the Bill of Rights and featured Virginia's original copy of the Bill of Rights as well as an elaborate museum-like presentation.

Anti-tobacco activists feared that Philip Morris' association with the Bill of Rights would foster a positive image of tobacco manufacturers and thus promote smoking. In addition, Philip Morris clearly sought to promote the false notion that tobacco advertising is a protected form of speech under the first amendment. In response, the Washington State chapter of DOC constructed a 15-foot replica of the Statue of Liberty called "Nicotina," featuring a cigarette in place of the torch of freedom and a chain representing addiction.

The protest against Philip Morris was spectacularly successful. As the tour moved from state to state, activists set up Nicotina and protested with such slogans as "Bill of Rights—YES; Philip Morris—NO." Rather than the positive publicity they had anticipated, Philip Morris was dogged by negative coverage, with headlines such as "Bill of Rights Display Opens to Protests," and "Tobacco Firm Blasted on Bill of Rights Link" (Pool, 1991; Krebs, 1990). Ultimately, the tour was shortened and Philip Morris ceased publicizing it altogether.

Other examples of media advocacy to counter tobacco promotion include use of the media to end tobacco sponsorship of a specific event. A good example of this occurred in 1993 in San Luis Obispo County, California. The huge California Mid-State Fair, held in the county each year, had planned to include a major Marlboro Adventure Team promotion in exchange for sponsorship funding. The county tobacco control coalition pressured the fair organizers to drop Philip Morris as a sponsor. After the issue was widely covered in the media, the fair's board prohibited Marlboro's promotional activities, and Philip Morris pulled out as a sponsor (San Luis Obispo County Telegram-Tribune, 1993).

Another example of media advocacy is Los Angeles' "death clock," an electronic billboard that continuously updates the number of smoking-related deaths in the United States. Built by billboard owner William E. Bloomfield, the death clock has received extensive media coverage both nationally and internationally. In the process, millions have been impacted by a pro-health, anti-tobacco message.

Options

- Contact the media to express concerns about specific tobacco industry-sponsored events.
- Conduct protests or counter events to draw attention to the negative public health consequences of tobacco sponsorship and promotion.

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7. Program Services: Reaching the Individual

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7. Program Services: Reaching the Individual

The three critical components of the American Stop Smoking Intervention Study (ASSIST)—mass media, policy, and program services—were highly interrelated. However, the approach to the delivery of program services was very different from the ways in which mass media and policy interventions were provided. The role of program services, as defined in ASSIST, was to guide and support individuals in making changes consistent with tobacco-free norms. Program services are usually considered individual-level interventions, whereas policy, environmental, and, at times, strategic use of the media are systems-level strategies. These latter interventions are directed at changing organizations, communities, and the society in which people live.

Considerable research and dissemination of evidence-based, individual-level interventions had occurred, and various organizations and health-care providers were providing services by the late 1980s. However, research findings indicated that without supportive social and physical environments, individual behavior changes and their benefits were often short-lived. Research at that time had demonstrated the effectiveness of applying policy and environmentally focused strategies to tobacco prevention and control as well as combining individual- and systems-level change interventions. Limited work had been done on disseminating evidence-based policy and environmental interventions. Work also remained to be done on building the state- and local-level capacity to deliver these interventions.

ASSIST planners focused on strengthening state and community capacity to implement the policy and environmental interventions needed to support individual behavior change. They determined that promoting policy change and media advocacy would have the greatest long-term impact on behavior change and that the funding of program services would be a low priority for ASSIST. The National Cancer Institute's (NCI) contracts with the states prohibited them from spending substantial funds directly on program services, but those prohibitions were not intended to diminish the importance of, or the need for, program services. The strategy was to build states' capacity to offer program services without using public funds to pay for them. Anticipating that the strategic use of media and media advocacy would result in policy development and that the implementation of policies would stimulate the need for improved and expanded individual-level services, ASSIST contractors were required to encourage, advise, and partner with appropriate community organizations to ensure that program services were provided.

The Challenge of Services Delivery: Setting Priorities

Support for Individual Change

In addition to mass media and policy, the ASSIST model incorporates interventions that concentrate on individual behavior change as an essential element of a comprehensive tobacco control program. Called *program services* in ASSIST, these individual-level interventions (cessation, prevention of tobacco use initiation, and education of the general public) were defined as "smoking control activities involved directly in assisting individuals to make behavioral changes."[1(p4)]

NCI's *Standards for Comprehensive Smoking Prevention and Control*, which informed the design and planning of the ASSIST project, represented the composite of what had been learned from NCI's smoking research initiative and from other related research studies. These *Standards* define the interactions and interrelationships of the three types of interventions that are included in the ASSIST model—mass media, policy, and program services—as follows:

> The mass media and policy components of a comprehensive smoking and prevention intervention raise awareness of the smoking issue and motivate people to make changes in their behavior relative to smoking. Such efforts must be accompanied by a wide range of program services that guide and support individuals in making those changes. Most program services are delivered via the identified channels for smoking prevention and control, that is, through the health care system, worksites, schools, and community networks.[2(p27)]

ASSIST was innovative in its approach to providing program services. Whereas ASSIST staff engaged directly in media and policy intervention activities, they used indirect methods to stimulate and expand the capacity of others to do the direct delivery of the individually focused program services. This indirect approach to providing program services was supported by several factors. After years of research on individually focused tobacco control interventions, the evidence was there to guide the application of these findings.

When ASSIST was conceptualized, the effectiveness of various program services had been established, and these findings were being disseminated and implemented. As research from NCI, the National Institute on Drug Abuse (NIDA), and other researchers provided a scientific foundation for these individually focused efforts, a proliferation of programs and services developed to help people avoid tobacco use.[3–7] Tobacco cessation programs and school prevention programs were abundant. However, these interventions were resource intensive, and their benefits, when achieved, were often short-lived.[8–11] Avoiding tobacco use or maintaining a quit attempt often required a Herculean personal effort in a climate where tobacco use was glamorized in the media, championed by friends, and practiced at worksites and public places.

Studies demonstrated the effectiveness of policy and environmental-level changes and of combining this approach

with the individual approach.[12] This was documented in NCI monograph number 1, *Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's*, on strategies to control tobacco use: "The current state of the art in combating tobacco use combines multiple environmental changes with multiple programs directed to individuals in different stages of the smoking initiation and cessation process."[9(px)]

Program services were an integral part of ASSIST's policy-based approach to tobacco prevention and control, but the emphasis had shifted from individual-level to policy- and environment-level interventions to complement the already existing capacity to deliver program services. When they received their contracts, the ASSIST awardees were instructed about the prohibition on direct funding of program services. The intent of this restriction was not to diminish the importance of program services. The goal was to increase the number of program services, monitor and ensure the quality of existing program services, and enhance their reach and effectiveness. The ASSIST objectives for program services are listed below:

> By 1998, major community groups and organizations that represent the priority populations and have broad-based statewide reach should be involved in ASSIST activities.
>
> By 1998, worksites reaching major target populations will adopt and maintain a tobacco use cessation focus.
>
> By 1998, 100 percent of all schools serving grades K through 12 will use a tested, efficacious tobacco use prevention curricula.
>
> By 1998, at least 75 percent of primary medical and dental care providers will routinely advise cessation and provide assistance and followup for all of their tobacco-using patients.[13(p3)]

Students participate in a tobacco use prevention activity

Self-directed tobacco use prevention program booklet used in Colorado

(See table 2.1 in chapter 2 for a list of all of the ASSIST program objectives.)

As ASSIST progressed from the planning phase to the implementation phase in 1993, the need for a transition from direct to indirect provision of program services was reiterated. Financial restrictions for program services were spelled out in detail in ASSIST training materials, including the following prohibitions:

- No funds will be provided to develop new smoking prevention, cessation, and education materials.
- No funds will be provided for labor to support the delivery of smoking prevention, cessation, or education programs.[14]

The director of the NCI ASSIST project stressed that program services were an essential component of a comprehensive tobacco control program, but he reminded state staff of the spending restrictions. He cited a checklist of imprudent use of funds on program services that included (1) duplication of services, (2) services with negligible effect, (3) services that were not the primary responsibility of ASSIST state or local staff, (4) services that were part of an unsustainable effort, and (5) updating of materials. He described specific examples of misuse of funds: (1) a media campaign encouraging smoking cessation that exceeded the cap on media spending or was not coordinated with other ASSIST activities, (2) delivery of curriculum training for large numbers of teachers that could be better accomplished by departments of education, and (3) paying for labor to staff a cessation hotline.[14]

The ASSIST funding itself, $140 million, seemed enormous at that time but would have been quickly depleted if the 17 ASSIST states were unconstrained in their use of the funds to develop and directly provide program services. The indirect approach to providing program services freed ASSIST funds to address

A student studies material on the consequences of smoking

Materials and activities for tobacco-free schools in Colorado

the gaps in policy, media, and environmental interventions that were needed for a comprehensive tobacco prevention and control program.

The Contract

NCI's use of a contract mechanism, rather than a grant or cooperative agreement, ensured that expenditures for program services remained focused on ASSIST program goals. Instead of state-level agencies proposing their plan of action to NCI, NCI specified what was to be done, how it was to be done, and how much could be spent. States developed annual action plans within the confines of the requirements. The contract mechanism helped state program managers limit program service expenditures of their local contractors.

One reason that NCI used a contract mechanism to fund ASSIST was to help insulate program managers and other state staff from political pressures within their health departments and states. Early on, NCI staff acknowledged the politically sensitive nature of bold tobacco control interventions and the potential influence of the tobacco industry. Therefore, NCI elected to use contracts and require specific deliverables to help ensure that precious resources were not diverted to ineffective or inconsequential interventions. Once state staff became comfortable with the intent of the contract approach, they embraced this model.

This directive approach from NCI was critical to maintaining the integrity of ASSIST. The challenge was to filter these funding restrictions down to the local level. When ASSIST funds arrived in the states, there was an expectation at the local level that cessation program efforts could be expanded to draw in more smokers and pay for more staff time. That was not allowed under the contract.

The contractual restrictions for program services meant that health department staff had to partner with service providers within the communities. The ASSIST staff collaborated with organizations to promote and support existing services so that they would be prepared to meet the anticipated increase in demand for services stimulated by policy interventions and an environment where nonsmoking was becoming the norm. This was a challenge for many of the local staff and volunteers, health department contractors, and the American Cancer Society (ACS); with time and continued monitoring and support, however, the transition from direct to indirect provision of program services was realized.

The Role of ASSIST in Service Provision

Types of Program Services

Program services in the ASSIST project were grouped into the following three categories:

1. Smoking Education of the General Public: Education of the general public to raise individuals' awareness and shape attitudes on tobacco issues
2. Cessation: Support for smoking cessation, such as physician counseling, group cessation classes, and self-help materials

3. Prevention of Tobacco Use Initiation: Education to prevent tobacco use, such as school-based prevention curricula and parent-based interventions[1]

The "ASSIST Program Guidelines" specified that these three types of program services would be offered in a variety of settings, for example, in physicians' offices, outpatient clinics, workplaces, schools, and community facilities.[1] Organizations such as ACS, the American Lung Association (ALA), and the American Heart Association (AHA) each had programs designed to educate the general public about the health effects of tobacco and to provide smoking cessation classes. Smoking cessation programs were also available through hospitals, health maintenance organizations, worksite wellness programs, and many private entrepreneurs. To reduce early adoption of tobacco use, schools were enjoined to provide coordinated school health education, which included drug, alcohol, and tobacco use prevention.

For guidance on allowable activities and how ASSIST was to ensure that program services would be provided, program managers could refer to the "ASSIST Program Guidelines,"[1] which offered examples in each program service area of activities that could provide self-help materials and referral guidelines for smokers:

- Identify current resources that provide smoking cessation resources and encourage them to target priority worksites with their marketing efforts . . .
- Identify model worksites in which intensive smoking cessation activities are occurring, and promote them through business media targeted to business owners in priority industry areas.[15(pp4–5)]

Of the three types of program services, one—smoking education for the general public—could be provided directly by ASSIST staff. In addition, to ensure the provision of all program services, staff were to (1) identify existing program services, (2) increase capacity for

Treating Tobacco Use and Dependence

The Public Health Service guideline *Treating Tobacco Use and Dependence* presents strategies for providing appropriate treatments for current and former tobacco users. The guidelines were designed to assist clinicians and smoking cessation specialists, as well as health-care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. The guidelines were based on an exhaustive systematic review and analysis of the scientific literature from 1975 to 1999 and included more than 50 meta-analyses.

Source: Fiore, M. C., W. C. Bailey, S. J. Cohen, S. F. Dorfman, M. G. Goldstein, E. R. Gritz, R. B. Heyman, et al. 2000. *Treating tobacco use and dependence. A clinical practice guideline.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf

services delivery, and (3) identify and market science-based program services.[16] Each activity is elaborated on below.

Identification of Existing Program Services

All states conducted a site analysis. The 1991 "ASSIST Program Guidelines" directed staff to analyze the target populations, identify channels for reaching those populations, ascertain existing tobacco control resources (including policy and media initiatives and existing program services), and identify the site's potential resource capability.[16]

These site analyses yielded specific quantitative information on the availability of program services. Those data proved very useful for the ASSIST planners and also formed the basis for community resource guides that were developed in most states. Excerpts from South Carolina and Wisconsin's site analyses are presented in a sidebar on page 292.

Increase in Capacity for Services Delivery

The passage below from the "ASSIST Program Guidelines" illustrates the intent of the ASSIST planners to stimulate increased program services capacity:

> The intent of ASSIST is not to create a new institution devoted to smoking control but rather to increase the capacity for existing groups and organizations to sustain and enhance their role as smoking control agents beyond the life of ASSIST.[17(p2)]

ASSIST staff were to identify groups whose memberships and constituencies were likely to contain smokers targeted by ASSIST and to help those groups become smoking cessation agents.[18] The ASSIST states used a variety of strategies to support the development of prevention and cessation program services, such as train-the-trainer programs, the development of materials, and awareness days to attract attention to cessation programs. Illustrative activities in Virginia and Missouri are described below:

- **Virginia.** Seven training workshops were held in Virginia for health-care providers and substance abuse treatment counselors. Topics ranged from nicotine addiction to developing and implementing a smoke-free policy for treatment facilities. The state certification board for substance abuse counselors adopted a policy requiring that anyone applying for recertification undergo 6 hours of training on the theory and treatment of nicotine addiction. In addition, 35 coordinators of a mentoring program for pregnant and parenting teens were trained in a smoking-cessation protocol.
- **Missouri.** Presentations on prevention of tobacco use, delivered in Missouri schools, focused on the health hazards of tobacco use. More than 1,108 sixth graders were reached. In addition, more than 80 teachers and counselors received training from two local coalitions concerning instruction on prevention of tobacco use.[19]

Case study 7.1 illustrates the benefits of an assessment of the North Carolina Safe and Drug-Free Schools Program. The assessment data revealed significant shortcomings, and dissemination of

Program Services Identified through Site Analysis Data

South Carolina

- ALA has 72 trained facilitators working in the Freedom From Smoking program. In 1991, participants in the program included 1,500 people in 120 worksites.
- AHA's Heart at Work program has a smoking cessation module that includes the Calling It Quits kit. During 1991–92, this kit was used by 9,000 employees from 36 companies. AHA also has a peer-oriented smoking intervention program for middle and high school students, called Save a Sweet Heart, which served 6,894 students in 41 schools in the state during the 1991–92 school year.
- During 1991, 68% of the 421 participating elementary schools were involved in the Smoke-Free Class of 2000 tobacco use prevention program, with 51,180 students participating.
- NCI offers a train-the-trainer program to provide smoking cessation training for physicians. This program is used only for training residents in Preventive and Family Medicine programs at the University of South Carolina School of Medicine.

Wisconsin

- Most cessation programs offered are modules that were developed by ACS, ALA, or AHA. Eighty-one percent of hospitals offer tobacco cessation programs at their facilities.
- Programs related to tobacco or smoking are offered by 85% of local public health agencies. Counseling about the health risks of smoking is offered by 82% of these agencies, group smoking cessation is offered by 21%, and referrals to smoking cessation programs are offered by 70%.
- Both ACS and ALA offer worksite smoking cessation programs. In 1990, ALA helped 300 companies with 30,000 employees develop and implement smoking policies and cessation programs.
- According to a survey of 541 schools that was conducted in April 1990, 93% of those surveyed offered smoking prevention or cessation programs during the previous year.
- During ACS's 1989–90 Fresh Start smoking cessation programs, 7,840 smokers participated and 37% remained smoke-free 1 year later.

Sources: Center for Health Promotion, South Carolina Department of Health and Environmental Control. *South Carolina Project ASSIST. Site Analysis.* Contract Number N01-CN-15382. October 1, 1992. Columbia: South Carolina Department of Health and Environmental Control; Wisconsin Department of Health, Tobacco-Free Wisconsin Coalition. *ASSIST Wisconsin Project: Site Analysis Report.* October 1, 1992. Milwaukee: Wisconsin Department of Health.

those results led to increased demand for more effective tobacco-free school policies and increased capacity for delivering direct program services.

The focus of tobacco control efforts on groups likely to contain targeted smokers is illustrated by case study 7.2. The Mother's Stress Management Task Force in Massachusetts involved a number of groups that work with low-income women in workshops that offered stress management techniques as an alternative to smoking. Those groups had little previous involvement in tobacco control, and this initiative is a case in which new capacity was created in program services.

Case Study 7.1
Helping Schools Shift to a Tobacco-Free Norm in North Carolina

Situation: The 1994 Pro-Children Act (20 USC 6083) included restrictions on smoking inside all school facilities for any school accepting federal funding. Assessment of data collected by ASSIST staff and coordinators of the Safe and Drug-Free Schools Program in 90 of the 122 North Carolina (NC) school districts showed that all districts restricted tobacco use by students and that 95% of them restricted tobacco use by employees—both requirements of the Pro-Children Act. Most policies were not comprehensive, and in a few cases, the policies were not fully in compliance with the federal law. Most student policies did not address enforcement procedures. Of those that did, most used out-of-school suspension as the penalty. Coordinators of the Safe and Drug-Free Schools programs expressed an interest in alternatives to suspension programs. Working with the NC Department of Public Instruction, ASSIST informed school districts about the results of the assessment; this disclosure resulted in (1) an increased demand for technical assistance with developing and enforcing tobacco-free school policies and (2) the opportunity to expand program services, as described below.

Program Services Provided: A new partner was brought into the effort—the dropout prevention and substance abuse prevention staff at the NC Department of Public Instruction.

Together, the ASSIST Schools Task Force, ASSIST staff, and NC Department of Public Instruction staff proposed a plan that included the following three elements:

1. A four-session educational alternative to suspension for student violators
2. A tobacco-cessation program for youths
3. A variety of promotions to encourage a tobacco-free norm

As a result of publicizing and implementing this plan, the task force gained new volunteers from the schools and expanded tobacco use prevention education and tobacco cessation program services. A local coalition piloted activities in one of its high schools to learn more about what approaches improve enforcement.

ASSIST developed *Tobacco Free Schools in North Carolina: A Handbook for School Administrators*. The handbook educated school administrators regarding model policies on tobacco use and appropriate implementation of those policies. The North Carolina School Boards Administration also distributed to their districts a strong model policy on tobacco use.

Working with a pilot school in Charlotte, North Carolina, ASSIST was able to broaden the handbook to include the following three components:

1. An educational alternative to suspension for students caught violating the school's tobacco use policy

2. Sample activities for the prevention and control of tobacco use
3. A reference to Tobacco-Free Teens, a voluntary cessation class developed by the American Lung Association of Minnesota

When the manual was complete, 10 high schools across North Carolina were recruited to pilot this tobacco-free schools program. As more schools instituted and then enforced tobacco-free school policies, the demand for model policies, enforcement strategies, tobacco use prevention education, and cessation services grew. Working with the NC Department of Public Instruction, ASSIST used the manual on tobacco-free schools that had been pilot-tested and began offering regional training events to school districts interested in creating tobacco-free school environments.

— Melissa Albuquerque, former ASSIST Field Director for North Carolina and Program Consultant, Office on Smoking and Health, CDC

Sources: Adapted from T. Enright Patterson and G. Davenport-Cook. 1997. Helping schools shift to a tobacco-free norm. In *Entering a new dimension: A national conference on tobacco and health* (Case studies, September 22–24, 1997). Rockville, MD: ASSIST Coordinating Center. 209–10; 1994 Pro-Children Act. 20 U.S. Code 6083.

Identification and Marketing of Evidence-based Program Services

Effectively marketing existing prevention and cessation services that had been proven to be effective was an important strategy, as cited in the "ASSIST Program Guidelines." In the mass media section of the guidelines, one objective related to the marketing of cessation services was to "provide critical information to smokers about the effectiveness and availability of cessation services."[17(p2)]

The "ASSIST Program Guidelines" suggested that communities use information gleaned in their site analysis to compile a resource guide to cessation services. Many such resource guides had been developed by the end of ASSIST,[16] and these guides were important for marketing program services.

Successful marketing also occurred in Michigan where a smoking cessation hotline was set up for Medicaid recipients. Case study 7.3 describes how Michigan established and marketed cessation programs that were needed as a result of a policy that mandated coverage of cessation services for the Medicaid population.

As illustrated in case study 7.4, Colorado's new tobacco-free schools law prompted a number of public and private organizations to sponsor and promote tobacco cessation programs for teens.

The effectiveness of physician counseling of smokers to quit, coupled with structured follow-up, was cited in the "ASSIST Program Guidelines": "When advice is coupled with structured follow-up programs and/or pharmacologic agents, cessation rates of 18 to 27 percent

Case Study 7.2
Diapers, Dishes, and Deep Breathing: Stress Management and Smoking Cessation for Low-income Mothers in Massachusetts

Situation: The Tobacco-Free Greater Franklin County Coalition in Massachusetts convened the Mother's Stress Management Task Force in 1995. By using stress management techniques taught in pilot workshops, the task force sought to offer low-income mothers concrete alternatives to smoking. All area providers who served low-income women and their families were invited to participate in the task force. Representatives from Head Start, adult literacy programs, a family planning agency, a community college, and other organizations met monthly to plan the intervention. Many of these organizations were only peripherally involved in tobacco control before the creation of the task force; this intervention helped to institutionalize tobacco control as a permanent program component in many agencies.

Program Services Provided: A curriculum was made available to agencies working with low-income women (including literacy programs, homeless shelters, and other tobacco control programs) and to partners with local coalitions. With state funds from the Massachusetts Department of Public Health, the coalition hired a part-time substance abuse counselor for the position of stress management specialist. Based on the curriculum "Diapers, Dishes, and Deep Breathing," 4- and 5-week workshops were offered regularly to clients in various settings to teach coping skills, develop individual stress management plans, and motivate smoking cessation attempts. The workshops used a harm-reduction model, encouraging women to reduce smoking if they were not ready to quit.

A 3-week workshop series was piloted in four areas of the county; thus it was accessible to nearly all of the region's rural residents. Food, childcare, and transportation were offered to participants. The pilot workshops were advertised through newspapers, local radio stations, and human service agencies. Each session was 2 hours long and was facilitated by two task force members. The workshops were conducted at local agencies, libraries, and schools—familiar locations in which the women would be comfortable.

Task force members subsequently developed the curriculum "Diapers, Dishes, and Deep Breathing." A fourth week was added to the curriculum to give participants more time to support each other and to share experiences. Another session was added on creating personal stress-reduction action plans. With a grant from the Massachusetts Department of Public Health, the curriculum was made available to the general public and to agencies working with low-income women. The curriculum has been distributed to more than 20 literacy programs for use in adult education classes.

Source: Jerome, K. 1998. Diapers, dishes, and deep breathing: Stress management and smoking cessation for low income mothers. In *No more lies: Truth and the consequences for tobacco*. (Case studies at the Fourth Annual National Conference on Tobacco and Health, October 26–28, 1998.) Rockville, MD: ASSIST Coordinating Center. 87–92.

Case Study 7.3
Smoking Cessation Quitline for Michigan Medicaid Recipients

Situation: Successful policy advocacy efforts by ASSIST resulted in coverage for all Michigan Medicaid patients, beginning in 1997, for nicotine patches, gum, and Zyban.

Program Services Provided: Concern about the availability and promotion of smoking-cessation services and information for Medicaid clients led to the development of a free smoking cessation counseling service by telephone for Medicaid patients. This service was funded by the Michigan State Health Department's Tobacco Program. Partners included Michigan State University and the Michigan Public Health Institute.

As often happens with these types of programs, it took a couple of years to find a contractor, negotiate a contract, and get the quitline up and running; it ran from January 2000 through December 2002. During that time, 1,785 clients were served by the quitline, and quit rates ranged from 10% to 30%. Six 15-minute counseling sessions and two 5-minute follow-up sessions were offered. The sessions were based on modules that follow the Agency for Health Care Policy and Research (now known as the Agency for Healthcare Research and Policy) guidelines. Nine health plans in Michigan referred Medicaid clients who were smokers to this service. Many were self-referred after seeing the quitline number. The quitline was also promoted by periodic mailings to Medicaid clients. Quit kits were sent to each participant, and individual pharmacies and physicians were notified via fax of the participants' enrollment in the program. Although this particular quitline was defunded, another statewide quitline that Medicaid clients may access has since been initiated (with CDC and American Legacy funds).

—Mikelle Robinson, former Project Manager, and John K. Beasley, former Project Director, Michigan Department of Public Health, and currently with the Tobacco Section of the Michigan Department of Health and the Michigan Public Health Initiative, respectively

Sources: The Smoking Cessation Clinical Practice Panel and Staff. 1996. The Agency for Health Care Policy and Research smoking and cessation clinical practice guideline. *Journal of the American Medical Association* 275 (16): 1270–80; Fiore, M. C., W. C. Bailey, S. J. Cohen, S. F. Dorfman, M. G. Goldstein, E. R. Gritz, R. B. Heyman, et al. 2000. *Treating tobacco use and dependence. A clinical practice guideline.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. www.surgeongeneral.gov/tobaccotreating_tobacco_use.pdf.

Case Study 7.4
Colorado Tobacco-Free Schools Law Creates Demand for Cessation and Prevention Programs

Situation: In 1994, the Colorado State Legislature passed the state's first tobacco-free schools law (Statute 25-14-103.5), prohibiting the use of all tobacco products on school property by students, teachers, staff, and visitors, and requiring enforcement of the policy. Between 1994 and 1995, the percentage of school districts reporting tobacco-free status increased from 51% to 76%, and by 1999, 84% were tobacco free. The increased number of smoke-free environments in the tobacco-free schools produced an immediate increase in the demand for youth cessation programs, to which community organizations responded.

Program Services Provided: Inquiries about cessation programs were often directed to the ALA, which had just launched a new drive to train educators to facilitate a program for youth on cessation of tobacco use. The Colorado State Department of Education offered additional financial support to any alternative high school willing to provide a tobacco use cessation program for its students. In addition to ALA's statewide efforts to provide youths with a tobacco cessation program, Kaiser Permanente in Denver sponsored a drop-in tobacco cessation support group for teens. Throughout the state, local administrators and teachers provided imaginative cessation programs (e.g., a 2-day retreat to a mountain camp and a nonsmoker's running group in which members received a new pair of running shoes).

The demand also rose for information and training on evidence-based programs on prevention of tobacco use. A local education training organization, the Rocky Mountain Center for Health Promotion and Education, took the opportunity to begin delivering teacher training programs on tobacco prevention. New alliances were formed. ASSIST staff worked closely with the state's school nurse consultant to provide training to school nurses statewide on teens and tobacco use. Staff also made annual appearances at statewide conferences for principals and school board members. Local ASSIST staff actively engaged area school administrators to help with implementation. The Colorado State Board of Health requested regular briefings on the status of tobacco-free schools in the state and gave certificates of merit to those districts that were tobacco free.

—Jane Pritzl, former ASSIST Field Director, Colorado Department of Public Health and Environment, and current Intervention Scientist, Division of Adolescent and School Health, CDC

NCI manual for physicians

Massachusetts Department of Health brochure

NCI manual for oral health practitioners

have been reported."[20(p1)] State ASSIST staff were encouraged to identify and train other health-care practitioners, such as public and occupational health nurses, dental hygienists, and pharmacists to conduct such interventions.[20] The "ASSIST Program Guidelines" also promoted the identification and training of individuals not in health-care roles who could deliver brief interventions supporting smoking cessation. Cessation aids such as print, video, or audio products as well as cessation materials tailored to the needs of a specific priority population (e.g., students) could be used by existing coalitions, organizations, agencies, community groups, and individuals who had access to the education community. This referral to cessation services through a cessation directory is another example of the marketing of proven program services during ASSIST.[21] The North Carolina experience described below is illustrative of ASSIST training of health-care practitioners in cessation counseling.

- **North Carolina.** North Carolina focused cessation efforts on pregnant women and developed an award-winning program, "Counseling Women Who Smoke," designed to meet the needs of practitioners working with pregnant women. Between 1995 and 1998, 557 North Carolina health-care providers were trained in the program, and several local communities formed Smoke-Free Baby clubs to supplement the program. In 1998, the American College of Obstetricians and Gynecologists chose this program as one of the best in the nation and disseminated a module based on it. The

Women's Health Branch of the North Carolina Division of Public Health now requires cessation counseling and referral to be implemented in its contracts with 87 local health departments.

Smoking Education for the General Public

Tobacco use affects everyone. It affects those who do not use tobacco products through exposure to environmental tobacco smoke, increased health-care costs, and loss of family or friends. It affects tobacco users directly by damaging their personal health. Education programs that reach the public with information about tobacco use can help individuals make informed decisions about quitting or not initiating tobacco use. Effective programs reinforce social attitudes that support a tobacco-free norm. Ideally, a tobacco use prevention education program is directed to a defined population and is sensitive to the social, economic, and cultural issues affecting that population. ASSIST planners made public education about the hazards of tobacco a required component, but the NCI "Standards for Comprehensive Smoking Prevention and Control" specified that such public education support "overall smoking prevention and control goals."[2(p32)]

State health department staff conducted educational workshops for policymakers. At these workshops, policymakers could learn about the negative health effects of environmental tobacco smoke, the benefits of policy change in reducing tobacco use, and ways to draft and implement effective changes in policy. (See chapter 4 for a discussion of ASSIST tobacco use prevention education activities that were encouraged for each channel.) Examples are presented below:

- **West Virginia.** West Virginia disseminated 270,000 "Through With Chew" campaign inserts to all weekly newspapers in the state, and 66,000 inserts were delivered to all elementary and middle schools for distribution to second, fourth, and seventh graders. Print and radio media publicized events and information regarding the "Through With Chew" campaign.[19]
- **Wisconsin.** At least five local coalitions conducted media advocacy to alert the public to the impacts of tobacco advertising. Specific media activities included running editorials in newspapers, sending letters to the editor, placing articles on tobacco in seven monthly tribal publications, providing news releases, and developing a counteradvertising billboard in cooperation with a parents' program.[19]

In 1993, when Denver passed a clean indoor air ordinance that affected all businesses with more than 5 employees and all restaurants with seating for more than 25 patrons, there was a need for organizations to conduct outreach to businesses by offering tobacco use prevention education in the workplace. State and local health departments worked with local employers' councils to help businesses implement this new ordinance, thus creating new capacity with these new workplace education programs. This aspect of the Colorado experience is described in case study 7.5.

The experience of the University of Maine at Farmington, described in case study 7.6, demonstrates that once a policy has been implemented, educating the affected individuals about the policy is a prerequisite to their accepting it and complying with it. At the University of Maine, when a policy was implemented requiring a smoke-free campus within 5 years, students provided educational services campus-wide to explain the policy and to promote adherence to it.

ASSIST identified specific high-risk populations as priority populations (adolescents, ethnic minorities, blue-collar workers, unemployed people, and women), and the states' partners designed many of their activities to serve those populations. Examples of such activities are described below.

- **Massachusetts.** Massachusetts launched an advertising campaign about smoke-free homes to increase awareness among the general public (especially adults and African Americans) about the harmful effects of secondhand smoke. Promotional materials for the campaign were provided to local programs. Newspaper ads, "swiss cheese" press releases, and a guide for local media outlets were also created.
- **New Mexico.** New Mexico conducted focus groups with Vietnamese men to ensure that a trainer's cessation program would be culturally appropriate for this population. Workshops, conducted in Vietnamese, were attended by six Vietnamese smokers, who were recruited via flyers inserted into a regional Vietnamese newspaper. Two Vietnamese men interested in becoming smoking cessation facilitators in their community completed their training. In another effort, train-the-trainer sessions were conducted to prepare 23 community members throughout the state to offer youth smoking cessation programs.
- **Washington State.** Training for smoking-cessation counseling, using the NCI "4 A's" of patient counseling about smoking—namely, Ask, Advise, Assist, and Arrange—took place in Washington State with an emphasis on underserved populations, including American Indians and farm workers. As part of World No Tobacco Day, King County purchased a full-page no-smoking advertisement in the *Seattle Times* that included a request form for a smoking-cessation guide and a smoke-free restaurant guide. Several hundred requests for the free materials were received.[19]

Interaction between Policy and Program Services

The interaction between policy and program services can be self-perpetuating. Program services such as smoking education of the general public can facilitate policy development, and policy implementation can stimulate an increase in program services. An example is the federal Synar Amendment, which requires states to enact and enforce youth access laws or risk forfeiture of block grants for substance abuse prevention and treatment. Efforts to comply with the Synar Amendment stimulated demand for program services, particularly for educating store owners regarding

Case Study 7.5
Employers: "Anybody Going to Tell Us What's Going On?"

Situation: In Denver, Colorado, the 1993 clean indoor air ordinance was passed without provisions for communication about or enforcement of the ordinance. Advocates hoped that media coverage of the ordinance would help businesses understand how the new law applied to them, but calls to state and local health agencies made it clear that the ordinance was not well understood. The city needed additional resources to successfully implement the ordinance.

Program Services Provided: Colorado ASSIST partnered with the City of Denver's local health department to disseminate the ordinance to businesses, to help provide business leaders with technical assistance on implementation, and to develop a training workshop to help Denver businesses and other employers throughout the state comply with the ordinance.

The local and state health departments collaborated on the production of a brochure to educate Denver businesses about the new law. The brochure was intended to provide initial notification about the law and to provide opportunities for follow-up. One panel of the flyer was a query/mailer asking employers to describe the policy that they intended to implement (100% smoke free or a designated smoking area within the limits of the law). It also invited them to request additional information and assistance. Initially, more than 5,000 brochures were mailed. The large number of employers who returned the tear sheet provided the city with policy information and an organized method for dealing with questions. After the first year, the local health department took over the printing and distribution of the brochure. The brochure became part of the application packet for a business license sent to any business new to Denver and was used by both the Metro Chamber of Commerce and the Small Business Administration.

For more intensive assistance, the private Denver-based Mountain States Employers Council (MSEC) volunteered a training staff and the use of their training facility to present workshops on the new Denver clean indoor air ordinance and associated workplace issues. The organization's legal staff taught a section on the legal implications of not providing a smoke-free workplace, and staff from the Colorado ASSIST Tobacco Control Program taught about the health issues and ways to support employees making the transition to a smoke-free workplace.

Multiple training sessions were held successfully in Denver, and the MSEC decided to disseminate the workshop regionally for business members in other parts of the state. In subsequent programs, they provided urban and rural employers with discussions on tobacco restrictions in their regions and encouraged them to put policies in place. The alliance between the ASSIST state staff, the Denver City and County health department staff, and the MSEC proved to be useful beyond these training

Case Study 7.5 (continued)

workshops. When other issues arose, such as clean indoor air ordinances and workplace smoking policies, pro bono legal guidance was often provided to ASSIST staff by MSEC for the price of a phone call.

After the first rush was over, the Denver Department of Public Health took all complaints about compliance; conducted all investigations; and provided technical assistance to hotels, restaurants, and other employers in making the law a success.

—Jane Pritzl, former ASSIST Field Director, Colorado Department of Public Health and Environment, and current Intervention Scientist, Division of Adolescent and School Health, CDC

Case Study 7.6
Clearing the Smoke at the University of Maine

Situation: A 1987 smoke-free policy that prohibited smoking within all institutional buildings at the University of Maine at Farmington (UMF) was replaced in the 1998–99 academic year by a new policy that outlined a 5-year plan progressing toward an entirely smoke-free campus. UMF was awarded an $80,000 grant by the Partnership for Tobacco-Free Maine, the state ASSIST coalition, to implement the policy on campus.

Services Provided: To make a smoke-free policy acceptable, the Tobacco-Free Maine project at UMF focused on two goals:

1. Ensure that information provided by students and faculty about tobacco issues would be uniform and accurate
2. Support student efforts to address their concerns about tobacco use on campus

To identify opportunities for integrating media presentations on tobacco control issues into the undergraduate curriculum, students first conducted a survey of course syllabi and content and then distributed information to the faculty.

In addition, a broad-based media campaign was essential for a successful campus dialogue about the effects of tobacco and secondhand smoke. Developed in a senior-level course on health education planning, the following five projects served as a campus-wide media campaign:

1. A Second Annual Health Beaver 5K walk/run, with a smoke-free theme—"Catch the Fever: Be a Smoke-free Beaver"
2. *The Art of Being Smoke-Free*—an exhibit showing the artist's idea of how tobacco affects the life of the entire community, coupled with a modern dance piece

entitled "Death with Smoking," which portrayed the personal effects of tobacco on youths
3. Females Against Secondhand Smoke and Tobacco (FASS/T)—a multimedia campaign spread broadly across the campus with the message "Tobacco Is Killing ME" (Maine), especially focusing on college women and factors that predispose them toward smoking
4. No Butts About It—a community gathering about tobacco use cessation services
5. Kickin Butts—a dissemination of smoking cessation media materials on the availability of local cessation services for smokers in the college population

The undergraduate curriculum initiative proved practical and timely, as the five media projects collectively served as a catalyst in shifting the social climate toward acceptance of a tobacco-free culture.

One first-year student testified to the effectiveness of the program:

"A while back, when I finally decided to quit for the sixth and final time, a good friend named June gave me a Quit Kit. The kit is put out by the Partnership for a Tobacco-Free Maine. In it there are flyers, articles, and reasons for quitting. Surprising enough many of the reasons in the kit were some of the same reasons I have. Some are: I want to feel better about myself, I want to quit coughing that sick mucus up, and I want to get back into sports. I want to take a second and thank June for all her support. She has been my new 'Saving Grace.'" (Stephen Akeley, May 4, 1999)

Source: Adapted from G. L. Bryant and L. Gamble. 1999. Clearing the smoke on campus: Policy change through grassroots advocacy. In *Tobacco-free future: Shining the light* (Case Studies of the Fifth Annual National Conference on Tobacco and Health, August 23–25, 1999). Rockville, MD: ASSIST Coordinating Center, 23–8.

enforcement strategies. In turn, these efforts motivated additional policy changes that would further limit youth access to tobacco products. This effect—whereby policy change and demand for program services stimulate each other—was a common phenomenon during ASSIST. (See case study 7.7.)

The relationship between policy and program services can be seen readily in school settings, particularly in schools with tobacco-free policies. In Colorado, school districts were governed by the state's Tobacco-Free Schools Law. This policy included a loophole, however, that allowed school boards to exempt any school or school property if "extraordinary circumstances exist" that warrant an exception. Hence, the state policy essentially allowed for voluntary implementation. Because of voluntary efforts of schools to implement the state's tobacco-free policy, coupled with assistance and materials provided from Colorado ASSIST to schools, the demand for prevention and cessation programs grew.[22] The wide array of program services that were developed to

Case Study 7.7
Strengthening the Enforcement of the Youth Access Law in North Carolina

Situation: The Synar Amendment, a component of the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1992, requires each state to conduct specific activities to reduce youth access to tobacco products. States were required to "enforce the youth access law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18."

Program Services Provided: NC ASSIST worked collaboratively with the NC Substance Abuse Services Section and other partners on six major actions to reduce tobacco sales to minors:

1. Educate state and local law enforcement officers on the federal Synar Amendment, state law, and model enforcement strategies. Training programs were conducted across the state and were tailored to motivate and strengthen enforcement efforts of the state's youth access to tobacco law. ASSIST staff conducted 1-day regional training sessions that reached more than 500 state and local officers. Enforcement checks were made by minors attempting to buy cigarettes; the results were reported in the media and conveyed how easy it was for the minors to buy cigarettes. The initial buy rate was 64%. Voluntary health agencies, ASSIST coalition members, and state and local law enforcement officers began a 2-year process to educate community and state decision makers, including the attorney general and the governor, about the importance of enforcing the youth access law.
2. Collaborate with key state and local partners to strengthen the state's youth access to tobacco law. Key voluntary agencies, law enforcement, and youth advocates worked with the NC Attorney General and key legislators during the 1997 legislative session of the NC General Assembly. The efforts resulted in important legislation that greatly strengthened the law, effective December 1, 1997.
3. Work with the governor's office on an executive order to create a designated statewide enforcement agency. In 1997, the governor signed Executive Order 123 designating the NC Division of Alcohol Law Enforcement (ALE) as the lead state agency to implement model merchant education and enforcement of the state's youth access to tobacco law.
4. Create a Governor's Interagency Workgroup on Reducing Tobacco Sales to Minors. Executive Order 123 also established a Governor's Interagency Workgroup on Reducing Youth Access to Tobacco Products.
5. Obtain a contract with the U.S. Food and Drug Administration to enforce the federal youth access to tobacco rules. The contract funded ALE to conduct 400

compliance checks per month to enforce the federal Food and Drug Administration rules and the state law.

6. Educate merchants about tobacco and the youth access law. To improve compliance, the governor's office called a meeting of the retail merchants statewide whose compliance with the law was low. Local ASSIST coalitions engaged youths and adults in retailer education regarding the new state youth access to tobacco law. One model merchant education program was conducted by UJIMA—an African American youth leadership initiative created through ASSIST. The NC Department of Health and Human Services designed and distributed merchant education materials across the state.

Since 1997, combined enforcement and educational efforts have reduced the rate at which minors can purchase tobacco products from 50% in 1996 to 19% in 2001. This reduction in sales to minors exceeded North Carolina's established Synar targets for compliance. Health and Wellness Trust Fund Commission resources from the Master Settlement Agreement have been allocated to ALE to enforce the access to tobacco laws in 2002–2005.

—Jim D. Martin, former ASSIST Field Director and currently with the North Carolina Department of Health and Human Services

support tobacco-free school policies ultimately contributed to the passage of the tobacco-free schools legislation. This example illustrates how program services can complete the cycle by stimulating demand for policy change.

Strength in Comprehensiveness

Comprehensive tobacco control programs include a multifaceted approach to the community's needs. The combined media, policy, and program services interventions address the critical issues of raising consciousness of the problem, motivating the community to take action, presenting the solutions in the strongest light to garner support from policymakers, and meeting the needs of individuals and communities once policies are in place. The strong focus of ASSIST on policy interventions stimulated others to provide program services and to develop capacity. Service programs were generated by private vendors, nonprofit organizations, schools, and government organizations. Program development and delivery often brought together these diverse entities as partners. Ultimately, the policy focus helped to strengthen community linkages and infrastructures that made it possible to create a national tobacco prevention and control program. Those strengthened linkages also made it possible for ASSIST state personnel and top federal government officials to maintain the integrity of the program. They did this

while the tobacco industry aggressively sought to interfere with ASSIST and the public health policies toward which ASSIST personnel were working, as described in chapter 8.

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Program Services Case Studies:

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2. Nebraska—Implementing a Comprehensive Tobacco Control Program to Reduce Tobacco Use. www.healthierus.gov/steps/summit/prevportfolio/programs/tobacco.htm#nebraska.
3. Oregon—Reaching Target Groups With High Rates of Tobacco Use Through Comprehensive Tobacco Control: A Policy-Based Approach. www.healthierus.gov/steps/summit/prevportfolio/programs/tobacco.htm#oregon.
4. Washington State—Identifying and Eliminating Disparities in Tobacco Use Through a Cross-Cultural Workshop. www.healthierus.gov/steps/summit/prevportfolio/programs/tobacco.htm#washington.
5. Achievements in Tobacco Cessation: Case Studies. June 2000. U.S. Public Health Service. www.surgeongeneral.gov/tobacco/smcasest.htm.

8. Tobacco Industry Challenge to ASSIST

Part 1
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Table

Table 8.1. Search Terms Used with Tobacco Industry Document Sites 313

8. Tobacco Industry Challenge to ASSIST

If successful in bringing about policies that would help create a tobacco-free norm, the American Stop Smoking Intervention Study (ASSIST) would have the dual effect of decreasing tobacco use and decreasing the adverse health effects resulting from tobacco use. The tobacco companies were aware of this potential, even before ASSIST started. Because of ASSIST's potential impact, the tobacco companies undertook efforts to counter the project. The two parts of this chapter present the tobacco industry's challenge to ASSIST, first from the perspective gleaned from industry documents that became available as a result of litigation and second from the perspective of ASSIST personnel who experienced the challenges first-hand.

The tobacco companies burdened the states with requests for documents through processes allowed by the federal Freedom of Information Act (FOIA), accused ASSIST staff and local coalition members of using funds for illegal lobbying, and brought lawsuits against ASSIST staff members. The results of the systematic research of industry documents, presented in part 1 of this chapter, identify eight industry strategies to oppose the activities of ASSIST. The search yielded 1,350 documents relevant to ASSIST. Of these, 166 contained information about the tobacco companies' strategies, which were coded by a standard research method. This chapter documents the strategies with quotations from many of the documents.

Part 2 of this chapter describes the legal and temporal contexts in which ASSIST staff members responded to the tobacco industry's requests and charges. The National Cancer Institute (NCI) made continuous efforts to educate the ASSIST staff about their responsibilities and limitations regarding advocacy and lobbying activities and their obligation to respond to FOIA requests for ASSIST materials. The accusations of illegal lobbying that the tobacco companies brought against ASSIST staff nevertheless caused confusion about which activities were legitimate, and the time burden of responding to FOIA requests diverted the staff members from tobacco control activities. As the industry's challenges repeated themselves and became more widespread, the ASSIST states became more effective at responding. The case studies in this chapter describe the responses of the state staff to the challenges and, in some cases, the unfortunate personal damage experienced by individual staff members.

Part 1. The Tobacco Industry's Response to ASSIST: An Analysis of Tobacco Industry Internal Documents

Methods for Researching the Tobacco Industry Documents

Lawsuits in the 1990s against the tobacco industry have resulted in the release of internal tobacco industry documents as part of the litigation and settlement agreements; these documents are now available to the public on the Internet. They provide an unprecedented look at tobacco industry motives, strategies, and operations—information that is not available from any other source. The documents describe an industry whose actions are directed at, among other things, promoting tobacco initiation and sustaining its use.[1]

To understand the tobacco industry's reaction to ASSIST, the Legacy Tobacco Documents Library of the University of California–San Francisco (http://legacy.library.ucsf.edu), three tobacco industry document Web sites (www.pmdocs.com, www.tobaccoinstitute.com, www.rjrtdocs.com), and Tobacco Documents Online (http://tobaccodocuments.org) were searched between June 10, 2002, and April 28, 2003. The search was deliberately broad, the goal being to identify all documents that mention ASSIST. Exact duplicates were excluded. The search terms are listed in table 8.1.

The authors searched on the name of the program, "American Stop Smoking Intervention Study for Cancer Prevention." This resulted in a number of documents that were official reports belonging to the ASSIST program itself, which did not provide the information needed to analyze the tobacco industry's strategies regarding ASSIST. The authors next searched on the term *ASSIST*, which resulted in over 21,000 hits. Many of these documents contained the verb "assist" in the title and had nothing to do with the ASSIST program. The number of these irrelevant documents was significantly reduced by combining the search term *assist* with relevant terms such as *smoking* or *NCI*. The search was then further narrowed to specific document types such as *memo, confidential,* or *letter* to identify the more interesting ones (docu-

Locations of Tobacco Industry Documents

For consistency and ease of retrieval, tobacco industry documents in this chapter have been referenced according to the Legacy Tobacco Documents Library Web site of the University of California–San Francisco. These documents became public in the late 1990s as a result of litigation against the tobacco industry. The tobacco industry Web sites are subject to changes and, because the Tobacco Master Settlement Agreement requires the Web sites to be maintained for only 10 years, these sites may not be available in the future. The Legacy Library is permanently archiving the tobacco industry documents from the Minnesota depository and elsewhere. Therefore, the documents cited in this chapter can be found by searching for them by Bates number (unique page number) on the Legacy Tobacco Documents Library Web site at http://legacy.library.ucsf.edu.

Table 8.1. Search Terms Used with Tobacco Industry Document Sites

ALPHA
American Stop Smoking Intervention Study for Cancer Prevention
ASSIST
attorney client work product
Bennett, JT
Bonilla
budget
Cancerscam
Capitol Research Center
Chilcote
confidential
cost effective
DiLorenzo, TJ
Earhart Cancerscam
Earhart Foundation
Fish, JH
Hays and Wilson
HHS
Istook
Klausner, R
letter
lobbying
Mapes 1
Massachusetts ASSIST Summary
memo
Minnesota Project ASSIST
National Cancer Institute
NCI
New England Convenience
North Carolina ASSIST Summary
O'Keefe Project ASSIST
Project ASSIST in Colorado
Rhode Island ASSIST Summary
Shalala
Slavitt, J
smoking
Stuart Cloud
Sunmark
Tom Huff
Washington
Washington Legal Foundation
West Virginia ASSIST Summary
work product

ments from the tobacco industry, not reprints of ASSIST program reports, for example). Further search terms were developed on the basis of these documents. This is called "snowball searching by topic."

Terms were combined in various ways and also limited to specific date ranges. Tobacco industry personnel often added prefixes "x" and "xx" to names to preserve confidentiality; therefore, the authors also searched most names, both as correctly spelled and with "x" and "xx" prefixed. Additional documents were obtained through snowball searches that identified related documents by examining adjacent Bates numbers (unique numerical identifiers assigned to documents during litigation).* A document was included if it contained a discussion of the ASSIST program. In addition, where possible, government documents identified in the tobacco industry document collections were verified with copies from the original source.

LexisNexis (http://web.lexisnexis.com/congcomp) was searched for legislative history on the following terms between November 7, 2002, and January 22, 2003:

- House or Senate, 104, SMOKING
- Shalala, House Appropriations, 2/11/97
- Stop Smoking Intervention, House, Appropriations
- SMOKING, Shalala, House, Appropriations

For example, a search on 202607951 (with the asterisk substituted for the last number) resulted in three additional documents. But a search on 202401712* resulted in just one document, because all the other Bates numbers in the sequence 2024017121 through 2024017129 were either missing or were part of the one document.

The Tobacco Institute

The Tobacco Institute was the lobbying and trade organization for the American tobacco industry. Tobacco companies supported the Tobacco Institute financially in return for its lobbying, public relations, and other activities requiring industry-wide coordination. The Tobacco Institute was formed in 1958 and in 1998 was dissolved as a result of the Tobacco Master Settlement Agreement (MSA).

- Shalala, House, appropriations, smok*
- National Cancer Institute, smoking
- Smoking, House, Appropriations, 1996
- Smoking, House, Appropriations, 1995
- Federal Acquisition Streamlining Act

The Library of Congress Thomas Web site (http://thomas.loc.gov) was searched for congressional hearing transcripts, testimony, bills, and laws on the following terms between November 7, 2002, and January 29, 2003:

- Lobby, *limited to* Istook, Ernest J., Jr. (OK-5)
- Lobbying, 104

Supplemental searches were also performed to find commentary on the history of ASSIST by using the PubMed database and various Web sites, including those for the Cato Institute, George Mason University, *The National Review*, and ForceS.

The tobacco industry Web-site search focused on the Tobacco Institute, Philip Morris USA, and R.J. Reynolds Tobacco Company because, in the searches conducted in the Legacy Library, these three entities were the primary and, in most cases, the only sources for documents relating to ASSIST. Among the companies, Philip Morris appeared to play a predominant role in efforts to counter ASSIST and, indeed, viewed itself as spearheading the effort: "This company is viewed as a leader. . . . If this company takes the initiative [regarding ASSIST], other members of the industry will follow. . . ." [2(Bates no. 2048621158)]

The documents that met the inclusion criteria were analyzed inductively using a "grounded theory" approach,[3(p1)] although the authors were guided by their previous analyses of tobacco industry documents.[1,4] Grounded theory entails "the discovery of theory from data systematically obtained from social research."[3(pp2–3)] "In discovering theory, one generates conceptual categories or their properties from evidence; then the evidence from which the category emerged is used to illustrate the concept."[3(p23)] For ASSIST, the first documents examined were preliminarily or "openly" coded according to draft conceptual categories.* As the document evidence accumulated, the conceptual categories were finalized, and documents subsequently found were coded according to the final categories ("selective coding"). The final categories, which are listed in the Table of Contents, are

*These initial categories were information gathering, legislative activities, bring complaint to the Department of Health and Human Services (DHHS) inspector general, harassment, diversion, infiltration, submit competing proposals, the Schools Channel, media/public relations, "scholarly works," allies, local "astroturf" coalitions, litigation, and "redbaiting."

- The Tobacco Industry's Perception of ASSIST as a Major Threat
- Tobacco Industry Plans for Countering ASSIST
- Strategy 1: Gather Information on ASSIST and Monitor Its Activities at the State and Local Levels
- Strategy 2: Enlist Congressional Allies
- Strategy 3: Enlist Business and Consumer Allies
- Strategy 4: Discredit ASSIST—File Legal and Regulatory Actions
- Strategy 5: Infiltrate ASSIST
- Strategy 6: Divert Funds from the Community Environment Channel and Promote Alternative Programs
- Strategy 7: Discredit ASSIST through Public Relations Tactics
- Strategy 8: Promote Preemption Laws and Ballot Initiatives

According to Glaser and Strauss,

> Theory . . . must fit the situation being researched, and work when put into use. By "fit" we mean that the categories must be readily (not forcibly) applicable to and indicated by the data under study; by "work" we mean that they must be meaningfully relevant to and be able to explain the behavior under study.[3(p3)]

Another researcher may interpret or code the initial data differently and develop a different theory from those codes; this is only a different interpretation and does not invalidate the original researcher's concepts. The only valid criteria are that the original researchers' categories "fit" and "work." On the basis of the evolving categories, words, phrases, sentences, or whole paragraphs were labeled for purposes of subsequent qualitative data analysis. By organizing the data according to these conceptual categories, the authors identified the recurring ideas, reactions, and expressions found throughout the documents that referred to ASSIST.

Approximately 1,350 tobacco industry documents were reviewed by the authors. A number of these documents were copies of ASSIST proposals, plans of action, meeting minutes, and other documents that had been obtained by the tobacco industry through the federal FOIA and similar state laws. For the results reported in this chapter, all tobacco industry documents that pertained to developing and implementing strategies to counter ASSIST were analyzed.* These 166 documents were categorized by type of strategy, how strategies were implemented, tobacco companies' evaluations of their own efforts, and date.

Results of the Research

The Tobacco Industry's Perception of ASSIST as a Major Threat

On Friday, October 4, 1991, Louis Sullivan, then secretary of DHHS, announced the launching of ASSIST at a press conference. After describing the program, he commented, "But we are fully aware of what we are up against. The tobacco industry will do its best to

*The initial search strategy resulted in over 21,000 documents mentioning ASSIST. Over 19,000 were eliminated because they contained the verb "assist" in their title or other index category but did not concern the ASSIST program; because they were redundant copies; because they were standard reports produced by ASSIST state programs that did not pertain to the tobacco industry's interaction with ASSIST; or because they did not provide useful information for analysis.

undermine our efforts."[5(Bates no. TIMN0019104)] The tobacco industry did indeed consider ASSIST a major threat because of its scope, its emphasis on public and private policy change, and its fostering of local tobacco control coalitions and infrastructures.[6–10] In a speech prepared for a meeting of the Tobacco Institute's Executive Committee in June 1992, Susan Stuntz, senior vice president for public affairs at the Institute, outlined some of the threats:

> In California, our biggest challenge has not been the anti-smoking advertising created with cigarette excise tax dollars.
>
> Rather, it has been the creation of an anti-smoking infrastructure . . . right down to the local level. An infrastructure that for the first time has the resources to tap in to the anti-smoking network at the national level. . . .
>
> The ASSIST program has the potential to replicate our California experience in 17 other states. . . .
>
> It [ASSIST] will hit us in our most vulnerable areas . . . in the localities and in the private workplace.
>
> It has the potential to peel away from the industry many of its historic allies.[10(Bates no. TI13851814)]

By the mid-1990s, the tobacco control movement presented a challenge to the industry nationwide. ASSIST and others were involved in a number of major tobacco control initiatives. These initiatives included state excise tax increases; efforts to bring nicotine under Food and Drug Administration regulation; the Synar Amendment, which required states receiving substance abuse block grants to have laws restricting purchase of cigarettes to people aged 18 and over, and to conduct random unannounced inspections to ensure compliance; and lawsuits by state attorneys general to recover from the tobacco companies Medicaid costs for tobacco-related illnesses. A Philip Morris USA Five-Year Plan for 1992–96 described an "increasingly hostile socio-political environment."[11(Bates no. 2024090296)] Tobacco control advocates appeared to "hold the high ground and the momentum."[2(Bates no. 2048621164)] A Philip Morris executive's draft of a briefing to the company's marketing branch, dated December 1, 1993, described how ASSIST was contributing to the tobacco industry's problems:

> . . . the social battle over smoking has escalated into an all-out war. Companies that market cigarettes are under constant attack at all levels of government as well as by an increasingly well organized and well financed anti-smoking movement that wants to tax, restrict, and regulate the industry out of business. . . .
>
> Project ASSIST is a windfall to the anti-smoking movement. Before Project ASSIST, anti-smoking groups were constrained like other organizations to raise funds for overhead and salaries, and what was left over could be used to attempt to put us out of business. Today, with Project ASSIST funds, those groups automatically have their overhead/salary nut [*sic*] paid for, and this means that they can use all of their own funds to ban all billboards from a town as has happened in Massachusetts, or ban sampling, couponing, or even in store point of purchase displays. . . .
>
> The way our issues manager Josh Slavitt puts it, "for marketing issues,

> you can look at the Synar law as a bullet and ASSIST as the howitzer to fire it. Synar is the way to inflict damage on us and ASSIST provides the shock troops and weaponry to inflict the damage. . . ."
>
> The simple fact is we are at war, and we currently face the most critical challenges our industry has ever met.[7(Bates no. 2024017124,7134–7135,7150)]

The Biggest Threat: The Community Environment Channel

The tobacco industry was well aware that it would have the most trouble with ASSIST's interventions in community environments because of the emphasis on local public and private policy change, and on use of local media.[7,8,12,13] As stated in the "ASSIST Program Guidelines," the objectives for the Community Environment Channel were the following:

> By 1998, cues and messages supporting non-smoking will have increased, and pro-smoking cues and messages will have decreased.
>
> By 1998, sites will substantially increase and strengthen public support of policies which (a) mandate clean indoor air; (b) restrict access to tobacco by minors; (c) increase economic incentives to discourage the use of tobacco products; and (d) restrict the advertising and promotion of tobacco.[14(Community Group Channel, p5)]

Philip Morris consultant Ted Trimpa of Hays, Hays & Wilson wrote, "The Community Environment Channel . . . has the strongest emphasis in ASSIST and focuses on goals and activities which are the most objectionable."[13(Bates no. TNWL0047245)] Significantly, a document by the Tobacco Institute, dated January 10, 1995, identified the population of smokers who would be most affected by the Community Environment Channel activities:

> The Community Environment Channel is very important in influencing [low-educated] population [*sic*]. The most effective way of reaching low-educated populations will be through policy and media advocacy.[15(Bates no. TI13850331)]

A Philip Morris executive briefing document from 1993 spelled out the local challenge as follows:

> . . . the antis—finally having learned that it's tough to win at the state level— . . . have gone local.
>
> They are focusing their energies on town vending bans, stadium advertising bans, county bans on couponing, city bans on advertising on city property or public transportation, and so on. It is a Pac-Man approach, gobbling up our ability to market a small piece at a time until suddenly this patchwork of marketing regulations coalesces into a crazy quilt that is as effective as a national ban.[7(Bates no. 202401746–7147)]

Tobacco Institute executive Kurt Malmgren described the situation in a lengthy memo dated November 30, 1992, to Executive Director Samuel Chilcote:

> The anti-tobacco forces have developed a more sophisticated and well-funded structure to address local government affairs. . . .
>
> ASSIST guarantees that local matters will take increasing portions of our time and effort.
>
> Clearly, there is a well-orchestrated effort among the anti-tobacco

> leadership to strike where it perceives the tobacco industry to be most vulnerable: the local level. . . .
>
> During the 1980's and until very recently . . . the clear priority for the industry was in the state capitals; local activities always took a back seat. . . .
>
> Today . . . local efforts must be placed on a par with state efforts. . . .[8(Bates no. 2023965875–5877)]

Malmgren illustrates these comments with an example from California:

> [In California] it became physically impossible to attend all the hearings held on certain days, let alone mount successful opposition campaigns. . . .
>
> More troubling still, the industry did not have in place a mechanism to make it aware of the introduction of some local ordinances while opposition was still feasible.
>
> Therefore the industry was, on occasion, forced to address local concerns at the ballot box, an extremely expensive undertaking.[8(Bates no. 2023965878)]

Malmgren concluded:

> Industry leaders have recognized that state laws which preempt local anti-tobacco ordinances are the most effective means to counter local challenges. . . .
>
> However state preemption is, at best, difficult to achieve. Thus our local plan is crucial.[8(Bates no. 2023965880,5887)]

Tobacco Industry Plans for Countering ASSIST

By Monday, October 7, 1991, following DHHS Secretary Sullivan's Friday announcement, several tobacco industry executives appeared to be communicating about a broad range of strategies to "manage the situation."[16] A memo from Cathey Yoe of the Tobacco Institute to other Institute executives outlined recommended actions:

- Public Affairs Division will obtain [ASSIST] technical proposals . . . under the Freedom of Information Act. . . .
- Federal Division will alert key Members of Congress to protest use of federal taxpayer dollars. . . .
- Federal Division will attempt to amend National Cancer Institute's [NCI's] next authorization or appropriation bill (a) to prohibit use of grant funds for influencing state or local legislation, ballot initiatives, or other regulatory activities, and (b) to require detailed auditing and reporting of grant expenditures. . . .
- State Activities' regional staff will identify local business and labor interests in 17 grant states who could gain representation in community-based ASSIST coalitions.
- State Activities' regional staff will explore possible [ASSIST] grant-sponsored local activities educating against youth smoking which could use industry's "It's the Law" and similar programs. . . .
- Such plans may include limiting state health department's [*sic*] authority to fund community coalitions which pursue adoption of legislation or regulations.[17(Bates no. TI13851417–1418)]

The same Monday, R.J. Reynolds executives M. B. Oglesby Jr. and Roger Mozingo wrote a memo stamped "Confidential" that described potential courses of action regarding ASSIST, including the following:

- Restrict or limit how the funds are used through the state appropriations process and contacts with executive branch officials. . . .
- Work with the tobacco-land Congressional delegation to eliminate ASSIST funds in future appropriations bills; alternatively, seek restrictions on how the funds can be used.
- In Colorado and Massachusetts, where California Proposition 99 type initiatives are expected to be on the 1992 . . . ballot, develop plans to make voters aware that ASSIST and other federal funds are already used in their states for these purposes, and additional state funding would be duplicative and unnecessary.[16(Bates no. 511073913–3914)]

Two days later, on October 9, 1991, executive director Samuel Chilcote wrote a memo to the Tobacco Institute executive committee that the Institute had already taken action to coordinate with the state government relations departments of each member company to "counter potential state and local legislative action resulting from" ASSIST contracts to the 17 states.[18(Bates no. TI13851380)] According to the memo, activities already under way included the following:

> We have filed a Freedom of Information Act request and will review the documents we obtain for "public policy" activities which could spark state or local legislation on tobacco issues.
>
> Members of Congress have been asked to protest to the Administration this use of federal taxpayer dollars in an era of mounting deficits.
>
> In addition, we are pursuing the possibility of including in the Department of Health and Human Services Appropriations Bill for Fiscal 1992 language that would prohibit use of NCI funds for influencing state or local legislation. . . .
>
> At the state level, plans are under development to ensure that the use of ASSIST funds is limited to appropriate activities and not targeted to anti-smoking lobbying campaigns.[18(Bates no. TI13851380)]

Chilcote also wrote that the Tobacco Institute would hold a series of 50 state planning sessions with state government affairs experts from tobacco companies. The goal of the planning sessions was to discuss a range of strategies that included the following:

- Work with state administrative and legislative leaders to ensure that those applying for grants meet stringent state guidelines for the use of ASSIST funds and face regular and rigorous state auditing processes.
- Work to limit state health departments' authority to fund community coalitions which pursue adoption of legislation or regulation; and limit state funding of anti-tobacco programs by amounts received under the federal ASSIST program. . . .
- Massachusetts, New Jersey, North Carolina, Virginia, West Virginia, and Wisconsin are among the many ASSIST states which continue to face severe budget shortfalls. Explore the feasibility of introducing legislation or specific regulatory language to redirect current state anti-tobacco education monies to other programs. . . .
- Identify appropriate local business and other groups in the 17 states to apprise them of the ASSIST grant program so that they might be better

positioned to join a community-based ASSIST coalition and apply for grants. . . .
- Focus special attention on the industry's youth programs in the 17 ASSIST states. . . .
- Focus legislative efforts on passage of anti-discrimination and/or indoor air quality laws to counter encouragement of smoking bans. . . .
- Expand current monitoring of the activity of anti-tobacco groups in the states to ensure that misuses of ASSIST funds are made known in a timely fashion to state leaders and the public.
- Promote expanded education of existing independent scholarly works that call into question the motives and operating techniques of certain voluntary health organizations.[18(Bates no. TI13851380–1381)]

By July 1992, tobacco industry strategies had begun to be implemented, but a document found in the office of Josh Slavitt* (who appears to have been the primary strategist regarding ASSIST at Philip Morris) expressed impatience with the tobacco industry's efforts:

> FACT: . . . 6) ASSIST implementation phase commences this fall—coalitions have been developed and the program has faced no major threat.
>
> CONCLUSION: . . . 6) The company/industry has taken no action since the program's inception—the longer the program goes, the more difficult it is to stop.[2(Bates no. 2048621155)]

The document also mentioned the costs involved in an effective counter-ASSIST program, "As this is a time intensive project that requires immediate action, low financial commitment will not achieve the objective."[2(Bates no. 2048621158)] Then, after a lengthy section detailing "Strengths, Weaknesses, Opportunities, and Threats" for both the tobacco industry and ASSIST, the document concluded by arguing that an effective action plan to counter ASSIST will have long-term benefits for the tobacco industry overall—regardless of the expense involved:

> Use first year of ASSIST program implementation as a means for launching an investigation to discredit NCI, HHS and opponents. . . . Having all Anti organizations involved could substantially damage the movement if ASSIST is brought down. . . . Use overall investigation to develop a public relations program designed to erode credibility of opponents over the long term. . . . If any lasting impact is to occur from an investigation of ASSIST, it must be broader in scope and have a longer political and public lifespan.[2(Bates no. 2048621166,1169,1174)]

The documents describing the tobacco industry's early response to ASSIST suggest that the industry was prepared to launch a coordinated effort to oppose ASSIST, even if it was costly. The following sections describe the eight strategies identified from the documents, which the tobacco industry used to implement its plans.

The Strategies

Numerous strategy papers, memos, and briefings on comprehensive plans to counter ASSIST appear to have been developed and discussed throughout the

*The document did not list an author but was stamped as having been retrieved from Slavitt's office.

first 4 years of the project by tobacco industry executives, and by public relations firms, legal firms, and others with whom they contracted.[2,7,8,12,13,16–26] This section describes the major strategies recommended in these documents as well as in other, briefer communications,[23,27,28] how they were implemented, and how the tobacco companies evaluated the results of their efforts. Most of these strategies were implemented simultaneously, although gathering information on ASSIST appears to have been a priority at the beginning. Below are listed the 8 strategies and 10 major messages about ASSIST intended to be conveyed by those strategies.

Tobacco Industry Strategies to Counter ASSIST

1. Gather information on ASSIST and monitor its activities at the state and local levels
2. Enlist congressional allies
3. Enlist business and consumer allies
4. Discredit ASSIST—File legal and regulatory actions
5. Infiltrate ASSIST
6. Divert funds from the Community Environment Channel and promote alternative programs
7. Discredit ASSIST through public relations tactics
8. Promote preemption laws and ballot initiatives

Tobacco Industry Messages Regarding ASSIST

- Misuse of taxpayer dollars
- "Illegal lobbying," "tax grabs," conflict of interest/"cronyism," commingling of funds, use of front groups
- Government waste
- Duplication of existing programs, unnecessary, diversion from legitimate uses (e.g., breast cancer, prenatal care), not effective
- Greedy health professionals, volunteer charities, academics
- Discrimination
- Unfair tax burden on poor
- Workplace discrimination
- Freedom of choice and "commercial free speech"
- Conspiracy of the Left ("an instrument of the left designed to destroy a legal [tobacco] industry")[13(Bates no. TI13850215–0253)]

Strategy 1: Gather Information on ASSIST and Monitor Its Activities at the State and Local Levels

Freedom of Information Act Requests. The federal FOIA was passed in 1966 to ensure that all citizens have access to records and other information generated and stored by tax-supported federal agencies. The purpose of this law is to maximize accountability for the actions of government agencies. The records can be requested from agencies through an established process, and the agencies have an obligation to provide the copies requested.

Tobacco industry strategists appeared to agree that a crucial first step was to gather extensive information about the ASSIST programs, primarily through "aggressive open records efforts,"[24(Bates no. TI13850208)] using the FOIA and similar state legislation, but also using materials gathered by private investigators and infiltrators.[2,12,13,16–18,24,25] The latter tactics are similar to those used over the years

by the tobacco industry to learn about a variety of public health groups.[29] A Philip Morris document categorized as having been found in Josh Slavitt's office described the need for more knowledge:

> Fact: Internal knowledge of workings of Anti's is sporadic.
>
> Conclusion: Need more information about how opponents operate to fight them proactively. . . .
>
> Who/what/where/why/how is available and more information is coming in—knowing where/how the Anti's will strike is a plus. . . .
>
> Although their frontal assault continues, their flank may be vulnerable (over-extended and over-confident).[2(Bates no. 2048621156)]

The strategists recommended obtaining such documents as proposals, "letters, correspondence, memoranda, notes, plans, proposed plans and agendas. . . . drafts, working drafts, . . . handwritten notes, typewritten notes . . . position papers. . . . Newsletters, handouts, brochures, signs . . . transcripts. . . ."[30(Bates no. TIMN0044291)] "ownership, tax status, etc., of vendors, consultants, companies receiving ASSIST funds . . . research competitive bidding process on ASSIST awarded contracts . . . review committee sign-up sheets."[25(Bates no. TNWL0020835)]

By June 1992, the Tobacco Institute had obtained from NCI, through FOIA requests, "the contracting documents for the national program, as well as for the 17 state programs. [Our staff] have completed their review of these documents and have begun to identify possible opportunities to raise concerns . . . about the manner in which some of these funds are being spent."[31(Bates no. 2023608217)] Numerous documents show that the tobacco industry, its allies, and paid consultants were extremely active throughout the life of the ASSIST project in gathering information by a variety of means, primarily through FOIA.[25,32–42] The documents also include copies of responses from the NCI contract officer for ASSIST[43,44] and state health department officials[45] promising or enclosing the requested documents.[13,15,30,46–59]

Thomas Briant, a lawyer from Minneapolis who reported to the Tobacco Institute during the ASSIST era, pointed out in a document that the FOIA requests not only provided valuable information but also had a "chilling" effect on ASSIST activities:

> [FOIA requests in Minnesota] have been beneficial for several reasons. First, and most important, the documents furnished by the Department of Health set forth in great detail the local activities to be engaged in by the ASSIST grantees. That is, the documents are like a road map because they indicate what cities are being targeted for ordinances, when the ASSIST groups will attempt to pass the ordinance and what kind of restrictions will be proposed to the city council of the targeted locality. The information contained in these documents is invaluable and allows retailers to prepare a response to take a proactive approach when deemed appropriate.
>
> Second, based on the ASSIST group proposals approved by the Dept. of Health, the activities of the ASSIST groups are tracked by surveying the targeted cities via telephone to learn what actions are being taken. This

> provides additional advance notice of activities and allows more time in which to prepare the necessary response.
>
> Third, the survey results show a reduction in the number of cities actually being contacted by the ASSIST groups even though the grants require [them] . . . to attempt to pass a local ordinance in the targeted cities. . . . one reason for the reduction may be the chilling effect the document requests have had and the greater sensitivity of the Dept. not to allow ASSIST funds to be used for lobbying activities.
>
> Fourth, the retail associations submitted another grant proposal about three weeks ago for the 1996–1998 ASSIST years. The ASSIST documents obtained through the FOIA requests are helpful in drafting the retail ASSIST grant proposal.[60(Bates no. TI14200702)]

Documents indicate that the Tobacco Institute also saw the value of obtaining proposals submitted by states that were not awarded ASSIST contracts. As Karen Fernicola Suhr of the Institute wrote in 1992,

> Though these states have not received ASSIST funds, they'll probably be using their proposals as blueprints for at least limited anti-smoking activities anyway, having gone through the trouble of developing them. So, a review of these proposals at some point would probably be useful.[61(Bates no. 2021253352)]

Thus, not only did these states not receive ASSIST contracts, they exposed their plans to the tobacco industry.

Reasons for Monitoring ASSIST Activities. In the tobacco industry documents, the most frequently mentioned purpose of information gathering was to find evidence of "lobbying," the label used by the tobacco industry to describe ASSIST policy initiatives in the Community Environment Channel. In a prepared speech to be delivered to the Executive Committee on June 11, 1992, Susan Stuntz stated, "We think that catching the ASSIST coalitions in lobbying activities offers our best shot at working through Congress, or in the states to redirect the anti-smokers' activity."[10(Bates no. TI13851818)] A Philip Morris document characterized as having been found in Slavitt's office and dated June 1992 pointed out that "Fact: . . . HHS Secretary Shalala has gone on record against using HHS funds for lobbying activities. Conclusion: . . . The precedent is being established (GAO, Shalala statements) to force government agencies to live up to their statutory obligations and their rhetoric regarding lobbying."[2(Bates no. 2048621155)]

The definitions and restrictions for lobbying with public funds vary widely among the states and the federal government. These restrictions on lobbying do not preclude public health officials from doing policy work but rather direct how they can do it.[62] People affiliated with the tobacco industry used as broad a definition of "lobbying" as possible, in order to include most ASSIST policy advocacy activities under that rubric.[27,38,63] Field reports from the 17 ASSIST states described ASSIST policy advocacy activities; industry public statements also misconstrued those activities in a way that implied that staff members of publicly funded health departments were themselves lobbying.[15,49,52–59,64–68] Throughout ASSIST, no federal funds could be used to lobby Congress. Begin-

ning in fiscal year 1997 (i.e., starting October 1, 1996), lobbying state legislatures with federal funds was also prohibited.[69] Beginning with the ASSIST contract extension (October 1, 1998), the prohibition against using federal dollars to lobby was extended to local legislative bodies as well. However, nongovernmental entities using unrestricted funds were always allowed to lobby, subject to restrictions, at every level.

Although these varied and confusing restrictions on lobbying were introduced over a period of time, the restrictions had a "chilling effect" on ASSIST coalition members as early as 1995.[39,62] The complex and changing rules were not always completely understood by local activists. The result was often a decrease in advocacy activities because the activists were confused and unsure about the nature of their activities.[45,70] Some tobacco industry affiliates occasionally became confused about how they should be defining the term "lobbying,"[39(Bates no. TI14304071)] as shown in the following memo from tobacco industry advocate Sara Mahler to several Philip Morris executives:

> Some of these [documents I am sending] may indicate illegal lobbying. . . . I don't have a clear idea of how to find the line that separates "education" from "lobbying." . . . Best wishes from "the grassroots."[71(Bates no. 2046641500)]

Tobacco industry affiliates at the state level continually provided to tobacco companies' headquarters and to the Tobacco Institute detailed information on ASSIST coalition advocacy of local and state tobacco control legislation, or "lobbying."[15(Bates no. TI13850329)] A 1995 memo from the Tobacco Institute's Bob McAdam in Washington State appears to show that these continual requests did indeed have an effect on ASSIST's ability to advocate for policies:

> Our probing for documents has clearly caused some internal concern within the coalition. They have spent some considerable time and discussion on developing a "crisis management plan" to address the public disclosure request that we have initiated. . . .
>
> They now say they will not have any direct contact with members of the legislature while the legislature is in session. . . .
>
> At the same time, they continue to talk about influencing local ordinances.[39(Bates no. TI14304071)]

A second purpose of information gathering was to "expos[e] the wasteful and inefficient use of ASSIST funds."[13(Bates no. TI13850214)] A Tobacco Institute report on the Missouri ASSIST project provided examples:

> Most ASSIST projects appear to be 1) duplicating existing programs 2) unnecessary due to already-widespread awareness about possible negative health effects of smoking 3) opposed by many Missouri residents, legislators, teachers, etc. who object to the program on financial and/or philosophical grounds. . . .
>
> ASSIST programs are forced on unwilling participants. . . .
>
> Teachers and principals have become resistant to calls for additions to already overcrowded curricula. . . .
>
> . . . state legislators ranked funding for tobacco control programs *last* in comparison to other cancer control legislative and budget items. . . .

> Low-educated populations. . . . cherish their independence, as reflected in their rural lifestyle and purchase of trucks, motorcycles, and all-terrain vehicles.[15(Bates no. TI13850334–0336)]

A third, and equally important, purpose of information gathering was to "gain more extensive intelligence concerning current and planned ASSIST activities in order to develop potential counter-activities."[13(Bates no. TI13850214)] Ted Trimpa wrote a thorough report for Tobacco Institute consultants Hays, Hays & Wilson in 1994 on Colorado ASSIST.[30] The report described various crucial internal ASSIST documents he had obtained (with substantial portions redacted) as well as material that could be used to allege that ASSIST was using the Coalition for a Tobacco-Free Colorado as a "shelter for documents and activities that Colorado ASSIST Project personnel believe to be beyond the purview of the taxpaying public."[30(Bates no. TIMN0044290)]

FOIA requests were detailed and exhaustive.[72] An example was described in a memo from Trimpa, dated July 22, 1994, in which he announced that he had requested

> All letters, correspondence, memoranda, notes, plans, proposed plans, and agendas that are on Coalition for a Tobacco Free Colorado stationary [*sic*] date 1991 to the present . . .
>
> The Colorado ASSIST media plan, . . . including all documentation, drafts, working drafts, proposed drafts, memoranda, handwritten notes, typewritten notes, computer-produced notes, position papers, plans, proposed plans, and letters that were used, are being used, or those anticipated to be used in the creation . . . of the State Media Communication Plan . . .
>
> All notes, news releases, newsletters, handouts, brochures, signs, advertisements, transcripts, letters, speeches, memoranda, overhead display sheets, and statistics used in Arnold Levinson's* presentations on tobacco taxes . . .
>
> All handwritten and typewritten notes, memoranda, letters, brochures, and correspondence used or distributed by Arnold Levinson* in providing technical assistance, . . .
>
> assisting the "Project Director in designing implementation of annual channel activities . . . of the Community Environment Committee . . ."[30(Bates no. TIMN0044291–4292)]

The Tobacco Industry's Evaluation of Its Efforts. In January 1995, Tobacco Institute executive Bob McAdam presented an evaluation of progress in gathering ASSIST documents:

> The first phase of research on the current usage of ASSIST funds is virtually complete. . . . we have learned . . . how the[y] intend to spend the funds. . . .
>
> Only in Colorado have we gone beyond phase I research to learn how the money is actually being used at the local level. We must expand this level of research to other ASSIST states.[12(Bates no. TI13850204)]

McAdam had commissioned a report from Trimpa, of the Colorado consulting firm of Hays, Hays & Wilson, titled "Analysis and Recommendations Con-

*At the time, Arnold Levinson was the executive director of the Fair Share for Health Committee.

cerning Selected State ASSIST Projects" and dated January 26, 1995.[13] Trimpa was to "look at all of the material that we currently had on file from the various states to determine where our search would be most fruitful."[24(Bates no. TI13850208)] The report's detailed analysis of ASSIST in seven states (Minnesota, Washington, Michigan, Wisconsin, Massachusetts, Virginia, and West Virginia) included sections on "Interesting Facts and Possible Political Opportunities," such as the following concerning Washington:

> Dr. Robert Jaffe, the leader of the TFWC [Tobacco Free Washington Coalition] . . . is a principal Investigator with the Robert Wood Johnson Foundation. Which may mean:
>
> a. Jaffe is probably involved with the Washington DOC (Doctors Ought to Care) group, which is the recipient of RWJF Smokeless States money (almost $200K). Washington DOC is an ASSIST contractor;
>
> b. Given Jaffe's multiple roles and the self-proclaimed aggressive legislative agenda . . ., there may be some exploitable self-dealing/misuse of funds opportunities;
>
> c. Jaffe is probably an "ends justify the means" type of person which in turn may provide exploitable political opportunities.[13(Bates no. TI13850235–0236)]

In his cover letter to the Trimpa report, McAdam provided names of lawyers who might pursue open records requests in each state, with additional comments such as the following:

> Minnesota
>
> A sizeable amount of work has already been done by Tom Briant, who also represents the wholesalers. . . . Briant has demonstrated an ability to use the open records laws in an expedited fashion. We can expect to reach pay dirt level in a relatively short amount of time.
>
> Washington
>
> I am more concerned about Washington than almost any other state in that we have clear indications that they plan to launch a tax initiative against the industry. If we are able to identify the use of ASSIST funds for this purpose early on, we could both derail the initiative and limit the abuse of ASSIST.
>
> I have identified a law firm that can handle the pursuit. Brad Keller has represented RJR in a successful Joe Camel lawsuit and represented the restaurant association in the Puyallup smoking ban case. They appear to have an aggressive attitude and have extensive experience in going up against government entities.[24(Bates no. TI13850209–0210)]

Tobacco Institute executive Patrick Donoho appears to have sent the Trimpa report and McAdam cover memo on to executive director Samuel Chilcote on February 2, 1995, with the following note:

> I highly recommend that we pursue ASSIST research, as outlined in the attached memo. The research has a projected budget of $135,000. I recommend that we use the excess funds from the Colorado Initiative, which amount to $374,000.
>
> With your approval, we will move forward immediately.[73(Bates no. TI13850207)]

By 1996, the Tobacco Institute had prepared comprehensive analyses of ASSIST in most ASSIST states,[15,30,46–50] including detailed reports on alleged

lobbying activities by all 17 ASSIST states. The latter reports were combined into a single 95-page document that demonstrated the comprehensiveness and consistency of analysis the Tobacco Institute was able to accomplish. The report included precise examples of alleged lobbying as well as examples from ASSIST contracts and planning documents in each state that might be interpreted as intent to lobby, all useful for any legal or political action the tobacco industry and its allies might want to initiate.[64]

Hays, Hays & Wilson prepared lengthier analyses of selected ASSIST states for the Tobacco Institute. The 59-page analysis of Washington ASSIST, for example, had a 35-page section describing the program, and sections on the responsibilities and background of key individuals in ASSIST, the Tobacco Institute's legislative agenda, and "legal and political opportunities."[66(Bates no. TNWL0046638)] The report listed a number of "ASSIST Activities Possibly in Violation of Federal and/or State Law"[66(Bates no. TNWL0046699)] but cautioned, "given the loopholes under federal law, such as for 'educational activities,' maintaining a federal claim may be difficult."[66(Bates no. TNWL0046698)] The solution was to exploit politically those activities which "lack[ed] specific evidence to maintain a federal or state law claim."[66(Bates no. TNWL0046700)] These "Potential Political Opportunities" included items such as the following:

> There are indications that tax dollars . . . are being used to build and further the grassroots lobbying and coalition-building efforts of the allegedly "independent" Tobacco Free Washington Coalition.[66(Bates no. TNWL0046700)]

> TFW/Washington ASSIST appears to be fraught with self-dealing. Many of the contractors who have received . . . ASSIST funds also sit on the task forces which recommended their hiring.[66(Bates no. TNWL0046700)]

R.J. Reynolds[51–56] and Philip Morris[57–59] also prepared state-based analyses. A set of e-mail correspondence within Philip Morris in October 1995 indicated the tremendous workload tobacco industry affiliates had in keeping track of the multidimensional ASSIST program and the pressure they were under in implementing the demands of their "Counter ASSIST Plan." Some of the documents, quoted in part, suggest that the tobacco industry thought that its progress in monitoring ASSIST was slow.

From Lance Pressl to Tina Walls and others (October 4, 1995): "[We need to] discuss how to establish a system where the Tom Briant's and Joe C's of the world can send the material for analysis."[74(Bates no. 2047077445)]

Response from Walls to Pressl and Scott Fisher, later on October 4, 1995: ". . . quite frankly, the issues group has been overwhelmed by other assignments and under staffed."[74(Bates no. 2047077445)]

From Pressl to Josh Slavitt, October 5, 1995: "What do we need to do to get this jump-started?"[74(Bates no. 2047077445)]

Slavitt to Pressl later on October 5, 1995:

> I'm not sure what you mean by jump starting? . . . We are now going down to a lower level in each state to determine what local groups are receiving from the state agencies—this is a time consuming process fraught with delays

> and snags as the states attempt to avoid answering these kinds of questions. We've also suggested repeatedly that all ASSIST states be FOIA'd. I've prepared questions which Scott has used to encourage state legislators to inquire specifically where funds have gone . . . and what audits and controls have been put in place to conform with federal requirements (specifically the federal Single Audit Act, which requires states to audit any program receiving federal funds that makes expenditures of $25K or higher to local groups). ASSIST expires in 1997—What else CAN we do to jump start this?[74(Bates no. 2047077445)]

Nevertheless, tobacco industry monitoring of ASSIST is impressive in its scope, detail, and depth of analysis. The documents reflect a well-coordinated effort, with consistency in strategies and messages.[2,24,64]

Strategy 2: Enlist Congressional Allies

Tobacco industry strategists saw a number of ways in which their allies in Congress, state houses, and state legislatures could help with the efforts to undermine ASSIST, including holding hearings on ASSIST and promoting legislation that would limit ASSIST's effectiveness in some way.[12,25] Tobacco industry staff members were available to draft testimony for congressional hearings, text for questioning ASSIST leadership and staff, and even letters for legislators to sign.[67,75–79] The importance tobacco industry executives attached to the role of their political allies is reflected in the memo Tobacco Institute director Chilcote sent out 3 days after ASSIST was launched in 1991, announcing that Tobacco Institute staff members had already contacted "appropriate congressional offices concerning this announcement, and [had] raised concerns about the manner in which these funds are being spent."[80] According to one Philip Morris strategist,

- If framed right, it's a "good government" story for reform-minded politicians.
- Fiscal watchdogs are interested in taking on this issue.
- The Republicans need an issue with the Democratic controlled Congress and White House—abuse of public funds is viewed as a haymaker. . . .
- ASSIST has a "mother-pie" veneer—whoever takes it on will have to be prepared for criticism.[2(Bates no. 2048621167)]

At the same time, tobacco industry analysts understood the need both to protect their political allies and to keep them in line:

> We should have our legislative political allies make certain that these [ASSIST] funds cannot be used . . . to educate the community as to the anti-tobacco beliefs of a particular public official or the pro-tobacco beliefs of a particular official. . . .
>
> . . . we should continue to support our allies, particularly in the state legislatures and in other high political posts at every level to help them resist the pressure that may come as a result of these programs.[81(Bates no. TI13850725–0726)]

On August 10, 1992, U.S. Senators Malcolm Wallop, Orrin Hatch, and Mitch McConnell sent to DHHS Secre-

tary Sullivan a letter about ASSIST that began as follows:

> We have recently received information which indicates that federal funds made available through the National Cancer Institute will be used to fund lobbying activities at the state and local level. Given the disturbing precedent that this would establish and the numerous legal and policy problems which could arise when the federal government finances one side of a debate, we ask that you take necessary steps to stop this practice immediately.[82(Bates no. 2024103356)]

After this initial paragraph, the letter contains a number of sentences that are remarkably similar to an R.J. Reynolds document, undated but with a fax date of March 24, 1992 (4.5 months earlier).[67] Selected parts of the texts are placed side by side for comparison on the next page.

Hearings on annual appropriations for DHHS also provided opportunities for industry advocates to press their cases against ASSIST. On February 24, 1994, Cathey Yoe of the Tobacco Institute wrote to colleagues regarding the upcoming House appropriations hearings in which Secretary Donna Shalala would testify: "Since ASSIST is a priority for Burleigh Leonard at RJR, perhaps we should coordinate with him on using the appropriations hearings to point out abuses of ASSIST funding. I have taken a first stab at a draft question for Shalala. . . ."[75(Bates no. TI13850617)]

Yoe attached two draft versions of questions to be asked of Secretary Shalala. Excerpts are given below:

> Secretary Shalala, . . .
>
> when this program first got under way, my colleague Mrs. Bentley expressed concern that ASSIST funds would be used for lobbying state and local officials. . . . You assured the Committee that federal ASSIST funds would not be used for lobbying. . . .
>
> Surely you are aware that in nearly every state receiving ASSIST money, the stated goals include passage of legislation. ASSIST funds are being used to train "volunteer advocates" or "volunteer activists" in the art of lobbying. . . .
>
> I don't think any of us quarrel with getting greater participation of citizens in the legislative process at all levels. But when the Federal government hands those citizens an agenda and a T-shirt, aren't those taxpayer dollars being used in lobbying? . . . Calling it "policy advocacy" or "engaging" state legislators doesn't make it anything other than lobbying. . . .
>
> how are you ensuring that those federal funds do not get used in "targeting legislatures" with lobbying efforts?[76(Bates no. TI13850618)]

Two years later, R.J. Reynolds staff drafted questions to ask Secretary Shalala regarding ASSIST at the 1996 hearings of the House Appropriations Subcommittee on Labor, Health and Human Services, and Education. A document dated March 26, 1996, by John Fish of R.J. Reynolds to Eric Fox, staff assistant to Congressman Henry Bonilla, who apparently was not familiar with ASSIST at the time, contained the following questions:

> Attached are a few questions for Secretary Shalala—if Mr. Bonilla has the opportunity to ask them. They deal with a program called ASSIST. . . .

Portions of RJR Nabisco Memorandum Faxed March 24, 1992

"The model program does include a disclaimer on lobbying, but then includes in each of the grants awarded to the states a form entitled, 'Disclosure of Lobbying Activities.' . . .

"The Department of Health and Human Services will spend $115 million over seven years on the ASSIST program. An additional $25 to $30 million will be provided by the American Cancer Society. Moreover, the Department also will spend approximately $20 million for national coordination and evaluation. . . .

"The Massachusetts ASSIST program will use part of its federal funds to finance a conference involving legislative and advocacy leaders to draft legislation which would be submitted simultaneously to all of the New England state legislatures. . . .

"Some of the grantees were a bit skittish about being too directly involved in lobbying. For example, the Minnesota ASSIST program indicated that it would consider retaining the state's existing tobacco control lobby as a subcontractor. . . .

"Once the federal government begins to finance one side of a public policy debate, there can be no debate. There will only be the federal government's position."

Source: RJR Nabisco. Using Federal Funds to Lobby State and Local Leaders. March 24, 1992. http://legacy.library.ucsf.edu/tid/zuu24e00 (accessed June 24, 2002). Bates no. 2026079534–9535.

Portions of Wallop/Hatch/McConnell Letter August 10, 1992

"Your department will spend approximately $115 million over seven years on the program, and the American Cancer Society will provide an additional $25 to $30 million. Your department will also spend roughly $20 million for national coordination and evaluation. . . .

"The model program does include a disclaimer on lobbying, but then includes in each of the grants awarded to the states a form entitled, 'Disclosure of Lobbying Activities.' . . .

"The Massachusetts ASSIST program will use part of its federal funds to finance a conference involving legislative and advocacy leaders to draft legislation which would be submitted simultaneously to all of the New England state legislatures. . . .

"Some of the grantees were a bit skittish about being too directly involved in lobbying. For example, the Minnesota ASSIST program indicated that it would consider retaining the state's existing tobacco control lobby as a subcontractor. . . .

". . . once the federal government begins to finance one side of a public policy debate, there will no longer be a debate. There will only be the federal government's position."

Source: Hatch, O., M. McConnell, and M. Wallop. Letter to Health and Human Services Secretary Louis Sullivan. U.S. Senate. August 10, 1992.

One concern with asking Shalala about this contradiction [regarding lobbying] is it gives her the ability to get on her soapbox about tobacco. . . .

One word of warning, Shalala has already indicated that the whole FDA and tobacco issue is going to be a campaign issue—and a winner for the Democrats. I say this to warn you that any questions asked need to be very focused so that the door isn't opened to her. . . .[77](Bates no. 522629314–9315)

> In 1993, my colleague, Helen Bentley, raised with you her concern about ASSIST funds being used to lobby at the state and local levels. Your response left no room for uncertainty—no funds would be used to lobby. . . . Is it still your policy that federal funds shall not be used for lobbying at the state and local levels? . . . I have a copy of a [communication] from a contracting officer at NCI to ASSIST project directors which contradicts your previous statement. My question for you is who sets policy for HHS—you or the Project Officers? What actions are you going to take to make sure that federal funds are not used to lobby state and local officials?[77(Bates no. 522629316)]

No evidence is available that Congressman Bonilla used this text to question Secretary Shalala at the 1996 appropriations hearings. A Tobacco Institute memo dated a month later mentions that "transcripts of Secretary Shalala's testimony before the House Appropriations Subcommittee on Labor, HHS, and Education will be unavailable for some time, due to a technical glitch with the transcribing service."[83(Bates no. 518239758)] However, a committee report dated July 8, 1996, from the Committee on Appropriations to accompany the appropriations bill (H.R. 3755) for, among others, DHHS, included the following passage:

> The Committee is concerned that the National Cancer Institute may not be adequately overseeing the so-called ASSIST Program (the American Stop Smoking Intervention Study Program). Questions have been raised about some of the expenditures in this program. The Committee strongly urges the Inspector General to conduct an audit of the contractors in the program to determine if the funds are being properly spent and that the program is meeting its goals.[84(p124)]

Transcripts are available for the next year's hearings on the DHHS appropriations, dated February 11, 1997, at which Secretary Shalala testified.[85] The transcripts provide the full text of Secretary Shalala's response to questioning by Congressman Bonilla as well as by Congressman Ernest Istook. The questions from the two congressmen are not available; the transcript lists them as "inaudible." Secretary Shalala's responses suggest that they are questioning her intensively:

> Rep. Bonilla: (Off mike, inaudible.)
>
> Secretary Shalala: I think we've provided extensive information to you about the activities of the ASIS (?) [*sic*] contracts. We have informed all of our contractors and all of our grantees that they are not to engage in lobbying activities, which is prohibited under the Federal Acquisitioning and Streamlining Act.
>
> We have made it very clear that violations of the act will not be tolerated by the Department. If allegations of violations of the act are serious enough, we will turn them over to the Inspector General. The Inspector General is conducting an investigation.
>
> We have thus far found no lobbying violations in the course of our internal inquiry and, as you indicated, no one on this committee, and I don't know anyone in this country, that's in favor of smoking by children.
>
> It's a major public health problem, but we intend to obey the law and to make sure our contractors obey the law, and

thus far we have not found any violations, but we have made it very clear to the contractors that they are not to violate the law.[85(p11)]

A few moments later, Congressman Istook again raised the subject of lobbying:

Rep. Istook: (Off mike, inaudible).

Secretary Shalala: Let me repeat again. We have taken the position that once the law was passed, any contract after the law was passed cannot use federal money for lobbying. . . .

We also are taking the position that if there is a renewal of any existing contract, it ought to be covered by the law that was passed so that we would catch, as there are any extensions or renewals contract [*sic*], any new people coming up.

As to whether before the law was passed, which is October 1st, 1995, whether we have actually gone back to see whether anyone continues to lobby because they have a contract that's before that, I'm not sure I know the answer to that question.

Rep. Istook: (Off mike, inaudible).

Secretary Shalala: I think that we must not have understood the question at the time. We've been consistent in our interpretation of the law, and that is, any contract that was awarded after October 1st and any extension of a contract after October 1st, is covered by that law, but apparently we have not gone back to look whether—and we have sent notifications to everyone who is on our contracts, or they've signed an affidavit saying that they understand what the rules are, but apparently we have not gone back to see whether, even though it's a legal activity under our interpretation of the law.

Rep. Istook: (Off mike, inaudible).

Secretary Shalala: Well, first of all, a year ago was 1996, and a year ago was a year after the—I mean, some time after the law had been passed.

Our responsibility is to enforce the laws once they're passed, and what I've indicated to you is as of October 1st, 1995, any contracts or any renewals of contracts by our lawyers' interpretation are covered by this law, and we will enforce that.

Rep. Istook: (Off mike, inaudible).

Secretary Shalala: Mr. Istook, I'm interpreting the law as passed by the Congress. The law, as passed by Congress, my understanding of that law is it was not retroactive. Now, if there is a different interpretation of that law, and if—

Rep. Istook: (Off mike, inaudible).

Secretary Shalala: I probably couldn't under the law. I'd have to ask my counsel.

Rep. Istook: (Off mike, inaudible).

Secretary Shalala: You know, all I can do is obey the law, as the law is passed. I can't talk to a contract that was a contract in the previous Administration about a new law that was passed that doesn't apply to them. So I can do my best and enforce the new law, and that's what you should hold me accountable for.[85(pp13–14)]

Congressman Istook had offered an amendment to a 1995 Lobby Reform Bill[86] and another to the March 1996 Balanced Budget Down Payment Act,[87] requiring all organizations receiving federal grants to provide an annual report of expenses for lobbying activities. Organizations and businesses receiving govern-

ment contracts or tax exemptions were not required to report lobbying expenses.[86] The 1996 version of the Lobby Reform Bill passed. In arguing for this legislation, Congressman Istook had made the following points:

> It is time to end taxpayer-funded political advocacy! . . .
>
> The term "lobbying" is too narrow to be useful for this purpose. The broader term "political advocacy" should be used. . . .
>
> No federal funds should be used for political advocacy.
>
> No grant funds should be used to provide support to other organizations who, in turn, conduct political advocacy. . . .
>
> Any Federal grantee should be subject to an audit. . . .[88(pp1–2)]

One tobacco industry document indicated that Congressman Istook worked with the tobacco industry to prevent the use of federal funds for political advocacy. A *Weekly Bullet Report* prepared by Philip Morris (PM) lobbyists in Washington, DC, dated February 21, 1997 (10 days after the above hearing), included the following passage:

> Labor, HHS [Appropriations Subcommittee]: PM consultants do not think we can chop funding for anti-tobacco programs, given the obvious sensitivity of the issue and the vote count on the Sen. subcomm. We can at least work w/ Northup's office on HHS failure to promptly implement SAMHSA/Synar vs. how quickly FDA put together its rule, and Istook and Bonilla's office on use of ASSIST funds for lobbying.[89(Bates no. 2078293672)]

In conclusion, the tobacco companies' documents indicate that corporate executives understood how important it was to cultivate political allies and take advantage of some allies' previously defined political positions. The tobacco industry appears to have provided these allies with information and drafted language about ASSIST for their legislative efforts.

Strategy 3: Enlist Business and Consumer Allies

While the tobacco companies worked closely with their political allies and had extensive sales force networks and other internal resources to address the ASSIST situation as well, they also recognized the need to recruit and use outside organizations linked to the tobacco industry economically or philosophically for their efforts to counter ASSIST.[2,7,8,10,18–20,90,91] These potential allies included tobacco vendors, restaurateurs, grocers, convenience stores, and hoteliers; organizations and business groups concerned with "taxpayer abuse" and "government excess"; conservative and libertarian think tanks; and consumer groups (smokers). Josh Slavitt at Philip Morris described several ways in which tobacco industry allies could contribute to "opportunities to disrupt ASSIST funding:"[19(Bates no. 2023916866)]

> A more thorough investigation should be launched . . . particularly in terms of the NCI/ACS relationship and the use of federal funds for state and local lobbying purposes. . . . Various tax and fiscally responsible organizations could get involved.

> Washington Legal Foundation/other groups could at the same time launch concurrent injunctive challenges in ASSIST states to stop dispersal of funds while the Congressional investigation is going on, as well as to determine whether the program violates Federal or state ethics/ lobbying laws. . . .
>
> Local anti-tax groups could also weigh in because the program will affect budgets by adding state DoH jobs with many ASSIST states looking to reduce major deficits.[19(Bates no. 2023916866–6867)]

Tobacco industry ally activity appears to have begun early in the ASSIST project. By June 1992, Slavitt reported, ". . . fiscal watchdog groups are examining spending at HHS to point out wasteful spending in a number of areas, in order to put the department on the defensive. . . . Derek has also contacted Citizens Against Government Waste (the former Grace Commission), which has agreed to include ASSIST in their "PIG Book."*,[20(Bates no. 2078755122)]

Kurt Malmgren of the Tobacco Institute developed a lengthy strategy paper in November 1992 on how to recruit and work with allies at the local level. The following strategies were included:

A. Develop effective monitoring systems to ensure that the industry learns of the introduction of unfair local anti-tobacco proposals in a timely fashion. . . .

   Nothing . . . works more effectively than a system in which city and county clerks are contacted on a regular basis to determine if anti-tobacco activity is scheduled. . . . Unlike Massachusetts, where convenience store allies and member company sales representatives fill the role, in Minnesota, the wholesalers have implemented a similar program which has proved effective.

B. Employ effective local advocates. . . .

   Identifying and deploying the local person who can "make the sale" before local government entities . . . accounts for an extremely large portion of the reason the industry achieves its goals. This is the single most important non-managerial element of the program.

C. [Build strong local coalitions.] The constant claim on the local front is that "It's only the out-of-state tobacco industry that opposes this ordinance." . . .

   [In California], coalition coordinators . . . develop support from individual restaurateurs, retailers, hoteliers, local labor leaders and others. The coordinators get in the door, educate the potential allies, form official local groups if necessary, . . . encourage their attendance at the hearings, motivate them to testify . . . and even encourage them to write letters to lawmakers and the press. [Coordinators should be local too], . . . on the ground every day working these potential allies. . . . "[8(Bates no. 2023965881–5883)]

In an early 1995 report to the Tobacco Institute, the public relations firm The Madison Group recommended aggres-

*The *Congressional PIG Book* is an annual summary of alleged waste and "Pork in Government" expenditures. Citizens Against Government Waste (www.cagw.org) was formed as a nonprofit to continue the activities of President Reagan's Grace Commission.

sively mobilizing local coalitions. They suggested

> identifying third party allies who share a concern with taxpayer abuse and government excess. . . .
>
> - Cultivate the coalition that will carry the attack against Assist [*sic*]. . . .
> - Organize coalition indignation and uprising against Assist [*sic*]. . . .
> - Extend the issue and general indignation for as long as possible.[90(Bates no. TNWL0047343)]

Allies were also used to send FOIA requests, using sample letters provided by the tobacco companies;[21,41] request hearings or file complaints regarding "illegal lobbying" and other allegations;[41,92] file lawsuits;[35] write letters to politicians at various levels issuing complaints or demanding investigations;[93] and publish articles criticizing ASSIST in their newsletters.[94] In some cases, allies required "financial assistance to enable the organization to improve its capabilities in dealing with tobacco issues. . . ."[95(Bates no. 2023965833)] This was the case with the American Wholesale Marketers Association, which received contributions from the Tobacco Institute in 1993,[95] and the Minnesota Candy & Tobacco Association, which received $20,000 from the Tobacco Institute in 1991.[96]

The Tobacco Industry's Self-evaluation of Their Efforts to Recruit Allies. It is difficult to assess overall how successful the tobacco industry was in enlisting and using these various allies. At the beginning of ASSIST, the Tobacco Institute's Susan Stuntz, in a speech to the executive committee, had listed in detail some of the diverse coalition members ASSIST states had successfully recruited, including major employers, the Urban League and NAACP, state newspaper publishers associations, Blue Cross, Prudential, and state AFL-CIOs. Many of these had also been heavily recruited by the tobacco industry. Stuntz pointed out that

> those coalitions that involve major employers in the state, state or local chambers of commerce, or unions and other employee organizations are of major concern. . . .
>
> In one state, it appears that outdoor advertising agencies are working quietly with the ASSIST coalition to develop anti-smoking messages.[10(Bates no. TI13851814)]

Malmgren of the Tobacco Institute reported in November 1992 that the industry had been successful in recruiting and collaborating with a retail association in the northeast:

> . . . the industry established a formal, solid working relationship with the New England Convenience Store Association to develop better coordination of their resources. . . .
>
> For monitoring purposes, we fund our allies in the convenience store group to regularly report on ordinance introductions and assist in campaigns to stop unreasonable measures. . . .
>
> As a result [primarily of this alliance], the industry is prepared to deliver direct mail, run phone bank operations and otherwise attack local proposals with our local business allies in a generally coordinated and productive fashion.
>
> The team is beginning to export the Massachusetts efforts to other states in New England to prepare for the increase in local activity expected from ASSIST funding in Maine and Rhode

> Island, as well as Massachusetts.[8(Bates no. 2023965879)]

In contrast, in a memo dated November 29, 1995, Josh Slavitt of Philip Morris expressed some frustration with the lack of a strong key ally in New Jersey:

> . . . as an ASSIST state, NJ is beginning to catch fire on the local level where communities are attacking our sales and marketing practices. It is difficult to implement our traditional methods of heading off legislative/regulatory marketing restrictions at the local level in New Jersey due to the lack of a strong retail trade association in the state.[97(Bates no. 2045887287)]

A Philip Morris planning document of July 1992 also had expressed doubts about the tobacco industry's ability to recruit smokers in their efforts against ASSIST:

> Fact: 1) Consumers are diminishing resource and have doubts—doubts reduce effectiveness. 2) Efforts to enlist consumers in fighting the Anti's directly have been generally unsuccessful. . . .
>
> Conclusion: 1) Fewer consumers will affect the pool of available activists who can/will articulate their own defense. . . . [2(Bates no. 2048621157)]

Minnesota lawyer Thomas Briant echoed this concern in a handwritten note, dated August 16, 1994, that accompanied a letter to a Philip Morris executive and complained, "The political environment in MN is going further south with 'stings' at retail all over the place and now the state suing PM! Any NY help available to fight back? Our people are getting overwhelmed."[98(Bates no. 2044135472)] Thus, individuals affiliated with the tobacco industry expressed frustration with their inability to recruit useful allies.

Strategy 4: Discredit ASSIST—File Legal and Regulatory Actions

In the tobacco companies' documents, the authors found discussions of a number of tactics to discredit ASSIST and those involved with ASSIST. These tactics included injunctions, lawsuits, complaints to the DHHS inspector general, audits, changes in federal regulations, and complaints before ethical practices boards. A 1993 Philip Morris document titled "Synar ASSIST Task Force" identified the single overarching objective for these activities as eroding the credibility of those involved with ASSIST:

> ASSIST
>
> Objective
>
> . . . Launch investigation of ASSIST program in Congress and in state legislatures. . . .
>
> Use overall investigation to develop a public relations program designed to erode credibility of opponents over the long term.[26(Bates no. 2023961348)]

Injunctions and Legal Actions. Tobacco company executives planned to use their legislative allies to carry out various legal actions. These included Slavitt's idea for filing injunctions against the distribution of ASSIST funds:

> In order to determine whether a member of Congress has grounds to file an injunction, Legal should review the original RFP from HHS and the state proposals to determine the potential for litigation. . . .
>
> Senator McConnell has previously filed a letter to HHS criticizing

> ASSIST. However, based upon the legal analysis, there may be an opportunity for other Members of Congress to file an injunction against distributing these funds.
>
> Identifying the appropriate MoC [member of Congress] must be pursued aggressively by the Washington Relations Office—in the best case, the member should be from a non-tobacco state.[20(Bates no. 2078755122)]

A lengthy Tobacco Institute document reported on the success of one legal action in Colorado:

> On February 13, 1995, a Colorado administrative law judge ("ALJ") found that the Colorado Department of Public Health and Environment ("DPH") violated state election law by using public funds and resources, apparently including money provided through the ASSIST program, to further a pending tobacco tax initiative.[40(Bates no. TI30519007)]

Federal Acquisition Regulations. In March 1993, the ASSIST Coordinating Center provided a training workshop for state ASSIST staff regarding policy advocacy limitations on lobbying under current law, and the Center prepared a "white paper" titled "Restrictions on Lobbying and Public Policy Advocacy by Government Contractors: The ASSIST Contract."[99(Bates no. TNWL0046714)] Among its conclusions, the paper found that, under current law,

> state public health agencies . . . may not use federal Government contract funds to lobby Congress. . . . [However, no current law] precludes lobbying the executive or administrative branch of government, at any level. . . . State public health agencies are likewise free to lobby the legislative branch at the state or local level, and to attempt to influence initiatives or referenda.[99(Bates no. TNWL0046721–6722)]

The Tobacco Institute obtained a draft copy of the ASSIST paper on lobbying. From the tobacco industry's viewpoint, a serious weakness in existing laws was that lobbying restrictions on federal funds did not apply to local legislation and ordinances, so the Tobacco Institute strongly advocated for amending the Federal Acquisition Streamlining Act (FASA). As described in a Tobacco Institute document dated December 15, 1994,

> . . . this fall we were able to attach an amendment to the Federal Acquisition Streamlining Act ("Act") legislation . . . which—for the first time—would prohibit federal funds from being used to lobby a local legislative body. . . .
>
> The Act will result in a revision of the Federal Acquisition Regulations ("FAR"), which govern all federal contracts, including the ASSIST program. . . . the new lobbying prohibition will not be enforceable until final regulations are promulgated, probably some time in the fall of 1995.[23(Bates no. TI13850309–0310)]

The amended FASA stated that "Costs incurred to influence (directly or indirectly) legislative action on any manner pending before Congress, a State legislature, or a legislative body of a political subdivision of a State" were not allowed in federal contracts.[100(§§1587–68)]

The new law took effect on October 1, 1995, and it applied only to government contracts based on solicitations issued after that date. Because the original ASSIST contracts had been awarded prior to that date, they were not governed

by FASA—as the Tobacco Institute discovered when it attempted to use the new regulations to restrict ASSIST activities. Nevertheless, tobacco companies used this amendment as a basis for requesting official government audits of ASSIST contract activities.

HHS Inspector General Audits. The December 15, 1994, Tobacco Institute document cited above also pointed out that, even with the FASA amendment, certain clauses in the Federal Acquisition Regulations (FAR) would make it difficult to challenge ASSIST:

> . . . complaints involving the ASSIST program may not fit under the Federal Acquisition Regulations framework for several reasons. . . .
>
> the regulations envision an interested party to be . . . a company that may have submitted a contract bid and lost. . . .
>
> Second, . . . the probable remedy is very mild. . . . the contractor . . . would be expected simply to reimburse the government for the cost of its lobbying efforts.[23](Bates no. TI13850310–0311)

The author of the document mentions the role played by two U.S. Senators in attempting to fit the legislation to the tobacco industry's needs, then introduces a new strategy involving not only congressional allies but also allies at the state and local levels:

> As you know, Senators Hatch and Ford were unsuccessful in their attempt to amend the Act to make sure that individual ASSIST grantees could be sued by any interested party under the Federal Acquisition Regulations.
>
> Consequently, the best way to use the new lobbying prohibition may be to bring a complaint to the Inspector General of the Department of Health and Human Services. . . . [This] has three distinct advantages over the FAR. First the Inspector General has a great deal of discretion over the scope of his investigations and has a wide spectrum of remedies from which to choose if he determines that federal funds are being used to lobby. . . . Consequently, even if the complaints would not be actionable under the FAR on procedural grounds, the complaints coupled with political pressure from the Hill eventually might be more effective than a FAR complaint to the GAO [General Accounting Office] or the GSBCA [General Services Admin-istration Board of Contracts Appeals].
>
> Second, unlike the FAR framework, there are no procedural technicalities that hinder outside third parties from bringing complaints before the Inspector General. In fact, by sending the complaints to the Inspector General, we could coordinate a grassroots effort that would send dozens of complaints to the Inspector General's office, forcing the Inspector General to address the problem.
>
> Finally, if the Inspector General dismisses the complaints, or if he chooses to engage in a less than vigorous investigation, his actions will be of interest to the appropriate congressional oversight committees. And, given recent political changes, the Department of Health and Human Services may be more sensitive to Congressional pressure.
>
> Procedurally, filing a complaint with the Inspector General is very straightforward. . . . The letter should . . . request that the Inspector General investigate and audit ASSIST to determine whether such violations are indeed occurring.[23](Bates no. TI13850311–0313)

The author finishes by suggesting that the complainant "request that the Inspector General recommend that the ASSIST program be eliminated and that the federal government be reimbursed for federal funds that were illegally spent."[23(Bates no. TI13850313)]

In 1996, the House Appropriations Subcommittee on Labor, Health and Human Services, and Education requested that the inspector general of the DHHS perform an audit of ASSIST.[101] A year later, R.J. Reynolds's John Fish again wrote Congressman Henry Bonilla's office, this time with a set of questions for the inspector general, including the following:

> Does your office conduct periodical [*sic*] reviews of all contracts to ensure that the money is used in appropriate ways? . . .
>
> You are currently conducting an audit of the ASSIST program. Can you tell me when your audit will be completed?[78(Bates no. 522524229)]

In June 1997, the deputy inspector general for audit services at DHHS wrote the following to Congressman Bonilla, with a copy to Congressman Istook:

> This is to provide you the status of our review, made at your request, of the . . . (ASSIST) program. . . . Your staff expressed particular concern about (1) whether ASSIST funds were used for lobbying activities, (2) whether the program was effective, and (3) the relationship of ASSIST to other initiatives to reduce smoking. The Committee on Appropriations also requested the Office of Inspector General (OIG) to conduct an audit of the program. . . .
>
> To determine whether the activities were reimbursable under the provisions of Federal cost principles and laws which prohibit use of Federal funds for lobbying elected officials, we:
>
> - interviewed NCI ASSIST officials and officials of one ASSIST contractor [NJ], . . .
> - reviewed progress reports, . . . [and]
> - engaged the Office of Counsel to the Inspector General (OCIG). . . .
>
> Our review of the list of eight reported activities and progress reports submitted by ASSIST contractors disclosed (1) one instance where nonreimbursable lobbying activities occurred, and (2) six instances had not violated applicable Federal lobbying laws. We are continuing to review one instance to ensure that no Federal funds were used for lobbying activities.[102(Bates no. 522524692–4693)]

The single case found involved a journal advertisement in New Jersey regarding banning of smoking in casinos. The advertisement's cost was $1,470.[102] NCI auditors followed up with an audit of the New Jersey contract and found that the $1,470 expense was appropriate. The deputy inspector general also "concur[red] with the observation of NCI ASSIST officials that more analysis is needed in order to determine the effectiveness of the ASSIST program."[102(Bates no. 522524696)]

State Audits. Demands for audits were also used at the state level.[21,25,28,93] In Michigan, Philip Morris's Scott Fisher wrote a memo (April 25, 1994) to executives at the Tobacco Institute, Philip Morris, and R.J. Reynolds detailing how the tobacco industry could use a local politician to force an audit of the state ASSIST program:

> Michigan's Co-Speaker of the House has taken a keen interest in uncovering more information regarding the state's seven-year involvement in the ASSIST program. Attached you will find a copy of a letter Speaker Hertel sent to . . . Director of the Michigan Department of Public Health . . . seeking detailed information on the ASSIST program. . . . Please note . . . [three counties] have received over $25,000 each year. . . . The Single Audit Act of 1984 requires any sub-recipient which received over $25,000 in federal grant monies to be audited. No such audit of these agencies has been done by [Fiscal Year] FY '91, '92, or '93.[21(Bates no. 2041190064)]

Fisher then made several recommendations, among them,

1. What specific follow-up questions should the Speaker send back to the Director of the [Department of Public Health]? . . .
5. Can a letter be sent by Speaker Hertel to federal officials such as Michigan's Congressional representatives or HHS and/or its auditor regarding the lack of enforcement of the Single Audit Act of 1984 which could jeopardize future funding for Michigan's ASSIST?[21(Bates no. 2041190065)]

On October 18, 1995—less than 2 weeks after the new legislation took effect—a tobacco ally, the Minnesota Grocers Association,[28,103] wrote a letter to Governor Arne Carlson and the state auditor, with copies to the Minnesota congressional delegation. Portions of the letter follow:

> Information has been brought to the attention of the Minnesota Grocers Association which indicates that taxpayer dollars dispensed under the direction of the Minnesota Department of Health's ASSIST Project have been used unlawfully and improperly to fund lobbying activities. . . . Using the more than 500 pages of documents provided to us, . . . we are asking the Governor's Office and the State Auditor to launch an immediate investigation. . . .[93(Bates no. 513967722)]

Four months later, the Minnesota Grocers Association received a letter from the Minnesota ASSIST project director pointing out that, according to the NCI,

> the Federal Acquisition Streamlining Act of 1994 only affects contracts awarded on or after October 1, 1995. Since the ASSIST contracts were awarded in September of 1991, the new cost principles do not apply to Minnesota's ASSIST contract. Further, the Office of General Counsel, Department of Health and Human Services, has advised NCI that in its opinion the ASSIST subcontractors are also not covered by the changes of October 1, 1995 because ASSIST contractors are not expected to pass on the new cost principles to their subcontractors.[104(Bates no. 2046957021)]

A similar effort to use the new FASA regulations in New York also failed, as shown by an undated Tobacco Institute document from around 1996, which includes a letter from New York's ASSIST program manager to his coalition project directors and contacts, with the following announcement:

> I am happy to tell you that a final interpretation of the regulations by the Department of Health and Human Services has determined that contracts awarded prior to October 1, 1995, are not subject to the FASA, and, there-

> fore, these regulations do not apply to contractors or subcontractors participating in the ASSIST program. . . .
>
> This news should encourage all coalitions to redouble their policy advocacy efforts. All coalitions may use contract funds to appropriately advocate for tobacco control at the local level, and most may do so at the state level. Local legislation, regulation, and voluntary policies are the cornerstone of our effort to eradicate tobacco-caused disease. Your vigorous advocacy for tobacco control is the key to our success.[105](Bates no. TI16270186)

In Washington State, tobacco industry operatives drafted letters for state Representative Tom Huff. Representative Huff appears to have been recruited to request an audit of ASSIST, as described in a memo (March 15, 1996) from Bill Fritz of Public Affairs Associates, a public relations firm working with the Tobacco Institute:

> Here is the State Auditor's reply to Rep. Tom Huff's request for an audit of the ASSIST program.
>
> The audit appears to have been "a once over lightly" effort that either avoided some questions poised [*sic*] by Rep. Huff or provided inadequate answers. . . .
>
> we should draft another letter for Rep. Huff's signature pointing out and reasking the questions that were not answered. . . .[79](Bates no. TNWL0046478)

In Maine, an attorney from the law firm Doyle & Nelson met with and then wrote to Maine's attorney general on April 23, 1997, regarding "possible failure to follow the law and inappropriate conduct" by ASSIST. The attorney requested that the attorney general "launch an immediate investigation in conjunction with the State Auditor's Office." [106](Bates no. 518270712) The attorney cited "lobbying activities" and "lack of bidding procedures," but he was most indignant that the local program had sent to the ASSIST Coordinating Center a list of Maine tobacco lobbyist lawyers and selected clients and then encouraged health care clients to switch to other lawyers:

> Carol Allen clearly was told that she lost the Maine Teachers Association . . . because of her representation of tobacco clients; I personally was told that there were attempts to remove me as head of the United Way campaign . . . because of my representation of tobacco clients; My partner Craig Nelson, who serves on one of the affiliated boards of the Kennebec Health System, was told by several persons that he should resign, and there was some pressure to do that until I intervened. (I spoke with the President of the Maine Lung Association . . . who heads up this years [*sic*] anti-smoking effort and told him that if his organization or any unknown members of that organization persisted that we would sue them both collectively and individually.) . . . I am absolutely outraged that state tax dollars can be used to attempt to deprive attorneys engaged in private practice of their clients.[106](Bates no. 518270715)

Investigation by Ethical Practices Board. In addition to demanding an audit, as mentioned earlier in this chapter, the Minnesota Grocers Association, a tobacco industry ally, sent a letter on October 18, 1995, to the State Ethical Practices Board requesting that "the Governor's Office and the State Auditor . . . conduct a

formal investigation of the Minnesota . . . ASSIST Project . . . [regarding] lobbying activities. . . . the vast majority of these groups that have engaged in lobbying activities have not registered with the Ethical Practices Board as lobbyists and have failed to file lobbyist reports."[107(Bates no. 513967726)] On February 4, 1996, lawyer Thomas Briant, writing on Minnesota Wholesale Marketers Association letterhead, wrote to Tobacco Institute, Philip Morris, R.J. Reynolds, and U.S. Tobacco executives that the Ethical Practices Board had dismissed 15 of the 16 complaints brought by the Minnesota Grocers Association because the amount of money and time spent lobbying had not exceeded the threshold.[28] Undeterred, Briant went on to say that he would be "sending a letter to the Minnesota Department of Health informing them which ASSIST grantees intended to engage in local and/or state lobbying activities and request that the Department of Health take all necessary to steps to prevent such lobbying."[28(Bates no. 517759156)]

The above examples demonstrate the industry's perseverance in bringing federal and state complaints against ASSIST; adverse rulings did not deter the tobacco industry from repeated attempts to stop ASSIST's policy advocacy efforts. In Washington, public relations consultant Fritz described "our objective" in a memo to the Tobacco Institute as follows:

> turning the public spotlight on the improper and illegal use of public funds for anti-tobacco lobbying, producing a "chilling effect" on the zeal and cavalier manner in which the anti-tobacco activists conduct their programs, leading to the diminishment and eventual curtailment of some of these programs funded with public money.[108(Bates no. TNWL0020096)]

Strategy 5: Infiltrate ASSIST

The tobacco companies' documents reveal that they planned to infiltrate ASSIST as they have infiltrated other public health groups, such as Stop Teenage Addiction to Tobacco (STAT) and Infant Formula Action Coalition (INFACT).[29] Proposed strategies included joining and reporting on ASSIST coalitions as well as applying for ASSIST grants and contracts.[109] One of the Tobacco Institute's initial action plans, in October 1991, included the following: "State Activities' regional staff will identify local business and labor interests in 17 grant states who could gain representation in community-based ASSIST coalitions."[17(Bates no. 518143180)]

The tobacco industry took advantage of the openness with which ASSIST coalitions welcomed new members. Briant, a Minneapolis attorney who, as noted above, worked for both the Tobacco Institute and the Minnesota Wholesale Marketers Association, included the following recommendation in his analysis of the Minnesota ASSIST proposal:

> As indicated in the Best and Final Offer Proposal, . . . "any organization desiring to join [the ASSIST Coalition] will be welcomed." Given this open membership, I would recommend that business groups which would be effected [*sic*] by the ASSIST study as a result of reduced smoking rates become members of the Minnesota ASSIST Coalition.[91(Bates no. TI14021167)]

The Minnesota Wholesale Marketers Association then applied for funding from

the ASSIST program. In a letter dated February 4, 1996, however, Briant reported that the Minnesota Grocers Association had applied for but had not been awarded a grant from ASSIST.[28] The tobacco industry, through its "retail association" allies, tried again in May with another grant proposal for 1996–98.[60]

Research documented a single example of outright infiltration by a tobacco industry operative; this instance occurred in Colorado in 1992. An individual, apparently working for the Denver public relations firm Karsh & Hagan, reported on attending a meeting of an ASSIST coalition in Fort Collins:

> I arrived after the meeting commenced and, despite my effort to remain invisible, ended up seated at the head of the table. I signed in as a student and hoped that my baggy clothes and backpack would make this credible. . . .
>
> One attendee said that tobacco companies often worked through . . . rights groups to make their efforts seem "local." This person believed that informational breakfasts were already being conducted along these lines in Denver. She suggested sending a spy to these events, as well as to a smoker's rights group that meets at Gabby's . . . restaurant in Ft. Collins.
>
> At this point, I felt extremely conspicuous and decided it would be a good time to leave. I waited until the group moved on to a more benign topic so as not to seem abrupt, looked conspicuously at my watch and left. Would advise future "plants" to arrive late and leave early, avoiding the awkward small talk with other attendees that might create suspicion.[110(Bates no. 2023667420,7422))]

Strategy 6: Divert Funds from the Community Environment Channel and Promote Alternative Programs

The sixth strategy identified in the review of the tobacco industry's documents was to diminish the effectiveness of ASSIST by diverting funding from the strongest part of ASSIST to alternative programs that would either weaken ASSIST's effectiveness or strengthen the tobacco industry's image. Specifically, the tobacco industry wanted to move resources away from the Community Environment Channel, which had "the strongest emphasis in ASSIST . . . and focuses on goals and activities which are the most objectionable."[13(Bates no. TI13850215)] Within 3 days of the announcement of ASSIST, Tobacco Institute executives were discussing how to involve their political allies in ways to divert ASSIST funding from activities to mobilize the community around tobacco control:

> We should have our legislative political allies make certain that these [ASSIST] funds cannot be used for any anti-tobacco strategy which is political in nature. . . .
>
> We could also work to assure that the money is so widely disbursed that its impact is lessened. . . .[81(Bates no. TI13850725)]

One way to lessen the impact could be to restrict ASSIST funding to specific populations:

> Restrict or limit how the funds are used through the state appropriations process and contacts with executive branch officials.
>
> Make reasonable grants for programs directed at pregnant women and youth a priority; secondary priorities to be

> developed, but may include smoking cessation programs for people who have decided to quit.[16(Bates no. 511073913)]

Tobacco Institute executive Bob McAdam recommended that the tobacco industry attempt to "restrict ASSIST funding to school-based anti-tobacco eduction [*sic*]."[12(Bates no. TI13850205)] Consultant Ted Trimpa agreed, recommending that the Institute "provide a basis to advocate shifting all ASSIST funds to the Schools Channel. . . ."[13(Bates no. TI13850215)] Nevertheless, he warned that this strategy might inadvertently fund activities in the Community Environment Channel:

> The Community Environment Channel . . . has a number of youth access objectives which may overlap with the Schools Channel. By shifting funds to Schools, the Community Environment Channel activities may be inadvertently supported/funded.[13(Bates no. TI13850215)]

One reason that the tobacco industry might have preferred the schools channel to the Community Environment Channel is because school interventions alone are not as effective as those combined with community-based or comprehensive programs.[111–114] In addition, as Slavitt, of Phillip Morris, pointed out, "The tobacco industry could also offer our own youth initiatives . . . and suggest that further Federal or state funding is not needed for youth anti-smoking campaigns."[19(Bates no. 2023916867)] (Philip Morris had its own youth initiative, titled "It's the Law," which emphasized smoking as an adult pastime.) In other words, the tobacco industry could argue for a shift in funding to the Schools Channel followed by an argument to eliminate school programs.

While one Philip Morris executive wrote that "the industry's 'Youth Initiatives' have ground to a halt" in the summer of 1992,[2(Bates no. 2048621164)] by 1993, the company had distributed a total of 1.9 million "It's the Law" kits nationally.[115(Bates no. 2023916805)] A report prepared for Philip Morris's Task Force on Smoking by Minors announced that the company had a database of more than 50,000 subscribers to "It's the Law," with a budget of $1,199,000.[116]

The tobacco industry strategists also suggested diverting funding entirely from ASSIST to nontobacco programs. One of Philip Morris's strategies involved taking advantage of the needs of groups not normally considered allies of the tobacco industry:

> Use of Health Advocacy Groups:
>
> At both the state and Federal levels a number of Health Advocacy groups could attack Sullivan for failing to address major health care issues—AIDS, pre-natal, teen pregnancy, affordable health care, child immunization—instead of wasting more Federal dollars on anti-smoking programs.[19(Bates no. 2023916867)]

In a later memo (June 1992), ACT-UP and expanded low-income health services were added as "other health constituencies" which "can criticize waste in state [Department of Health] DoH's."[20(Bates no. 2078755123)] The Corporate Affairs section of the Philip Morris 1992–96 marketing plan listed as a long-term goal: "Work with grass roots organizations to divert state health department funds, equivalent to the amount of ASSIST funding, to support other health programs (pre-natal care, half-way houses, etc.)."[11,117(Bates no. 2046454338)]

Strategy 7: Discredit ASSIST through Public Relations Tactics

Proposed tobacco industry public relations tactics identified in this research were coded into four categories: identify and assist tobacco-friendly investigative reporters;[12,20,25,90] work with local grassroots coalitions;[90] sponsor "scholarly works" that criticize voluntary health organizations, particularly ASSIST partner the American Cancer Society;[18,118] and publicize the tobacco industry's youth programs (for example, Philip Morris's "It's the Law").[17,18]

The Tobacco Institute and tobacco companies planned to make the most of FOIA requests by organizing media coverage regarding the information gathered. In 1995, the Tobacco Institute commissioned The Madison Group, a public relations firm, to develop a public relations/public affairs plan for FOIA requests. The proposed plan outlined a number of activities including the following:

> Prepare for FOIA request, identify spokesperson and provide adequate media training. . . .
>
> Counter efforts by project Assist [*sic*] to stir up animosity in the media and among elected officials . . .
>
> Identify investigative reporter(s) likely to independently pursue Assist [*sic*] abuse . . .
>
> If an interested reporter has been identified, brief and provide with information that will support the reporter. . . .
>
> Provide targeted contact on the results to key office holders.[90(Bates no. TNWL0047342–7343)]

The Madison Group proposed a budget of $40,000 for these and other activities. This analysis did not uncover documentation about whether the activities were funded.

A number of documents reveal the tobacco industry's activities of writing press releases,[118] providing information to friendly reporters,[40,119] and developing messages about ASSIST,[120] which they often shared with each other to prevent duplicating efforts. For example, a Tobacco Institute publication about ASSIST, titled, "Federal Tax Funding to 'ASSIST' State Tobacco Control Lobbying," appeared 19 times in the Philip Morris, Lorillard, and Tobacco Institute document collections.[121] (See page 323 of this chapter for additional messages that were to be conveyed in public relations materials about ASSIST.)

The Tobacco Institute appears to have been consulted on a comprehensive media plan to publicize a complaint filed with the Washington Public Disclosure Commission in 1995 against ASSIST and alleging "taxpayer-funded lobbying."[92(Bates no. TI14303912)] The complaint was brought by Stuart Cloud, proprietor of a small chain of Seattle-area tobacco shops. Public relations consultant Bob Kahn stayed in touch with the Tobacco Institute while developing a press release,[92] writing a backgrounder,[68] arranging for interviews with Cloud and his attorney,[68] and sending information to reporters.[122] On October 13, 1995, Kahn sent a list of questions and answers to the Tobacco Institute's Bob McAdam to review[120] in preparation for the upcoming press conference regarding Cloud's

filing. The purpose was to "be sure that I'm positioning this properly. My intent is to suggest abuse without actually claiming it. I assume that's the best we can do at this point."[120(Bates no. TI14303899)] Kahn's comments included a recommendation that the attorney general investigate ASSIST. McAdam wrote back with additions that included a number of the main messages the tobacco industry wanted to convey to the press:

> [Handwritten note] Using taxpayer money to lobby is not right. . . .
>
> We hope there will be a healthy public debate. . . .
>
> If they confined the use of ASSIST funds to education, no one would quarrel. However they have pursued an overtly political agenda. . . .[123(Bates no. TI14303898)]
>
> Many of the grants went to advocacy groups that are part of the Democratic party coalition (e.g., Planned Parenthood, Gay and Lesbian groups). . . . Audits . . . have never been performed. . . . There is no accountability in this program. . . .[124(Bates no. TI14303897)]

The tobacco industry also publicized its criticism of ASSIST on the Smokers' Rights ForceS Web site, www.forces.org. At least fifty-one different articles attacking ASSIST appeared on the Web site during the lifetime of ASSIST.[125,126]

A major public relations tool for the counter-ASSIST effort was the 1998 book, *CancerScam: The Diversion of Federal Cancer Funds to Politics*, by James T. Bennett and Thomas J. DiLorenzo, established critics of tobacco control researchers and private health charities.[127–136] *CancerScam*, a 170-page criticism of the American Cancer Society, presents the ASSIST project as a prime example of "blatantly illegal tax-funded politics"[127(p13)] involving "front groups, illegal lobbying, and other improper uses of federal funds."[127(p13)] Although no documents were found that showed Drs. Bennett and DiLorenzo had been recruited to write the book, a review of documents found three copies of early drafts—one was apparently of the entire book, and the others were of different sections—on the Philip Morris Web site, www.pmdocs.com. The drafts came from the office of Lance Pressl, who was director of government affairs at Philip Morris, and all were dated 1994 by Philip Morris—4 years before the book was published.[118,137,138]

The tobacco companies' documents also provide evidence that Philip Morris surreptitiously gave Bennett materials on ASSIST coalition member organizations. An e-mail, dated May 27, 1993, to John Ostronic from Slavitt of Philip Morris (PM) concerning the Coalition for a Smoke-Free Colorado, states the following:

> I talked with Lindsay Steyer at Russell, Karsh & Hagan [a Denver public relations firm]. . . . She will collect all of the state agencies, universities, and organizations involved in anti-tobacco activities in CO and forward them to you. . . .
>
> Please also forward a copy to Jim Bennett, be careful to ensure that nothing on Lindsay's materials references her firm, or contains any other references to PM—if there is a cover note, shred it. Please remember not to use a PM return address, or any

> thing [*sic*] which indicates that the info eminated [*sic*] from us—PM postal stamp, etc.[139(Bates no. 2073248267A)]

The information was forwarded in a letter to Dr. Bennett at his office at George Mason University.[140] Philip Morris then began working on public relations for the book. A handwritten memo faxed on August 13, 1993, and found in Philip Morris executive Victor Han's office, reads:

> I got all the 411 on Jim Bennett. We need first to get this guy media-trained. We then need to identify key markets across the US to publicize his book and information. . . . Why not cultivate the very talented Grace Martin (formerly of Burson Marsteller, a public relations firm/D.C. and now newly-married, living in Roanoke, Va and unemployed) to do the publicity for Bennett. . . . She could . . . be very effective for us, without having any ties to us![141(Bates no. 2046527199–7200)]

A proposed 1994 Philip Morris budget for communications, found in the company's documents, listed $50,000 for "Assist [*sic*] Book Publicity."[142] Philip Morris was also a "benefactor" for George Mason University in 1994–95, donating in the $10,000 to $99,999 category.[143]

Strategy 8: Promote Preemption Laws and Ballot Initiatives

The tobacco industry appears to have launched several legislative efforts in response to ASSIST, and it worked hard to undermine initiatives sponsored by ASSIST coalitions. A document describing Philip Morris's 1992–96 Marketing Plan announced as one of its long-term goals a "Rollback Program" to do as follows: "Particularly in localities, introduce legislation to reinstate sales practices, such as free-standing displays, that have been banned or restricted" and "Pass state preemption."[117(Bates no. 2046454338)] Philip Morris executive Tina Walls, in a draft speech dated July 8, 1994, noted the importance of preempting local initiatives with weaker state laws as a key strategy for dealing with the tobacco control advocates' "PAC-man" approach:

> Our goal, simply stated, is to see some form of accommodation/pre-emption legislation passed in all 50 states. . . .
>
> . . . the anti-smoking movement has become more sophisticated in its efforts to enact bans and restrictions on smoking. . . .
>
> they can be in more places than we can and, thanks to Project ASSIST in 17 states, Proposition 99 in California, and Question 1 in Massachusetts, the "antis" now have the deep pockets necessary to intensify their local efforts.
>
> The solution to "PAC-man" is statewide pre-emption. . . .
>
> we're dead serious about achieving pre-emption in all 50 states.[144(Bates no. 2041183752–3753,3756)]

Tobacco industry efforts to promote statewide preemption are illustrated by a letter, dated December 13, 1994, from Geoffrey C. Bible, President and Chief Executive Officer of Philip Morris, addressed to then Governor-Elect George Pataki of New York. Bible wrote this letter to follow up on a visit with the governor-elect the previous evening. In it,

Bible described what he perceived to be the negative implications of the Vallone Bill, which would restrict tobacco use in workplaces; restaurants, bars, and hotels; recreational areas; public buildings; and transit facilities in New York City. Bible asserted that Philip Morris would support an amendment to the Vallone Bill that would reduce the permitted smoking area from 50% to 25%, and he also raised the option of statewide preemption. The following excerpt from that letter highlights Philip Morris's view on preemption:

> I trust that this will only be the beginning of what I know can be a mutually beneficial dialogue. . . .
>
> Another option to consider, and one on which we would be pleased to work with you, is statewide pre-emption, something that 17 other states have on their books with regard to smoking restrictions. Reasonable statewide preemption would provide a uniform standard for all localities throughout New York. One county would not be placed in competition with another for business and tourism, and New York would not be forced to compete with more hospitable climates in surrounding states such as New Jersey and Connecticut.[145](Bates no. 2046988148–8149)

Bible closed the letter by listing his views on the many ways that Philip Morris has contributed to the economies of New York State and New York City. (See case study 8.5).

During the early 1990s, the number of local tobacco control initiatives across the country increased dramatically, in part because of ASSIST. By the end of 1995, 1,006 communities had adopted local tobacco control measures. However, at the same time, 29 states had enacted laws that preempted local tobacco control ordinances. Twenty-six state preemption bills were introduced in 19 states during the 1996 legislative session alone; 17 states defeated these laws, and 2 states passed them.[146] Attempts to repeal preemptive tobacco control laws were initiated in six states.[146] As of late 1998, Maine, an ASSIST state, was the only state that had succeeded in repealing a youth-access preemptive tobacco control law.[147] In 2002, Delaware was the first state to repeal preemption of local clean indoor air regulations.[148]

The considerable costs of the many local battles generated by ASSIST activities were an issue of concern, as shown by this 1995 memo from McAdam of the Tobacco Institute:

> . . . many of the activities and organizations of the ASSIST coalitions in the states have used the funds to influence state and local legislators. . . .
>
> [This] clearly raises the level of activities the industry must respond to. In Minnesota, for example, ASSIST documents . . . indicate there will be at least 90 local ordinance battles during 1995. Several groups receiving ASSIST money are part of the statewide coalition attempting to pass a large tobacco tax increase in the legislature. Documents in other states indicate a variety of local and state battles that the industry will be compelled to address. These battles will significantly add to the projected costs of our operation.[12](Bates no. TI13850203)

Discussion

During the 1990s, the U.S. tobacco industry had tremendous resources with which to counter tobacco control efforts in the nation. This analysis of the internal documents of the Tobacco Institute, Philip Morris USA, and R.J. Reynolds Tobacco Company shows that the industry moved quickly and relentlessly against ASSIST. The tobacco companies appear to have used their resources in a coordinated way to aggressively monitor, audit, and attempt to infiltrate ASSIST coalitions; pursue legal actions; preempt local tobacco control initiatives; generate negative publicity about ASSIST; and use their political and other allies to confront ASSIST at every level of government. These tactics were not new to the tobacco industry.[1] Furthermore, the documents strongly suggest that the tobacco industry attempted to hide its efforts by, for example, working through third parties such as public relations firms and legislators in nontobacco states, providing information but not disclosing that the Tobacco Institute or a tobacco company was the source, and secretly infiltrating public health groups.

This analysis of tobacco industry documents has several limitations related to using internal tobacco industry documents as a data source. Because of the enormous volume of tobacco industry documents available, and the variable indexing of these documents, there is no way to determine if all key documents related to the tobacco industry and ASSIST were retrieved. Furthermore, time and financial resources presented a limitation because the documents are spread across depositories worldwide and are on multiple Web sites. The purpose of this research was to document and highlight the tobacco industry's plans related to ASSIST and their implementation, not to establish causality between the industry's efforts and the outcomes of ASSIST. This analysis suggests that tobacco control advocates should expect a vigorous, sophisticated, and well-coordinated response from the tobacco industry to any efforts to implement major policy change at the local, state, and national levels. The tobacco industry's response to ASSIST also shows that mobilizing local coalitions—the "grass roots"—in a policy-focused approach presents the greatest challenge for the tobacco industry in its efforts to keep Americans smoking.

Part 2. ASSIST's Response to the Tobacco Companies: Facing the Opposition

Part 1 of this chapter analyzes tobacco industry documents to reveal and categorize the strategies that the tobacco industry planned to counter the effects and the very existence of ASSIST. Part 2 presents the experiences of ASSIST staff members as they encountered those strategies over the life of the ASSIST project. The case studies, which depict both the programmatic and the personal effects of tobacco industry activities, are preceded by an explanation of the legal and temporal contexts in which these events occurred. In particular, as government employees, ASSIST staff members had an obligation to respond to FOIA requests and to spend funds in compliance with state and federal regulations. Therefore, background information is presented about FOIA and about what constituted legitimate lobbying and advocacy practices by ASSIST personnel and coalition members.

When ASSIST staff members were experiencing the tobacco industry's charges of misuse of funds and illegal lobbying, they did not know that the tobacco industry was very determined to disrupt the project. The tobacco industry documents were only beginning to become available near the end of the ASSIST project. The case studies presented in this chapter describe events that occurred from 1993 through 1997.

Although ASSIST staff members anticipated that the industry would oppose their efforts, they did not anticipate the types of strategies or the amount of time that would be required to respond. Complying with the multiple FOIA requests reduced the time that ASSIST staff members could spend on their tobacco control work. When the tactics took the form of accusations of wrongdoing—of illegal lobbying—some advocates were intimidated, and some coalitions struggled to keep their partners involved. When the tobacco industry leveled accusations against ASSIST at the state level, program intervention activities sometimes slowed down or became less effective. Not all advocates in the movement were intimidated, however, and some became stronger and more committed in the face of attacks.

Understanding the Obligation to Respond to FOIA Requests

As explained in part 1, strategy 1, of this chapter, the federal FOIA was passed in 1966 to ensure that all citizens have access to records and other information generated and stored by tax-supported federal agencies.[149]

Eventually, through conversations with one another, ASSIST project managers and directors realized that many of them were receiving FOIA requests for documents. The FOIA requests made the material in the ASSIST files accessible to the tobacco industry and its allies. When served with FOIA requests, the public health staffs at the state and local levels interrupted their activities to comply with the relevant laws and to provide

the requested documents. These documents included ASSIST plans for future activities that the departments of health and coalition partners would have preferred not to release at that time.

To assist the states with understanding the extent of these requests and to respond to them, the ASSIST Coordinating Center contracted with a consultant to assess the experience of the ASSIST programs receiving FOIA requests. The consultant conducted telephone conversations during February 1996 with most ASSIST project directors and other individuals who were knowledgeable about FOIA activity. These conversations revealed that all 17 states had received at least 1 written request from Fiscal Planning Services Inc. (a private firm in Bethesda, Maryland, that was contracted by Philip Morris to coordinate this[20,150]) for a listing of all recipients and awards made in fiscal year 1995.[151] Additional FOIA requests varied in number and scope. They included (1) what appeared to be requests from interested individuals following the instructions in *ASA News*, a publication of the American Smokers Alliance;[152] (2) follow-up requests from Fiscal Planning Services for more detailed information; (3) formal requests filed by trade associations in which tobacco companies were overt or covert participants (Walter 'Snip' Young, e-mail message to E. Bruce, April 5, 2004);[153] and (4) requests filed by law firms that typically did not (and did not have to) reveal the client whose interests they were representing.

An obvious pattern of using information from previous FOIAs to construct the next FOIA was discerned in the information derived from the telephone interviews—building on information from previous FOIAs. Some ASSIST states, such as Massachusetts, received very burdensome FOIA requests that required increasingly greater specificity and detail from local health departments and ASSIST subcontractors. These continuing requests seemed, in a well-coordinated way, to build on information obtained through prior FOIA requests. The internal tobacco industry documents quoted in part 1, strategy 1, of this chapter subsequently provided a clear picture of the extent of the tobacco industry's FOIA strategy. Described also is the extensive public relations/public affairs plans to use information extracted from ASSIST documents to erode public and legislative support for the program. Typically, the tobacco companies, their trade associations, and other allies garnered voluminous documents from which they culled small parts that they later used as part of their legal and ethical challenges in Colorado, Washington State, Minnesota,[154–157] and Maine.[158]

The tobacco industry's use of FOIA did have a disruptive effect on the operation of ASSIST. In some cases, fulfilling FOIA requests disturbed communication and cooperation among coalition members who felt that their confidences had been betrayed. Responding to the requests diverted resources and staff from tobacco control work and was burdensome. Washington State staff members reported spending hundreds of hours to respond with extensive information about coalition members statewide. Massachusetts hired an attorney half-time to coordinate and oversee re-

sponses to the almost constant flow of FOIA requests. Many ASSIST staffs, however, related that they had received little legal assistance in complying with the requests. Over time, the ASSIST states learned to share information about their FOIA experiences, to coordinate responses to the tobacco industry's use of FOIA, and to reduce the disruption of their programs.

Understanding the Regulations on Lobbying

Policy advocacy is distinct from lobbying, and that distinction became an important legal issue during ASSIST. *Lobbying* refers to promoting or fighting a bill that is actually under consideration by a legislative body. *Policy advocacy* refers to expressing support for a position on an issue or on a policy before it is under consideration for passage into law. Policy advocacy is a legitimate activity for federal and state government agencies and their employees and has never been prohibited. However, some ASSIST staff and coalition members tended to overinterpret restrictions on lobbying and believed that they could not do advocacy work. When ASSIST interventions began in the early 1990s, federal money could not be used to lobby at the federal level, but could be used to lobby state governments and local policy-making bodies in regard to policies. The laws and regulations changed during the course of the 8-year ASSIST project. Beginning with federal fiscal year 1997, the law that appropriated money for DHHS broadened the ban on using federal funds for lobbying and prohibited the lobbying of state legislatures.[159]

FASA also was enacted during the course of ASSIST.[160] The final rules implementing FASA were published on August 16, 1995, and the law became effective on October 1, 1995. Under FASA, "Costs incurred to influence (directly or indirectly) legislative action on any manner pending before Congress, a State legislature, or a legislative body of a political subdivision of a State"[160] were deemed unallowable under federal contracts. By its own terms, FASA applied only to government contracts based on solicitations issued after October 1, 1995. Because the original ASSIST contracts preceded that date, they were not affected by it. FASA's total prohibition against using federal money to lobby at any level of government did apply to the 1-year extension contracts issued to ASSIST states beginning October 1, 1998, because these were considered new contracts.

From the beginning and throughout ASSIST, the principal planners at NCI, the American Cancer Society (ACS), the ASSIST Coordinating Center, and state departments of health were highly sensitive to the myriad restrictions on how federal contract money could be spent. They were especially careful, because these numerous restrictions were occasionally contradictory, and often confusing, and they changed during the ASSIST era. The Internal Revenue Code (IRC) definition of lobbying is complex and in itself could be confusing. The IRC definition of lobbying excludes many kinds of activities (e.g., advocating for regulations and administrative

Example of Instructions to the States Regarding Lobbying

"In the absence of an explicit definition, government specialists in cost principles urge reliance on the 'customary' definition of lobbying. . . . The best articulation of the customary definition of lobbying would be exactly what is contained in the Internal Revenue Code [IRC]. Therefore, for purposes of ASSIST, the IRC definition should guide contractors in determining what would be allowable costs under the contract.

"Specific examples of likely activities that can and cannot be reimbursed under FAR and OMB Circular A–122 may help to clarify these rules. Under this regulatory scheme, for-profit and 501(c)(3) awardees may not use federal contract money to:

- participate in electoral activities;
- work for or against passage of referenda or initiatives;
- lobby Congress to introduce or to pass legislation;
- lobby state legislators to introduce or to pass legislation;
- conduct grassroots lobbying on state or federal legislation;
- lobby members of the executive branch to urge the signing or vetoing of legislation;
- advocate that state or local officials should lobby Congress or state legislatures;
- conduct legislative liaison activities in 'knowing preparation for,' i.e., in support of unallowable activities.

"It is equally clear that, until FASA applies to the ASSIST contract (i.e., beginning October 1, 1998), for-profit and 501(c)(3) contractors may use federal contract money to:

- lobby legislative or policy-making bodies at the local level;
- lobby the executive branch (except to sign or veto a bill);
- lobby regulatory agencies at all levels (e.g., OSHA, EPA, FDA, state health departments, etc.);
- advocate the enactment or enforcement of 'private' or voluntary policies, e.g., workplace smoking policies, bans on smoking in restaurants, etc.;
- advocate the enforcement of existing laws, e.g., those that control tobacco sales to minors;
- conduct educational activities that help people understand issues and supporting evidence . . . ;
- conduct public education campaigns to affect the opinions of the general public . . . ;
- respond to documented requests by providing technical and factual presentations on topics directly related to your contract performance."

Source: ASSIST Contracting Officer. 1997. Restrictions on lobbying and public policy advocacy by government contractors: The ASSIST contract. July 18. Internal document, ASSIST Coordinating Center, Rockville, MD (pp. 11–12).

actions, enforcement activities, and public education activities).[161] In addition, activities that would constitute lobbying under some circumstances would not under others. For example, if the chair of a congressional committee asks an individual or organization to testify about an issue, nothing done in preparation for or delivery of that testimony constitutes lobbying.

Throughout the life of ASSIST, much effort was invested in tracking, analyzing, and explaining to ASSIST contractors and subcontractors the laws and regulations that applied to their federal contract money and the different rules

that applied to state governmental and nongovernmental partners. Assistance was provided through written guidelines,[162] numerous training events,[163] individual consultations, and other forms of technical assistance.[164] For example, a 1993 "White Paper," which covered the limitations on lobbying, was updated and circulated by NCI to all ASSIST project directors and managers in 1997.[99,164]

Because the effectiveness of tobacco control efforts depends on various types of organizations fulfilling different roles, it was important that ASSIST coalitions include nongovernmental partners. Nonprofit organizations (including ACS)—sometimes known as 501(c)(3) groups or public charities—are legally allowed to lobby up to certain limits.[165] In fact, the 1976 Tax Reform Act specifically encourages nonprofit organizations to participate in public policy making. Although the ASSIST partners could and did use unrestricted nonfederal funds to lobby, the tobacco industry repeatedly made accusations of illegal lobbying, as described in the experiences of five states later in this chapter.

Case Studies

The tobacco companies continuously challenged ASSIST activities and staff. Case studies 8.1–8.5 describe the reactions of tobacco control advocates in Colorado, Washington State, Minnesota, Maine, and New York to the opposition their programs encountered. In Colorado, the tobacco industry filed five legal actions; although only minor infractions were upheld, the legal actions seriously impaired tobacco control initiatives in the state and had grave and serious repercussions for the Colorado ASSIST codirector. Similar complaints of illegal lobbying were filed against ASSIST in Washington State. Although minor infractions had occurred in reporting spending, the ruling indicated that they had *not* improperly used public funds for lobbying. In Minnesota, the tobacco industry's strategy significantly deterred the implementation of local tobacco control ordinances but was unsuccessful in defeating comprehensive youth access legislation. Maine, on the other hand, having learned of the strategies used in other states, was ready when the tobacco industry brought charges there and attempted to discredit ASSIST publicly. In New York, when Philip Morris tried to implement a preemption strategy, tobacco control advocates turned the tables on the company, made charges of illegal lobbying, and won. The accusations that the tobacco industry had made against health advocates were actually used against the industry.

Onward after the Opposition

The ASSIST project was based on solid research, which had clearly indicated that public and private policy advocacy—in local, state, and federal legislatures, businesses, schools, and local communities—is an effective way to reduce smoking initiation and prevalence. This policy focus was a major problem for the tobacco industry. The documents demonstrate that tobacco industry executives were under a great deal of pressure in dealing with ASSIST's local, commu-

Case Study 8.1
Full-Scale Challenge in Colorado

In relation to the tobacco industry's full-scale challenge to ASSIST in Colorado, industry opposition in the other states seems piecemeal. In Colorado, the tobacco industry took a comprehensive approach through five legal actions: a lawsuit in Colorado's district court, three complaints to the Colorado secretary of state, and a lawsuit in Federal District Court. These legal actions were a principal strategy of the tobacco industry to defeat a state-wide grassroots question for the November 1994 ballot that would raise the tax on cigarettes from 20¢ to 70¢. Through legal actions, the tobacco industry built a case in the popular press that ASSIST had violated Colorado's Campaign Reform Act by spending state dollars to support a political campaign issue.

Supporting the Tax Initiative

Two principal entities worked on the public health side of the tobacco tax initiative: the Coalition for a Tobacco-Free Colorado (CTFC), a nonprofit 501(c)(3) public health organization with experience in policy advocacy acitivities, and the Fair Share for Health Committee, a tax-exempt 501(c)(4) political organization, which, by law, was permitted to lobby. CTFC had helped position Colorado to be competitive in the ASSIST application process.

An All-Too-Personal Experience

With my forehead in my palms and elbows perched on the edge of a long, dark mahogany conference table, I heard my attorney say, "Don't worry, everything will be all right. I'll be back in a few minutes. I have an urgent call to take." Then, alone in the empty and unfamiliar room in a high-rent office building, I suddenly felt lonely and besieged. I gazed out the window over the 16th Street pedestrian mall in downtown Denver and became frightened, thinking, . . . If the attorney general's office doesn't represent me, where will I get $50,000 for my legal defense? . . . Mortgage my house? . . . Borrow from family? Had my careful research into the legal parameters for state employee participation in setting public policy been faulty? Is this my reward for trying to prevent tobacco-caused death and disability? What will my family think? Are my children hearing negative comments about me at school? Will the media ever let up? . . . The door swung open and my attorney exclaimed, "Let's make that call now to the attorney general." In this call, my attorney implied that he might bring a suit against the state if the attorney general did not represent me.

Replacing the phone receiver in its console, I said to my lawyer, "Thanks for your help. I don't think I would have convinced them to represent me without your help." They believed that I had willfully broken the law and therefore they would not have been obligated to represent me.

"But I'm still worried about the outcome of these lawsuits. What will it mean for me? . . . my career in public health? . . ." I asked with great pause.

In a commanding tone, my attorney said, "Don't worry, just tell the truth, and the truth will set you free."

Never before had such a trivial statement meant so much. I felt immense relief. Finally, there was someone in my corner, someone with credibility who believed I had not broken the law.

—Walter 'Snip' Young

Case Study 8.1 (continued)

Walter 'Snip' Young, the director of the Colorado Department of Health Division of Prevention Programs, was a long-time active member of CTFC and was the Colorado ASSIST project director. He was appointed to chair an ad hoc committee formed to plan a February 1993 community meeting where a proposed increase in the tobacco tax would be discussed.

Through his research of Colorado statutes and consultation with an attorney knowledgeable in these matters, Young was aware that Colorado law permitted state employee involvement in matters of policy that could lead to voter initiatives, as long as he was not involved in his official capacity after the matter was before the electorate. In this case, that date was December 15, 1993. After the ballot petition language was filed, government employees could participate in voter-initiated actions only on their own time, as citizen advocates.

This understanding of the law and his compliance with it provided Young with a false sense of security. He did not anticipate that his strict adherence to the law would not protect him from litigation and criticism in the press.

Tobacco Industry Groups

The tobacco industry used many law firms and various organizations and individuals to oppose the tax initiative.[a,b] The Colorado Executive Committee—the political action committee formed to oppose the proposed tobacco tax increase—was organized by Colorado lobbyists at Hays, Hays & Wilson[c] for the Tobacco Institute and other tobacco industry interests. The Colorado Executive Committee spent $5.5 million, mostly for television and radio air time, on the political and public relations campaigns to defeat the tax initiative. The Colorado Executive Committee also formed a 501(c)(4) tax-exempt political organization called Citizens Against Tax Abuse and Government Waste. This organization's name was attached to political ads run by the tobacco industry during the campaign. Groups supported by the tobacco industry (such as the American Constitutional Law Foundation, Smoker Friendly Stores, and a few individual owners of smoke shops and discount cigarette stores) filed the lawsuits described in the following paragraphs. Most of the open-records research that went into building the cases for the American Constitutional Law Foundation was conducted by an attorney employed by Hays, Hays & Wilson. According to a 1996 Tobacco Institute budget document, disclosed during the Minnesota tobacco consumer fraud lawsuit, the American Constitutional Law Foundation was paid $60,000 in 1995 after the defeat of the Colorado tobacco tax initiative.[c]

After acquiring more than 6,000 pages of documents from the Colorado Department of Health, the tobacco industry groups filed a second open-records request, which produced about 5,000 pages of documents that were never claimed. This action

reflected a tactical strategy used by the tobacco industry affiliates to divert Colorado Department of Health resources and ASSIST staff and volunteers from matters related to tobacco control.

Legal and Regulatory Actions

Action #1. The first lawsuit was triggered by a series of requests for documents that were filed under Colorado's public records law by a local lobbying firm known to represent the Tobacco Institute.[c] Although the request in February 1994 came from a Colorado state representative on the Legislative Audit Committee, staff suspected that the letter was written by tobacco industry attorneys, because it sought specific documents by names generally known only to those close to the program and the tobacco industry (e.g., ASSIST annual action plan, comprehensive tobacco use reduction plan). The letter signaled the start of a year-long legal and public relations struggle for Colorado ASSIST.

At the time, files and records for CTFC were stored in the ASSIST office of the Colorado Department of Health and had been kept in these offices for many years before the start of ASSIST because the Colorado Department of Health provided administrative and clerical assistance to CTFC. When the open-records request for CTFC files was received, Young told the president of the coalition about the request, and CTFC removed the files the next day. The Tobacco Institute's local attorneys then filed a lawsuit in Colorado's district court to obtain the CTFC records. According to Young, the state attorney general did not vigorously defend this suit, because it was determined that since the Colorado Department of Health employees had access to these records, they were deemed public records under Colorado statute.

Tobacco Institute attorneys were interested primarily in obtaining a copy of the recently completed application for funds submitted to The Robert Wood Johnson Foundation's (RWJF's) SmokeLess States Project. This application proposed to run a prevention and public education campaign about tobacco use during the fall of 1994. The tobacco industry prevailed in district court, and CTFC records (including the RJWF application for funds) that had been on site at the Colorado Department of Health were turned over to tobacco industry attorneys.

On July 12, 1994, a Washington, D.C., law firm sent a letter to the RWJF staff member managing the SmokeLess States competition, complaining that the planned timing of the CTFC public education campaign was "no coincidence." It stated that "this [public education campaign] obviously could have adverse tax consequences for the foundation" and that "our clients and we would strenuously object to any use of the private foundation funds to support . . . a lobbying effort."[d] The tobacco industry was trying to intimidate the RWJF Board into not funding the Colorado application, claiming that it was an illegal contribution to the tax initiative campaign.

Case Study 8.1 (continued)

A few days later, a letter from a Colorado attorney was sent to the major media outlets and advertising firms in Colorado "warning" them that they might not recover money that they might spend to purchase television, radio, and newspaper ads under contract with CTFC or RWJF. The letter stated, "We will pursue this matter vigorously and, if necessary, file complaints against the Robert Wood Johnson Foundation and CTFC with the Internal Revenue Service as well as seek injunctive relief in Federal Court."[e]

Action #2. The second legal action was a complaint filed with the Colorado Secretary of State by the Citizens Against Tax Abuse and Government Waste. In a promotional campaign, a Denver radio station gave away baseball tickets to smokers who would toss their cigarettes into a coffin that was set up at a bus station where American Cancer Society volunteers were seeking signatures to qualify the excise tax initiative for the November state ballot. The complaint charged that the activity constituted "bribery." The radio station publicized the complaint, which was then dropped.

Action #3. The third legal action, a complaint by the American Constitutional Law Foundation, charged that the Colorado Department of Health and Young himself had violated Colorado's Campaign Reform Act by helping to plan the state initiative to raise tobacco taxes. The secretary of state ultimately exonerated the Colorado Department of Health and Young of any illegal activity and rejected the complaint, except for three minor violations:

1. Mentioning the tax initiative in an ASSIST newsletter
2. Preparing a presentation (which was never delivered) about the Colorado tax initiative for an international lung cancer conference in Colorado Springs
3. Contributing to the Fair Share for Health Committee (FSHC) through its annual dues to CTFC[f]

Action #4. The American Constitutional Law Foundation also filed a complaint against the Fair Share for Health Committee. The complaint alleged that the Fair Share for Health Committee had failed to disclose in-kind contributions (totaling less than $100) to the campaign made by the Colorado Department of Health. The secretary of state subsequently determined that three items should have been reported that were not, and the Fair Share for Health Committee amended its campaign contribution reports to reflect the items.

Action #5. In an apparently frivolous lawsuit brought in Federal District Court, the American Constitutional Law Foundation charged the Boulder County Health Department, the Colorado Department of Health, and specific staff members with violating the First, Fifth, Ninth, Tenth, and Fourteenth Amendments and Article IV, Section 4, of the U.S. Constitution by using public funds to support a voter-initiated

action. The court dismissed this lawsuit in 1995 for lack of evidence. It was appealed and dismissed again later the same year.

A Lost Opportunity

Ultimate exoneration from these various charges was a hollow victory. These public health groups and individuals all operated within the confines of the laws that chartered and governed them (with the exception of the minor violations mentioned in Action #3), yet the tobacco industry was successful in spinning the public health involvement as illegal. By casting the collaborative activities of these entities as an improper and perhaps illegal entanglement of the government and private sector, the tobacco industry diverted attention away from the public health message and toward the message of big government acting improperly or illegally.

Specifically, Young's involvement in the early planning stages for the tax initiative, although prior to placement of the ballot question before the electorate and, therefore, within the confines of the law, was eventually characterized in the popular press as "improper," if not illegal. Tobacco industry attorneys provided to the local press excerpts that they had drawn from their open-records requests—with the tobacco industry's spin on the information and supporting documentation. Simply by raising questions about the propriety of ASSIST actions, the tobacco industry put the Colorado Department of Health, ASSIST, and Young on trial in the court of public opinion.

Eventually, the Colorado attorney general agreed to represent Young and the other state employees who were named personally as defendants (after Young's attorney threatened her office with a lawsuit), but the social and psychological stresses imposed on these people were severe.

The costs to Colorado's tobacco control effort were also large. A poll conducted in spring 1993 had documented that 72% of Colorado voters supported the proposed 50¢ per pack increase in Colorado's cigarette tax. Nevertheless, the tax initiative campaign, hampered by insufficient funding and mired in the legal challenges, was overwhelmed by the tobacco industry, which spent more than $5 million to oppose the referendum. In November of that year, the initiative (Amendment 1/CO Tobacco Tax Initiative) was defeated at the polls by a margin of 20% (60% against, 40% for).[g]

Insights

Being named as a defendant in a legal action is traumatic; however, such experience offers valuable insights that might benefit other state tobacco control programs and their community partners.

First, a state health agency tobacco control program should establish a working relationship with the state attorney general's office. In this way, trust and understanding

Case Study 8.1 (continued)

between attorney and client will be established prior to any tobacco industry legal actions. It is particularly important that this be done now that state attorneys general are responsible for monitoring compliance with the Master Settlement Agreement. State tobacco control program staff should be aware of violations of the Master Settlement Agreement, learn of complaints filed by others, and/or bring their own complaints to the attorney general's office.

Second, each state tobacco control program should develop a strategic communication plan that guides responses of the health agency and nongovernmental agencies to tobacco industry challenges (see chapter 3). Each should monitor the actions of the tobacco industry, examine potentially vulnerable areas of the state program, and anticipate the tobacco industry's opposition to public health advocacy actions.

Third, engaging state and local public health leaders in planning tobacco control efforts has never been more important. High-level state government officials tend to be more involved now because of the need for executive management of Master Settlement Agreement funds, yet this involvement could be more broadly based and involve communities. Involvement of high-level leadership and management will help to deflect assaults on government agencies and criticism of policy actions.

—Walter 'Snip' Young, former Colorado ASSIST Project Director and Director of the Division of Prevention Programs of the Colorado Department of Health (CDH) and currently Scientist, The Cooper Institute, Golden, Colorado

[a]Flora, M. E. Letter to Betsy Zakely. June 9, 1994. Kelley, T. B. Letter to Julie Merrick. June 22, 1994. Hays, F. L. III. Letter to select Colorado advertising firms. July 15, 1994. Perlman, B. A. Letter to Joyce Herr. September 30, 1994. O'Toole, N. D. Letter to Joyce Herr. December 1, 1994. In the author's possession.

[b]U.S. District Court for the District of Colorado. Civil Action 94-2239. September 29, 1994.

[c]Adams, W. A. 1995. Memorandum re: 1996 Tobacco Institute budget. October 27. The Tobacco Institute. http://legacy.library.ucsf.edu/tid/rju28d00 (accessed May 18, 2004). Bates no. 2041212088–2216.

[d]Temko, S. L. 1994. Letter to Edward H. Robbins, proposal manager, The Robert Wood Johnson Foundation, July 12. Internal document, Covington & Burling, Washington, DC.

[e]Hayes, F. L. III. 1994. Letter to select Colorado advertising firms. July 15, 1994.

[f]Hopf, N. A. Before the Secretary of State, State of Colorado. Case no. OS 94-02. Initial decision, American Constitutional Law Foundation and Lonnie Hayes v. Colorado Department of Public Health and Environment and Pueblo CI, 25. http://legacy.library.ucsf.edu/tid/ygo60d00 (accessed May 18, 2004). Bates no. 522525513–5541.

[g]Schrader, A. "Smoke tax goes down in flames. Tobacco lobby fends off Amend. 1" *The Denver Post*. November 9, 1994.

Case Study 8.2
Work Disruptions in Washington State

The ASSIST project in Washington State began to receive requests under FOIA in September 1994; over time, the requests grew in size, scope, and specificity. Soon the Washington Department of Health had supplied to tobacco lawyers more than 5,000 pages of records; supplying these records consumed 360 person-hours of state employees' time.[a] Subsequently, attorneys purporting to represent an individual tobacconist filed a 425-page complaint with the State Public Disclosure Commission against ASSIST, the Washington Department of Health, the Washington State Division of ACS, and the Tobacco-Free Washington Coalition. The complaint charged, among other things, violations of state law by using public funds improperly for lobbying. These charges were almost identical to those made against Colorado ASSIST (described in case study 8.1). It was discovered and eventually reported in the news media (1) that the attorney who filed the complaint against Colorado ASSIST also helped prepare the complaint against Washington State ASSIST[b] and (2) that the Tobacco Institute, not the individual tobacconist, had paid the legal fees involved.[c–e]

Tobacco Institute Strategy for Investigating and Impeding the Washington State ASSIST Project

"We would recommend that you hire a private investigator to pursue the following:

1. Research ownership, tax status, etc., of vendors, consultants, companies receiving ASSIST funds.
2. Compile aggregate totals of all expenditures made by state employees and reimbursed expenses received.
3. Total all entertainment, catering, hotel, travel expenses.
4. Determine connection, if any, between temporary services provided and campaign consultants.
5. Cross match Prop. 43 expenditures, contributions, etc. with TFW and ASSIST accounts.
6. Research actual expense vouchers presented by ASSIST employees.
7. Research competitive bidding process on ASSIST awarded contracts to determine any violations of state law.
8. Review committee sign-up sheets for names that match with ASSIST payments in order to determine if any of the witnesses received payment for appearing before the Legislature.

Potential Actions:

1. State Auditor Review: The State Auditor could audit the ASSIST program upon a request of a legislator.
2. Media: We could turn information over to an investigative reporter or to a tax 'watch dog' group for public distribution.
3. Legislative: We could request a standing committee of the Legislature to hold hearings & investigate.
4. Legal Action: Depending on what we find . . . ?"

Source: Fritz, B., T. K. Bentler, J. Daniels, and S. Halsan. 1995. ASSIST information. Memorandum to B. McAdam of the Tobacco Institute, May 23, 1995. http://legacy.library.ucsf.edu/tid/txt07d00 (accessed May 18, 2004). Bates no. TNWL0020835.

Case Study 8.2 (continued)

The Washington State Public Disclosure Commission issued its final order in this case in December 1999. In the final order, the department of health conceded that it had inadvertently failed to disclose the funding of four programs that it was required to report. The department paid a $2,500 penalty and implemented a training program about compliance with Washington State's lobbying laws.[f] Substantial tobacco industry resources were spent, with minimal identification of program misconduct.

—Anne Marie O'Keefe,
former Policy and Media Advocacy
Manager, ASSIST Coordinating Center

[a]Levin, M. 1996. Legal weapon. *Los Angeles Times*. April 21. (Kim Dalthorp, a former Washington Department of Health tobacco control official and ASSIST Co-Project Manager, is quoted in this article.)

[b]Murakami, K. 1995. Tobacco Institute backs complaint against state anti-smoking program. *Seattle Times*. November 10.

[c]Paulson, T. 1995. Cough up documents, agency told. *Seattle Post-Intelligencer*. October 24.

[d]Paulson, T. 1995. Smokers' rights advocate files complaint against state. *Seattle Post-Intelligencer*. November 10.

[e]Mapes, L. V. 1995. Smokers' rights advocate says foes aren't fighting fair. *The Spokesman-Review.com.* November 10.

[f]Washington Public Disclosure Commission. 1999. *Enforcement Action v. Washington State Department of Health* (PDC case no. 97-192). Final order, December 21, 1999. Olympia: Washington Public Disclosure Commission.

Case Study 8.3
In Minnesota: Multiple Strategies, Multiple Defeats—Ultimate Victory

In June 1991, Minnesota was awarded an ASSIST contract of $6.3 million over a 7-year period. (It was later extended for 1 year as all the state contracts were.) Within months, the tobacco industry began a coordinated effort of multiple tactics to interfere with the plans and interventions of ASSIST local coalitions. The extent of the industry's tactics and the degree to which they were coordinated were not apparent to ASSIST staff and volunteers. Only after the tobacco industry documents became public, as a result of the lawsuit *State of Minnesota and Blue Cross/Blue Shield of Minnesota v. Philip Morris, Inc., et al.*, did they understand what they had been working against. Tobacco industry tactics to counter ASSIST in Minnesota included threats of lawsuits, FOIA requests, confrontational face-to-face meetings with health department staff, and even an application for an ASSIST grant. The industry filed complaints against ASSIST grantees with elected officials and filed a formal complaint with the state Ethical Practices Board. Tobacco lobbyists attended at least one ASSIST quarterly meeting. As illustrated and documented in this case study, the

industry's strategy in Minnesota resulted in repeated defeats of comprehensive youth access legislation and delays in implementing local tobacco control ordinances. The industry's tactics intimidated the tobacco control practitioners.

FOIA Requests

The tobacco industry used FOIA requests to learn the plans that ASSIST had for tobacco prevention and control interventions. Between September 7, 1993, and February 8, 1996, tobacco-related interests filed 11 FOIA requests with the Minnesota Department of Health (MDH). Through a FOIA request, the Minnesota ASSIST comprehensive tobacco control plan became available to the industry.

Minnesota attorney Tom Briant was retained as a consultant by individual tobacco companies and the Tobacco Institute to coordinate the Minnesota Local Response Project, the purpose of which is clear from the following memorandum from Thomas A. Briant to Minnesota Sales Representatives/Sales Managers/Sales Directors of Philip Morris, July 20, 1994:

> The Project involves coordinating the response of the tobacco retailers to local ordinances and state legislation that seeks to regulate tobacco products. . . . A significant part of the Project is the development of a communications network between you and myself. I need your assistance to inform me of any proposed local ordinances or other local restrictions on tobacco products or the sale of tobacco products.[a]

As an example of his involvement, Briant noted, in a letter to tobacco retailers in Litchfield before a City Council meeting on a proposed ordinance, "I represent the Minnesota Coalition of Responsible Retailers. The Coalition is comprised of five state trade associations that have an interest in the retail issues."[b]

Threats of Lawsuits

On September 23, 1993, Briant filed a FOIA request for materials related to the ASSIST contract, but his activities were not limited to opposing ASSIST initiatives. For example, in December 1993 and January 1994, he spoke against an ordinance that would restrict point-of-sale advertising in the Minnesota city of Brooklyn Center. He attended the public hearing on the ordinance and wrote a letter to the city council suggesting that the city would face litigation with the tobacco industry if the ordinance were to become law.

Lawsuits

In May 1994, Preston, a town of 1,500 residents in southern Minnesota, passed an ordinance restricting point-of-sale advertising. In December, Jim Larkin, a founding partner at one of Minnesota's largest law firms that was representing the owner of a Preston convenience store, filed a lawsuit against the city. Larkin claimed not to know who was paying his fees to represent Binh Chiglo,[c] but Peggy Carter of R.J.

Case Study 8.3 (continued)

Reynolds was quoted in a newspaper article as saying that R.J. Reynolds is "helping with some of her [Ms. Chiglo's] legal fees."[d] While the Preston case was pending, the Stillwater city council tabled a proposal to ban in-store advertising of tobacco products; the ban was proposed by the ASSIST coalition, Tobacco-Free Future.[e] Briant, representing the Minnesota Coalition of Responsible Retailers, then wrote letters to Stillwater tobacco retailers, urging them to oppose the proposal.[f] The court overturned the ordinance, ruling that the Preston ordinance was preempted by federal law. Preston did not appeal, and Stillwater did not go ahead with its ordinance.

The FOIA requests for the Preston case had other reverberations. On June 30, 1995, Larkin wrote a letter to the MDH ASSIST project director stating that in the discovery process for the Preston case they had learned of activities by ASSIST that they believed violated the Federal Acquisition Streamlining Act:

> See for example, the attached materials from your records of the application of Brian Bates for ASSIST funds. No applications for ASSIST funds should be approved which contemplate the use of ASSIST funds to lobby state or local legislative bodies. I believe that this would include use of such funds to defend these ordinances. In discovery in the above case, the City of Preston admitted that its ordinance was prompted by direct solicitation from Mr. Bates' organization.[g]

The letter concludes,

> Thus I believe it is clear that the department should not approve any ASSIST subcontracts or subgrants that contemplate use of federal funds for such purposes.[g]

As a result of the letter, even though ASSIST staff believed they were acting properly and legally, they began devoting increasing amounts of their time to documentation due to concerns about potential lawsuits.

Formal Complaints

Another large FOIA request was submitted to MDH in August 1995; four pages detailed documents beginning with the first quarterly reports of ASSIST. These documents became the basis for a complaint filed by the Minnesota Grocers Association, Inc. The complaint, "RE: Unlawful Use of Federal Taxpayer Dollars by Minnesota Department of Health and Violations of State Lobbyist Registration and Reporting Laws" was filed with Minnesota Governor Arne Carlson and State Auditor Judy Dutcher, with a copy sent to the Ethical Practices Board. Two months later, the Minnesota Grocers Association filed ethical practices complaints against 17 ASSIST subcontractors. The complaint received newspaper and television coverage. The outcome of the filing was described by Briant in a confidential memo to five persons at the Tobacco Institute, two at Philip Morris, one at RJR, and one at U.S. Tobacco:

> The entire Minnesota ASSIST Project has been placed on indefinite hold until the outcome of the pending investigation by the Minnesota Department of Health and the Ethical Practices Board. This includes 1995–1996 ASSIST grants which have been

> approved, but the contracts between the Department of Health and the ASSIST groups have not been executed nor have the 1995–1996 ASSIST funds been disbursed. These revelations come directly from Barbara Nerness, the Assistant Commissioner of the Minnesota Department of Health, in a telephone conversation I had with her earlier today.[h]

The memo continued,

> Barbara [Nerness] also stated that if the Department's investigation demonstrates that the ASSIST groups did indeed use federal funds for lobbying, then the Department of Health will take all necessary corrective action. She also stated that the Department will not protect anti-smoking zealot groups (her words) if they used federal funds for lobbying purposes.[h]

In a September 1995 activity report to Philip Morris, Media Services Incorporated reported having "launched a major effort to interest local editors and reporters in an investigative story on the anti-tobacco lobby illegally using federal ASSIST monies to lobby local and state officials contrary to federal rules and regulations."[i]

In February 1996, however, the Ethical Practices Board dismissed the Minnesota Grocers Association complaint against 15 of 16 ASSIST groups and found only that the Minnesota Coalition for a Smoke-Free Society 2000 did not disclose $40.00 spent for producing and distributing an action alert that urged others to communicate with legislators about a retail tobacco licensing bill.

Countering Legislation

The First Youth Access Bill. In 1995, a bill was introduced in the Minnesota state legislature that would have required mandatory licensing of retail cigarette sales and would have supported compliance checks and fines for selling to minors. The tobacco industry opposed the bill and instead promoted bills to limit the licensing authority of local governments and to preempt local ordinances in favor of the industry. The industry-backed bills called for (1) a statewide mandatory training standard for retail clerks engaged in retail sales of tobacco and (2) a system for compliance checks.[j]

On February 25, 1996, 2 days before the Minnesota House of Representatives vote on the industry-promoted bill, the Association for Nonsmokers–Minnesota staff found an envelope under their office door. The document in the envelope appeared to be a status report that Briant had sent to individuals at the Tobacco Institute, Minnesota Wholesale Marketers Association, Licensed Beverage Association, Minnesota Retail Merchants, Minnesota Petroleum Marketers, RJR Grassroots Consulting, Philip Morris, Lorillard, U.S. Tobacco, Brown and Williamson Tobacco Company, R.J. Reynolds, and the Smokeless Tobacco Council. The document showed the deep reach of the tobacco industry into local communities, with monitoring and reporting to the highest level of the tobacco industry activities of towns as small as 2,000 residents. State representative Matt Entenza read the memo on the floor of the House

Case Study 8.3 (continued)

of Representatives, effectively taking the mask off the Coalition for Responsible Retailers, which had argued that they were merely a group of local retailers, with no connection to the tobacco industry. "After rather lengthy and heated debate" the House voted to delete preemption from the bill and the bill was pulled.[k]

The Second Youth Access Bill. A renewed effort was made to pass a comprehensive youth access law when the legislature reconvened in 1997. Both sides were fully mobilized. Preemption was the issue. The health campaign fighting preemption included the Smoke-Free Coalition, ASSIST coalitions, the Children's Defense Fund, health maintenance organizations, medical associations, voluntary health organizations, and the state's attorney general. The League of Minnesota Cities weighed in heavily against preemption. On the other side were the tobacco industry and their retail allies.

At a critical point in the legislative battle, a member of the health coalition thought that compromise could be worked out with the retailers, but the other members disagreed. One person overheard a tobacco lobbyist say, "Don't worry about the coalition; when they start to go down, they eat their own." Subsequently, "Don't eat our own" became a rallying cry for the coalition, and the coalition members pulled together and won passage of one of the strongest youth access bills in the country—with no preemption.

Tobacco Industry Tactics

To achieve "desired results of putting the antis on the defensive regarding ASSIST funding"[l] the tobacco industry called editorial board meetings and wrote guest editorials. In addition, the tobacco industry sponsored media fly-arounds (airplane tours from town to town to meet with media representatives) and phone banking (contacts with a list of supporters to request that they call their legislators to oppose the bill). The media fly-arounds were planned and managed for Philip Morris by Media Services Incorporated.[m] The telephone bank operation was proposed by Briant on letterhead of the Minnesota Coalition of Responsible Retailers.[n,o] In the end, the tobacco industry succeeded in intimidating tobacco control practitioners and delayed tobacco control interventions, but ASSIST continued to function, and the coalitions passed and implemented numerous local and state initiatives while developing a formidable grassroots network in response.

—Jeanne Weigum, Association for Nonsmokers–Minnesota

[a]Briant, T. A. Confidential memorandum to Minnesota sales representatives, sales managers, and sales directors of Philip Morris. July 20, 1994, 1. http://legacy.library.ucsf.edu/tid/rin38c00 (accessed May 25, 2004). Bates no. 2061902465.

[b]Briant, T. A. Letter to Litchfield tobacco retailers. February 16, 1995. http://legacy.library.ucsf.edu/tid/rbj61d00 (accessed May 25, 2004). Bates no. 51512003-2005.

[c]Franklin, R. 1994. Preston, Minn., sued for banning tobacco ads where products sold. *Minneapolis Star Tribune*. December 13.

[d]Dougherty, M. 1994. Cigarette ad ordinance pits tiny Preston against tobacco giant. *Rochester (MN) Post Bulletin.* December 13.

[e]Broede, J. 1995. Town #2 may ban in-store tobacco ads. *St. Paul (MN) Pioneer Press*. June 12.

[f]Briant, T. A. Letter to the Stillwater Tobacco Retailer, January 12, 1996. http://legacy.library.ucsf.edu/tid/rms13c00 (accessed May 25, 2004). Bates no. 94040084.

[g]Larkin, J. P. Letter to Richard Welch. June 30, 1995. http://legacy.library.ucsf.edu/tid/kze30d00 (accessed November 9, 2004). Bates no. 518239682–9684.

[h]Briant, T. A. 1995. Update on Minnesota Project ASSIST investigation. Confidential memorandum to five persons at the Tobacco Institute, two at Philip Morris, one at R.J. Reynolds, and one at U.S. Tobacco. Minnesota Wholesale Marketers Association. November 21. http://legacy.library.ucsf.edu/tid/qyx83e00 (accessed May 25, 2004). Bates no. 2047077566–7567.

[i]Media Services Inc. 1995. Activity report to Philip Morris. September. http://tobaccodocuments.org/pm/2044420610.html (accessed April 28, 2005). Bates no. 2044420610.

[j]Lenzi, J. 1996. MN-3A game plan. Memorandum to T. Walls, D. Crawford. January 10. http://legacy.library.ucsf.edu/tid/ugt28d00 (accessed May 25, 2004). Bates no. 2062985025–5027. Note: Master document ID range 2062985024–5027 contains T. Walls document.

[k]Lenzi, J. Memorandum to T. Walls re: Minnesota retailer bill. February 29, 1996. http://legacy.library.ucsf.edu/tid/clo52d00 (accessed May 25, 2004). Bates no. 2047216418A-6419. Note: 6418A also contains memo from Walls to Lenzi.

[l]ASSIST conference call agenda. February 29, 1996. http://legacy.library.ucsf.edu/tid/bgu28d00 (accessed May 25, 2004). Bates no. 2047062557.

[m]Media Services Inc. 1995. Plan for media fly-arounds. June 25. http://legacy.library.ucsf.edu/tid/thu28d00 (accessed May 25, 2004). Bates no. 20478700052.

[n]Briant, T. A. 1996. Telephone bank operation proposal. February 2. http://legacy.library.ucsf.edu/tid/pzt28d00 (accessed May 25, 2004). Bates no. 2062976202.

[o]Briant, T. A. 1996. Telephone bank operation proposal. February 5. http:legacy.library.ucsf.edu/tid/rzt28d00 (accessed May 25, 2004). Bates no. 2062976204–6205.

Case Study 8.4
On Alert in Maine

By the time the tobacco industry brought its strategy of FOIA requests and legal accusations to Maine, ASSIST personnel had discerned the pattern in other states and were prepared. The Maine Department of Human Services (DHS) received a FOIA request, dated November 21, 1996, for all ASSIST documents. The request, filed by an Augusta attorney who stated that he was acting on his own initiative, reflected almost verbatim requests made in other ASSIST states. In responding to the request, the department's staff invited local television stations to film the staff members hunting through boxes and filing cabinets of documents. This coverage exposed the tobacco industry's tactics as burdensome harassment and presented opportunities for media advocates to frame tobacco use as the chief preventable cause of death in Maine. Rather than presuming her staff had done something wrong, Dr. Dora Mills, director of Maine's Bureau of Public Health, went on the offensive, declaring, "The public has a right to know this is happening and it will tie up our staff for quite a few

Case Study 8.4 (continued)

days."[a] A newspaper headline asked, "The smoking gun? Some Mainers think cigarette makers' request for hundreds of documents is an attempt to stall legislation."[a] An editorial announced, "Tobacco industry bungles use of right-to-know law."[b]

The documents obtained from the FOIA requests later appeared in a notebook labeled "Survey of DHS ASSIST Files," distributed by a Maine tobacco lobbyist to every member of the legislative committee then considering an increase in the cigarette excise tax. The notebook organized its accusations into five sections, the last of which included the familiar false charge of illegal lobbying. The "survey" included details such as copies of travel and expense account vouchers for ASSIST staff seeking reimbursement for attending meetings. The notebook featured a graph labeled "Maine Adult Smoking (Age 18+) and Cumulative ASSIST Dollars Spent to 9/30/96," cited as compiled from Maine DHS ASSIST files. The graph plotted Maine's annual smoking prevalence from a high of 27.8% in 1986 to 25% in 1995 against the steep upward curve of cumulative annual ASSIST spending—making tobacco control look like a bad investment.

An April 23, 1997, letter from another Maine lawyer to Maine's attorney general advised him that a review of the ASSIST files revealed illegal activities. Among other demands, the letter said that the attorney general "should launch an immediate investigation in conjunction with the State Auditor's Office to determine the responsibility of state officials who knew of, condoned or encouraged illegal lobbying practices and determine what steps the State of Maine should take to put an immediate end to these activities."[c]

Tobacco control leaders in Maine immediately responded to the charges in the survey notebook and in the letter to the attorney general. With speed and accuracy resulting from its nationwide information sharing and readiness, the national ASSIST program staff prepared and distributed its own notebook, titled "Tobacco Industry Campaign of Harassment Against State Public Health Agencies: Latest Target—Maine." The notebook exposed the false allegations and distortions and the similarities between the FOIA requests and charges made in Maine and those made in other ASSIST states. It also accurately described the goals and activities of ASSIST.

On May 22, 1997, the assistant attorney general for health responded to all charges made in the letter, corrected the misstatements of law and fact, pointed out the "lack of any evidence that any state laws have been violated," and concluded that "a closer look at federal law reveals that these allegations do not violate any specific provisions of federal law and certainly do not warrant investigation by the Attorney General's Office."[d]

—Anne Marie O'Keefe, former Policy and Media Advocacy Manager, ASSIST Coordinating Center

[a]The smoking gun? Some Mainers think cigarette makers' request of hundreds of documents is attempt to stall legislation. 1996. *Lewiston (ME) Sun Journal*. December 17.

[b]Tobacco industry bungles uses of right-to-know law. 1996. *Kennebec (ME) Journal*. December 17.

[c]Doyle, J. R. Letter to Andrew Ketterer, Esq., Maine attorney general. April 23, 1997. http://legacy.library.ucsf.edu/tid/pce30d00 (accessed October 1, 2004). Bates no. 518270712–0716.

[d]Leighton, C. C. (assistant attorney general; director, health and instructional services unit). Letter to Jon R. Doyle. May 22, 1997.

Case Study 8.5
New York State Defeats Tobacco Industry's Attempt to Impose Preemption

In 1994, the New York City Council, led by Speaker Peter Vallone, enacted smoking restrictions that were far more comprehensive than existing state law. The new legislation prohibited smoking in the indoor dining areas of restaurants with more than 35 seats. Smoking was still permitted in smaller restaurants, bar areas of restaurants, and stand-alone bars and taverns.[a] Internal industry documents show that the tobacco companies battled the proposed restrictions fiercely, spending hundreds of thousands of dollars and deploying a team of corporate and contracted lobbyists in a vain effort to defeat the measure.[b] At the time, the New York tobacco control coalition did not know the extent of specific tobacco industry funding and other resources expended to obstruct the coalition's efforts.

Shortly after the bill was passed by the New York City Council in November 1994, George Pataki was elected governor of New York. On December 13, Philip Morris chief executive officer Geoffrey Bible sent a letter to governor-elect Pataki.[c] Bible wrote, "It was a pleasure visiting with you last night."[c] His letter laid out the company's objections to the "Vallone Bill" and argued that the bill should be weakened to protect the "City's economy from sudden economic fallout" that would result from the regulations on smoking in restaurants and other public places. In fact, no such "fallout" occurred; rather, New York City's hospitality industry enjoyed an unprecedented boom in the following years.[d] On December 15, 1994, a check from Philip Morris in the amount of $25,000 was deposited to the governor's then-undisclosed inaugural account.[e] (See part 1 of this chapter, strategy 8.)

On December 19, 1994, Philip Morris corporate lobbyist Sharon Portnoy distributed the "NY SWOT and preemption plan" to advocacy and communication staff within the company and scheduled a meeting to discuss it.[f] A Lorillard memo (dated February 27, 1995) reported that the tobacco companies had developed a "New" New York City Plan. The memo said, "The United Restaurant and Tavern Associa-

Case Study 8.5 (continued)

tion of New York State was a tremendous ally during the legislative battle [in New York City]. They have agreed to spearhead continuing efforts. . . ."[g]

On April 25, Scott Wexler, executive director of the New York Tavern & Restaurant Association (the group operated under several names), sent a nine-page proposal to the Tobacco Institute's New York lobbyist requesting between $307,400 and $419,900 to "seek enactment of state legislation that establishes uniform standards for the regulation of smoking which preempts any local action in this area."[h] The Tobacco Institute's 1996 budget shows that in 1995 its special projects account center allocated $279,700 to a "New York State Preemption Plan."[i]

On May 11, 1994, New York State senate majority leader Joseph Bruno met with chief executive officer Geoffrey Bible, Sharon Portnoy, and Ellen Merlo at Philip Morris's Manhattan headquarters. Merlo followed up with a letter that said, "We all took great comfort in the message that you had to deliver."[j] On June 12, the state senate rules committee, controlled by State Senator Bruno, introduced legislation preempting all local laws and regulations "concerning the sale, distribution, use or display of tobacco products."[k]

Alerted to the preemptive legislation by the ASSIST program director, New York's commissioner of health, Dr. Barbara DeBuono, criticized the legislation to a newspaper reporter, even though State Senator Bruno was quoted in newspapers as saying that the governor's office had asked him to introduce the measure—something the governor's office denied. The storm of controversy created by the commissioner and health advocates ensured that no action was taken on the bill. A second attempt to pass preemptive legislation in 1996 failed when the state assembly refused to consider the legislation.

In 1998, advocates gained access to the Tobacco Institute's 1996 budget and filed a complaint with the New York Temporary Commission on Lobbying alleging that the Tobacco Institute's spending on the "Preemption Plan" had not been appropriately reported as legally required. After an investigation by the commission, the Tobacco Institute acknowledged that it had failed to report $443,072 spent in 1995 on lobbying and that those funds had been transferred to the New York State Tavern & Restaurant Association to lobby the state government on its behalf. The Association similarly admitted that it had failed to report the expenditures.[l] In July 1999, after reviewing materials in the online Philip Morris archive, the *New York Times* reported that between 1995 and 1997, Philip Morris lobbyist Sharon Portnoy had spent tens of thousands of dollars on entertainment, as well as on gifts for state legislators and executive staff—expenditures that she failed to report to the Lobby Commission as required by law.[m]

After a second investigation by that commission, Philip Morris amended its reports to reflect the spending and paid a $75,000 fine. Portnoy was fined $15,000 and was banned from lobbying in New York State for 3 years.

The Philip Morris preemption plan was dead.

—Russell Sciandra, former New York ASSIST Department of Health Project Manager and current Director, Center for a Tobacco-Free New York

[a]Smoke-Free Air Act. Local Law 5 of 1995. Int. No. 232-A. New York City code §§17-501–17-514. www.nycosh.org/NYC_Smoke-Free_Air_Act.htm.

[b]Philip Morris. 1994. A chronology of the tobacco lobby's efforts to repeal smoking laws. http://legacy.library.ucsf.edu/tid/oey97d00 (accessed October 1, 2004). Bates no. 2073535531–5535.

[c]Bible, G. 1994. [Letter to Governor-elect George Pataki]. Philip Morris. December 13. http://legacy.library.ucsf.edu/tid/wjg45d00 (accessed October 1, 2004). Bates no. 2046988148–8149.

[d]Hyland, A., K. M. Cummings, and E. Nauenberg. 1999. Analysis of taxable sales receipts: Was New York City's smoke-free air act bad for restaurant business? *Journal of Public Health Management Practice* 5 (1): 14–21.

[e]Governor-elect Pataki's Inaugural Fund, 12/15/94.

[f]Portnoy, S. 1994. New York SWOT and preemption plan. December 19. http://legacy.library.ucsf.edu/tid/coo52d00 (accessed October 1, 2004). Bates no. 2044716234–6240.

[g]Lorillard memo on "New" New York City plan. February, 1995. http://legacy.library.ucsf.edu/tid/kcl00e00 (accessed October 1, 2004). Bates no. 93766255–6261.

[h]New York Tavern and Restaurant Association. 1995. Hospitality coalition proposal to establish a statewide standard for the regulation of smoking. April 26. http://legacy.library.ucsf.edu/tid/wnn00e00 (accessed October 1, 2004). Bates no. 92104063–4071.

[i]The Tobacco Institute. 1996. The Tobacco Institute 1996 proposed budget. Revised October 26, 1995. http://legacy.library.ucsf.edu/tid/bfr90d00 (accessed October 1, 2004). Bates no. 518257876–7999.

[j]Merlo, E. 1995. [Letter to New York State Senate Majority Leader Joseph Bruno]. May 16. http://legacy.library.ucsf.edu/tid/ivm38d00 (accessed October 1, 2004). Bates no. 2044313530.

[k]Tobacco Industry Relief Act, New York State bill 5414, 104th Cong., 2nd session. 1995.

[l]Levy, C. J. 1998. Lobby admits to higher spending in smoking-law fight. *New York Times*, December 12.

[m]Levy, C. J. 1999. Tobacco giant spends heavily around Albany. *New York Times*, July 27.

nity-based approach to policy advocacy and other activities.[10] From the number of planning memoranda, meeting minutes, e-mails, contacts with legislators and other allies, and other communications available in the tobacco industry documents, it is clear that the industry invested an enormous amount of time, money, thought, and energy into undermining ASSIST.

There is no question that the continual FOIA requests, lawsuits, complaints, and negative publicity brought against ASSIST had a dampening effect on the program. A lawyer affiliated with the tobacco industry, Thomas Briant, saw this

very clearly in Minnesota when he spoke of the reduction in the number of cities actually being contacted by ASSIST groups to pass local ordinances, and the "chilling effect" the document requests had had in that state.[166] As public health staff became better versed in FOIA and other requirements, the requests became less disruptive and local public health associations and state agencies maintained their resolve to initiate policy actions to prevent and control tobacco use.

At the end of ASSIST, the tobacco control movement was at the threshold of a new opportunity—an opportunity for all agencies, organizations, and individuals supporting tobacco control to unite nationally around common goals. Chapter 9 describes how ASSIST leaders worked with other stakeholders in the tobacco control movement to plan and act strategically to bring about a national tobacco prevention and control program.

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9. Planning Strategically for the Future

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9. Planning Strategically for the Future

Through the work of its various committees, subcommittees, and working groups, the American Stop Smoking Intervention Study (ASSIST) took a leadership position and became a nationally respected voice for the tobacco prevention and control movement. ASSIST leaders conducted or participated in major national activities designed to ensure that the essential components of the ASSIST model would be incorporated into the next generation of comprehensive tobacco prevention and control programs. ASSIST leaders met with tobacco control leaders from many states, the District of Columbia, and the U.S. territories; broadened the annual ASSIST training conferences to include non-ASSIST states; and advocated for funding for all states to continue and expand their programs after the ASSIST contracts ended.

This chapter describes the strategic planning approaches used from 1994 through 1998 at the state, local, and national levels to ensure that tobacco prevention and control programs would be incorporated into state and national infrastructures and would have sufficient funding to sustain the programs permanently. The National Cancer Institute (NCI) extended the ASSIST project for an additional year (through September 1999) while a decision about a national program was finalized and transition issues were resolved. The ASSIST Strategic Planning Subcommittee established working groups with representation from ASSIST and from Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT), the Centers for Disease Control and Prevention's (CDC's) program. The working groups addressed issues specific to the essential elements of a permanent national program: funding; technical assistance and training; surveillance, research, and evaluation; and advocacy opportunities. As more organizations became involved, their efforts catalyzed and strengthened an emerging tobacco control movement. Though the efforts are described separately in this chapter, many occurred simultaneously over the 4-year period, and all were highly interrelated.

At the Turning Point

Twenty-eight years after clearly establishing that cigarette smoking was a hazard of sufficient importance to warrant remedial action,[1] the U.S. surgeon general, in the 1992 report *Smoking and Health in the Americas,* acknowledged that a critical element to address this major health problem was missing—the federal government lacked a coordinated tobacco control program.[2] Since then, a number of reports have specifically recommended that the federal government support a national tobacco prevention and control effort. In 1994, the Institute of Medicine (IOM), whose mission is "to advance and disseminate scientific knowledge to improve human health,"[3] published a report,

Growing Up Tobacco Free, which recognized that ASSIST was a major turning point for tobacco control. It described ASSIST as a time-limited "demonstration program, a culmination of a research approach," whose emphasis in time "should shift from demonstration to permanent program operation and support."[4(p260)] The report recommended that funding for all states be commensurate with funding for the ASSIST states.[4] A 1998 IOM report reaffirmed the concept, stating, "It is time to apply the lessons of ASSIST nationwide."[5(p10)]

Early on, ASSIST leaders realized that the ideal outcome of ASSIST would be to permanently sustain the infrastructure built by ASSIST and to maintain public-private partnerships similar to the partnership between NCI and the American Cancer Society (ACS). As ASSIST came into its own and took a leadership role in advancing tobacco prevention and control, leaders evolved from state health departments, volunteer organizations, and local coalitions. From the outset, NCI's goal was that ASSIST, as a phase V demonstration project, would move from the institute's research cycle to full application and dissemination in community-based tobacco prevention and control programs. (See chapter 1.) Upon completion, a logical next step would be a national public health program positioned to administer long-term state-based programs.

Achieving a commitment from the federal government to fund a sustained national tobacco control program required a series of actions by ASSIST leaders and others (1) to build support and collaboration among the many segments of the growing tobacco control movement and (2) to present a well-founded, convincing appeal to the Secretary of Health and Human Services. The process led to a series of meetings with representatives from a variety of tobacco control programs and related organizations, who engaged in strategic planning. They developed concept papers that expressed the vision of a national program and the science base to justify the socioecological approach demonstrated by ASSIST. Those papers were shared with individuals and organizations that could engender support for the concept. As the concept became accepted within the tobacco control community, organizations collaborated and joined forces to approach essential policy makers, including Secretary of Health and Human Services Donna E. Shalala.

The States Work to Sustain Their Programs

Innovation and adoption of new practices require leadership. From the ASSIST project, leaders emerged to build a network of 17 tobacco control programs, collaborating and interacting as a recognized, effective national project. Initially, the ASSIST state tobacco control leaders worked with their coalitions to create a shared vision and a strategic plan of action for their state programs. Their overarching goal for the ASSIST state programs was *institutionalization*, which refers to "the process of integration and maintenance of programmatic activities within organizations."[6(p7)] Later, they defined their goal more broadly and referred to it as *durability*, that is, "the

maintenance and growth of the overall, broadly based tobacco prevention movement at the state and local level, with Federal/national support."[6(p7)] This broader goal included permanently incorporating practices, policies, relationships, and norms into the thinking and actions of individuals, groups, communities, and the nation.

Many factors affect this dynamic process—the complexity of the program, the characteristics of agencies and organizations, the availability of resources, and the sociopolitical environment.[7] A five-country study by the U.S. Agency for International Development identified five conditions that are considered to be essential for sustaining a program:

1. Achievement of clear goals and objectives
2. Integration of activities into established administrative structures,
3. Significant levels of funding
4. A mutually respectful process of give-and-take in program design
5. A strong training component[8]

Similar characteristics for sustaining community interventions have been identified from cardiovascular disease prevention projects.[9]

Examples of Insights from States on Building Support for Sustained Programs

Over the years, as the states worked with their partners and the communities, they encountered barriers. From this experience, the core elements of a sustained program became apparent. The following are some of the elements that ASSIST staff members identified as important to making programs permanent in a state's infrastructure:

- Data are needed to demonstrate the effectiveness of interventions and program activities and thereby to build support for continuing programs.
- A dedicated budget, well-trained staff, and distribution of dollars to community groups are essential elements for long-term success of a program and commitment to the program by community groups and coalition members.
- Establishing a basic awareness in communities of the issues of tobacco control and building community support for changing policy and social norms are essential to engendering the support for making tobacco prevention and control a permanent public health approach in a state's infrastructure.

—Kelly Alley, Managing Director, Smokefree Indiana

Technical Assistance to the States

At the onset of the ASSIST project, the 17 participating states were at various stages of incorporating tobacco control programs into their infrastructures. Some states, such as Massachusetts, Minnesota, and Michigan, had already built capacity, as was evident by their effective collaborations with diverse partners and recognized leaders. These states secured high-level support for preventing tobacco use within their health departments and the tobacco control community and capitalized on their relationships with NCI to support the growth and development of their infrastructures.

States that were in earlier phases of building capacity benefited greatly from the technical assistance and training support that they received from NCI. Beginning in 1994, at the suggestion of

state project managers, training sessions and information exchanges were tailored to focus on the process of sustaining tobacco control programs beyond the life of ASSIST. The information shared at these exchanges enabled the ASSIST Strategic Planning Subcommittee to identify trends and anticipate problems and opportunities that were critical to the future of tobacco control. Training was offered to state staff and coalition members on how to develop strategies to survive beyond the ASSIST funding, to build allies for funding, and to design interventions to foster institutionalization. Skill-building sessions were conducted for advanced participants.

In mid-1996, a training module, "Planning for Durability: Keeping the Vision Alive," was developed, and in October 1996, a training session was conducted for ASSIST staff.[10] The planning module was designed to help the states determine how best to mobilize resources, establish new and support existing partnerships, and recognize various agendas among partners. The individuals selected to participate in the training were state tobacco control leaders. These trained participants took the module back to their states to develop a state strategic plan for institutionalization, and the ASSIST Coordinating Center provided further technical assistance to the states for developing plans and for training representatives of the state and local coalitions. The ASSIST Coordinating Center also created a video, *The Tobacco Challenge: Communities at Work*, for use by the states to engage state and local policy makers in the public and private sectors in a dialogue about the need to support tobacco control and the necessary commitments of program staff and other resources.

Activities by the States

Key organizations needed to reach out to other partners to establish relationships and obtain commitments to continue to work together on tobacco control. As the ASSIST project ended, sustaining the momentum required reaching out to a wide variety of allies. By doing that, the ASSIST partners would be able to protect the investments that had been made. Even as they were making progress at obtaining commitments for collaboration, many partners were concerned that they would lose their trained staff who had become increasingly effective through their experience with ASSIST.

Fulfillment of Sustainability Conditions

As the ASSIST project approached the end of its original contract time, it had met all but one of the five conditions for program sustainability mentioned above. The goals and objectives of ASSIST had been clearly defined, and progress had been made in achieving these goals. Activities had been integrated at the national level through the NCI-ACS partnership and at the state level through the sharing of responsibilities by the health departments and ACS in the implementation and management of the project. Several planning groups, along with state and local coalitions, promoted communication among key project participants to support a give-and-take process in program design and

delivery. Training of staff and of trainers had been conducted to continue increasing capabilities. The condition that remained to be fulfilled was to acquire funding sufficient to support a solid infrastructure (1) for delivering effective tobacco control interventions after ASSIST ended and (2) for incorporating the essential elements of the ASSIST model into a national tobacco control program.

Developing Strategic Plans for a Sustained National Program

Through the contracts, NCI had provided a significant level of funding directly to the states and had established the ASSIST Coordinating Center to provide training, technical assistance, and support, but that funding would end in 1999. ACS supported one full-time staff person per state dedicated to tobacco control and was committed to continuing its support. It was apparent to many that, without federal funding, the ability to continue adequate tobacco control efforts beyond the life of ASSIST would be a problem in most participating states. At the end of the project, a few ASSIST states had state funding matching or exceeding the amount provided by ASSIST, but several states had no funding for continuing tobacco control in their state health departments. Continuation of tobacco prevention and control programs in the states, therefore, was seen as dependent on a federal commitment to funding for all states. States generally are reluctant to appropriate state monies for tobacco prevention and control despite the enormous health and economic burden. Federal support seemed to be in the nation's best interest because without organized state tobacco control efforts to create a constituency for tobacco control, national efforts would lack momentum.

The ASSIST Strategic Planning Subcommittee Plans for the Future

The ASSIST Strategic Planning Subcommittee's mission was to advance nationwide goals and institutionalize the practice of tobacco prevention and control in the United States. (See chapter 3.) From 1995 through the end of the project, four sets of issues emerged in the ASSIST Strategic Planning Subcommittee as critical to the continuation of the tobacco control programs and networks that had been developed through the ASSIST project:

1. Achieve a federal commitment to maintain and expand tobacco prevention and control efforts;
2. Determine which organizational entities would be responsible for a large-scale program that would include population-based applied research and public health interventions based on research and best practices;
3. Get public health professionals, opinion leaders, and responsible policy makers to understand and approve the level of resources required to achieve significant reductions in tobacco use; and
4. Build in time and resources to plan for a smooth transition from ASSIST to the next phase of federal involvement in tobacco control efforts.

The ASSIST Strategic Planning Subcommittee itself, and in collaboration

with other groups, developed concept papers and took steps to advance a strategic plan for ensuring long-term continuation of a national tobacco prevention and control program and movement. (See figure 9.1.) The concept papers, described below, were milestones that stimulated the desired combination of dialogue, research, analysis, and coordination to achieve two substantial goals:

1. To ensure the level of commitment and action required to fund effective tobacco prevention and control programs over the long term
2. To help catalyze a stronger, nationwide tobacco prevention and control movement

Concept Papers for a National Strategy and Program

"Planning for a Durable Tobacco Prevention Movement"
—Developed by the Institutionalization Working Group

With a vision for the future, in 1995 the ASSIST Strategic Planning Subcommittee created the Institutionalization Working Group to present the case for a comprehensive policy-oriented approach to tobacco prevention and control at the national, state, and local levels, through public-private partnerships. The working group presented a discussion paper titled "Planning for a Durable Tobacco Prevention Movement"[6] at the June 1995 meeting of the ASSIST Coordinating Committee. (See appendix 9.A for the executive summary of the paper.) The purposes of the paper were to contribute to planning for tobacco prevention within and beyond the ASSIST project and

Figure 9.1. ASSIST Strategic Planning Subcommittee Long-term Planning Products, 1995–98

May 1995: The Institutionalization Working Group produced a paper titled "Planning for a Durable Tobacco Prevention Movement."

↓

March 1996: The ASSIST Strategic Planning Subcommittee produced a paper titled "Advice to NCI About Their Future Role in Tobacco Control."

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May 1996: The Working Group on Durability produced a paper titled "Turning Point for Tobacco Control: Toward a National Strategy to Prevent and Control Tobacco Use."

↓

April 1997: The ASSIST Strategic Planning Subcommittee issued a resolution to the ASSIST Coordinating Committee on the future needs of state and local tobacco control programs.

↓

August 1997: The ASSIST Strategic Planning Subcommittee established Advance Groups on Funding; Technical Assistance and Training; Surveillance, Research, and Evaluation; and Advocacy Opportunities.

↓

December 1997: The Advance Group on Funding submitted recommendations to the deputy assistant secretary for DHHS.

↓

February 1998: The Advance Groups on Technical Assistance and Training; Surveillance, Research, and Evaluation; and Advocacy Opportunities submitted recommendations to the deputy assistant secretary for DHHS.

to stimulate discussion and offer proposals for next steps to be undertaken by state projects, NCI, ACS, and the ASSIST Coordinating Center. In the paper, the working group identified relevant issues and barriers to continuing effective tobacco control programs beyond the life of ASSIST and suggested methods for surmounting those barriers.[6]

Important Factors. The working group identified eight interdependent factors that could affect the institutionalization and durability of future tobacco prevention and control efforts and assessed the status of each factor. Within each of these factors, cultural diversity and cross-cultural competence were included as important topics. The factors are described in the following excerpts from the report:

> CONTEXTUAL FACTORS: Contextual factors . . . include the nature and extent of social and political support for tobacco prevention, economics . . . , history of involvement with tobacco . . . , and history of involvement in community and state broad-based health, social, or environmental movements.
>
> POLICY COMMITMENTS: Public policy commitments are reflected in . . . increases in tobacco taxation, . . . [and] may also be encoded in state legislation or local ordinances to curtail youth access to tobacco products, eliminate or greatly reduce secondhand smoke, or ban or restrict tobacco advertisements and promotions.
>
> FUNDING: Durability concerns most often arise from the realization that NCI contracting for the ASSIST demonstration is for a fixed period. . . . The tobacco prevention movement began [before] and will continue, at some level, after ASSIST.
>
> ORGANIZATIONAL CAPACITY AND INFRASTRUCTURE: The literature on the diffusion and institutionalization of health promotion programs within organizations shows that it is facilitated by change agents and program champions.
>
> SUPPORT (ENABLING) SYSTEM: Beyond ASSIST, the Centers for Disease Control and Prevention via the Office on Smoking and Health, have begun to create a support system for IMPACT state programs and national organizations. CDC is also supporting via a grant to the University of North Carolina a Summer Institute on Tobacco Control. The Robert Wood Johnson Foundation is supporting tobacco prevention in states via the American Medical Association and the Smoke-Less States Initiative.
>
> DIFFUSION OF INNOVATION FACTORS: Given the constraints on tobacco

Interdependent Factors That Affect Institutionalization and Durability

1. Contextual factors
2. Policy commitments
3. Funding
4. Organizational capacity and infrastructure
5. Support (enabling) system
6. Diffusion of innovation factors
7. Engagement of multiple channels, settings, systems, and organizations
8. System of monitoring and feedback on progress

Source: Institutionalization Working Group, Strategic Planning Subcommittee. 1995. Planning for a durable tobacco prevention movement. Discussion paper, ASSIST Coordinating Center, Rockville, MD.

Campaign for Tobacco-Free Kids Web banner

Source: Adapted from the Campaign for Tobacco-Free Kids Web Site, July 8, 2001. Photo courtesy of AP/Wide World Photos. Used by permission. Photo of tobacco industry executives from Hearings on Regulation of Tobacco Products before the U.S. House of Representatives Subcommittee on Health and the Environment, April 14, 1994.

IMPACT

In 1993, CDC, through the Office on Smoking and Health (OSH), began funding IMPACT, a state-based tobacco control program. Initially, CDC funded 32 states plus the District of Columbia with a budget of $5 million. Although CDC-funded states received only a fraction of the resources dedicated to ASSIST states, CDC provided stability for tobacco control by incorporating the function as a primary component of its National Center for Chronic Disease Prevention and Health Promotion. With low funding levels, IMPACT states had developed limited program structures.

Excerpt from the Committee's Transmittal Letter

"We recognize NCI's leadership role in tobacco control and are pleased that NCI is exploring how it and other DHHS agencies can collaborate in a national tobacco control strategy. . . . In the attached document, we identify major elements of a national strategy and suggest specific roles that NCI might play in implementing the strategy."

Source: Maldavir, J., and B. Motsinger. 1996. ASSIST Coordinating Committee letter to E. J. Sondik, March 27, 1996.

prevention . . . , change agents are both essential and critical to the movement. . . . The broad-based nature of the tobacco prevention movement leads to unevenness in knowledge, skills, and commitments to the movement.

ENGAGEMENT OF MULTIPLE CHANNELS, SETTINGS, SYSTEMS, AND ORGANIZATIONS: The ASSIST model explicitly recognizes the need to implement tobacco prevention in multiple channels—community groups, health care settings, schools, and worksites.

SYSTEM OF MONITORING AND FEEDBACK ON PROGRESS: For purposes of ensuring continuing progress and durability of the interagency tobacco prevention movement, there is a need for a system of monitoring, feedback, evaluation, and strategic redirection.[6(pp8–14)]

Recommendations: In "Planning for a Durable Tobacco Prevention Movement," the working group suggested numerous follow-up activities for each of

the eight factors. They addressed a number of recommendations for action within a broader strategic plan to the state ASSIST coalitions and the ASSIST Coordinating Committee. For example, the following was a recommendation to the coalitions:

> Starting with the factors and questions identified in this discussion paper, (a) explore the constraints and supports that will contribute to the durability of tobacco prevention in the state, and (b) develop a plan for the institutionalization and durability of tobacco prevention.[6(p22)]

Similarly, the working group recommended that the ASSIST Coordinating Committee involve more entities in developing a national strategy for tobacco control:

> Develop a concept paper on the vision, general strategy, and roles and responsibilities of major players in a national strategy to prevent tobacco use in America. Consideration should be given to how to further extend partnerships with CDC, RWJ, ASTHO, the Coalition on Smoking OR Health, and other agencies to build a national strategy that supports state strategies.[6(p22)]

"Advice to NCI About Their Future Role in Tobacco Control"
—Developed by the ASSIST Strategic Planning Subcommittee

The next concept paper defined NCI's future role in tobacco control. The ASSIST Coordinating Committee requested that the ASSIST Strategic Planning Subcommittee prepare this paper in response to a presentation by Dr. Edward J. Sondik, deputy director of NCI's Division of Cancer Prevention and Control, and a follow-up letter from Dr. Peter Greenwald, the division's director. Sondik had explained that NCI would be developing a strategic plan in the near future and forming a new Behavioral Sciences Working Group, which would advise NCI in this process. Sondik and Greenwald welcomed advice from the

National Center for Tobacco-Free Kids

In 1996, the National Center for Tobacco-Free Kids evolved from the Campaign for Tobacco-Free Kids, a program funded largely by The Robert Wood Johnson Foundation (RWJF). The center has established a collaboration of member organizations with an interest in preventing tobacco use. The 130-plus partners include health, education, medical, civic, corporate, youth, and religious organizations that are dedicated to reducing tobacco use among children and adults. The three primary goals of the Campaign for Tobacco-Free Kids are to:

- "Alter the public's acceptance of tobacco by deglamorizing tobacco use and countering tobacco industry marketing to youth and other practices.
- Change public policies at federal, state, and local levels to protect children from tobacco.
- Increase the number of organizations and individuals fighting against tobacco."

The Web site of the National Center for Tobacco-Free Kids (www.tobaccofreekids.org) offers a wealth of information for reporters and the media on events and issues in tobacco control. This information includes state-by-state comparisons, reports on industry marketing, and fact sheets about tobacco. The center is an excellent source of technical assistance and media strategies.

Source: Campaign for Tobacco-Free Kids. *Who we are.* www.tobaccofreekids.org.

ASSIST Coordinating Committee, both through the working group and directly to NCI staff. In the following excerpt of his follow-up letter to Jerry Maldavir, Greenwald explained his views in favor of a national strategy:

> I am in favor of a national tobacco use prevention strategy. A coordinated effort is essential if we are to continue to reduce this major cause of death and disease. A national strategy will require the participation of many organizations and agencies. NCI staff are currently working to determine the interest of other DHHS agencies in the planning process.

In the paper "Advice to NCI About Their Future Role in Tobacco Control," submitted on March 27, 1996, to Sondik, the ASSIST Coordinating Committee presented four issues with related recommendations regarding NCI's involvement in tobacco control.[11] In its transmittal letter (written by J. Maldavir and B. Motsinger), the committee outlined a national strategy and specified NCI's role in implementing that strategy; recommended that NCI increase its investment in tobacco control; supported continued development of the tobacco control infrastructure based on the ASSIST model, with related funding for technical assistance, training, and communication; and recommended that policy-based interventions be emphasized within the context of a balanced approach to research and development in the tobacco control program.

"Turning Point for Tobacco Control: Toward a National Strategy to Prevent and Control Tobacco Use"
—Developed by the Working Group on Durability

To move forward on the basic concepts and recommendations that the Institutionalization Working Group had presented, the ASSIST Strategic Planning Subcommittee established a Working Group on Durability in late 1995 and charged the members with the task of developing a concept for a national strategy for tobacco control. The working group researched the types of support—organizational, monetary, and theoretical—that already existed and could be drawn into the strategic process. The working group's May 1996 working paper, titled "Turning Point for Tobacco Control: Toward a National Strategy to Prevent and Control Tobacco Use,"[12] presented a framework and general description of elements that should be included in a comprehensive national, state, and local strategy. (See appendix 9.B for the executive summary of the report.) The report described several policy studies, reports from consensus conferences, and comprehensive tobacco control interventions that delineated future directions for tobacco control and prevention in the United States. The report suggested that these documents

> provide a basis for the development of a national strategy. . . . Nevertheless, a single unified statement of vision for a national comprehensive tobacco control and prevention strategy does not exist. These documents could provide the basis for such a vision and plan.[12(p21)]

(The reports referred to are listed in the sidebar.)

The "Turning Point" paper emphasized the need to bring together the many players in tobacco control to create a new level of influence and effec-

Reports: A Starting Point

"The following is a list of reports that articulate recommendations and a vision for the future of tobacco control. Based on the contents of these reports and documents, using the framework presented in this paper, a national strategic plan for tobacco control could be written.

- "Reports from the Surgeon General on Smoking and Health, including the recent report on *Preventing Tobacco Use Among Young People* [1994];
- Report of the Institute of Medicine, *Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youths* [1994];
- National Cancer Institute's American Stop Smoking Intervention Study (ASSIST), as articulated in *Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's* [1991];
- Tobacco Control Objectives for *Healthy People 2000* [1992];
- Program descriptions for the Centers for Disease Control and Prevention's IMPACT program;
- Program descriptions of the Robert Wood Johnson Foundation's SmokeLess States Initiative;
- Coalition on Smoking OR Health's Blueprint for Success: *Countdown 2000—Ten Years to a Tobacco-Free America* [1990];
- Association of State and Territorial Health Officials' *Policy Statement on Tobacco Use Prevention and Control*;
- Conference Report and Recommendations from America's Health Community, *Tobacco Use: An American Crisis* [1993];
- And various plans for tobacco control and prevention developed at the state level (e.g., Comprehensive State Smoking Control Plans developed by ASSIST states) [1993]."

Source: Working Group on Durability, Strategic Planning Subcommittee. 1996. *Turning point for tobacco control: Toward a national strategy to prevent and control tobacco use.* Discussion paper, ASSIST Coordinating Center, Rockville, MD (p. 29).

tiveness. The paper presented a table that suggested roles and responsibilities for nearly 40 organizations and agencies, including federal and state agencies, private and governmental scientific research organizations, national health advocacy groups, foundations, and voluntary organizations.[4,12] The working group emphasized the need for flexibility in implementing an effective strategy for tobacco control.[12]

The paper also identified seven elements that the working group considered important in a national, state, and local strategy:

> Public health objectives,
> Health promoting tobacco-control policies,
> Movement infrastructure and programmatic interventions,
> Social marketing and mass media interventions,
> Intervention research, development, and dissemination,
> Monitoring and evaluation, and
> Management and coordination mechanisms.[12(p21)]

Again, the working group acknowledged that there would be differences of opinion but expressed confidence that there was agreement about a broad, integrated approach:

> It must be acknowledged that there are various opinions within the tobacco control movement about the relative value of different intervention options and where resources should be invested in the short term. However, there is apparent agreement that a comprehensive, multifaceted, and integrated approach is necessary to address the problem.[12(p21)]

The Robert Wood Johnson Foundation's SmokeLess States National Tobacco Policy Initiative

"Founded in 1993, the SmokeLess States National Tobacco Policy Initiative is a private-sector effort that supports activities of statewide coalitions working to improve the tobacco policy environment with the goal of reducing tobacco use. The initiative is a collaborative effort among RWJF, the American Medical Association, and statewide coalitions receiving the grants."[a]

"During the first seven years of the program, RWJF provided approximately $40 million for educational and policy efforts undertaken by statewide coalitions in 36 states and the District of Columbia. In 2001, RWJF committed an additional $52 million to the initiative, funding 42 statewide coalitions. Policy efforts undertaken by these coalitions, which receive additional funding from their member organizations, including the American Cancer Society, the American Heart Association, the American Lung Association, and state medical societies, focus on three areas:

- "Promoting ordinances to reduce public exposure to environmental tobacco smoke, including smoke-free work places and public places;
- Increasing state tobacco excise taxes in order to reduce the demand for tobacco products; and
- Fostering changes in Medicaid and state employee health insurance coverage and encouraging private health insurers to cover tobacco dependence treatment as part of routine coverage.

"Some of the coalitions are also working to secure tobacco settlement funds for comprehensive tobacco control programs in their states. . . .

"The coalition structure that is at the heart of SmokeLess States grants has been crucial to the program's effectiveness. This is because each coalition member-organization brings to the table different strengths and resources which, when taken together, make many victories possible. Specifically, the grantees and the partnerships they create under the program should:

- "Strengthen statewide coalitions and diversify their active membership base;
- Develop a plan to improve the tobacco policy environment within their state with the goal of reducing the use of tobacco; and
- Educate the public about the need for stronger tobacco control policies.

"To help underwrite these policy campaigns, coalition member organizations contribute matching funds as a condition to receiving the SmokeLess States grant. No SmokeLess States grant money is used for lobbying-related activities."[b]

[a]American Medical Association. n.d. *SmokeLess States National Tobacco Policy Initiative.* www.ama-assn.org/go/smokelessstates.

[b]American Medical Association. n.d. *More on the initiative: SmokeLess States National Tobacco Policy Initiative*.

With the completion of the "Turning Point" paper, the conceptual foundation and strategic approach for garnering support for a national tobacco prevention and control program were sufficiently described. It was time to implement the approach in a calculated, persistent manner.

Taking Action to Get Commitment

The national context in which ASSIST leaders were moving their agenda forward was particularly opportune for growing a tobacco control movement

ASTHO, NACCHO, and NALBOH

Association of State and Territorial Health Officials

"The Association of State and Territorial Health Officials (ASTHO) is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. ASTHO's members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy, and to assuring excellence in state-based public health practice."

ASTHO's origins go back to the late 19th century, and the current form of the organization, with membership limited to executive officers of the departments of health of any state, territory, or possession of the United States, was founded on March 23, 1942.

National Association of County and City Health Officials

"NACCHO was formed in July 1994 when the National Association of County Health Officials and the U.S. Conference of Local Health Officers combined to form a unified organization representing local public health. The two predecessor organizations were formed separately in the 1960s.

"NACCHO is a nonprofit membership organization serving all of the nearly 3,000 local health departments nationwide—in cities, counties, townships, and districts. NACCHO provides education, information, research, and technical assistance to local health departments and facilitates partnerships among local, state, and federal agencies in order to promote and strengthen public health.

"NACCHO aims to promote the concerns of local public health in the nation's capital by:

- Educating Members of Congress and other policymakers about local public health issues;
- Analyzing the impact on local public health of legislative and regulatory actions;
- Disseminating legislative alerts and legislative reports to all local public health departments; and
- Providing the latest updates on key public health issues."

National Association of Local Boards of Health

"MISSION: The National Association of Local Boards of Health (NALBOH) represents the interests of local boards of health and assists them in assuring the health of their communities.

"NALBOH has been engaged in establishing a significant voice for local boards of health on matters of national public health policy."

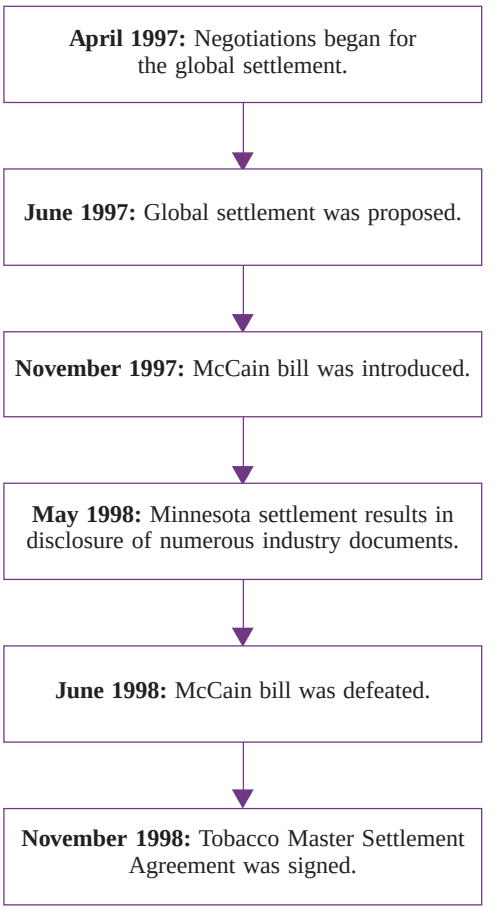
Sources: Association of State and Territorial Health Officials. About ASTHO: ASTHO history. www.astho.org; National Association of County and City Health Officials. About NACCHO. www.naccho.org; National Association of Local Boards of Health. About NALBOH. www.nalboh.org.

and for establishing and sustaining a national program. At their May 31, 1996, meetings, the ASSIST Coordinating Committee and its Strategic Planning Subcommittee discussed the need to unite all of the principal tobacco control organizations in the country and to effect a dialogue about how to build a national cohesive movement that would be successful over time. The "Turning Point" paper was reviewed and placed on the ASSIST Coordinating Committee conference call agenda to discuss ways for using the paper to initiate multiple outreach efforts on a national strategy for institutionalization. ASSIST leaders

planned to use the paper to initiate multiple outreach efforts with state and national organizations to begin collaboration on a national strategy for institutionalization.

During the early and mid-1990s while the ASSIST states brought intensive attention to tobacco prevention and control as a public health issue, the social-environmental climate became more favorable for tobacco prevention and control interventions throughout the nation, and more programs and organizations supported initiatives to decrease tobacco use. A number of non-ASSIST tobacco control programs and unanticipated political events brought tobacco issues and the tobacco industry to the forefront of media attention and further strengthened the social and political climate. These events, briefly summarized in sidebars in this chapter and in figure 9.2, provided the context in which ASSIST leaders took action to involve other entities supportive of tobacco control and to approach the Department of Health and Human Services (DHHS). It was in this context that the deputy secretary of DHHS represented DHHS at an October 1996 ASSIST conference, described in the subsequent section, and that Secretary of DHHS Donna E. Shalala recognized ASSIST.

Figure 9.2. Tobacco Settlement Negotiation Milestones



Joining Forces

The ASSIST Strategic Planning Subcommittee faced an extraordinary challenge: integrating national tobacco control ideas and visions with state-level tobacco control ideas and realities. Therefore, to strategically plan for maintaining tobacco prevention and control at a national level, it was paramount to have diverse representation from as many state and national agencies as possible and as quickly as possible, especially from entities that already had a track record in working for tobacco control on a national or multistate scale. At the national level, NCI and ACS provided strong leadership and strategic guidance to the ASSIST project and recognized

Food and Drug Administration

Because nicotine is an addictive drug and cigarettes are drug-delivery devices that contain more than 40 cancer-causing agents, FDA Commissioner Dr. David A. Kessler attempted to assert jurisdiction for FDA to regulate tobacco products. A consideration was that if FDA were to regulate tobacco product ingredients like other products, the agency would have to ban them, which would not be feasible. Instead, FDA attempted to regulate the sale, access, and advertising of tobacco to minors as a child protection rule. In August 1996, FDA issued a rule with the following requirements:

- Restrict tobacco advertising in magazines with high teen readership.
- Prohibit tobacco brand-name sponsorship of sporting and entertainment events.
- Ban outdoor tobacco advertising near schools and playgrounds.
- Require age verification and face-to-face sales, and eliminate free samples, self-service displays, and most cigarette vending machines.
- Prohibit tobacco brand names from appearing on clothing, bags, and other promotional items.
- Require the tobacco industry to fund an annual public education campaign to reduce youth smoking.

The FDA effort was mired in court battles until March 21, 2000, when the U.S. Supreme Court ruled 5–4 that FDA does not have, and has never had, the authority to regulate tobacco products. However, while the legal battles were being waged, the provisions for identification checks remained in effect. FDA granted funds to state enforcement agencies to train enforcers to conduct compliance checks. The attention to the FDA issues and legal battles helped keep tobacco control a major political issue, especially during the 2 critical years (1996–97) of ASSIST activity to promote support for a national tobacco prevention and control program.

Source: U.S. Department of Health and Human Services. 2000. *Reducing tobacco use: A report of the surgeon general.* Atlanta: National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. www.cdc.gov/tobacco/sgr/sgr_2000/chapter5.pdf.

the potential strength of a collaboration with CDC's Office on Smoking and Health, the U.S. Food and Drug Administration (FDA), the Association of State and Territorial Health Officials (ASTHO), the American Lung Association, the American Heart Association, the National Center for Tobacco-Free Kids, RWJF, and other partnering agencies and organizations. The combined leadership from all these entities would not only empower the ASSIST states to reach their potential but also motivate others to support tobacco prevention and control efforts over the long term.

During this early phase, several entities were important collaborators. The Tobacco Control Network of State Health Agency Program Managers for Tobacco Prevention and Control had been conducting efforts that paralleled those of the ASSIST Strategic Planning Subcommittee. The network was formed by ASTHO at its 1994 annual meeting in San Antonio, Texas. (The ASTHO network at that time was supported by a cooperative agreement between OSH and NCI.) The initial purpose of the network was to bring together all states to plan collectively for national strategies that would advance tobacco control. The network rotated the duties of the chair between ASSIST and IMPACT states annually.

The Substance Abuse and Mental Health Services Administration and the Synar Amendment

A major federal effort to reduce tobacco sales to minors resulted from a 1992 amendment to the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act by the late Congressman Mike Synar. The new law created the Substance Abuse and Mental Health Services Administration and required states to take steps to reduce tobacco sales to minors or risk losing federal block grant funds for substance abuse prevention and treatment. Each state was required to establish a minimum sale age of 18 and to conduct random, unannounced inspections of tobacco outlets and report these findings to the DHHS. The goal of the inspections was to reduce illegal sales to minors to less than 20%. Regulations for implementing the Synar Amendment were published in the *Federal Register* in January 1996.

Implementation of the Synar Amendment affected states across the nation and prompted media coverage at the national and local levels. Not only public attention in all states, but also political pressure was brought to the problem of tobacco sales to minors by the Synar Amendment. An important effect of implementing the requirements of the Synar Amendment was the need to bring in more substance abuse professionals to tobacco control activities. Tobacco control claimed a legitimate place among their many responsibilities because of the Synar requirements and created a need for permanent staff and programs within departments of health.

Source: U.S. Department of Health and Human Services. 2000. *Reducing tobacco use: A report of the surgeon general.* Atlanta: National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. www.cdc.gov/tobacco/sgr/sgr_2000/chapter5.pdf.

At the May 1996 ASSIST Strategic Planning Subcommittee meeting mentioned earlier, the subcommittee developed a motion for consideration by the ASSIST Coordinating Committee at its May 1996 meeting to facilitate the implementation of a national strategy that would reinforce ASSIST goals. After considerable discussion, the committee voted to amend the motion to reflect a proposal drawn up by ASTHO and the National Association of County and City Health Officials (NACCHO). The following motion was adopted by the committee:

> A copy of the paper titled "Turning Point for Tobacco Control" will be sent to Philip R. Lee, M.D., Assistant Secretary for Health. The accompanying cover letter should state: (a) the importance of state and community based comprehensive tobacco control interventions beyond ASSIST; (b) the need for continuing support in ASSIST states while a national strategy is developed (i.e., extension to 2005); (c) the need to increase the IMPACT funding equivalent to the levels of Project ASSIST, using the ASSIST model; (d) assure funding for national training and technical assistance for all states based on the ASSIST model; (e) the ASSIST Coordinating Committee wishes to offer assistance to Dr. Lee in his new endeavor to lead the development of a national strategy; and (f) that the cochairs will contact Mr. Ripley Forbes to determine how the ASSIST project may assist him to formulate the DHHS plan.[13(p6)]

A few months later, in September 1996, ASTHO and NACCHO published their formal policy statement, "Tobacco Use Prevention and Control." One tenet of the policy covered institutionalization:

> Tobacco use prevention and control programs must be institutionalized within state and local health agencies to ensure that activities supported by this policy statement are completed.[14(p4)]

In the meantime, the cochairs of the ASSIST Coordinating Committee were approaching DHHS Secretary Donna Shalala and her senior staff through telephone conversations and letters. The series of communications described the essential elements and goals of ASSIST, emphasized the effectiveness of the project's community-based approach, and expressed the need for states to be assured of long-term funding in order to build state infrastructure for permanent programs.

Encouraging DHHS to Extend ASSIST

Simultaneously with efforts to strengthen the tobacco control movement, ASSIST leaders had to articulate the need for extending the funding of ASSIST. An extension would require a commitment of additional funds from NCI and a renewed commitment from ACS as a partner. A critical step toward ensuring both the immediate future of ASSIST and a national tobacco prevention program that would incorporate the essential elements of ASSIST was a commitment from DHHS to support long-term, state-based programs to prevent and reduce tobacco use.

An Early Expression of DHHS's Commitment

At an ASSIST information exchange conference in October 1996 in Crystal City (Arlington), Virginia, Kevin Thurm, the deputy secretary of DHHS, first expressed the commitment of DHHS to the Synar Amendment and to the FDA tobacco regulations. He then conveyed the department's commitment to continue the type of community-based tobacco control efforts exemplified in ASSIST:

> I can't tell you at this time whether our support for your activities will come from the existing ASSIST program or from another HHS program or agency. But what I can tell you is this: This Department, and this Administration, are 100% committed to continuing your work.[15(p3)]

In a follow-up to the conference, at an ASSIST Coordinating Committee meeting in October 1996, a senior advisor at DHHS commended the group for the significant achievements attained through the work of the ASSIST project. He underscored the deputy secretary's comments delivered at the conference regarding the department's commitment to the continuation of tobacco control activities throughout the United States.[16]

Funding Approved for the Temporary Continuation of ASSIST

To maintain the infrastructure and capacity for sustaining the work of ASSIST while providing adequate time for planning the future program, in January 1997 NCI approved funding to extend the ASSIST contracts for one year. In a 1997 letter to ASSIST project managers written by R. Klausner and P. Greenwald, NCI announced the extension:

> NCI will extend the current ASSIST contracts, with full funding, for one full year. From now until September of 1999, we all will be working together to determine the most effective way to

support and manage future tobacco prevention efforts as we move beyond the research phase of ASSIST and make the transition to the essential task of supporting disseminated programs in public health.

Encouraging DHHS to Establish a National Program

With the 1-year extension of ASSIST confirmed, the informal consortium of organizations and their leaders could refocus their efforts on promoting a national program that would endure beyond the ASSIST project. The activities in 1997 were numerous.

On March 5, 1997, representatives of ASTHO, NACCHO, and NALBOH (J. Dillenberg, M. Vignes-Kendrick, and J. Saccenti) wrote a letter to Secretary Shalala thanking her for the department's commitment to tobacco control reflected in the extension of ASSIST and increased funds for CDC programs and requesting a meeting with her.

Meanwhile, on March 31, 1997, to make the case to NCI for the expansion of the ASSIST model to all 50 states, a senior advisor to ASSIST presented testimony to NCI's National Cancer Policy Board that suggested that the 17-state ASSIST project continue and serve as a research arm of NCI's tobacco control program; that NCI be designated the lead agency in establishing ASSIST in the other 33 states; and that, once implemented, the project be transferred to CDC for continued implementation and evaluation.[17] (See appendix 9.A.)

The 1-year extension of ASSIST had implications for ACS in terms of commitment and funding; therefore, ACS organized a meeting in Atlanta in April 1997 to bring together key stakeholders to discuss the ASSIST public-private partnership as well as NCI's and ACS's future roles in a sustained, federally funded, national tobacco control program. Given the complexity of the issues, the meeting was the first of many discussions among many stakeholders for articulating a position regarding recommendations for DHHS. In addition, ACS was undergoing tremendous organizational change and needed to evaluate current tobacco control efforts and operations and the training needs of state health departments and regional ACS staffs. An evaluation was being designed to aid ACS staff in future planning and budget allocations.[18]

In June 1997, in preparation for a meeting with Secretary Shalala, ASTHO, NACCHO, NALBOH, and ACS formalized a proposal to DHHS regarding federal involvement with state and local programs for tobacco use, with the following recommendations to DHHS (according to a memo and excerpt from the ASTHO-ACS proposal, sent by J. Moore and D. Magleby to S. Malek on June 4, 1997):

1. CDC would fund all 50 states at ASSIST levels by FY 1999 to be
   - coalition/partner based in order to leverage new resources;
   - policy oriented.
2. The NCI will fund applied research on statewide programs. This research will test new or expanded interventions and will guide and inform state programs funded by the CDC.
3. Safeguards must be developed so that no gaps or reductions in funding

for state tobacco prevention and control programs occur while funding is in transition.

4. A training and technical assistance center and plan will be developed with input from the states and national partners and will be funded collaboratively by NCI and CDC in order to bridge research and practice.

The next activity was a meeting on July 25, 1997, between Secretary Shalala and a small group of ASSIST state-level tobacco control practitioners. In a follow-up letter to the secretary, R. Schwartz, the cochair of the ASSIST Coordinating Committee, summarized the committee's requests and concerns:

> State and local tobacco control programs such as those funded through ASSIST must continue and must be extended to all states. To ensure the continuity of ASSIST projects and coalitions, the DHHS needs to make a commitment to these programs in the immediate future. Without a commitment now, not only will continuity and momentum of programs be lost, but experienced and trained staff will also be lost to other, more certain endeavors. . . . We look to your strong leadership to give state tobacco control programs the commitment they need for long term support.

The meeting that ASTHO requested on behalf of the key stakeholders took place shortly after, on August 4, 1997. Representatives from ASTHO, NACCHO, NALBOH, ASSIST, and ACS attended that meeting. A follow-up letter to the secretary, on August 7, 1997, signed by M. Caldwell, B. Motsinger, J. Rice, J. Saccenti, and R. Todd, after the meeting reiterated the major themes that the group had presented:

The McCain Bill

On November 7, 1997, Senator John McCain introduced "a bill to reform and restructure the processes by which tobacco products are manufactured, marketed, and distributed, to prevent the use of tobacco products by minors, to redress the adverse health effects of tobacco use, and for other purposes." If passed, the law would have had a profound effect on the tobacco industry and tobacco control. Although this comprehensive bill was defeated by the U.S. Senate in June 1998, it represented a high-water mark for conceptualizing national tobacco control legislation and was yet another event that brought attention to the need for a sustained tobacco control program. Features of the proposed bill included the following: a $1.10 (per pack) increase in cigarette taxes; penalties on the tobacco industry if youth smoking rates did not drop significantly; the delegation of complete authority to FDA to regulate sale, manufacturing, labeling, and marketing of tobacco products; and the use of collected money to fund antismoking campaigns, research, and health-related activities.

Sources: National Cancer Institute. 1998. NCI legislative update for September 15, 1998—Tobacco page. www3.cancer.gov/legis/sept98/tobacco.html; Blendon, R. J., and J. T. Young. 1998. The public and the comprehensive tobacco bill. *Journal of the American Medical Association* 280:1279–84.

It was very reassuring to hear again that the Administration is fully committed to a vision of statewide, community-based tobacco prevention and control programs throughout the country. It is our intent that this includes:

- Increasing federal funding to assure all states an ASSIST-level minimum;
- Maintaining continuity in existing programs to avoid loss of personnel and infrastructure;

ASSIST manual for training session on durability

Informational brochure accompanying ASSIST-produced video The Tobacco Challenge: Communities at Work

Forging an NCI/CDC collaboration to link applied research and increase interdependent program planning and implementation;

Expanding the training and technical assistance resources that assure skilled leadership at the national, state and local levels.

The outcomes of the meeting with Secretary Shalala were far-reaching. The department's commitment invigorated the efforts of the lead organizations in the movement for a national program. At the meeting on August 4, 1997, Secretary Shalala proposed the formation of an interorganizational team to work with the department on the strategy for a federally supported national tobacco prevention and control program, which the group endorsed. Also attending the meeting was the deputy assistant secretary of DHHS, James O'Hara, who was appointed to be the DHHS primary contact for tobacco control issues. ASSIST leaders shaped the concept of an interorganizational team, which took the form of four *advance groups*. The ASSIST Strategic Planning Subcommittee took the lead in establishing the advance groups to address the issues of funding; technical assistance and training; surveillance, research, and evaluation; and advocacy opportunities. Representatives from ASSIST and IMPACT states, California, and ACS formed the membership of the advance groups, whose charge was to develop recommendations to submit to the deputy assistant secretary of DHHS.

Resolution to DHHS from the ASSIST Coordinating Committee

While the advance groups were busy preparing a report with a detailed plan, ASSIST and other organizations maintained the momentum. The ASSIST Coordinating Committee met with Jim O'Hara, the deputy assistant secretary for health of DHHS, in September 1997 in Houston.[19] The committee thoroughly briefed him about four matters:

1. The issues and concerns of ASSIST regarding the durability of state and local tobacco control

The Tobacco Master Settlement Agreement and the Minnesota Lawsuit

In April 1997, the tobacco industry began negotiations with the state attorneys general. The global tobacco settlement was proposed June 20, 1997, but was only finalized after months of debate and negotiation. The negotiations generated considerable media attention: Nationwide, nearly 1,000 articles ran in newspapers around the country during June 1997, following the announcement of the global settlement agreement.

The plaintiffs had sued the tobacco industry to recoup Medicaid costs for the care of persons injured by tobacco use. The suit alleged that the companies had violated antitrust and consumer protection laws, had conspired to withhold information about adverse health effects of tobacco, had manipulated nicotine levels to maintain smoking addiction, and had conspired to withhold lower-risk products from the market.

During settlement negotiations, there were divisions among the ranks of public health advocates. Some in the public health community were skeptical of any federal initiative, and others argued that compromise was unnecessary. Critical issues surfaced during these negotiations, but the participants ultimately failed to reach agreement.

The cohesiveness of the tobacco control movement was seriously at risk over the issue of either halting the settlement or incorporating provisions that would give the tobacco industry immunity from future lawsuits and other advantages. Tobacco control advocates were bitterly divided. Although advocates agreed that the millions of dollars to be given to states annually should be spent on health causes, specifically tobacco use prevention and control, ASSIST was strongly opposed to providing immunity to the tobacco industry under any foreseeable circumstances, and the ASSIST Coordinating Committee passed a resolution to express its objections to the concept of immunity.

On November 23, 1998, 46 attorneys general signed the Tobacco Master Settlement Agreement (MSA) with four tobacco companies to settle state suits to recover costs associated with treating smoking-related illnesses. Tobacco companies were projected to pay in excess of $206 billion over the next 25 years. In addition, the settlement agreement contained a number of important public health provisions. Similar to the experience with the global settlement agreement, settlement of the state lawsuits generated intense media attention, with numerous articles running in newspapers around the country.

Meanwhile, individual states were pursuing separate negotiations. Minnesota was conducting a trial of its state lawsuit against the tobacco industry, which was eventually settled on May 8, 1998, for $6.1 billion. The disclosure of numerous industry documents that resulted from the Minnesota case exposed the tobacco industry's deceptive behavior and formed the basis for future lawsuits. The case generated front-page coverage in the *Minneapolis Star Tribune* and frequent television coverage in the state. The media attention to tobacco issues made public, on a wide scale, the industry's deception about tobacco use and health. The discovery process in the Minnesota trial generated millions of industry documents, which became accessible to the media, tobacco control advocates, and the public.

Sources: Akhter, M. N., M. L. Myers, and J. Seffrin. 1998. Comment: The past and future national comprehensive tobacco control legislation. *American Journal of Public Health* 88 (11): 1606–7; Bloch, M., R. Daynard, and R. Roemer. 1998. A year of living dangerously: The tobacco control community meets the global settlement. *Public Health Reports* 113:488–97; National Association of Attorneys General. NAAG projects: Tobacco page. www.naag.org/issues/issue-tobacco.php; U.S. Department of Health and Human Services. 2000. *Reducing tobacco use: A report of the surgeon general.* Atlanta: National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. www.cdc.gov/tobacco/sgr/sgr_2000/chapter5.pdf; ASSIST Coordinating Committee. 1997. ASSIST Coordinating Committee meeting summary, April 17, 1997, meeting, Rockville, MD: ASSIST Coordinating Center; Pertschuk, M. 2001. *Smoke in their eyes: Lessons in movement leadership from the tobacco wars.* Nashville, TN: Vanderbilt Univ. Press.

2. A resolution of the ASSIST Coordinating Committee, which is discussed below
3. The creation of the advance groups—composed of representatives from ASSIST and IMPACT states and NCI, CDC, and ACS—to formulate recommendations about funding of programs, research and development, technical assistance and training, and other issues
4. The interest of all concerned to work with and support DHHS in advancing a multilevel strategy of tobacco control based on the experience of the state and local movement

The ASSIST Coordinating Committee resolution included the following requests:

1. Federal funding for tobacco control should be reflected in the President's FY99 Budget through multiple funding streams, with *no reductions or gaps* in the funding for state and community-based tobacco control; and, request that the Department's commitment to continuous and expanded program funding be communicated to state and territorial tobacco control programs by January 1998.
2. Federal funding for comprehensive, culturally diverse, policy-oriented tobacco control should be provided to all 50 states, the District of Columbia, and the territories regardless of state levels of funding, at a level consistent with the activity levels in California and Massachusetts as soon as possible.
3. Additional federal funding should be available for applied research on statewide tobacco control strategies.
4. Federal support should include more than provision of funds and should include an organized system of consultation, technical assistance, and training available to state and territorial tobacco programs.[19(p3)]

At the meeting, the deputy assistant secretary for health of DHHS reaffirmed the administration's commitment to programs like ASSIST and communicated President William J. Clinton's intention to continue state and local programs. He recognized the legitimate concern about the uncertainty of funding for tobacco prevention and said that the budget for fiscal year 1999 would likely not be finalized until January 1998. In closing, he commented that the advance groups signify the advance of the ASSIST program to all 50 states. He expressed interest in actively communicating with the advance teams and invited their recommendations about the future of state and local tobacco control, including the role of the federal government in supporting initiatives such as ASSIST.[19]

Report from the Advance Groups: Realizing America's Vision for Healthy People: Advancing a Federal Commitment to Effective Tobacco Control

The advance groups prepared their report, titled *Realizing America's Vision for Healthy People: Advancing a Federal Commitment to Effective Tobacco Control*, in two parts. (See appendix 9.D.) Part 1 was prepared by the Advance Group on Funding and was sent to the deputy assistant secretary of DHHS on December 12, 1997. Part 2 was prepared by the other three groups and was made available in February 1998.[20,21]

In the advance groups' report, the ASSIST Coordinating Committee rec-

ommended that DHHS commit to fund the following:

- A $2.5 billion per year program capable of reducing the tobacco epidemic, with the following components:
  - Public health programs at the national, state, and local levels to build community support for policies and programs that prevent tobacco use
  - Tobacco-free schools or interventions by youth service organizations and programs
  - Mass media-based public health education campaigns
  - National program of technical assistance, training, and communication throughout the tobacco control network
  - Surveillance, evaluation, and applications research conducted through the NCI and the CDC and national and state partners
- A minimum program of state and local tobacco control at a rate of $70 million per year
- A $50 million per year program of research, development, and dissemination of effective tobacco control innovations[19(pp1–2)]

Affirming the Commitment

In a January 1998 letter to state tobacco control leaders, Secretary Shalala affirmed an intensified commitment to state-based programs. She stated that, in the president's fiscal year 1999 budget, DHHS had proposed to expand support for state and community programs from $34 million in fiscal year 1998 to $51 million in fiscal year 1999. This 50% increase would enable CDC to fund all states and the District of Columbia to implement innovative tobacco prevention programs as a core component of public health practice. Federal support for state tobacco prevention programs will be maintained or expanded in all 50 states. This is a model of government working at its best: We are moving the proven research findings generated from the National Cancer Institute's (NCI) successful ASSIST program into widespread public health practice.

State-based programs are a critical part of the Administration's overall national effort to prevent tobacco use among our youth. Local input allows programs to be tailored to local needs and benefit from local innovation. Multiple agencies at HHS have a part to play in this effort. CDC, the Food and Drug Administration, the Substance Abuse and Mental Health Services Administration and several of the Institutes at the National Institutes of Health, will continue to work together to ensure that our strategies remain state-of-the-art and responsive to changes in our dynamic environment. The NCI, in particular, will continue to support a broad range of research that will help support these community and state tobacco control programs.[22(p1)]

Secretary Shalala's statements that the future program would be state based and would include local input embraced the essential ASSIST element of community involvement and provided the opportunity to incorporate media interventions and policy development into the nationwide program that would be planned and administered by CDC. Under CDC's leadership, the capacity built

by the ASSIST states during 8 years would benefit the future program. With funding of $51 million, which was made available for fiscal year 1999 in the federal budget, the planning process would begin to move toward a funding level equivalent to that of ASSIST.

Turning to Transition

Public health practitioners across the nation applauded Secretary Shalala's announcement. Many had worked for nearly a decade toward such an outcome. The national commitment was the outcome of two forces. First, the leaders of the ASSIST project and of numerous organizations had formulated the concept and funding requisites of an enduring state-based national tobacco prevention and control program. Through discussions and negotiations that over time involved more and more stakeholders, they anticipated the fundamental needs of and potential barriers to a national program. In working sessions, they focused their thoughts on strategies designed to articulate a credible proposal and build support for the concept. They produced documents to use in reaching out to other entities and in refining the concept. Consequently, they were able to approach the leaders of the funding agencies with a unified voice.

Second, all the planning and strategies would have been fruitless had there not been the success story of the in-the-trenches work of the state health department staff, of ACS volunteers, and of coalitions composed of other organizations and individuals committed to public health through tobacco control. The work of the communities made it clear that the preferred social norm is to be tobacco-free and that a tobacco-free norm can be achieved through persistent efforts to adopt and enforce appropriate policies. The ASSIST demonstration study successfully involved communities in media interventions and policy advocacy to enact measures to protect the public's health. ASSIST's achievements were evidence of the need for a long-term commitment from DHHS and Congress to support a national program that would help states build their permanent tobacco control infrastructures.

The leaders of ASSIST, the staffs of the state departments of health, and the coalitions underwent a remarkable process of professional and organizational development in learning how to implement a community-based program of policy interventions achieved through advocacy. For them, Secretary Shalala's announcement represented the highest form of congratulations for a job well done.

It also represented a turning point for them. The transition from a demonstration study to a national public health program administered by CDC would require a transition not merely of contractual locus, but also of operational adjustments and conceptual broadening. As the ASSIST staff participated in planning the transition, they encountered new developmental challenges, professionally and institutionally. Chapter 10 recounts the transitional activities in the context of what it means to implement a public health program for the long term.

Appendices 9.A through 9.D are reproduced faithful to the originals, including minor errors.

Appendix 9.A. Executive Summary from "Planning for a Durable Tobacco Prevention Movement: Sustaining Tobacco Prevention beyond the American Stop Smoking Intervention Study"

Executive Summary

Purpose:

The Strategic Planning Subcommittee was requested by the ASSIST Coordinating Committee to consider the issue of the institutionalization of tobacco prevention. The Strategic Planning Committee created a Working Group to explore this issue, to prepare a brief discussion paper, and present this to the June 1995 meeting of the Coordinating Committee.

This paper is intended to contribute to planning for tobacco prevention within and beyond the ASSIST project by identifying relevant issues and possible methods to resolve these. It is intended to stimulate discussion and offer proposals for next steps to be undertaken by state projects, NCI, ACS, and the Coordinating Center.

Institutionalization and the durability of tobacco prevention is seen as a priority for the ASSIST project.

Terms:

The term *institutionalize* is used to refer to the process of integration and maintenance of programmatic activities within organizations. The term *durability of tobacco prevention* is used to refer to the maintenance and growth of the overall, broadly based tobacco prevention movement at the local and state level, with federal/national support.

Factors affecting durability of tobacco prevention:

Several interdependent factors that affect the durability of tobacco prevention are identified and discussed. These are:

- contextual factors (including the degree of public support and willingness to pay for prevention activities),
- policy commitments (including non-partisan commitments to public health),
- funding commitments (including special tobacco taxation revenues earmarked for tobacco prevention),
- organizational capacity and infrastructure (including change agents/champions, and staffing),
- support (enabling) systems (technical assistance, training, funding, etc.),
- diffusion of innovation factors (complexity, etc.),

- engagement of multiple channels, settings, systems, and organizations, and,
- system of monitoring and feedback on progress (e.g. tracking progress toward state defined strategic goals, objectives and implementation of interventions).

The critical role for state health agencies as linkage agents in the national, state, and community-based tobacco prevention movement is highlighted; as is the essential role of voluntary networks to mobilize citizen action for policy advocacy.

Support (enabling) systems—that deliver training, technical assistance, resource materials, funding, and facilitate networking—are seen as important to the continued growth of the tobacco prevention movement. Change agents (champions) to affect policy and funding commitments may prove to be the most critical of all.

The factors identified in this paper should be explored and a plan developed to support institutionalization in each state. Support should be provided by the National Cancer Institute and the ASSIST Coordinating Center.

Major developments affecting durability:

Major developments affecting the durability of tobacco prevention are identified and discussed briefly, including:

- progress within the ASSIST states;
- Robert Wood Johnson Foundation funding of the SmokeLess States initiative;
- Centers for Disease Prevention and Control IMPACT program;
- Institute of Medicine Reports;
- Association of State and Territorial Health Officials' policy developments;
- initiatives of the Center for Substance Abuse Prevention;
- National Cancer Institute's model for and stated interests in cancer control research; and,
- American Cancer Society commitments to tobacco prevention.

Recommendations:

Recommendations are made for consideration by State ASSIST and the Coordinating Committee as follows:

Recommendations for State ASSIST Coalitions

1. Make institutionalization of tobacco prevention within state health departments, American Cancer Society, and other tobacco prevention organizations a priority for ASSIST. Pursue institutionalization by: (a) continuing to position tobacco prevention as a priority in the media and through policy advocacy initiatives, (b) working with key organizations within the state tobacco movement to seek reaffirmation of commitments to tobacco prevention and exploring specific strategies to ensure institutionalization of tobacco prevention within these organiza-

tions, (c) integrating tobacco prevention into chronic disease prevention, health promotion and alcohol, tobacco and other drug initiatives, (d) ensuring a prominent and unique role for tobacco prevention in each state and local health agency, and (e) further developing the voluntary networks to mobilize citizen action for policy advocacy at local, state, and national levels.

2. Starting with the factors and questions identified in this discussion paper, (a) explore the constraints and supports that will contribute to the durability of tobacco prevention in the state and (b) develop a plan for the institutionalization and durability of tobacco prevention. (Note: This recommendation is linked to recommendation number 4 below.)

3. In ASSIST states with SmokeLess State initiatives, further develop working relationships with SmokeLess State initiatives in order to explore issues related to long term funding of and fund raising for tobacco prevention, including raising taxes on tobacco products.

Recommendations for the Coordinating Committee

1. Develop a strategy to support CDC initiatives to establish performance partnerships between CDC and state health departments for tobacco prevention. Watch for language in federal legislative proposals that would support mandatory, comprehensive, policy based tobacco prevention via federal grants. Refer this item to the Strategic Planning Subcommittee.

2. Develop a concept paper on the vision, general strategy and roles and responsibilities of major players in a national strategy to prevent tobacco use in America. Consideration should be given to how to further extend partnerships with CDC, RWJ, ASTHO, the Coalition on Smoking OR Health and other agencies to build a national strategy that supports state strategies. Refer this item to the Strategic Planning Subcommittee and request them to report on their work to the fall 1995 meeting of the Coordinating Committee.

3. Work with NCI on future tobacco prevention research projects giving consideration to durability issues; and, ask NCI to consider extending ASSIST to at least the year 2000 in order to further contribute to the attainment of the Healthy People 2000 objectives. Refer action on this item to the Strategic Planning Subcommittee and Chair of the Coordinating Committee.

4. Advise NCI about technical assistance and training needs with respect to the exploration of constraints/opportunities for and the development of state plans to ensure the durability of tobacco prevention in the states beyond the year 2000. Refer these issues to the Project Managers' and Training Subcommittees.

5. Encourage ACS to continue its support of NCI and state and local health agencies to advance tobacco prevention efforts and advocate for policy and funding commitments for tobacco prevention.

Appendix 9.B. Executive Summary from "Turning Point for Tobacco Control: Toward a National Strategy to Prevent and Control Tobacco Use"

Executive Summary

1. Introduction (pp. 3-5)

Despite 30 years of progress, today:

- Tobacco remains the leading cause of preventable death;
- About one-quarter of adults still use tobacco products;
- Tobacco use continues to rise among adolescents;
- Tobacco is responsible for more preventable deaths than are alcohol, car crashes, AIDS, murder, suicide, fires, and illegal drugs combined.

The tobacco control movement is at a turning point. A renewed effort by public, private, and voluntary sectors is needed to move the country toward the goal of a smokefree society. This paper is written for the ASSIST (American Stop Smoking Intervention Study) project and suggests that participants in ASSIST now work to communicate a vision of a smokefree society, to reaffirm commitments and reunite efforts that are ongoing, and to seek greater coordination and planning within a comprehensive, policy-oriented approach to preventing and controlling tobacco use. This paper makes the case for continued widespread application of the ASSIST model of tobacco control.

2. Public Health Burden (pp. 5-7)

The toll of tobacco-related morbidity and mortality remains high. Tobacco:

- Causes more than 400,000 premature deaths annually;
- Causes 87% of lung cancer deaths;
- Causes 30% of all cancer deaths;
- Is responsible for $68 billion per year in health care expenditures and lost productivity due to premature death and disability.

Environmental tobacco smoke:

- Causes about 3,000 lung cancer deaths in non-smokers annually;
- Increases risk of respiratory tract infections such as bronchitis and pneumonia, including 150,000 to 300,000 cases in infants and children under 18 months;
- Causes additional episodes and increased severity of symptoms of asthma in children.

3. Making The Case for Comprehensive Tobacco Control (pp. 7-15)

Nicotine Addiction in Children Is a Pediatric Disease Requiring a Comprehensive Approach.

Federal institutes and leaders have acknowledged that nicotine is addictive and that mass addiction to tobacco products is a public health problem resulting from child and adolescent use.

- More than 3 million adolescents smoke cigarettes;
- 3,000 children and adolescents become smokers each day;
- If a person smokes, the younger the person begins, the more likely that he or she will become a heavy smoker;
- Tobacco products are heavily advertised; the ads are pervasive and reach children; children buy the most heavily advertised tobacco products.

Why a Multigoal Orientation to Tobacco Control Is Needed

Tobacco control efforts must seek to prevent mass addiction in children, to reduce environmental tobacco smoke, and motivate and support tobacco users to stop. This multigoal approach has been attempted and supported by the ASSIST program and others. Multiple public health goals are accomplished by policy interventions.

Why a Comprehensive, Integrated, Policy-Focused Tobacco Control Strategy Is Needed

A multilevel approach to community health promotion views health behavior as a social behavior developed and shaped in part by social context. A combination of policy and programmatic interventions can work together to promote health through synergistic interaction. The ASSIST program emphasizes policy-based interventions—in particular, policies in these areas: reducing youth access, increasing clean indoor air, restricting tobacco advertising and promotion, and increasing the price of tobacco products. The rationale for the ASSIST strategy is as follows:

- Smoking is a public health problem and a social epidemic. It affects everyone in a community, not only smokers. Community empowerment is required to address this issue.
- Significant and enduring changes in smoking behavior require a change in social norms. Broad participation is required to effect environmental changes supportive of non-smoking.
- Each minute of every day the tobacco industry invests tremendous resources to encourage young people to begin smoking and to portray smoking as normal acceptable behavior. Resources for tobacco control need to be mobilized from private, public, and voluntary organizations.

The Need to Further Develop Multicultural Competence

As a comprehensive and inclusive approach to tobacco control, ASSIST embraces and values cultural differences and is able to draw strength from the diversity and breadth of communities concerned about tobacco use. Further efforts are necessary to gain cultural proficiency within the tobacco control movement.

Why a Coordinated National/State/Community Tobacco Control Strategy Is Needed

The tobacco industry has developed a coordinated, comprehensive, and multilevel approach to countering the tobacco control movement. For example, the industry:

- Frames tobacco as a non-health issue in the media and other communications;
- Organizes national campaigns to convince state and local legislators that legislative interventions are unneccessary because the industry is addressing the problem;
- Harasses state governments with freedom-of-information requests;
- Has developed a broad base of support from constituencies with a financial dependence on tobacco.

The national, state, and local strategy needs to consider and address these and many other industry tactics. Also, state health agencies and other public and private sector agencies can play a pivotal role in the process of research translation and application in communities.

4. Overview of Tobacco Control Efforts in ASSIST States (pp. 15-20)

Coalitions. The ASSIST experience has shown that leadership is essential; that focusing on policy reforms can mobilize broad support; that coalitions can be of strategic value in facilitating access to and making changes in communities, and can be organized effectively in many different ways.

Planning. Site analyses can be valuable for planning interventions. Long-range planning helps to develop and communicate a vision for tobacco control. A heavy focus on planning to the exclusion of action early in a project can result in attrition of participants.

Capacity Building. The ASSIST model has led successfully to capacity building. The role of the national partners has changed from “top down” to “interactive.” Planning and support for training and technical assistance have become based on interests, needs, and capacities at state and local levels.

The Intervention. It has been found that public education and tobacco control policy interventions are complementary; that persistence is essential; that providing small resources to local community groups can stimulate substantial efforts.

5. The Future for Comprehensive Tobacco Control: A Framework (pp. 20-28)

Following from lessons gained from the ASSIST project, we propose that it will be productive to articulate a vision and set guidelines for comprehensive tobacco control. These can be used as points of reference for planning implementations.

A vision for a comprehensive strategy should be drawn from a variety of policy studies, reports from consensus conferences, and descriptions of interventions (Appendix 1).

Elements of a national strategy should include the following:

- Public health objectives
- Health-promoting tobacco-control policies
- Movement infrastructure and programmatic interventions
- Social marketing and mass media interventions
- Intervention research, development, and dissemination
- Monitoring and evaluation
- Management and coordination mechanisms.

Finally, the Institute of Medicine has described possible roles and responsibilities of partners in a national tobacco prevention and control strategy (Table 6).

It is suggested that the vision articulated in various reports, elements of a national strategy, and the IOM report's analysis of roles and responsibilities could be used as a starting point for the further development of a national strategy to prevent and control tobacco use.

Appendix 9.C. Helene Brown Testimony

TESTIMONY FOR NATIONAL CANCER POLICY BOARD
RE: ASSIST, March 31, 1997
By Helene Brown
Senior Advisor
Director, Community Applications of Research
UCLA Jonsson Comprehensive Cancer Center
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310-794-8583

Please allow me to express my views about your service as a National Cancer Policy Board. All of us hunger for the day when cancer will no longer be a threat to our lives. There are those of us who believe that Dr. Klausner, in bringing a torrent of change to the National Cancer Institute, has shown that he is clearly willing to take some risks to ease that hunger. Establishing this policy board is a neat idea, and one that deserves applause. The objective manner in which you will seek to establish policy related to cancer issues is an absolute necessity. We are not engaged in idle conversation today. This is truly a matter of life and death. I cannot possibly tell you what a pleasurable experience this is for us. We have a critical issue to put before you. I hope you are as pleased to see and to hear what we have to offer as we are to be here.

The American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) is only midway through its intervention phase. ASSIST is implemented in 17 states (Slide 1) with a control group of the rest of the United States. These states do not exist in a vacuum. There are other forces both for and against the use of tobacco active in both sets of states for the playing field is level. Excellent cigarette consumption information is derived from tax data. The ASSIST states are now consuming 10 percent fewer cigarettes than the non-ASSIST states (Slide 2). We are just half-way through the clinical trial. This is an astounding trend. This difference in consumption equals 70 MILLION packs of cigarettes not smoked each month (Slide 3). ASSIST has actually managed to suppress the market for the tobacco companies by 10 percent . . . In anyone's language, that is a "market share" of enormous proportions.

ASSIST is a clinical trial of a protocol developed by the National Cancer Institute (NCI) to reduce mortality from cancer caused by the use of tobacco. It is a dynamic human laboratory of phenomenal proportions. There are over 200 coalitions with more than 6,200 organizations and individuals offering the intervention protocol. Please think of this in the same manner that you would any other clinical trial. If this were a drug or a vaccine and had this level of success in a clinical trial, the pharmaceutical manufacturers in the private sector would be vying with each other to further develop the "drug" or "vaccine," and then to profitably market the product. This is the wonder

of our public/private partnership that uses the NCI well to develop the knowledge that makes possible the private sector development of products.

However, the ASSIST clinical trial is different. There is no profit to be made in the market place by selling "do not smoke or chew." Thus, it clearly becomes the responsibility of government (that's us . . . of the people, by the people, for the people) to see that the 400,000 premature deaths (slide 4) due to the use of tobacco continue to be reduced. Please take a good look at this slide. Alcohol, motor vehicle accidents, suicides, AIDS, homicides, illegal drug use and fires taken all together do not offer the reduction in mortality that is possible by ridding ourselves of the use of tobacco. Looking at it in another sense, it is the underlying cause of death (Slide 5) in heart disease, cancer, stroke and chronic obstructive lung disease . . . the top four killing agents in our society.

The ASSIST model has established the proper minimum dose. Like a drug or vaccine the ASSIST model is dose-related. In California and Massachusetts, consumption is further reduced simply because they have tobacco tax revenues that offer the ASSIST protocol in larger doses.

The rates of cancer mortality in the USA have begun to decline. The turn-around started in 1990, and the trend is continuing (Slide 6). It is equally clear that the cancers caused by the use of tobacco are responsible for a goodly portion of this decline (Slide 7). Lung cancer is down 5.6 percent in the under-65 group, bladder cancer down 9.3 percent and oral cancer down 14.1 percent. We are on a roll, and we dare not lose the advantage.

The problem that must become the policy interest of this Board is this. Government has the true responsibility to continue using the ASSIST model for all the 400,000+ of its citizens who are in need. Government is meant to offer to the people that which the private sector cannot offer – highways, public parklands, defense, flood control, etc. The list is long and delivery of the ASSIST model for the reduction of mortality is top priority on this list. To date, the federal expenditures in this arena are pitifully minuscule (Slide 8).

With all of this in mind, we respectfully make these suggestions.

A) That this Board does what it must do to assure that the policy of this Administration is one that delivers the ASSIST model to all 50 states.

B) That ASSIST I (17 model states and the coordinating center) remain fully funded at this point in time. That it also be the vanguard group and serve as the research arm of the NCI in tobacco control. There are still new research questions to be asked. Retaining such a human laboratory with the experience and record of accomplishment of ASSIST I makes good sense.

C) That the NCI be designated the lead agency in establishing ASSIST II with the monetary cooperation of the various public agencies and members of the NIH that

have a stake in this problem such as CDC, HCFA, Medicare, Medicaid, NHLBI, NIAID, NIDA, the VA and others, including the private sector agencies like the ACS, AHA, and ALA. This plan would emulate the successful funding of the AIDS research program where one agency was the "lead" agency and was funded for the work in a great part with contributions from the other Institutes.

D) That the staff, budget, training, reporting and evaluation mechanisms needed to support this complex initiative be established and put into place for the other 31 states (Massachusetts and California excepted) under the ASSIST I model by the NCI, thus becoming ASSIST II.

E) That after the ASSIST II model is experienced, up and running well, the lead agency responsibility could be transferred to the CDC for continued implementation and evaluation.

It is imperative that this nation not have such remarkable returns as reduced mortality interrupted or delayed. If the reduction of mortality from cancer is truly the mission of the NCI, then it must truly be the mission of this Policy Board to carefully consider the consequences if the NCI declares that further implementation and delivery of this life-saving methodology is "not my job," and walks away from the task without setting in place that which will ultimately preserve 400,000 premature deaths.

I don't know many things for sure, but I do know this. If we do not shoulder this responsibility and make it happen, no one else will. If we do not shoulder this responsibility, it will likely become one more of America's dirty little secrets.

I pledge to you my full concern and effort to help and guide this project until the day that I can no longer do it. I hope we – all those involved in ASSIST – can join with you to forward these plans and to see that this becomes the tobacco policy of the Administration.

Thank you and may I now introduce Sally Malek, who is the Manager of the ASSIST Project in North Carolina, and is the Chair of the Association of State and Territorial Health Officers Tobacco Prevention Network. Sally, please make whatever remarks you wish to make and then we can try to reply to your questions.

Appendix 9.D. Realizing America's Vision for Healthy People: Advancing a Federal Commitment to Fund Effective Tobacco Control

Report of the Advance Group on Funding With Membership from State Health Agencies and American Cancer Society

December 31, 1997

Executive Summary

The Funding Advance Group prepared this report in response to the Department of Health and Human Services (DHHS) request for advice about how the Federal Government should support tobacco control. The Funding Advance Group is a group of tobacco control leaders and experts from many states, including public health professionals from states engaged in the American Stop Smoking Intervention Study (ASSIST) and Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT), American Cancer Society (ACS), and the ASSIST Multicultural Subcommittee.

It is time for Federal Government leadership in funding an effective nationwide state- and community-based program to control the epidemic of tobacco-caused disease.

Our vision for the nationwide federal program is one that is based on the great American traditions of participatory democracy and free speech, in which diverse communities are empowered to oppose the tobacco industry and create their own futures free from tobacco addiction and disease, and public health professionals are free to play their important role of informing the public and policymakers about the implications of tobacco control policies.

Recommendations

After giving careful consideration to the massive public health concern presented by tobacco use and the requirements to reduce the epidemic, the Advance Group makes the following three recommendations. It is recommended that:

1. DHHS fund a program capable of reducing the epidemic that includes:
   - Public health programs at the national, state, and local levels to build community support for policies and programs that prevent tobacco use, motivate and support efforts to stop tobacco use, and control secondhand smoke
   - Tobacco-free schools or interventions by youth service organizations and programs, including tobacco prevention education curriculum, tobacco-free policy implementation, and school and community collaborative activities with an emphasis on policy reforms that promote the nonuse of tobacco (limited but important role)

- Mass media-based public health education campaigns, including a focus on tobacco industry practices, information about tobacco products, the public health benefits of tobacco control policies, in addition to some programming aimed to prevent tobacco use and motivate and support attempts to quit tobacco use
- National program of technical assistance, training, and communication throughout the tobacco control network
- Surveillance, evaluation, and applications research conducted through the National Cancer Institute (NCI) and Centers for Disease Control and Prevention (CDC) and national and state partners.

Such a program would cost at least $2.5 billion per year, which is substantially less than current federal spending on other important public health problems of lesser magnitude. Funding for such a program should be in place by the year 2000.

2. DHHS fund, in Fiscal Year 1999, a minimum program of state and local tobacco control at a rate of $70 million per year.
3. This program would be commensurate with current ASSIST funding levels and would immediately support a base level of state and local tobacco control in all states, territories, and the District of Columbia. Such a program would ensure cultural inclusiveness and sensitivity, an emphasis on policy development that supports the nonuse of tobacco and minimizes protobacco messages, and be comprehensive in terms of interventions, settings and locations, and priority populations engaged.
4. DHHS fund, in Fiscal Year 1999, a $50 million per year program of research, development, and dissemination of effective tobacco control innovations.

   This research program would include funding for innovation by national, state and community tobacco control organizations and research institutions in several states. Knowledge gained from this program would be used to guide the implementation of future programs. This immediate funding should be augmented annually to reach approximately $100 million annually.

Rationale

The rationale for this request is as follows.

Tobacco-related addiction, disease, disability, and death make up the nation's largest public health epidemic.

The Administration has publicly committed to address the problem. However, lack of a strong federal commitment to funding perpetuates the epidemic.

The Administration spends more money on other public health problems of lesser magnitude.

Evidence from the evaluations of the Massachusetts, California, IMPACT, and ASSIST programs demonstrates that state and local tobacco control can be effective. Larger investments yield greater success. This knowledge should be used to guide the next generation of tobacco control.

Research investments by the NCI and CDC have made a substantial contribution to the field of tobacco control. These investments must continue in order to ensure the continuing development of tobacco control innovations and the translation of scientific knowledge into effective public health practices.

Background

A. Introduction

In this paper, the Advance Group on Funding[1] [2] identifies the funding requirements for federal support of a national tobacco control program that works. We discuss the rationale and assumptions that were used in preparing recommendations for consideration by the DHHS. First, we provide a brief summary of the context and general values that have guided the development of this paper. Then, we estimate the requirements for a federally funded nationwide tobacco control intervention capable of reducing the epidemic of avoidable tobacco-caused disease, disability, and death. Finally, we identify the immediate minimum funding requirements that are required to protect recent initial accomplishments, and provide a platform from which to launch an effective national effort.

B. Context

Planning for the long-term continuation of tobacco control efforts has proceeded within the ASSIST project since the first year of the intervention (cf. Planning for a Durable Tobacco Prevention Movement–Sustaining Tobacco Prevention Beyond the American Stop Smoking Intervention Study, May 1995; Turning Point for Tobacco Control: Toward a National Strategy to Prevent and Control Tobacco Use, December 1996). Since the ASSIST Coordinating Committee initiated this planning, much dialogue has occurred within the tobacco control movement about the need for an en-

[1] Advance Groups were created to plan for the future of tobacco control. There are five funding groups addressing funding requirements; technical assistance and training; surveillance, evaluation, and applications research; advocacy opportunities; and liaison/communication issues. These groups are comprised of representatives from state health departments (IMPACT and ASSIST states) and the American Cancer Society. In convening these groups, care was given to ensure cultural sensitivity through inclusion of members of the ASSIST Multicultural Subcommittee. CDC and NCI staff were consulted on matters of fact.

[2] Members of the Advance Group on Funding are as follows: John Beasley – MI (Cochair), David Bourne – AR, Pam Eidson – GA, Julie Harvill – IL, Jennie Hefelfinger – FL, Jerie Jordan – ACS/National, Sally Herndon Malek – NC, Bob Moon – MT (Cochair), William S. Robinson – SC, Nancy Salas – CO, Carter Steger – VA, Joan Stine – MD, and Ron Todd – ACS/National.

hanced federal role in supporting tobacco control interventions and research. CDC has made a long-term commitment to fund states not receiving funding from NCI.

A broad consensus now exists within the tobacco control community (e.g., ASSIST, ACS, ASTHO, AMA, NCTFK, ANR, CDC, NCI, and others) that DHHS should fund comprehensive, culturally inclusive, policy-focused, state and local tobacco control initiatives in all states (cf. ASSIST Coordinating Committee resolutions, AMA resolution, ASTHO decisions, joint statement by ASTHO and ACS, CDC's IMPACT Program, etc.). It is also widely acknowledged that technical assistance, training, and network support should be provided to all states. Furthermore, the tobacco control community has reached a broad consensus that an effective tobacco control effort must continue to include public health applications research on tobacco control within NCI, as well as surveillance and evaluation efforts within CDC and other federal agencies.

At the October 1996 ASSIST Information Exchange Meeting, Mr. Kevin Thurm, Deputy Secretary for DHHS, indicated that the Department and the Administration are "100 percent committed to continuing" the work of tobacco control. Mr. Thurm also acknowledged that an overall coordinated strategy—built on state and community efforts—is necessary to achieve the Administration's policy objectives. However, no decision had been made at that time about which agency within DHHS would take responsibility for the continuation of Project ASSIST. The National Cancer Institute has agreed to extend ASSIST state contracts for an additional year until September 1999.

Secretary Shalala met on at least two occasions with leaders in state and local tobacco control during the summer of 1997. During these meetings, the Secretary reiterated the Administration's commitment to continuing support for state and local tobacco control.

The President's 1998 budget proposed funds for tobacco control programs and research to be implemented by the CDC, FDA, SAMHSA, and the NCI. The Administration is committed to reducing tobacco use by 50 percent within the next 5 years (FDA objective). CDC is committed to implementing tobacco control in all 50 states, funded at levels commensurate with the problem. CDC also wishes to work with the NCI to ensure the integration of public health research and practice. The President's 1998 budget proposal included a $15 million increase for the CDC to support tobacco control initiatives. Congress appropriated $7 million.

Mr. Jim O'Hara, Assistant Deputy Secretary of Health and Human Services, has been designated by the Secretary as the departmental coordinator of tobacco control interventions. At its recent meeting in Houston, the ASSIST Coordinating Committee met with Mr. O'Hara and gave him a thorough briefing about (a) the issues and concerns of the ASSIST project about the durability of state and local tobacco control; (b) a resolution of the ASSIST Coordinating Committee (see attached); (c) the creation of "transition task forces"–composed of representatives from ASSIST and IMPACT states–to formulate recommendations about funding of programs, research and development, technical assistance and training, and other issues; and, (d) the interest of all concerned

to work with and support the Department in advancing a multilevel strategy of tobacco control based on the experience of the state and local movement.

Mr. O'Hara communicated his clear understanding of the issues, as well as his personal commitment and the department's commitment to advance tobacco control at the state and local level. He demonstrated his understanding of the need for an urgent resolution of the issues presented. He also expressed an interest in the "transition task forces" and suggested the use of a more positive term such as "advance groups," that is, planning to advance tobacco control, not just transition it. At the meeting, Mr. O'Hara indicated that he would follow-up within two weeks with the chairpersons of the Coordinating Committee about receiving input from the Advance Groups. He followed through on this commitment by further communication with Mr. Randy Schwartz, cochair of the ASSIST Coordinating Committee, expressing interest in input as soon as possible. This report is prepared in response to Mr. O'Hara's request for advice.

C. Values Guiding This Exercise

The Advance Group discussed several values that served to guide this exercise. These considerations are as follows:

1. Resolve to address the epidemic. Tobacco-caused disease, disability, and death are of enormous proportions that demand resolute government intervention to address the public health crisis caused by the tobacco industry. In fiscal year 1997, the Federal Government allocated about $15 billion for substance abuse control, $8 billion for HIV/AIDS, and about $0.046 billion for tobacco control. The leading cause of preventable death is currently at the bottom of the funding pyramid of major public health problems.

The failure to meet the Healthy People 2000 Goals for tobacco use is directly attributable to lack of resources applied to the problem. The goal of 15 percent smoking prevalence may be realized in only one state. The states that had the most success in reducing tobacco use have applied resources commensurate with the problem. The FDA objective to reduce tobacco use by 50 percent will meet a similarly disappointing fate unless a commitment is made to fund programs at a level that works.

2. Cultural diversity and inclusive participation. The tobacco control movement is defined by and draws its strength from its breadth of participation. We believe that our current and future strength emanates from our cultural diversity and our commitment to the inclusion and active participation of individuals and organizations of many cultures, including, but not limited to, those defined by ethnicity, race, language, geographic, sexual preference, and age.

Tobacco use has caused unnecessary and avoidable morbidity and mortality among African Americans, Native Americans, Asian Americans, and Hispanic-Latinos. Furthermore, high tobacco use continues in other cultures such as the physically disabled, the gay and lesbian community, and illegal drug users. The tobacco industry has spent disproportionate dollars targeting many of those communities in promoting tobacco prod-

ucts. We believe that a share of any funds available should be allocated for programs, research, advocacy, training, media and all other elements of the national tobacco control program, commensurate with the impact of tobacco use in those communities. We believe that only through a sustained commitment to cultural inclusiveness will we begin to reduce tobacco use and its impact on all the cultures cited above.

3. Building on experience. During the 1990's tobacco control has gained momentum through programs and actions of the federal and state governments, voluntary and philanthropic agencies, and activists. We believe that the national commitment should build on and extend this experience by increasing the capacity of organizations and programs already active. Through this mechanism we can reach and enable action through a growing tobacco control network.

4. Implementing what works. Evidence is available from the evaluations of the California, Massachusetts, IMPACT, and ASSIST interventions. Comprehensive, policy-oriented, culturally inclusive state and local tobacco control is effective, and effectiveness is dose related. Greater investments in tobacco control are associated with larger impacts on tobacco use at the population level. Puny investments by the Federal Government will only serve to perpetuate the epidemic and ensure that generations will continue to suffer more unnecessary, avoidable deaths.

5. Comprehensiveness and integration, with a focus on policy. A key defining characteristic of effective tobacco control is comprehensiveness with a focus on policy. Policy reform is the first priority for tobacco control at all levels. Creating environments that denormalize tobacco use and establish nonuse as the norm represents the best method to influence tobacco use. Such interventions should be implemented through multiple settings (health care, school, workplace, community organizations, etc.), address the needs of multiple priority populations (e.g., minority, blue collar, children, etc.), and through multiple approaches (e.g., programmatic, policy, and media advocacy).

6. Continuity. Federal funding should ensure that current programs at the state and local level are not disrupted by reductions or gaps in funding. A broad-based movement has been mobilized against the epidemic with federal funding and support. It is essential that this work not be discontinued in the short or long term.

The current ASSIST program funding commitment extends to September 1999 (the end of the fiscal year). IMPACT state funding cycles are from December through November. Funding for all states should be extended and there should not be discontinuity of the programs.

7. Nationwide intervention. The benefits of effective tobacco control should be available to all Americans. DHHS funding is needed for interventions in all states, territories, and the District of Columbia.

8. Minimum federal program in all states. A minimum federal program contribution is necessary for all states, even those that have earmarked state taxes or legal settlement funds for significant tobacco control program investments. It is necessary that

the Federal Government fund staff positions in all states, foster innovation and the transfer of effective tobacco control interventions among states, and ensure participation of all states in national events such as national meetings, planning activities, and trainings.

9. Federal flexibility to support state and local changes. Federal funding for a nationwide, state, and locally based tobacco control program would be an important expression of federal leadership. We respect the Federal Government's role in supporting change at the state and local level. We believe that federal support for state and local changes can best be achieved through the establishment of a base budget for all states and a grants program that can be awarded on the basis of changing need and strategic opportunities. Successful programs can be incorporated into base budgets. Moreover, through such a mechanism the Federal Government can ensure that all states have a minimum program, respond to opportunities for strategic development as these occur at the state level, and build programs over time. Some flexibility should be preserved.

10. National program infrastructure. The creation of an adequately funded nationwide state- and community-based program requires a central infrastructure. Federal Government staff and budget, as well as training, technical assistance, planning, and communication networks, must be expanded to ensure the expanded state/local program is appropriately supported, monitored, and managed.

11. Multiple complementary federal funding sources. Given the breadth of the tobacco problem and the need for the involvement of multiple federal agencies, we believe that it is important for DHHS to employ multiple complementary funding streams. CDC, NCI, SAMHSA, and FDA all play important complementary roles.

D. Controlling the Tobacco Epidemic: Funding Requirements for an Effective Nationwide Tobacco Control Program

While funding at current ASSIST levels for a nationwide intervention would protect gains and strengthen the tobacco control efforts in many states, it is insufficient to substantially reduce the tobacco epidemic within the foreseeable future. Rather, funding levels based on the California and Massachusetts experiences can effectively reduce tobacco use within a decade. Funding at higher than current ASSIST levels could be expected to have an increased effect on public health in a similar period of time.

The Advance Group gave consideration to the elements of the program and based its cost estimates on these components. Elements of the program that have proven to be effective are as follows:

- Public health programs at the national, state, and local levels to build community support for policies and programs that prevent tobacco use, motivate and support efforts to stop tobacco use, and control secondhand smoke
- Tobacco-free schools or interventions by youth service organizations and programs, including tobacco prevention education curriculum, tobacco-free policy

implementation, and school and community collaborative activities with an emphasis on policy reforms that promote the nonuse of tobacco
- Mass media-based public health education campaigns, including a focus on tobacco industry practices to provide information about tobacco products, the public health benefits of tobacco control policies, in addition to some programming aimed to prevent tobacco use and motivate and support attempts to quit tobacco use
- National program of technical assistance, training, and communication throughout the tobacco control network
- Surveillance, evaluation, and applications research conducted through the National Cancer Institute (NCI) and Centers for Disease Control and Prevention (CDC) and national and state partners.

School-based programs are an important element of the national program. However, we should not expect the educational system to fully address the problem. We strongly recommend that funding to this sector be focused to those endeavors shown to have a significant impact at a reasonable cost.

We estimate that the cost of a truly effective national program would be $2.487 billion.

We advise that these funds be allocated and the program be fully operating by the year 2000. We believe that the tobacco crisis demands such a commitment as soon as possible.

This funding commitment should not be contingent on the outcome of any arrangement, deal, or "settlement" with the tobacco industry. The responsibility to deal with the national epidemic is that of the Federal Government, regardless of what the tobacco industry may or may not agree to. Government should not stand in line waiting for a donation from the industry that caused the problem.

While we do not believe that funding for the national program should be contingent on a tax increase, we agree with the Administration that a tax increase would have clear public health benefits, particularly in reducing tobacco addiction among youth. We note that an increase of 75 cents per pack would generate about $11 billion per year in new revenue (Congressional Joint Committee on Taxation, 1995). Nevertheless we do not believe that funding for the tobacco control program should be contingent on a tobacco tax increase.

E. Immediate Requirements for a Nationwide Tobacco Control Program

1. Funding for all states, territories, and the District of Columbia based on ASSIST funding levels

The Advance Group believes that DHHS should address the public health epidemic of tobacco through an aggressively led national program implemented in all states, territories and the District of Columbia. We believe that the California and Massachusetts tobacco control interventions—based on the ASSIST model—present the best examples of what should be implemented across the country.

However, given the evidence that the ASSIST project has been effective, we believe that the Federal Government should immediately fund a nationwide program at ASSIST levels. NCI currently funds the ASSIST project at a rate of about $25 million per year for funding to state health departments, technical assistance, and training and evaluation. Given that ASSIST states represent about 95.7 million people or 36 percent of the U.S. population, the rate of spending is about 26 cents per person. Applying this rate of spending to the total U.S. population (about 265.3 million) suggests a requirement of about $69.31 million to implement an immediate minimum nationwide program based on the ASSIST model.

The Advance Group suggests that these funds, at minimum, need to be made available and the funding mechanism communicated to all concerned immediately. Such a program would make a significant contribution to the public's health. However, the amount of funding is insufficient to reduce smoking prevalence to 15 percent of the adult population which is the Healthy People 2000 objective. Therefore, we believe it is critical that greater funding be pursued to implement a program with the scale necessary to control the tobacco epidemic.

2. Funding for research, development, and dissemination

Scientific innovation and collaboration are needed between the scientific/academic and public health communities. This goal can be accomplished only through an expanded program of research, development, and dissemination with leadership from NCI and should be given priority by DHHS as the Department proceeds toward the implementation of a fully funded, effective, national tobacco control program.

We believe that NCI should implement a research program in 15 to 20 states to study the impact of innovative tobacco prevention and control interventions at the community, state, and multistate level. This research program would simultaneously provide resources to research institutions and established state tobacco control coalitions to undertake multiple studies collaboratively. The results of this research would guide tobacco control programs in the remaining states and provide knowledge that would focus the larger national program on effective, state-of-science interventions.

The goal of this program would be to incorporate rigorous research as an ingrained feature of state and local tobacco control programs by expanding existing tobacco control coalitions to include research institutions. This would be accomplished by the development and expansion of collaborative relationships in 15 to 20 states between research institutions, state health departments, voluntary health organizations, and tobacco prevention and control coalitions at the state and local levels. The collaborative nature of this relationship would be defined in a written document from each state, clearly defining the roles of the research institution, the state health department, and the named voluntary health organization and how they would make collaborative decisions regarding all aspects of the research.

Research institutions for each of the states or for groups of states should be funded directly by NCI to conduct multiple studies of interventions at the community, state, and

multistate level. The research institution would have experience and expertise in multidisciplinary tobacco control studies at the community and state level. Appropriate areas of expertise would include psychology, preventive oncology, economics, pharmacology, medicine, nursing, communications, sociology, and political science. The research institution in each state would manage all aspects of state and local study design, data collection, and data analysis with members of the partnership. An important objective for this research would be to create in these institutions a cadre of cancer control researchers with experience in community and state public health research (including being sensitive to the collaborative requirements of such research). These institutions would also support the training of new professionals and serve as a locus for continuing professional education about tobacco control.

NCI would also make competitive awards to state health departments to implement innovative interventions. These interventions would be conducted through state and local coalitions and with the active participation of a named voluntary health organization that would contribute resources to the project. All states would include a paid counter-advertising campaign as one of their interventions. Policy interventions at the state and local level would also be required. State coalitions must have experience at implementing comprehensive tobacco control programs with an emphasis on policy interventions and at reaching diverse population groups with culturally appropriate interventions, and be willing to participate in collaborative research.

Many different aspects of the interventions are appropriate subjects of research. Examples of research questions that may be addressed through this project are as follows: In the context of a statewide program, what is the impact of a large counteradvertising campaign on (1) attitudes toward tobacco advertising, tobacco use, and the tobacco industry, and (2) tobacco use behaviors? What themes of counteradvertising campaigns are most effective in achieving the goals of the campaign? How do state laws that preempt local tobacco control legislation influence the public's knowledge, attitudes, and behavior related to tobacco? How should tobacco control programs be modified to be most effective in tobacco-growing states? How should tobacco control programs be modified to meet the needs of special population groups? How can new funds be used to reduce tobacco use as rapidly as possible? What is the optimal level of per capita spending on tobacco control programs? What public policies are most strongly predictive of reductions in tobacco use?

A more detailed listing of research questions is being developed by the Surveillance, Evaluation, and Applied Research Advance Group.

Attachment #1 – ASSIST Coordinating Committee Resolution (9/26/97)

WHEREAS there is evidence from the evaluation of the California, Massachusetts, and ASSIST interventions that comprehensive, policy-oriented, culturally inclusive tobacco control is effective and effectiveness is dose-related; and,

WHEREAS there is broad consensus within the tobacco control movement that the Federal Government should support effective tobacco control in all states and this should include funding for state and local tobacco control, as well as technical assistance, training and network support based on the ASSIST model; and,

WHEREAS the Secretary of Health and Human Services has communicated her Department's commitment to support effective tobacco control in all states; and,

WHEREAS beyond the current funding commitment, a specific funding plan does not exist to ensure that the momentum for tobacco control is not lost; and,

WHEREAS if momentum for tobacco control is lost at the state and local level, this would be a public health disaster; and,

WHEREAS the National Cancer Institute, Centers for Disease Control and Prevention, American Cancer Society, Association of State and Territorial Health Officers, and other state and local health organizations share a commitment to ensure that effective tobacco control continues and expands, without gaps in funding to impede these developments; and,

WHEREAS lives depend on NCI advancing the science of tobacco control through vanguard state tobacco control initiatives; and,

WHEREAS the current media and public policy attention on tobacco control policy has raised the public health priority of effective tobacco control programs to the President's agenda and there are national expectations that the Administration would implement an effective national tobacco control policy regardless of any outcome of the proposed settlement;

THEREFORE, BE IT RESOLVED that the ASSIST Coordinating Committee requests the following of the Department of Health and Human Services.

1. Federal funding for tobacco control should be reflected in the President's FY99 Budget through multiple funding streams, with no reductions or gaps in the funding for state and community-based tobacco control; and, request that the Department's commitment to continuous and expanded program funding be communicated to state and territorial tobacco control programs by January 1998.
2. Federal funding for comprehensive, culturally diverse, policy-oriented tobacco control should be provided to all 50 states, the District of Columbia, and the territories, regardless of state levels of funding, at a level consistent with the activity levels in California and Massachusetts as soon as possible.
3. Additional federal funding should be available for applied research on statewide tobacco control strategies.
4. Federal support should include more than provision of funds and include an organized system of consultation, technical assistance, and training available to state and territorial tobacco programs.

Realizing America's Vision for Healthy People: Advancing a Federal Commitment to Effective Tobacco Control. Part II.

Report of the Advance Groups on Training and Technical Assistance Surveillance, Evaluation, and Applications Research Advocacy Opportunities With Membership from State Health Agencies and American Cancer Society

February 4, 1998

OVERVIEW

Tobacco control leaders and experts from many states, including public health professionals from the American Stop Smoking Intervention Study (ASSIST) and Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT), along with the American Cancer Society (ACS), and the ASSIST Multicultural Subcommittee, formed four Advance Groups to provide direction and input into the design of a nationwide comprehensive tobacco prevention and control program and to respond to a request from the Department of Health and Human Services (DHHS) for advice about how the Federal Government should support such a program. The issues addressed by the four Advance Groups are:

- Funding
- Training and Technical Assistance
- Surveillance, Evaluation, and Applications Research
- Advocacy Opportunities.

The Funding Advance Group has submitted separately its recommendations for the financial resources needed to adequately address the epidemic of tobacco use in this country. This document combines the reports of the other three groups.

TRAINING AND TECHNICAL ASSISTANCE ADVANCE TEAM REPORT

Introduction

The Training and Technical Assistance (TAT) Advance Team includes members from 16 states,[1] from both the IMPACT and ASSIST programs, and the American Cancer Society.

[1] Jeanne Prom, ND; Deborah Borbely, NM; Wendy Boblitt, IN; Chuck Bridger, NC; C. Ann Houston, NC; Bob Leischow, AZ; Jane Moore, OR; Rebecca Murphy, UT; Jane Pritzl, CO; Deborah Quinones, NY; April Roessler, CA; Judy Schmidtke, WA; Ron Sherwood, OH; Shannon Spurlock, MA; Kerry Whipple, IL; Mikelle Whitt, MI; Gary Wilson, MO. CDC and NCI staff provided technical and editorial assistance.

Training and technical assistance is a critical element of any successful tobacco prevention and control program. Training delivers information and develops skills that are needed to prepare effective plans and turn them into a reality. Technical assistance is the ongoing support needed to respond to the ever changing environment of tobacco control. Both training and technical assistance should provide content information on best practices in tobacco control and build skills to enable grantees to plan, implement, and evaluate tobacco control interventions and policies appropriate to their setting. Additionally, training and technical assistance should be provided which strengthens the ability of the funding recipient to receive and utilize government funds and implement programs nationally. Currently, training and technical assistance is provided at different levels to the 17 ASSIST states and the 33 IMPACT states, the District of Columbia, and California. Consistency is needed in designated funding for technical assistance and training for all states.

The members of the team analyzed six components of technical assistance and training, and from that preliminary analysis developed the following recommendations.

Recommendations

Funding:

Funding for technical assistance and training in each state must be at an adequate level to provide information and skills necessary to reduce the prevalence and adoption of tobacco use.

Therefore, states recommend that federal government funders:

1. Designate funds to ensure that each state receives adequate and consistent technical assistance and training and that national training sessions are conducted.
2. Raise funding in Fiscal Year 1999 for all states to the level of the ASSIST Program for training and technical assistance. Future funding for all states should be increased in proportion to total resources allocated for tobacco control.
3. Support and strengthen training and technical assistance at the federal level by contracting services to facilitate conference arrangements and increase response time to states' needs.

Location and Schedule:

Training opportunities must be available to all states, with technical assistance provided that is consistent, both proactive and reactive to national, state, and local needs.

Therefore, states recommend that federal government funders:

1. Assure that state tobacco control plans include goals for training and technical assistance to facilitate effective strategies.
2. Conduct national training and coordinated regional trainings.
3. Provide training schedules and locations which permit accessibility and affordability to the largest number of state representatives.

4. Seek and use substantial state input in planning and in the accountability of the contracted services.

Information and Dissemination/Rapid Response System/Transfer of Technology

Information dissemination occurs through many channels, such as conferences, train the trainer workshops, the Internet, conference calls, overnight mail, video conferences and fax. Coordinated linkages from the designated agency to all states is necessary for fast and efficient information dissemination.

Therefore, states recommend that federal government funders:

1. Establish a central repository, possibly through a contractor, to gather and disseminate information to all state program contracts and grantees.
2. Establish and fund, at the federal, state, and local levels, minimum hardware and software compatibility recommendations to promote compatibility among users and facilitate information exchanges and the transfer of technological advances.

Consultation

Consultation and visits to states by federal funders are necessary to provide on-going intensive, tailored training and technical assistance addressing each state's specialized needs. State tobacco prevention and control programs have training and technical assistance needs unique to their own environments. These specialized needs require that federal funders adapt the content and delivery of the technical assistance and training they provide to help individual states operate more effectively in these environments.

Therefore, states recommend that federal government funders:

1. Maintain at their agency a point of contact for each state to provide ongoing consultation and technical assistance.
2. Establish formal teams from the federal funding agency that visit each state at least once per year to provide on-site program review and technical assistance.
3. Build teams of experts on specialized subjects who can serve as traveling technical assistance and training units. These teams will be available to provide on-site consultation and training to all states as needed, and will be available to all states for ongoing technical assistance. Federal funders would fund these teams as part of their training and technical assistance budgets.

Multicultural Considerations

It is critical to structure program expectations so that individual multicultural groups can develop strategies that are tailored to the needs and unique cultural characteristics of their communities. At the same time, multicultural training and programs should focus on shared objectives and activities to foster unity, trust, and strength among all groups. This approach recognizes individual differences while acknowledging that we live in a diverse society.

Therefore, states recommend that federal government funders:

1. Establish and maintain a process for "start to finish" multicultural input and review in all tobacco control programs.
2. Increase the awareness and skills, via a range of training opportunities, of state site staff to work more effectively with all multicultural groups (including newly arrived immigrants) in developing long term commitments to tobacco control.
3. Encourage the states, via technical assistance and training opportunities, to partner with national and community-based multicultural organizations to implement their own specific realistic community norm changes.

Overcoming Barriers to Out-of-State Travel

Overcoming barriers to traveling out-of-state is necessary for federal programs in order to develop competent state staff and share information and implement programs nationally. In addition, overcoming barriers to out-of-state travel is necessary for staff to meet training requirements imposed by federal funding agencies.

Therefore, states recommend that federal government funders:

1. Add language to all contracts and cooperative agreements that 1) require certain personnel to attend specified regional and national trainings, and 2) include dedicated funding solely for this purpose.
2. Establish a national point-of-contact, e.g. a grants management or contract office or a designated officer, to manage all issues relating to overcoming barriers to out-of-state travel. This office or officer would enforce the cooperative agreement and contract requirements concerning required participation in regional and national trainings.

SURVEILLANCE, EVALUATION & APPLICATIONS RESEARCH ADVANCE TEAM RECOMMENDATIONS FOR ADVANCING TOBACCO CONTROL ACTIVITY REPORT

Introduction

The purpose of the Surveillance, Evaluation and Applications Research Advance team[2] was to produce a list of recommendations regarding surveillance, evaluation and applications research that states believe will address their priority needs to move ahead tobacco control activities.

Recommendations for surveillance, evaluation and applications research were generated from state level tobacco control staff representing a range of programs from those with extensive experience and funding to those with limited experience and very low

[2] Ellen Capwell, OH; Marianne Ronan, MO; Neal Graham, VA; David Fleming, OR; Phil Huang, TX; Lodie Lambright, RI; Michael Johnson, CA; Jesse Nodora, AZ; Tracy Enright Patterson, NC; Deborah Quinones, NY; Lois Suchomski, IL. CDC, ACS and NCI staff provided technical and editorial assistance.

levels of funding. The recommendations listed below resulted from generation and prioritization of ideas by members of this Advance Team, followed by review and comment from members of the Tobacco Control Network Coordinating Committee (representing ASTHO, ASTHO Affiliates, NACCHO, NALBoH, regional tobacco control coalitions, representatives from IMPACT, ASSIST and Smokeless states).

Recommendations fall into three broad categories, presented in priority order: evaluation guidance, tobacco control strategies, and surveillance/monitoring. Specific recommendations within each category are also presented in priority order. Recommendations are made with the expectation that needs will be addressed through communication with those working at state and local levels and that guidance and resources will be disseminated to those working at all levels.

Recommendations to be Addressed by the U.S. Department of Health and Human Services

Evaluation Guidance

1. (Primary priority) Identify common indicators/measures of environmental/systems changes in tobacco control that lead to reduced initiation and use of tobacco. Common indicators should include both quantitative and qualitative measures to be taken as part of process, impact and outcome evaluation at the local, state, and national levels. Systems changes to be measured include:
   - Legislation and policy formation (effectiveness of policies and tracking and monitoring of policies) in the areas of:
     Youth Access
     Second Hand Smoke
     Advertising
     Economic Disincentives
   - Coalition development and management
2. (Primary priority) Make available exemplary or recommended evaluation models, protocol, and instruments for assessing comprehensive and diverse state and local tobacco control initiatives. These tools and resources should facilitate mid-course modifications to programs, as well as evaluation of impact and outcome of programs operating under different conditions.

Tobacco Control Strategies

3. (Primary priority) Identify the current best practices and most effective combinations of strategies for tobacco control over broad areas of interest including promotion of clean indoor air policies and prevention of tobacco use, particularly among youth. All areas need to be addressed, including:
   - Why and how are strategies effective in diverse and complex settings (community and state programs); best approaches with low SES groups, racial/ethnic and other cultures?

- Youth access; relationship between reduced sales to minors and youth tobacco use initiation and prevalence rates; social acceptability of selling to youth; primary source of tobacco for youth; the significantly lower initiation and use rate among African American youth.
- Youth tobacco use cessation; best motivation strategies.
- Restrictions (voluntary policies or local ordinances) on advertising; how to initiate; effectiveness, relationship of youth tobacco use rates to ad campaigns and tobacco use in movies.
- What training techniques are most effective in disseminating skills for tobacco control?

4. (Secondary priority) Answer research questions related to tobacco product and promotion that impact tobacco control, e.g.:
   - Youth perceptions of Tobacco Industry
   - Status of tobacco promotion in media, movies, TV, and effect
   - Effect of cigar trend
   - Changes in tobacco products; addictiveness, harmful chemicals
   - Social and political acceptability of accepting money or being an ally of the Tobacco Industry

Surveillance & Monitoring

5. (Primary Priority) Surveillance to address research and monitoring needs including:
   - Population-based studies of patterns of tobacco use behaviors including initiation, cessation, and nicotine dependence, brand preference, product selection, and ethnic and gender variations.
   - Population-based studies of environmental tobacco smoke exposure, its prevalence, implementation and enforcement of policies and legislation
   - Evaluation of current and future tobacco products, added ingredients and product design
   - Environmental factors which either promote or discourage tobacco use
6. (Primary priority) Determine the type, quantity, quality, and location of tobacco control initiatives currently being implemented and establish a system to monitor application of best practices, such as local ordinances and voluntary policies to restrict tobacco advertising, extent and impact of counseling by health care providers, etc.
7. (Secondary priority) Determine current status and establish systems to identify and monitor emerging trends in tobacco industry tactics, by location, related to:
   - Advertising and promotional spending
   - Point of purchase ads, billboards, print ads, special offers
   - Political influence through lobbying, contributions and ads
   - Pricing patterns

Recommendations for Addressing Identified Needs

It is recommended that the needs identified above be addressed through a shared and collaborative role by CDC, NCI, FDA, SAMHSA, and other federal agencies.

Evaluation guidance may be provided through guidelines, training, and technical assistance. Policies need to be established regarding inclusion of standard index items in state and national surveillance instruments. Materials from states that have had significant funds to devote to evaluation should be compiled and distributed to all states. Following gathering of baseline information regarding program evaluation activities for tobacco control programs, surveillance systems need to be developed and maintained. It is strongly recommended that the "Tobacco Control Research Framework," developed by ASSIST states, and the Proposed Plan for a Tobacco Surveillance System, prepared by the DHHS Tobacco Data Workgroup, be reviewed by all states and involved federal agencies, and considered for use as models for evaluation and surveillance.

Information about current best practices should be compiled and disseminated by federal agencies. Identification and testing of tobacco control practices may be accomplished through linkages with CDC Task Force on Community Preventive Services and/or through extension of ASSIST like demonstration trials. Additional tobacco control research funds will be necessary for those activities as well as applied research into new and emerging strategies.

It is estimated that approximately 10% of the amount of funds allocated for program will be necessary for evaluation, surveillance and monitoring, and an additional amount should be directed to research. Additionally, of the FY99 funds appropriated to NIH for research, the percent directed toward applied research should be increased. Research should be driven by needs identified in the field of tobacco control practice.

ADVOCACY OPPORTUNITIES ADVANCE GROUP REPORT

Introduction

The Advocacy Opportunities Advance Group[3] included members from 14 states.

Recent advances in tobacco control are based on the results of research showing that policy and media advocacy help state and local communities achieve lasting changes and that coalitions are important agents of the change.

Tobacco control started as a grassroots movement. Those involved in carrying forward the environmental changes initiated by small groups of activists fully realize change is more successful and permanent when the people it impacts are involved in initiating and promoting the change. We recommend state and local health departments be

[2] Ellen Capwell, OH; Marianne Ronan, MO; Neal Graham, VA; David Fleming, OR; Phil Huang, TX; Lodie Lambright, RI; Michael Johnson, CA; Jesse Nodora, AZ; Tracy Enright Patterson, NC; Deborah Quinones, NY; Lois Suchomski, IL. CDC, ACS and NCI staff provided technical and editorial assistance.

authorized to engage fully in the work of communities toward sustaining the changes already in place and initiating new policies which will discourage tobacco use.

In the United States today, state and local health departments are confronted with a tangle of often contradictory restrictions on their activities, placing severe limitations on their effectiveness. Even more problematic is finding a clear and consistent definition of lobbying and differentiating it from educational activities. Programs funded through Department of Health and Human Services appropriations are restricted from lobbying for or against tobacco control issues at the state level (See Attachment A). The Federal Acquisition Streamlining Act (FASA) restrictions apply to lobbying for tobacco control ordinances at the local level (See Attachment B).

The existing constraints and the implementation of FASA may serve to further diminish the participation of communities, particularly communities of color, in tobacco control advocacy. Racial/ethnic non-profit organizations, which receive money from the tobacco industry have, at best, remained neutral about tobacco control advocacy. Their lack of participation in tobacco control advocacy could result in an even greater disparity in health outcomes for members of these groups**.**

FASA regulates contracts between for-profit contractors and federal agencies such as the Department of Defense and the National Aeronautics and Space Administration (NASA). The regulations implementing FASA were made generally applicable to all other executive agencies. Thus, FASA was law written to protect the public interest by preventing federal profit-making contractors from using federal funds to further their own self interest by lobbying state and local governments**.** It is vital to look at this issue from another perspective: do these restrictions prevent state and local health departments from protecting the health of the public? Tobacco use is the leading preventable cause of death in each of the 50 states, the District of Columbia, and the territories. Should the Federal government prevent itself and state and local governments from giving its citizens the tools to bring about the environmental changes needed to end the epidemic caused by tobacco? By this enforced silence, public health advocates are to some extent forced to abandon the very people we are charged with protecting.

Recommendations

These restrictions on the use of Federal funds, combined with contradictory regulations and ambiguous directives, continue to exert intense political pressures on states' current tobacco control programs and will impede future advances in tobacco control.

Therefore, the Advocacy Opportunities Task Force makes the following four recommendations:

1. Federal funds disbursed to states and local communities for tobacco control activities should not be restricted from use for lobbying/advocacy efforts at the state or local levels.

2. Tobacco control programs should be exempt from the FASA law.
3. The definition of "lobbying" should be that already adopted by the Internal Revenue Service and defined in the Treasury Department regulations.
4. Each state health department should choose a partner of record to serve as an advocate for the program and to assure state tobacco control program funds are spent wisely and effectively.

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10. From Demonstration Project to Nationwide Program

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10. From Demonstration Project to Nationwide Program

The National Cancer Institute (NCI) provided the public health leadership and federal funding for the 17 American Stop Smoking Intervention Study (ASSIST) states to organize community efforts for the successful delivery of interventions. Systematically progressing through the five phases of cancer control research in which substantive research precedes wide-scale intervention efforts, ASSIST incorporated the essential elements of an effective tobacco prevention and control program. However, as a demonstration project, ASSIST was not a national public health program with sustained funding and did not have to address all of the core functions of governmental public health agencies—policy development, assessment, and assurance. A national tobacco prevention and control program for 50 states, the District of Columbia, and the U.S. territories under the administration of the Centers for Disease Control and Prevention (CDC) would provide the funding and leadership to engage both the public and private sectors in preventing tobacco use. NCI and the Office on Smoking and Health (OSH) at CDC worked together with key stakeholders for more than a year to maintain the capacity built by ASSIST while transitioning the program from NCI to CDC and incorporating the core elements of ASSIST into the new National Tobacco Control Program (NTCP). The many issues to be considered are complex and illustrate the dynamic environment at the time of the transition. This chapter describes the processes and challenges of disseminating research and demonstration project results as standards and best practices in public health programs that the two federal agencies experienced as the demonstration project, ASSIST, came to its conclusion.

The Challenge of Dissemination

> One of the greatest challenges in tobacco control and public health in general continues to be overcoming the difficulty in getting advances in prevention and treatment strategies effectively disseminated, adopted, and implemented in their appropriate delivery systems.[1(p19)]
>
> —U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General—Executive Summary*

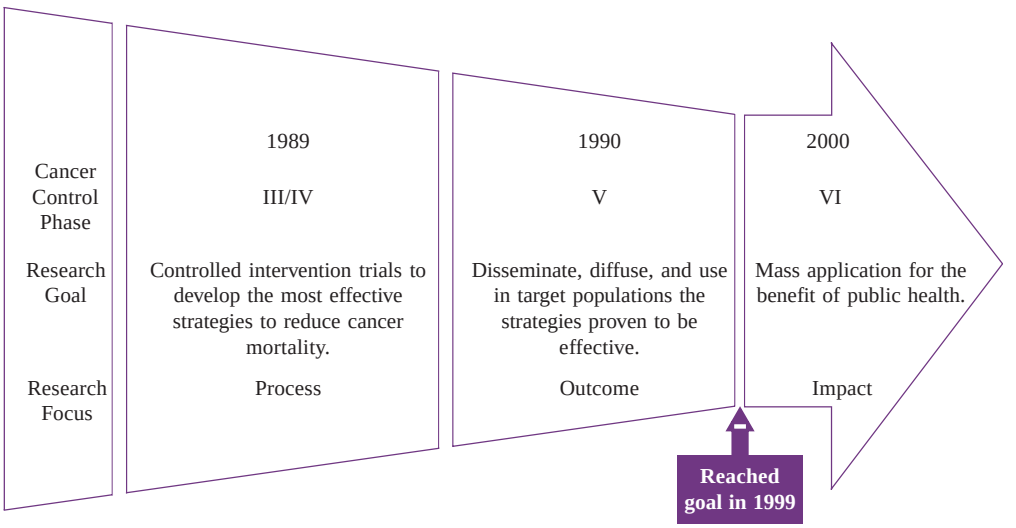
The transition of ASSIST, as the term implies, was a change, a passage from one form to another, not merely a replication or transfer of the program to a different administrative agency. ASSIST as a phase V demonstration and implementation project was ending, completing the five phases of cancer control research. The final step in NCI's cancer control model was to expand dissemination from the 17-state demonstration project to a nationwide tobacco prevention and control program. (See figure 10.1.) The challenge

was to maintain the capacity and capabilities that had been built by ASSIST while establishing the national program with sustained funding for all states and territories. In addition, the core elements of the ASSIST model were to be incorporated as evidence-based practices into all state tobacco prevention and control programs. Core elements are the features of an intervention that must be replicated to maintain the integrity of the intervention as it is transferred to a new setting.[2] Such full-scale dissemination would involve changes in funding sources and in administrative locus to a different federal agency. In addition, and perhaps most challenging, the transition would involve expanding, improving, and integrating already existing national, state, and local infrastructures to form the state-based NTCP.

Although much work remains to be done, considerable progress has been made in identifying and disseminating successful results of clinical research. The Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) has a long history of providing leadership for disseminating guidelines for clinical practice, such as the recently updated *Clinical Practice Guideline: Treating Tobacco Use and Dependence*.[3] In the early 1990s, a national preventive services education campaign, Put Prevention into Practice, was initiated. One of the first major products was a Put Prevention into Practice Education Kit that included the *Clinician's Handbook of Preventive Services*.[4]

Similar guidance for community preventive services, however, was not available to aid in expanding the dissemination of the ASSIST project's interventions. The *Guide to Community*

Figure 10.1. Goals Set for ASSIST in 1988



Source: Adapted from a presentation to the Board of Scientific Advisors, National Cancer Institute, 1988.

Dissemination

"Process through which target groups are made aware of, receive, accept, and use information and other interventions."

Source: National Cancer Institute, Center for the Advancement of Health, Robert Wood Johnson Foundation. 2002. *Designing for dissemination* (Conference summary report, September 19–20, 2002). http://cancercontrol.cancer.gov/d4d/d4d_conf_sum_report.pdf.

Preventive Services was made available later through articles in the *American Journal of Preventive Medicine* and *Morbidity and Mortality Weekly Report (MMWR)*. A report in the latter—"Strategies for Reducing Exposure to Environmental Tobacco Smoke, Increasing Tobacco-Use Cessation, and Reducing Initiation in Communities and Health-Care Systems: A Report on Recommendations of the Task Force on Community Preventive Services"[5]—was not released until November 10, 2000, in *MMWR*; the full presentation of recommendations and supporting evidence was published in the *American Journal of Preventive Medicine* in 2001.[6,7]

Nor were there established procedures for transitioning a federal public health demonstration project to a sustained national program or for transferring the administration of a program from one federal agency to another. ASSIST was transitioning to CDC as a sustained, federally funded public health program similar to other core public health programs such as cancer, cardiovascular disease, diabetes, and sexually transmitted diseases/AIDS. The timing of the decision to fund a national program created another challenge. The planning and implementation of the transition had to take place simultaneously, or the capabilities and capacity built by ASSIST would be compromised. A gap of months between the end of ASSIST and the start of the CDC program could have meant a loss of experienced staff at the state and local levels.

NCI and CDC share a mission that includes tobacco control research and the prevention and control of tobacco use. Issues in the transition to a national tobacco control program arose from differences in how the agencies pursue that mission. NCI's role is primarily research and the application of research results, whereas CDC focuses on implementing and monitoring effective population-based interventions, supported by epidemiology and surveillance.

Demonstration projects tend to be different from national public health programs in purpose, design, comprehensiveness, time frame, level of resources, degree of intensity and penetration, accountability, and approach to evaluation. In 1993, OSH recognized the critical need to build states' capacity for addressing tobacco use as a public health problem and began the process with limited funding for Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT). (See chapter 9.) It is critical to note the considerable differences in funding between a demonstration project—ASSIST—and a state-based public health program—IMPACT. Table 10.1 illustrates this point.

In her commitment letter, Secretary of Health and Human Services Donna E.

Table 10.1. Comparison of the ASSIST and IMPACT Programs

Issue	NCI: ASSIST	CDC: IMPACT
Funding mechanism and flexibility	ASSIST states had competitive contracts, with NCI-specified deliverables.	IMPACT states had cooperative agreements with CDC, with program deliverables negotiated by the states and CDC.
Funding level	The 17 ASSIST states received approximately $21.5 million per year (an average of $1.26 million per award).	The 32 IMPACT states and the District of Columbia received about $5 million in 1993 (an average of $156,250 per award) and about $12 million annually by 1998 (an average of $375,000 per award).
Technical assistance and training	ASSIST Coordinating Center provided the states with training, technical assistance, and staff to facilitate communication and participation by the states in planning and decision making.	CDC's training activities and technical assistance to the IMPACT states were provided by CDC staff and one annual training.
Public-private partnerships	ASSIST had a designated private partner, the American Cancer Society.	IMPACT states were encouraged to partner broadly.
Evaluation requirements	ASSIST states could not use NCI funds for evaluation of their programs (though the overall project was evaluated by a team of scientists who were not a part of the intervention itself).	The states were expected to participate in national surveillance and monitoring systems by gathering and reporting data to OSH.

Notes: NCI indicates National Cancer Institute; ASSIST, American Stop Smoking Intervention Study; CDC, Centers for Disease Control and Prevention; IMPACT, Initiatives to Mobilize for the Prevention and Control of Tobacco Use; and OSH, Office on Smoking and Health.

Shalala stated, "We are moving the proven research findings generated from the National Cancer Institute's successful ASSIST program into widespread public health practice." [8(p1)] The challenge was to maintain the integrity of that approach to tobacco prevention and control interventions while adapting it to the core functions of national public health programs: assessment, policy development, and assurance.[9,10] The Institute of Medicine report characterized those functions as follows:

- *Assessment* is an understanding of the determinants of health and of the nature and extent of community need;
- *Policy development* is leadership in developing public decisions that reflect a full examination of the public interest and sound analysis of problems and interventions; and
- *Assurance* is positive action to encourage other entities to make available the resources necessary to achieve goals for the common good, including public health.[9(pp140–142)]

American Cancer Society's Evaluation of Its Contributions to ASSIST

In addition to participating in the CDC-directed transition process of ASSIST, NCI's designated private partner, the American Cancer Society (ACS), conducted an evaluation to assess its contributions to ASSIST and to identify ways of improving future collaborative initiatives. The evaluation indicated that ACS had been an equal partner, with the ACS National Home Office contributing nearly $4.5 million in direct grants to the ACS divisions in the ASSIST states. The major contributions noted were ACS's advocacy, strong volunteer networks, and strong reputation. As ACS staff and volunteers worked with CDC to consider ways of involving the large network of individuals and organizations working in tobacco prevention and control, ACS also reviewed recommendations from its evaluation to do the following:

- Better define and document the roles of ACS during the initial planning stages of collaborative agreements
- Continue building community-based programs where ACS staff could specialize in one major area of cancer control
- Increase resources available at the national level to conduct training sessions specifically for advocacy and grassroots recruitment for staff and volunteers

Source: Shisler, J., and C. Dilorio. 1999. *The role of the American Cancer Society in ASSIST*. Final report. Atlanta: American Cancer Society.

The report also stated that

> the mission of public health is more fundamental and more comprehensive than the specific activities of particular agencies. Organized community effort to prevent disease and promote health involves private organizations and individuals, working on their own or in partnership with the public sector. But the governmental public health agency has a unique function: to see to it that vital elements are in place and that the mission is adequately addressed.[9(p140)]

An examination of how the expertise and capacity built by the ASSIST states were integrated into the new NTCP at CDC provides useful information for disseminating other effective science-based programs to public health practice. The transition to NTCP occurred in a context of at least three challenges:

1. Addressing funding and management issues related to shifting administration of a program from one federal agency to another
2. Maintaining the capacity and capability of funded programs from both agencies while integrating the essential core elements of each program into a single program
3. Identifying and addressing those forces within the larger tobacco prevention and control community that might affect program operations and effectiveness

Transition from Agency to Agency: Administrative Issues

Secretary of Health and Human Services Donna E. Shalala charged CDC with developing a comprehensive national tobacco prevention and control program and with overseeing the administrative transition of the tobacco prevention and control programs of the 17 ASSIST states. Within CDC, OSH was assigned the responsibility for developing and overseeing the program.

The Office on Smoking and Health Mission Statement

"OSH is responsible for leading and coordinating strategic efforts aimed at preventing tobacco use among youth, promoting smoking cessation among youth and adults, protecting nonsmokers from environmental tobacco smoke (ETS), and eliminating tobacco-related health disparities.

"OSH accomplishes these goals by

- expanding the science base of tobacco control.
- building capacity to conduct tobacco control programs.
- communicating information to constituents and the public.
- facilitating concerted action with and among partners."

Source: Office on Smoking and Health. 2003. *Mission statement.* Atlanta: Centers for Disease Control and Prevention. www.cdc.gov/tobacco/mission.htm.

The ASSIST contracts ended on September 30, 1999, and CDC funding for NTCP began on October 1, 1999. The transition brought new roles and responsibilities for the ASSIST states; for all the other states; for the American Cancer Society (ACS), NCI, and CDC; and for non–federally funded programs and initiatives.

Ensuring an orderly transition meant delineating the roles and responsibilities of NCI and CDC. Certain roles were self-evident and would not change. For example, NCI would conduct the evaluation of the ASSIST project and publish the findings. NCI would maintain the newspaper clipping database through December 1999 to complete a full 5 years for evaluation purposes. NCI would also continue to support the Tobacco Use Supplement of the U.S. Census Bureau Current Population Survey. As the administrative agency for the new NTCP, CDC would define program requirements and funding for all the states, the District of Columbia, and the U.S. territories. CDC would build its capacity to provide training, technical assistance, and other support for state tobacco prevention and control programs. Both agencies would be involved in the continued dissemination of ASSIST and other evidence-based tobacco prevention and control interventions. They would work together to identify strategies and elements for an expanded surveillance system, which would enable states to monitor trends in tobacco use and tobacco-related health problems and to advance methods for evaluating state programs.

In addition, written and unwritten expectations had to be addressed. Different stakeholders had various perceptions about what was meant by maintaining the evidence-based capacity and capabilities built through the ASSIST project. For example, although ASSIST states had been assured that their funding levels would be maintained for 1 year, CDC had made no commitment beyond that. NCI had provided considerable technical assistance and training support for the ASSIST state programs, and the states wanted this level of support to continue. Building the capacity to implement media and policy interventions had been the primary focus of ASSIST, and the expectation associated with

Among the Many Stakeholders

NCI, through ASSIST, collaboratively sponsored annual conferences on tobacco and health. In June 1995, ACS, CDC, The Robert Wood Johnson Foundation (RWJF), the Massachusetts Department of Public Health, and the Association of State and Territorial Health Officials (ASTHO) cosponsored the first national conference. Over the 8 years of ASSIST, the tobacco control movement grew. Other cosponsors of the conference included

- the American Heart Association,
- the American Lung Association,
- the American Medical Association,
- the Asian Pacific Partners for Empowerment and Leadership,
- ASTHO,
- the U.S. Environmental Protection Agency,
- the Substance Abuse and Mental Health Services Administration,
- the Indian Health Service,
- the National Association of African Americans for Positive Imagery,
- the National Center for Tobacco-Free Kids, and
- the National Coalition of Hispanic Health and Human Services Organizations.

The number of cosponsors reflects the breadth and challenge of engaging the full range of public health stakeholders in planning a comprehensive tobacco prevention and control program.

maintaining the integrity of these interventions was that these core elements would receive high priority in the new NTCP. To address these expectations and accomplish the work needed for developing and implementing NTCP, CDC had to assess the existing capacity of OSH. OSH would receive increased funding through the Department of Health and Human Services (DHHS), but neither funding nor staff would be transferred from NCI to CDC. OSH would quickly need increased numbers of experienced staff to successfully fulfill its expanded responsibility, not only to administer NTCP, but also to manage the transition.

Maintaining operations of the existing state-based programs while planning and managing the transition required an unprecedented level of collaboration and coordination between NCI and CDC. The two agencies had already begun to work together through jointly sponsored national tobacco prevention and control conferences. Also, CDC had participated in collaborative decision making at the ASSIST Coordinating Committee meetings. The director of CDC's IMPACT program gave updates on the program and described what OSH needed from the ASSIST Coordinating Committee members. CDC was also represented in the ASSIST Strategic Planning Subcommittee's advance groups composed of ASSIST and IMPACT program staff.[11]

Integrating and Maintaining Core Program Elements

During the 8 years that the ASSIST demonstration project planned and delivered media and policy advocacy interventions, its infrastructure, partnerships, networks, capacity, participant capabilities, and activities became increasingly complex. As the states made the transition to the national program at CDC, the value of these elements had to be considered. Should they be maintained, modified, or replaced with some other elements? Likewise, the IMPACT states had developed their own networks,

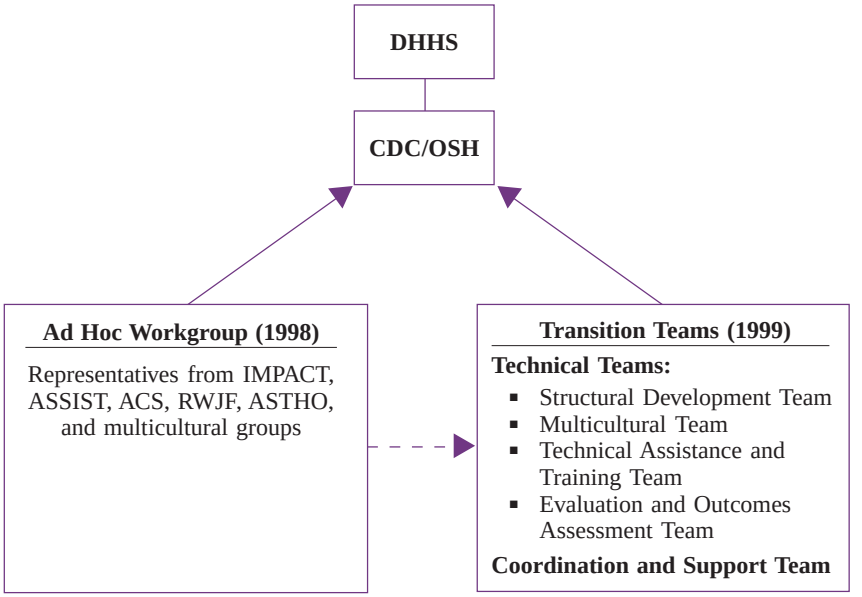
resources, and methods of implementing programs. These also would require decisions about which elements to adapt and integrate into the national program.

Ad Hoc Workgroup

Recognizing the importance of preserving the capacity built by ASSIST, OSH facilitated and coordinated a participatory process engaging all relevant partners to establish and implement the next generation of tobacco prevention and control programs. To do so, OSH developed the organizational structure depicted in figure 10.2. In the spring of 1998, OSH created an ad hoc workgroup representing the major stakeholders. The workgroup comprised representatives from ASSIST, IMPACT, ACS, the RWJF SmokeLess States program, ASTHO, and national organizations representing a variety of racial and ethnic groups. The workgroup was asked to provide direction for establishing a process to assist with the transition that led to the creation of the transition teams. The stated purpose of the ad hoc workgroup was to make recommendations to OSH on the following four issues:

1. The development of a request for applications for state health departments for NTCP funds

Figure 10.2. Organizational Structure during the Transition



Notes: DHHS indicates Department of Health and Human Services; CDC, Centers for Disease Control and Prevention; OSH, Office on Smoking and Health; IMPACT, Initiatives to Mobilize for the Prevention and Control of Tobacco Use; ASSIST, American Stop Smoking Intervention Study; ACS, American Cancer Society; RWJF, The Robert Wood Johnson Foundation; and ASTHO, Association of State and Territorial Health Officials.

2. The states' needs for technical assistance, training, and resource materials
3. The need for a strong research component to ensure evaluation of the best strategies and state-of-the-art science to advance the most effective state-based interventions possible
4. The roles for future advisory committees or workgroups

To fulfill its charge, the workgroup engaged in a 6-month planning process to develop the framework for a CDC-administered NTCP. During that planning process, the insights gained from ASSIST, IMPACT, and non-ASSIST state programs supported by tobacco excise tax funds (i.e., in California and Arizona) were incorporated into OSH program announcement no. 99038 (request for applications)[12] for NTCP funds. Many ASSIST project directors and managers encouraged OSH to put specific requirements into the request for applications to protect the tobacco control programs and funds from being diverted to less effective programs. This concern grew out of the controversy sometimes generated by an approach that promotes tobacco prevention and control through social change, policy, and advocacy. Such controversy engenders pressure to divert program activities to more traditional public health education approaches. Flexible funding mechanisms, such as cooperative agreements, can be vulnerable if spending requirements are not in place. The workgroup continued to discuss and negotiate the details of the program requirements to accommodate the needs of the states and CDC.

The program announcement, issued in late 1998, presented the NTCP framework and funding requirements that states had to address in their applications. The announcement stated the purpose of the request for applications as follows:

> The purpose of this program is to build and maintain tobacco control programs within State and territorial health departments for a coordinated national

About NTCP (2002)

"CDC's Office on Smoking and Health (OSH) created the National Tobacco Control Program (NTCP) to encourage coordinated, national efforts to reduce tobacco-related diseases and deaths. The program provides funding and technical support to State and territorial health departments. As of September 30, 1999, NTCP funds all 50 states, the District of Columbia, 7 U.S. territories, and 11 national organizations. NTCP-funded programs are working to achieve the objectives outlined in OSH's *Best Practices for Comprehensive Tobacco Control Programs*.

"The four goals of NTCP are to

- Eliminate exposure to environmental tobacco smoke,
- Promote quitting among adults and youth,
- Prevent initiation among youth, and
- Identify and eliminate disparities among population groups.

"The four components of NTCP are

- Population-based community interventions,
- Counter-marketing,
- Program policy/regulation, and
- Surveillance and evaluation."

Source: Centers for Disease Control and Prevention. n.d. *About the National Tobacco Control Program.* http://www.cdc.gov/tobacco/ntcp_exchange/about.htm.

program to reduce the health and economic burden of tobacco use. The focus of the award is population-based community interventions, counter marketing, program policy, and surveillance and evaluation.

These efforts are directed at social and environmental changes to reduce the prevalence and consumption of tobacco use by adults and young people among all populations, eliminate exposure to second hand smoke, and identify and eliminate the disparities experienced by population groups relative to tobacco use and its effects.[12(pp1–2)]

NCI and CDC worked together to fund states so that neither the ASSIST nor the IMPACT states would experience a time gap in funding. CDC established two funding levels for the proposals from the states:

The majority of State health departments (SHD) have minimal Federal or State funding for tobacco use prevention and control. However, a few States have dedicated funding from either tobacco excise tax, or from tobacco industry lawsuit settlements supporting implementation of comprehensive programs. Therefore, under this Program Announcement, States are classified into two groups—core and enhanced.

1. **Core States** are those needing Federal funds to support basic SHD infrastructure and program components to implement a comprehensive approach and to sustain a national effort.
2. **Enhanced States** are those needing Federal funds to enhance the States' existing comprehensive program, and to sustain a national effort.[12(p2)]

The distinction in the amount of funding core and enhanced states could receive was to maintain the ASSIST capacity. ASSIST states had been assured that their funding would remain level for 1 year. CDC awarded a total of $49,067,720, ranging from approximately $200,000 to $1,616,151 per award (B. Park, e-mail message to Mary Nishioka, September 18, 2003), in cooperative agreements to all 50 states, the District of Columbia, 5 territories, Puerto Rico, and the Virgin Islands.

Transition Teams

In late 1998, once the program announcement was developed, OSH implemented the ad hoc workgroup's recommendation to establish transition teams to address the remaining issues for which OSH had requested assistance. Figure 10.2 depicts the relationship be-

Membership of the Transition Teams*

IMPACT program coordinator
ASSIST program manager
IMPACT field staff (2–3)
ASSIST field staff (2–3)
CDC-funded national organization (1)
Representatives from ASTHO
  Tobacco control network (2)
  ASTHO affiliate representative (1)
ACS
At-large members (1–4)
Consultants, advisors (1–2, as needed)
OSH staff
NCI staff

*Multicultural representation was ensured on all teams. The Multicultural Team also had representatives from the Indian Health Service and from federal and state offices on minority health.

tween the transition teams and the ad hoc workgroup and other organizational structures. From March through November 1999, these teams worked collaboratively with CDC and NCI to develop recommendations concerning the roles of future advisory groups and to ensure that the states' needs would be met when NTCP was implemented.

As recommended by the ad hoc workgroup, the composition of the transition teams included critical stakeholders. Representation from ASSIST and IMPACT state programs was equal to or greater than representation from other sources. The transition teams included individuals from an array of public and private sector stakeholders.

Coordination and Support Team

The transition teams were composed of the Coordination and Support Team and four technical teams—the Structural Development Team, Multicultural Team, Technical Assistance and Training Team, and Evaluation and Outcomes Assessment Team. The Coordination and Support Team worked closely with NCI and CDC staff to provide leadership and direction. It relied on the four technical teams for research and recommendations on specific transition issues and was composed of the chairs and cochairs of those four teams. The transition teams addressed specific issues. In addition, a broader purpose of the transition teams was to ensure a public health approach to preventing tobacco use that would involve the many stakeholders, support public-private partnerships, and effectively leverage public and private resources. The recommendations and critical issues that had been identified by the ASSIST/IMPACT advance groups in *Realizing America's Vision for Healthy People* served as a framework for much of the transition teams' work. (See chapter 9.) Because of the positive experiences of the ASSIST project with committees and subcommittees, the transition teams recognized the importance of input from states, the need for strategic planning, the value of state involvement in planning for technical assistance and training, and the benefit of communication and interaction among the states. To this end, CDC began exploring ways of facilitating collaboration and of strengthening the tobacco prevention and control movement.

Technical Teams

Structural Development Team. The Structural Development Team was charged with developing a framework for coordinating the national program. Critical to ASSIST's success had been the participation in decision making and planning by all segments of the project's large network of individuals and organizations. Mechanisms had been created to facilitate a highly integrated, participatory process for implementing, managing, and advancing ASSIST. Representatives from all 17 state health departments and ACS affiliates served on the ASSIST Coordinating Committee and worked collaboratively with NCI to oversee and guide ASSIST. (See chapter 3.) For example, the ASSIST Coordinating Committee over time became the voice of the project and played a leadership role in the issues of a national strategy for tobacco control and the transition to CDC.

Skilled directors, program managers, field staff, and volunteers participated in information exchanges and served on the various subcommittees and work teams.

The new national program would embrace all 50 states, the District of Columbia, U.S. territories, and specific American Indian tribes. With the transition to this larger program came the major challenge of how to use a participatory decision-making and administrative approach to administer a national program through state programs that had different levels of funding and various levels of capabilities and capacities. The CDC program would be too large to have a committee with representatives from each state. Instead, OSH used less-structured means, such as holding meetings with representatives from all the states, to review specific plans and to discuss issues. For example, the draft request for applications for NTCP funding was reviewed at a meeting of representatives from all the states. Also, OSH funded ASTHO to establish a committee of the state tobacco control program managers. Through this mechanism, the states would have a voice and place to organize and prioritize their collective wants and needs not only from OSH, but also from other areas of CDC and DHHS. OSH has also reached out to the ASTHO affiliates of chronic disease and health education directors to seek their advice and support. NTCP convenes the state program managers twice a year to promote communications and feedback and to build a collaborative relationship. The funding instrument used with the states is a cooperative agreement that provides flexibility and a participatory process in the implementation of the state-based NTCP.

Multicultural Team. The Multicultural Team was created to ensure that multicultural representation and issues would be woven into all aspects of the transition. It was composed of individuals representing diverse organizations and perspectives, including the Indian Health Service. The team was charged with identifying issues and developing recommendations regarding diversity and the elimination of health disparities in keeping with the goals of NTCP. (See appendix 10.A, Recommended Benchmarks for Multicultural Programs and Activities.)

The team made suggestions to the other teams regarding incorporating cultural issues into the mainstream and ensuring adequate funding and resources for diverse populations, so that funded programs would have the staff, training, and other resources necessary to implement effective programs. Prominent among the team's recommendations was that CDC establish a group to fulfill the role formerly performed by the ASSIST Multicultural Subcommittee; the group would strive to ensure diversity at all levels of NTCP and to eliminate health disparities related to tobacco use. The team also strongly recommended that CDC establish a structure that would permit maximum input and participation of tobacco control specialists at the state and local levels.

The team endorsed the four program areas and program components that became the framework for CDC's request for applications for NTCP fund-

ing. The request for applications was open not only to the states, but also to U.S. territories, which are composed of multicultural populations. In addition, the program announcement included funding opportunities for national organizations to form coalitions among their multicultural constituencies. The Multicultural Team acknowledged the value of NTCP's goal to eliminate health disparities among population groups. The team insisted that diversity and representation from all sectors of the community be factors in the planning, implementation, and evaluation of the other three NTCP goals.

To build the capacity of the states to address multicultural needs during the planning and implementation phases, NTCP objectives and activities have emphasized providing opportunities to improve cultural competency, inclusion, and diversity in coalitions and staff through training, conferences, materials, consultation, presentations, and funding of special opportunities.

Technical Assistance and Training Team. The Technical Assistance and Training Team was charged with identifying the immediate and long-range technical assistance and training needs of all NTCP participants. The team addressed the following needs:

- Standardization of core competencies
- Assessment of the levels of experience of state staff
- Conceptual frameworks for organizing training activities
- Outreach to tobacco control practitioners at the local level
- Skill building for effective program planning and evaluation
- Train-the-trainer models
- Resources scaled to varying need levels

OSH had supported the Tobacco Use Prevention Training Institute's annual training sessions, which were conducted in collaboration with the University of North Carolina at Chapel Hill School of Public Health, and continued to do so after NTCP became operational. The institute provided an intensive weeklong training on tobacco prevention and control for NTCP state and local staff and coalition members. In addition, NTCP became one of the primary supporters, with other partners including NCI, of the National Conference on Tobacco OR Health. The following are other types of technical assistance and training activities offered through NTCP:

- In the 1st year of the program, two technical assistance meetings were held with each state health department program manager and with the state health department media staff.
- Program, media, policy, and epidemiology staff served as technical assistance liaisons with the state health departments.
- Seven tribal technical assistance centers were funded to address the specific needs of American Indians.
- In the 2nd year of the program, a 5-year technical assistance and training contract was funded to help support NTCP's work with the states.
- Satellite conferences, teleconferences, and workshops were offered, and training was cosponsored on best practices in tobacco control, evidence-based programs, adult and youth tobacco surveys, and other tobacco control-related topics.

Evaluation and Outcomes Assessment Team. The Evaluation and Outcomes Assessment Team was charged with developing options for evaluation and monitoring of state performance and for data collection and surveillance. In assuming responsibility for NTCP, CDC was obligated to put in place at the national and state levels elements of a public health program that ASSIST, as a demonstration project, had not required. Surveillance, monitoring, and evaluation—particularly increased capacity and expertise for these functions within the state health departments—had to be established.

As the ASSIST states adapted to requirements of the new NTCP, a significant mismatch became evident: they had a strong capacity to deliver effective interventions to prevent tobacco use but had little or no capacity for surveillance, monitoring, and evaluation. The CDC request for applications addressed this deficiency by requiring that states spend 10% of their total funding for surveillance and evaluation and that they hire at least one half-time person with expertise in epidemiology or evaluation. This 10% minimum for evaluation effectively reduced by 10% the funds that were available for interventions. The team identified expectations, resources, and needs of the states regarding program evaluation and outcomes and suggested strategies for monitoring program performance. In particular, the team suggested that OSH encourage coordination among agencies and organizations that conduct school-based surveys that include health behaviors.

Tobacco Master Settlement Agreement Establishes a Foundation

"The settlement requires the tobacco industry each year for ten years to pay $25 million to fund a charitable foundation which will support the study of programs to reduce teen smoking and substance abuse and the prevention of diseases associated with tobacco use.

"The foundation will:

- Carry out a sustained, nationwide advertising and education program to counter youth tobacco use and educate consumers about the cause and prevention of diseases associated with tobacco use.
- Develop, disseminate and test the effectiveness of counter advertising campaigns.
- Commission studies, fund research and publish reports on factors that influence youth smoking and substance abuse.
- Track and monitor youth smoking and substance abuse with a focus on reasons for increases or failures to decrease tobacco and substance use rates.
- Create an industry-funded $1.45 billion national public education fund for tobacco control. The fund is established to carry out a nationwide sustained advertising and education program to counter youth tobacco use and educate consumers about tobacco-related diseases."

The foundation today is the American Legacy Foundation. Its Web address is www.americanlegacy.org.

Source: National Association of Attorneys General. n.d. *Tobacco settlement summary*. www.naag.org/tobac/glance.htm.

Building on the work of the Evaluation and Outcomes Assessment Team, NTCP has made surveillance and evaluation a priority. It is one of the four major NTCP program components, and NTCP devotes significant resources to improving the states' capacity to conduct evaluation. NTCP-sponsored evaluation activities were designed to improve the state of the art of evaluation and to provide states with data and examples of programs that have been evaluated. The following are some examples of those activities:

- Extensive technical assistance and workshops to help states establish state baseline data by implementing CDC's adult and youth tobacco surveys
- A tracking system of state-level tobacco control policies and production of *State Tobacco Control Highlights* for publishing rates of use, economic impact, health consequences, expenditures for tobacco control, and policy data to facilitate cross-state comparisons[13]
- The State Tobacco Activities Tracking and Evaluation System (STATE), which collects and electronically warehouses state-level data on tobacco use prevention and control[14]
- Publication of *Best Practices for Comprehensive Tobacco Control Programs*, which links tobacco control expenditures to reduced consumption[15]
- Publication of the *Guide to Community Preventive Services: Tobacco Product Use Prevention and Control*,[16] which documents the effectiveness of evidence-based tobacco control programs

Challenges Resulting from the Tobacco Master Settlement Agreement

"While tobacco control advocates initially heralded the state attorneys general lawsuits as opening a powerful new front against the tobacco industry, the multi-state settlement opened the door to several threats including:

- "Preemptive language and other tobacco industry subversion of the state settlement enabling legislation and appropriations;
- Straitjackets on tobacco control funding, such as limiting media initiatives to ineffective 'just say no' campaigns;
- Tobacco industry payments under the settlement, even when not applied to tobacco control programs, providing politicians an excuse for opposing any new tobacco excise tax increases."

Source: Advocacy Institute. 1999. *A movement rising: A strategic analysis of U.S. tobacco control advocacy.* Executive summary. Washington, DC: Advocacy Institute (p. 5). www.advocacy.org/publications/pdf/amovementrising.pdf.

- Publication of the guide for state programs, *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs*[17]
- On-site technical assistance and workshops to improve the capabilities of states to evaluate their programs
- Development of issues of the *MMWR* on the California, Massachusetts, Oregon, Arizona, and Florida tobacco control programs to document the evaluation of the results of these statewide programs[18–22]

Post-ASSIST Funding for South Carolina

The range of funding for South Carolina's comprehensive tobacco control program that was recommended in CDC's *Best Practices* report was $23,905,000–$62,013,000. In fiscal year 2002, a total investment of $3,248,862 was made in South Carolina tobacco control. The breakout of that funding is illustrated below:

CDC/OSH	$1,200,000
SAMHSA	$190,000
State appropriation from settlement revenue	$1,620,470
Other state appropriation	$62,809
American Legacy Foundation	$175,583

Source: Centers for Disease Control and Prevention. 2002. *South Carolina highlights.* Tobacco Information and Prevention Source (TIPS). National Center for Chronic Disease Prevention and Health Promotion. www.cdc.gov/tobacco/statehi/html_2002/South_Carolina.htm.

The National Environment for Tobacco Control: A Consideration

The transition of the ASSIST project took place during a dynamic and volatile period in the history of tobacco prevention and control. The 1990s had been an active decade on many fronts—policy, legal, and regulatory. During the late 1990s when the ASSIST states were preparing for transition and when the framework of NTCP was being developed, many tobacco-related issues were being addressed at the national level and were receiving high visibility in the media. The outcomes and decisions had the potential to strongly influence the funding and the scope of NTCP and other federal agencies' roles. Public health staffs at the federal, state, and local levels were very involved, responding to requests for information and serving as technical resource staff. Both protobacco and antitobacco advocates labored hard to ensure that their voices and views were heard.

The Food and Drug Administration's assertion of its authority over the regulation of the marketing of tobacco products was successfully challenged in the courts. The Substance Abuse and Mental Health Services Administration (SAMHSA) enforced a congressional mandate (the Synar Amendment) to require states to document that they were enforcing state laws to reduce retail sales of tobacco to minors. Tobacco control researchers had formed a collaborative organization, the National Organization of Tobacco Use Research Funders, to encourage collaboration among funders and investigators in tobacco control research. In August 2000, RWJF announced its plan to increase the number of grantees and the level of funding for its SmokeLess States program, which had been initiated in 1993. The National Center for Tobacco-Free Kids, founded in 1996, continued to position itself as an important source for the media on events in the tobacco control world and as a resource for state-level advocates and grassroots organizations. Senator John McCain had introduced a national tobacco control bill that caused a major debate in Congress. Litigation by states against the tobacco industry came to a resolution in the Tobacco Master Settlement Agreement in 1998 and was a potential source of new funding for

tobacco interventions. In addition to funding the American Legacy Foundation, the Tobacco Master Settlement Agreement provided for about $195.9 billion in current dollars to be made available to states between 1998 and 2025.[23]

Despite these positive developments, tobacco prevention and control work was by no means over. For example, efforts to raise cigarette and spit tobacco tax rates had experienced limited success. Youth access and appeal measures were in flux after court rulings against the Food and Drug Administration's authority. Debate over terms of the Tobacco Master Settlement Agreement and the McCain bill resulted in some still-lingering divisions among tobacco control advocates. As ASSIST drew to a close, the tobacco industry dramatically increased its advertising expenditures and promoted a positive image of itself and its philanthropic activities. Tobacco prevention and control coalitions challenged those new image-changing industry strategies, for the industry was still heavily marketing to children.[24–26] Tobacco prevention and control advocates still had considerable work ahead of them to turn the new face of tobacco control into action to prevent death and disease resulting from tobacco use.

Availability of funds from the Master Settlement Agreement and the ensuing state-level campaigns focused tobacco control advocates on the problems of acquiring these funds for tobacco prevention and control programs. Interest in policy issues, such as increased excise taxes or clean indoor air, almost uniformly was displaced by more immediate concerns about developing a workable plan and explaining the need for long-term sustainable funding.

1999 CDC report on effective tobacco control programs

In 1999, the Advocacy Institute published a comprehensive analysis of the strengths and weaknesses of, threats to, and opportunities for the tobacco control movement in the United States. The report, *A Movement Rising*, excerpted in the box on page 462, also noted drawbacks that resulted naturally from the maturing of a large movement, such as bureaucratization and the dimming of energies.[27] Nevertheless, the report emphasized that the opportunities for tobacco control were robust. For example, new litigation to obtain industry documents could lead to further settlements, evidence from new documents could lead to additional demands for industry reform, and groups seeking portions of settlement funds could become new partners in the tobacco control movement.

Status of the Tobacco Control Movement

In late 1998, RWJF and ACS funded the Advocacy Institute to conduct a comprehensive strategic analysis of the current tobacco control movement in the United States. The analysis, published in March 1999, reflects the perspectives of tobacco control advocates across the country. It is a view from inside the tobacco control movement. The findings presented below are excerpted from the report. Many represent issues that the states had to consider as they were brought together in the National Tobacco Control Program under the auspices of CDC.

Excerpts from *A Movement Rising*

"Advantages—Internal Movement Strengths

While there have been disappointments and conflicts within the tobacco control movement, as well as unimagined advances, this movement continues to enjoy potent strengths, as well as the benefit of valuable lessons learned in the upheavals of the past several years. These strengths—or advantages—include:

- Moral authority grounded on a strong scientific base;
- A deep reservoir of dedicated human resources, among them a growing army of veteran advocates throughout the country;
- A solid movement infrastructure of technical support and funding;
- A growing diversity of advocates, both culturally and politically;
- Many mature, experienced state and local coalitions;
- New partnerships forged with public health and education organizations, trial lawyers, the faith community, elected policy makers, pharmaceutical companies, and even tobacco growers; and
- Hundreds of advocates adept at media advocacy and a veteran press corps with whom they have developed working relationships of trust and confidence.

"Challenges—Internal Movement Weaknesses

Many of our challenges are the mirror image of our advantages. Perhaps the most formidable challenges deal with our relationships with each other. . . .

Among the challenges we face are:

- The growth and bureaucratization of the movement, which has leeched some of the inspiration and energy that sprung [*sic*] from being citizen Davids challenging the industry Goliath;
- Dependence upon public and philanthropic funding, which constrains advocacy, coupled with an aversion to political engagement among too many tobacco control professionals, even in their role as private citizens;
- The persistent narrowness of the tobacco control movement's base, despite new outreach efforts to minority communities, parents and educators, labor, faith communities, business and tobacco farmers;
- Flawed intra-movement strategic communications that leave many state and local advocates feeling "out of the loop" in strategic decision making and sometimes lead to inflammatory misinformation;
- A lack of sufficient resources for state and local coalitions to address effectively all tobacco control policy objectives; this deficiency is often coupled with a reluctance to set priorities;
- The persistent gap between tobacco control funding and tobacco industry war chests;
- Serious internal divisions among tobacco control advocates over core values and goals, strategies, leadership roles, and issues of open communication and information exchange; and
- A residue of lingering resentments, valid or not, including perceived inequities in funding, perceived self-promotion, perceived patronizing arrogance of some newcomers toward tobacco control veterans, perceived patronizing by some national leaders of state and local leaders, and perceived conflicts of interest.

"Threats—External Threats to the Movement

The tobacco control movement's success has itself engendered a new set of external threats. Among them:

- High profile media coverage of the state attorneys general lawsuits and the multi-state settlement has left many Americans believing that the tobacco 'problem' has now been dealt with;
- Years of exposing tobacco industry wrongdoing has left the public numbed to additional revelations, and there is even evidence of nascent sympathy for an industry that appears to have been 'punished enough';
- There are signs of disenchantment with tobacco control programs that do not result in immediate and dramatic declines in youth and adult tobacco consumption;
- There is increasingly harsh commentary by journalists and others—not industry flacks—who raise concerns about the effectiveness, the fairness, the overreaching, and the political expediency of tobacco taxes and other tobacco control objectives;
- Some citizens suspect that advocates for new, large tobacco control programs are more motivated by self-interest in potential new jobs than in the public health."

Source: Advocacy Institute. 1999. *A movement rising: A strategic analysis of U.S. tobacco control advocacy.* Executive summary. Washington, DC: Advocacy Institute (pp. 4–5). www.advocacy.org/publications/pdf/amovementrising.pdf.

The many issues in the analysis are complex and illustrate the dynamic environment at the time of the transition.

Guidance to States on Acquiring Funding for Their Programs

The president's budget for fiscal year 1999 included a $51-million request for state-based programs to prevent and reduce tobacco use. But there remained a substantial shortfall between the $51 million that was budgeted and the level of funding that would be needed. Therefore, states would need to pursue other sources of public and private funding—from the Master Settlement Agreement; from federal, state, and local government funds; and from a variety of other sources, such as foundations and organizations.

Before the $51-million budget for NTCP was official, OSH had been preparing a set of recommendations for comprehensive tobacco prevention and control programs known as best practices. This report, mentioned earlier in this chapter, was released by CDC in August 1999 under the title *Best Practices for Comprehensive Tobacco Control Programs.*[15] *Best Practices* served as a guide for the states to plan comprehensive programs and to seek appropriate levels of funding through allocations from the Master Settlement Agreement and by continuing to advocate for financial support from a variety of public and private sources.

Best Practices recommends nine components of a comprehensive program, based on existing research and the experiences of states with large programs and relatively long-term funding. *Best Practices* provides a useful list of the essential elements of a comprehensive tobacco control program. However, it does not provide specific guidance on

evidence-based strategies of a comprehensive tobacco control program. That guidance was based on the 2000 Surgeon General's report[1] and recommendations of CDC's Task Force on Community Preventive Services.[5–7]

Best Practices:
Recommended Funding Levels

1. **Community programs to reduce tobacco use** ($850,000–$1.2 million per year for state personnel and resources; $0.70–$2.00 per capita per year for local governments and organizations)
2. **Chronic disease programs to reduce the burden of tobacco-related diseases** ($2.8 million–$4.1 million per year)
3. **School programs** ($500,000–$750,000 per year for personnel and resources to support individual school districts; $4–$6 per student in grades K–12 for annual awards to school districts)
4. **Enforcement** ($150,000–$300,000 per year for interagency coordination; $0.43–$0.80 per capita per year for enforcement programs)
5. **Statewide programs** (including policy and media activities, approximately $0.40–$1 per capita per year)
6. **Counter-marketing** ($1–$3 per capita per year)
7. **Cessation programs** ($1–$3 plus cessation services ranging from $137.50 to $275 per smoker served)
8. **Surveillance and evaluation** (10% of total annual program costs)
9. **Administration and management** (5% of total annual program costs)

Source: Adapted from Centers for Disease Control and Prevention. 1999. *Best practices for comprehensive tobacco control programs—August 1999.* Executive summary. Atlanta: Centers for Disease Control and Prevention. http://www.cdc.gov/tobacco/research_data/stat_nat_data/bestpracexecsummay.htm.

Armed with CDC's *Best Practices for Tobacco Prevention and Control Programs* and with the National Association of County and City Health Officials' local-level counterpart, *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs*,[28] local advocates monitored state legislatures to hold them accountable for providing resources to counteract the number one preventable cause of death. These documents provide state coalitions, particularly the private sector partners in those coalitions, with a much-needed, scientifically credible resource for planning their efforts and for making a case to acquire settlement funds for tobacco use prevention.

Case studies 10.1 and 10.2 illustrate the states' experiences in obtaining additional resources for tobacco control interventions while addressing their administrative, staffing, and program needs. Minnesota is one of the four states that did not participate in the Tobacco Master Settlement Agreement with the tobacco industry because it had previously settled its lawsuit against the industry, after a lengthy trial, which resulted in substantial additional financial resources being devoted to tobacco control efforts beginning in 1999.

Virginia, a leading tobacco-growing and -manufacturing state, along with 45 other states, participated in the Tobacco Master Settlement Agreement. Case study 10.2 illustrates how the infrastructure and strong partnerships built by ASSIST provided the leadership and creativity needed to leverage the relationship with tobacco growers to secure a portion of the funds for tobacco prevention and control activities.

Case Study 10.1
Transition at the State Level: Minnesota's Experience

Situation: As the ASSIST project was coming to a close and before the U.S. DHHS committed to a national tobacco control program, many states faced challenges in obtaining the financial, human, and technical resources needed to continue their work in this area. During this period of transition and uncertainty, states were at risk of losing talented, experienced staff and program momentum if existing funding streams were interrupted and if administrative systems were altered.

Strategy: Minnesota was fortunate to have new tobacco control resources available from two sources of state funding—the Governor's Children's Initiative (1997) and the Tobacco-Free Communities for Children Initiative—which together provided $1 million per year to support prevention activities of local public health agencies and the Minnesota Department of Health. In addition, with a portion of the funds from the 1998 Minnesota settlement with the tobacco industry, the 1999 legislature established the Tobacco Use Prevention and Local Public Health Endowment, which provided unprecedented tobacco control resources for statewide and local activities ($20.8 million in the first 18 months beginning January 2000, growing to about $25 million annually for these two areas when fully funded). Minnesota was well positioned financially to expand existing tobacco control activities, including those previously funded through ASSIST.

There were, however, challenges related to moving tobacco control forward in Minnesota:

- How could tobacco control activities be more effectively integrated within the Minnesota Department of Health? The department's funding for tobacco control efforts came from several different state and federal sources; because of lack of coordination among those funding sources, some duplication resulted. When new resources became available for statewide and local tobacco prevention initiatives, it became imperative that the department develop an internal structure for integrating these resources.
- What restrictions were associated with the use of tobacco endowment funds? Less than 1% of these new funds could be used to support technical assistance activities. This amount was inadequate for the support needed, and the existing staff members were unable to meet the demands placed on them. As tobacco control activities increased in Minnesota, the need to provide consultation, technical assistance, and training would continue to increase, but the new funds did not allow for expansion of staff at the state level.
- How would the state realign program priorities in light of these new sources of funds? The state legislature imposed a requirement on the Minnesota Department of Health that its tobacco prevention and control focus be limited to 12- to 17-year-olds.

Case Study 10.1 (continued)

- How could tobacco control staff and advocates maintain the momentum of ongoing initiatives and scale up their activities while adjusting to new administrative and funding mechanisms? Many public and private partners were very involved in tobacco control and contributed to maintaining the momentum in Minnesota. These included the Minnesota Smoke Free Coalition; the American Cancer Society, Minnesota Division; the Association of Nonsmokers Minnesota; the Minnesota Partnership for Action Against Tobacco; and Blue Cross and Blue Shield of Minnesota. All these partners participated in planning processes to determine the roles that various organizations would take on as new resources and funding mechanisms became available.
- How would the Minnesota Department of Health coordinate its efforts with those of other organizations? The Minnesota Department of Health began a process to define its role in tobacco control and to examine how the new federal funds could be used to support tobacco control activities.

The state worked at several levels to address these concerns. Beginning in January 1998, half of the funding for the Tobacco-Free Communities for Children Initiative ($500,000 per year) was distributed as noncompetitive grants to local public health agencies, and half was used to provide staffing at the state Department of Health for technical assistance and public education programs. These funds contributed significantly to the ability of state and local health departments to successfully expand and incorporate elements of the ASSIST model into their infrastructure.

Later in 1998, the Minnesota Department of Health began a process that successfully defined its role in tobacco control, consolidated tobacco control funds, and provided the structure for administering the funds but did not address the lack of administrative staff. Fortuitously, the transition to NTCP provided an opportunity to examine how the new federal funds could be used most effectively to support tobacco control activities. The new funds from the Centers for Disease Control and Prevention were used primarily to support staff at the Minnesota Department of Health in administering tobacco control activities and to provide technical assistance and training to local grantees. Because new resources would become available to fund local coalitions and other tobacco-related initiatives at the local level, the shift in use of federal funds did not diminish local activities.

Insights: Staff members were not trained to conduct an evaluation of ASSIST, nor were evaluation results or resources made available to them; otherwise, they could have identified and considered incorporating the most effective program elements into the planning process for NTCP. For a community-based demonstration project such as ASSIST, evaluation resources should be available, and expertise should be

built from the beginning of the project to increase the probability that the capacity and capabilities of successful tobacco control efforts can be maintained.

—Gretchen Griffin, Project Manager, Minnesota Department of Health

Note: For further reading on the Minnesota tobacco prevention and control movement, see the following source: Wolfson, M. 2001. *The fight against big tobacco: The movement, the state, and the public's health*. Hawthorne, NY: Aldine de Gruyter.

Case Study 10.2
Establishment of the Virginia Tobacco Settlement Foundation

Situation: Before Virginia was awarded an ASSIST contract in 1991, tobacco control efforts in the state were sporadic and limited. Between 1992 and 1998, the Virginia Department of Health's Tobacco Use Control Program (VDH-TUCP) established 1 state-level and 17 local tobacco control coalitions to conduct policy-related activities and to counter the long-standing cultural acceptance of tobacco use. These coalitions consisted of a wide variety of local nonprofit organizations, hospitals, schools, agencies, and other partners. One partner, the University of Virginia's Institute for Quality Health (IQ Health), was awarded a SmokeLess States grant from RWJF to focus on developing a relationship between the tobacco-growing community and tobacco control advocates.

In 1998, as a result of Virginia's participation in the Master Settlement Agreement (MSA), the state projected revenue of approximately $4 billion over the next 20 years from the tobacco manufacturers. Anticipating that numerous entities would seek funding from the MSA, a group of tobacco control advocates quickly mobilized to formulate a plan to secure a portion of the funds for tobacco control.

Strategy: Led by the American Cancer Society (ACS) and the American Lung Association (ALA), this group initially proposed that 20% of Virginia's MSA fund be used for a comprehensive approach to tobacco control. A foundation would be created to administer the fund. The foundation would be governed by a board of directors representing a wide variety of health interests related to tobacco use, including medical interests, educational interests, treatment, prevention, and enforcement. Acknowledging the legislature's past opposition to tobacco control legislation, the advocates anticipated a difficult campaign to secure passage of the proposed legislation.

At the same time, another group representing Virginia's tobacco-farming interests was drafting legislation to target all or a major portion of the MSA funds to compensate growers for loss of tobacco quotas and to provide economic incentives to tobacco-dependent communities. Because IQ Health had sponsored dialogue between the advocates and the growers for some time, the two groups met and decided to com-

Case Study 10.2 (continued)

bine forces to secure passage of legislation that would provide funding for both interests. They reasoned that the health advocates would offset opposition to funding being directed to tobacco farmers and that the growers could offset opposition to funds being used to reduce tobacco use. Both groups were careful not to include the manufacturers in the discussion or in the drafting of the legislation.

Negotiations were held, and compromises were made; the result was a combined bill to create the Virginia Tobacco Settlement Foundation to administer 10% of the funds for tobacco control activities and to create the Virginia Tobacco Indemnification and Community Revitalization Commission to administer 50% of the funds for grower reimbursement and economic development. The draft plan also included legislative members on the foundation's and commission's boards of directors to provide legislative oversight. The final sponsors of the bill were prominent supporters of grower interests and a known advocate for health. Although the plan reduced the amount of funding available and narrowed the scope of the program to focus specifically on prevention of youth tobacco use, advocates endorsed the legislation as a significant accomplishment.

The local tobacco control coalitions were mobilized to promote passage of the legislation during the 1999 Virginia General Assembly session. ACS and ALA developed fact sheets. They also developed call logs of selected legislators and promoted their use. A letter-writing campaign to the entire General Assembly was initiated. ACS and ALA testified before committees in conjunction with representatives from the grower community. The end result was that the bill passed both chambers with only minor technical changes.

The next campaign was focused on the governor's office. Both growers and tobacco control advocates were unclear on how the bill would be handled by the administration. Throughout the legislative process, the governor received contradictory advice from his staff concerning the content of the bill and the process of dedicating the MSA dollars. Letters, phone calls, and e-mails to the governor's office, as well as lobbying by the sponsors, resulted in the governor's signing the bill with amendments. The amendments related to increasing the governor's oversight of the foundation by his appointment of the chair and vice-chair of the board as well as the executive director. The legislation became effective on July 1, 1999, and directed approximately $14 million annually to programs to prevent youth initiation of tobacco use.

Summary: Of all the policy and legislative efforts that the tobacco control coalitions engaged in during the years of the ASSIST project, establishing long-term funding for tobacco control had the greatest potential for significant long-term impact.

—R. Neal Graham, former ASSIST Project Manager,
Virginia Department of Health

Toward the Future

The transition to the CDC-administered NTCP presented many challenges to NCI; CDC; and every participating state, territory, district, and American Indian tribe. No matter what its existing capacity, each entity had to assess its mission and role in relation to the goals and objectives of the national program and to realign and shape programs and functions as appropriate. Maintaining their capacities was high on the agenda for the ASSIST states, but they also had to expand their capacity and capabilities beyond policy development to undertake the additional core functions—assessment/monitoring and assurance of necessary services—of a public health program.

Transition between agencies and from one type of program to another is challenging. However, NCI and CDC staff worked very closely with extensive input from state departments of health staff and other key partners to ensure that the transition process was successful. Many issues of mission and role overlap, imbalances of resources and expertise, tradition, ideology, political climate, and administrative practicalities had to be considered. The transition required a highly participatory management process that minimized conflict, maximized commitment, and generated enthusiasm.

Various workgroups and especially the transition teams made suggestions to OSH about program administrative structures and methods of operation that would best suit their participation in NTCP, essential program elements, and training and technical assistance needs. Prominent among their suggestions was that CDC establish a mechanism for ensuring participatory decision making and establish a group to fulfill the role formerly performed by the ASSIST Multicultural Subcommittee; this group would strive to ensure diversity at all levels of NTCP and to eliminate health disparities related to tobacco use.

Considerable efforts were made to ensure that the essential elements of ASSIST became integral components of NTCP. Chapter 11 presents the contributions that ASSIST made to the tobacco prevention and control movement and describes ASSIST's continuing influence and the challenges ahead.

Appendix 10.A. Recommended Benchmarks for Multicultural Programs and Activities

Developed by the ASSIST Multicultural Subcommittee
March 1999

1. Recommended Benchmark:

Provide training in cultural sensitivity and cultural competency for all federal, state and local staff working on comprehensive tobacco reduction programs. Incorporate cultural inclusivity as a core value and central principle in all tobacco use reduction programs and practices. Work toward the goal of cultural competency in all programs and materials.

Examples:

- Provide plenary sessions, break-out presentations, and workshops to develop cultural competency during all national tobacco control conferences.
- Integrate cultural competency principles into local, state, and federal planning, coalition building, recruiting, training, implementation, and institutionalization processes.

Rationale:

- Racial, ethnic, and multicultural communities have unique social, cultural, and historic backgrounds. Culturally specific experiences directly influence the role of tobacco and the tobacco industry and how they are addressed in tobacco use reduction messages. People with limited English proficiency, or those who have recently arrived in the United States will have less information about the dangers of tobacco, and therefore, different needs than those more acculturated to U.S. customs.
- Representation from all groups impacted (diversity) is the beginning of this integration. Involving impacted groups in decision making (inclusivity) is another key step. Building on diversity and inclusivity to better understand and appreciate cultural differences leads to culturally competent programs and materials.
- Media and public education campaigns need to focus on strategies that impact populations at highest risk. Public health programs that underscore the importance of reaching multicultural populations with effective strategies will reduce tobacco use sooner than those that don't.
- Including training on cultural competency at national and state level conferences is one way to ensure that public health workers and tobacco prevention advocates have ready access to the information.

Accountability:

- Project Officers and Project Managers are responsible for ensuring cultural inclusivity in planning processes and designing state work plans.

- At a minimum, training for staff and volunteers, technical assistance, and training of trainers on the topic of cultural competency should be provided.
- Project Managers review state and local work plans for incorporation of cultural competency principles into recruiting strategies, coalition building, and funding for community organizations.
- Establish an [independent] advisory board to monitor multicultural resources, funding, and activities that are part of the state health department's tobacco reduction plan.

2. Recommended Benchmark:

Designate funding and other resources to community based organizations that serve multicultural communities as a standard component of the budget for each state's tobacco reduction program.

Examples:

- Make state level and community grants, contracts, and agreements accessible to community based programs that serve multicultural communities. Provide training in grant writing and comprehensive tobacco prevention strategies to community based organizations.
- Require all state and community grants, contracts, and agreements to include culturally appropriate and culturally sensitive activities.
- Develop training on alternative funding sources for community based organizations.

Rationale:

- The tobacco industry's targeted advertising, promotion, and philanthropy to multicultural populations may undermine tobacco use prevention and reduction strategies. Changes in cultural norms occur best when targeted populations are included in planning, funding, implementation, and evaluation stages.

Accountability:

- Project Officers, Project Managers, and staff include funding for community based organizations, mini-grants, and sponsorship of activities and projects that reach and involve each state's multicultural populations. Provide technical assistance and training in planning and evaluating activities.

3. Recommended Benchmark:

Collect reliable and valid data on tobacco prevalence and brand use, and review and disseminate research on effective tobacco reduction strategies impacting multicultural communities. (Note: both process and outcome data are needed.)

Examples:

- Over sample racial and ethnic populations on the Behavioral Risk Factor Survey and the Youth Behavioral Risk Factor Survey to obtain numbers representative of the state's racial and ethnic diversity.
- Add questions on tobacco use patterns within racial and ethnic populations to the Behavioral Risk Factor Survey i.e. brand preferences, menthol or non-menthol, and price sensitivity.
- Disseminate research on effective strategies to reduce tobacco use to multicultural populations.
- Budget additional resources and funding to data collection for racial and ethnic populations.

Rationale:

- Qualitative and quantitative reporting allows for a comparison to previous years to determine changes in tobacco use patterns, funding, targeted programming and culturally appropriate resource development, within multicultural communities. As many community groups serving racial, ethnic, and multicultural communities are in early stages of development for community tobacco prevention programming, process measure are equally important with outcome measures.

Accountability:

- Project Officer and Project Manager review data sources for reliable and valid information. Fund data collection or surveillance activities where inadequacies are found.
- Establish an [independent] advisory board to review, recommend, and monitor this benchmark.

4. Recommended Benchmark:

Promote hiring of staff that represent the state's ethnic/racial/and cultural diversity in leadership and managerial positions in federal, state, and local tobacco reduction programs. Establish a competitive process for selection of contractors, which requires cultural inclusivity. Adhere to federal guidelines regarding minority contractors.

Examples:

- Contact national minority (multicultural) organizations when publicizing position openings and recruiting qualified applicants.
- Publicize position openings in state and local multicultural media.
- Follow affirmative action guidelines.

Rationale:

- Hiring diverse staff increases the ability of the program to reach multicultural populations. The populations that bear the greatest burden of tobacco related disease and death should serve as decision-makers in reducing tobacco use within those populations.

Accountability:

- Incorporate multicultural outreach into existing hiring guidelines for state health departments.
- Add training in cultural competency to the list of basic qualifications for all tobacco prevention/reduction positions.

5. Recommended Benchmark:

Develop and distribute resource materials, consultant's lists, and media messages that promote culturally sensitive tobacco reduction strategies in languages understood within the target population.

Examples:

- Test market materials within target communities for acceptance and readability within their cultural norms.
- Provide tobacco prevention materials in languages other than English.
- Develop materials with guidance and approval from the target group.

Rationale:

- Language barriers prevent many people from receiving public information and media messages on tobacco prevention that are currently available. State and federal programs will never reach the goal of reducing tobacco use to 15% if the issue is not framed in terms that multicultural communities understand. Members of a target community are our best sources of accurate and culturally appropriate prevention messages.

Accountability:

- Federal and state tobacco reduction programs are accountable for producing culturally appropriate materials.
- New materials must be approved by the [independent] advisory board.

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11. The Promise of ASSIST

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Appendix 11.A. Tobacco Control Professionals Who Shared Their Insights regarding ASSIST 507

Chapter 11: The Promise of ASSIST

The American Stop Smoking Intervention Study (ASSIST) made significant advances in disseminating evidence-based interventions—building an effective infrastructure by mobilizing communities; establishing coalitions; and providing materials, training, and technical support for using media advocacy and policy development. These interventions were not necessarily designed and tested by ASSIST. Rather, they were incorporated into ASSIST because they had been proven effective by earlier research trials. ASSIST demonstrated on a massive scale how to effectively translate and disseminate them.

For some communities, the funding and technical assistance provided by ASSIST made it possible for people and organizations to mobilize around media and policy advocacy. For less experienced but nonetheless receptive communities, ASSIST provided the conceptual framework on which to build a foundation for tobacco use prevention and control efforts. For non-ASSIST states, ASSIST was an example—a viable, effective, adaptable, demonstration model—that gave insight and inspiration about what communities can accomplish. In brief, ASSIST's legacy to the field of public health is (1) the successful demonstration of the applicability of an ecological model to public health initiatives and (2) the development of effective methods for building state and community capacity for implementing public health interventions.

The core elements of a program endure because they have been proven to be effective. The core elements of ASSIST provide a process for shifting from a major focus on services for individuals to systems-level interventions for large population segments. With this systems strategy approach, ASSIST established enduring infrastructures in the ASSIST states that facilitate their continuing public health efforts over the long term. That infrastructure includes a network of public health professionals, local volunteers, and advocates trained by ASSIST in policy and media advocacy. ASSIST also demonstrated and brought to the forefront that adequate funding and high-quality training are essential for effective tobacco prevention and control programs and for developing and maintaining a competent workforce.

This chapter describes how the effective application of the ASSIST core elements contributed to a fundamental shift in the approach to tobacco use prevention and control and other behavioral health initiatives. ASSIST's reliance on ecological theory as a basis for its conceptual framework has provided a leading model for other systems-level public health programs. The complexity of evaluating ASSIST led to the development of new models that could be used for future evaluations of public health efforts and other community-based interventions. The complexity of the ASSIST evaluation highlighted the importance of a continued commitment to rigorous evaluation efforts and broadly disseminating results.*

*In order to develop this chapter, input regarding ASSIST's legacy was solicited from a wide array of public health experts who had integral roles throughout the project. Selected quotations from their input are included in this chapter. See appendix 11.A for a list of these tobacco control professionals.

Beyond ASSIST

The underlying philosophy and core elements of a project that continue to be incorporated into other initiatives constitute its legacy. Those conceptual and practical elements become apparent as they influence future programs and are carried forward in dynamic systems. ASSIST incorporated many of the key ingredients for successful public health efforts—highly credible scientific evidence, passionate advocates, media campaigns, and advocacy in favor of laws and regulations.[1] The conceptual underpinnings of ASSIST are based on almost half a century of public health efforts against tobacco use.[2] ASSIST borrowed from those legacies and built on its predecessors' successes. Now, 5 years after ASSIST has ended, what is its legacy?

In an unprecedented effort to apply the knowledge gained during the preceding decades, the National Cancer Institute (NCI), in partnership with the American Cancer Society (ACS) and 17 state health departments, established what was then the largest, most comprehensive public health tobacco control project ever initiated in the United States. Based on scientific evidence that emphasized the importance of community mobilization, community ownership, and the creation of structures in the community to ensure that successful programs are maintained, ASSIST built the most visible and promising aspect of its legacy—an evolving infrastructure for implementing comprehensive tobacco prevention and control initiatives.

This infrastructure provided the underpinning necessary for conducting media advocacy and policy development—a community-based participatory approach to decision making and program implementation.

> I think that ASSIST provided the blueprint to show all of us that it is possible to get major policy changes in states and communities despite the persistent opposition of the tobacco companies.
>
> *—Erwin Bettinghaus, former ASSIST Senior Advisor and current Senior Scientist and Associate Vice President at the Cooper Institute*

Another promising legacy of ASSIST is its focus on the use of media advocacy and policy development to shift the emphasis of public health interventions away from just individuals and incorporating systems-level interventions that change broad social, cultural, and physical environmental conditions of organizations, communities, and society at large. This change in emphasis was referred to as a "paradigm shift" among many in the tobacco control community because of its broad impact.

The core elements of the ASSIST model (community mobilization and organization, media advocacy, and policy development) guided the interventions, but other factors were also essential for success. Along with adequate program funding, public health workers needed new skills to effectively deliver these types of interventions. ASSIST provided an exceptional array of tools, materials, training, technical assistance, and other support to staff and volunteers and thereby increased recognition of the need for this level of technical support.

These multiple programmatic aspects have been incorporated into state-based tobacco prevention and control programs as well as into other health promotion initiatives. This chapter examines the aspects of ASSIST's legacy that derive from (1) its evolving infrastructure and (2) the effective applications of its core elements.

A Visible Promise: An Evolving Infrastructure

The quotation from Susan Stuntz (see sidebar) at the June 11, 1992, Tobacco Institute Executive Committee meeting illustrates the tobacco industry's recognition of the significant potential for the ASSIST infrastructure to thwart the tobacco industry's interests.

Tobacco Industry Perspective

"In California, our biggest challenge has not been the anti-smoking advertising created with cigarette excise tax dollars.

"Rather, it has been the creation of an anti-smoking infrastructure . . . right down to the local level. An infrastructure that for the first time has the resources to tap in to the anti-smoking network at the national level. . . .

"The ASSIST program has the potential to replicate our California experience in 17 other states."

Source: Stuntz, S. 1992. Comments on joint NCI/ACS ASSIST program. Tobacco Institute. June 11, 1992. http://legacy.library.ucsf.edu/tid/rjk86d00. Bates nos. TI13851813–1818, TI14311813–1818, and TIMN404296–4301. Accessed December 2, 2004.

ASSIST left a living legacy that is evident from the current actions of many (if not all) of today's tobacco control organizations.

—William R. Lynn, former ASSIST NCI Project Officer

NCI, ACS, and state health departments all played key roles in modeling what a true public-private partnership could accomplish, and the stature of these organizations brought legitimacy and credibility to ASSIST. As they worked together to build a solid infrastructure, there were conflicts and issues that had to be resolved. Although ACS was the designated partner, discussions and negotiations occurred to ensure that other organizations critical to the partnership such as the American Lung Association and the American Heart Association were involved in decision making and implementation of interventions. With

ASSIST taught health departments how to collaborate with community partners and the value and necessity of these partnerships in planning and implementing a comprehensive and integrated approach to tobacco control. It taught ACS and other community organizations how to work with the government to get the job done. ASSIST also caused local communities to come together as state and local coalitions.

—David Harrelson, former Tobacco Control Program Manager, ACS, and current Tobacco Prevention and Control Specialist, Washington State Department of Health

Helene G. Brown, former ASSIST Senior Advisor from the American Cancer Society, addresses the Fifth Annual National Conference on Tobacco and Health in Kissimmee, Florida, August 1999.

continued collaboration and participatory management, all partners came to a deeper appreciation of the value that local communities bring to tobacco prevention and control efforts. State health departments became more skilled at working collaboratively with community partners and came to appreciate the critical value of those partnerships in planning and implementing a comprehensive, integrated approach to tobacco prevention and control. ACS and other community organizations gained understanding in ways to work with and complement the efforts of governmental agencies to accomplish their common goals.

The momentum of the tobacco prevention and control movement increased as ASSIST grew—strengthening existing partnerships and engaging new partners. The strength of the infrastructure flowed from the network of tobacco prevention and control public health specialists and community advocates trained and tested in the skills essential to implementing a socioecological approach to public health problems. A communications network and extensive training and technical assistance opportunities were critical components developed during ASSIST to support the effective functioning of the infrastructure.

> The model of collaboration for coordinated action among the public, for-profit, and not-for-profit sectors was proven by the ASSIST project to be workable. The partners accepted and leveraged funding, sought and received in-kind contributions, and used one another's assets to make the project a success.
>
> *—Helene G. Brown, former ASSIST Senior Advisor from ACS and current Associate Director, Community Applications of Research, UCLA Jonsson Comprehensive Cancer Center*

One of the most significant contributions that ASSIST made to public health was the empowerment and mobilization of local volunteers. Along with professional staff, these volunteers were trained at ASSIST conferences known as information exchanges, especially in media and policy advocacy skills. In turn, many of the individuals trained at those meetings helped educate and mobilize state and local networks of people to influence the adoption of local poli-

In 1989, there was no state coalition [in West Virginia] and not even one full-time state employee devoted to tobacco control. ASSIST created a capacity of knowledge and infrastructure at the state and local level and laid the foundation for the enormous progress that has occurred since its inception. This is most evident in terms of clean indoor air. In 1989, people could smoke everywhere. Today, 91% of the public lives in counties with smoking regulations.

—Robert H. Anderson, Deputy Director, Prevention Research Center, West Virginia University

cies. (See chapter 4.) Without the contributions of local volunteers and the grassroots networks established in local communities, changes in policies and social norms may not have materialized.

With the development of effective infrastructures in ASSIST states came the recognition that every state needed such an infrastructure. As the scheduled end of the 8-year ASSIST demonstration project grew near, this recognition strengthened the appeals of ASSIST leaders in advocating for the establishment and funding of a national tobacco prevention and control program. In part because of the effectiveness of ASSIST state and local infrastructures, especially the work of coalitions, in stimulating policy changes, the 1998 Institute of Medicine (IOM) report *Taking Action to Reduce Tobacco Use* recommended continued funding of federal, state, and local initiatives, as well as the initiatives of nongovernmental organizations, to hold policymakers accountable because state and local efforts will "likely remain the bulwark of tobacco control."[3(p10)]

"The coalition model is valuable in that it will enable the demonstration project to: deliver interventions to the community that have been tested as effective in reducing tobacco use; involve multiple organizations and institutions capable of addressing tobacco prevention and control in a coordinated fashion; encourage smoke-free environments; and effect public policies regarding tobacco use. Furthermore, it is anticipated that by carrying out this effort through channels that are indigenous to our society, coalition members will develop a natural sense of ownership of the project which will strengthen and maintain their efforts."

Source: National Cancer Institute. 1988. *Concept: American Stop Smoking Intervention Study (ASSIST).* Bethesda, MD: National Cancer Institute (p. 3).

This infrastructure is now being threatened as states' antismoking program budgets are being reduced and landmark programs such as those in Minnesota, Massachusetts, and Florida are being dismantled by budget cuts. In Florida, those cuts constituted 99% of its antitobacco budget.[1] The ASSIST infrastructure that remains has left an important legacy of statewide networks of citizens, government agencies, private organizations, nonprofit agencies, civic leaders, and elected officials committed to reducing tobacco use. Public health specialists were trained with the knowledge and skills needed to mobilize communities, effectively obtain media coverage of their issue, and focus the public's attention on the need for policy change. Many of these trained individu-

als continue to work in the field of public health. As they left ASSIST for other opportunities, including staffing the new National Tobacco Control Program at the Centers for Disease Control and Prevention (CDC), they took with them the ASSIST concept, experiences, and skills, and had become familiar with its tools. This capacity was essential to demonstrating the applicability of the ecological model to tobacco use prevention and control, as described in the next section.

> "Ecological models of health behavior[:] Models proposing that behaviors are influenced by intrapersonal, sociocultural, policy, and physical-environmental factors; these variables are likely to interact, and multiple levels of environmental variables are described that are relevant for understanding and changing health behaviors."
>
> *Source:* Glanz, K., B. K. Rimer, and F. M. Lewis, eds. 2002. *Health behavior and health education: Theory, research, and practice.* 3rd ed. San Francisco: Jossey-Bass (p. 463).

The Promise of ASSIST: Shaping the Future

Ecological Theory and the ASSIST Conceptual Framework

The ecological model considers a system and all its components—from social factors (environmental, economic, political), to interrelationships (coalitions, agencies), to individual sectors (education, religion), to individuals. The use of ecological models to depict the connections and interrelationships between people and their environments—social and physical—and to guide interventions is not new. A 2003 IOM report *Who Will Keep The Public Healthy?* cites the lessons from community intervention trials that were conducted in the late 1970s and early 1980s that reinforced "the emergence of social ecology principles for informing public health interventions."[4(p86)] Ecological theory provided the basis for ASSIST's conceptual framework, and variations on the cube used by ASSIST have been adapted for use in the application of ecological theory to the prevention of other chronic diseases, particularly cardiovascular disease (see figure 11.1).

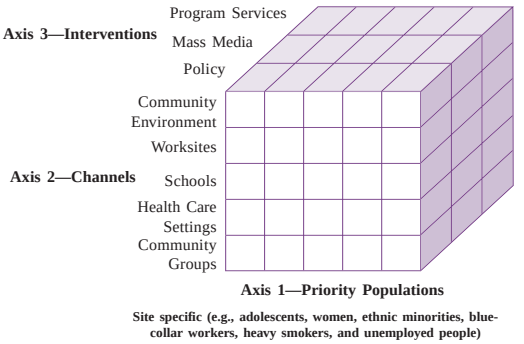
The magnitude of ASSIST and its success brought high visibility to the ecological approach, the ASSIST cube, and other systems-level approaches to preventing chronic diseases. Several IOM reports reaffirm the utility of the ecological approach in guiding public health interventions.[5,6,7] A 2000 IOM report, *Promoting Health: Intervention Strategies from Social and Behavioral Research,* identifies an "emerging consensus that research and intervention efforts should be based on an ecological model,"[5(p2)] and a subsequent 2003 IOM report stresses that the education of public health practitioners should be grounded in ecological theory.[4]

Interventions for Systems-Level Change

ASSIST was at the vanguard in shifting the focus of health behavior change interventions from primarily program

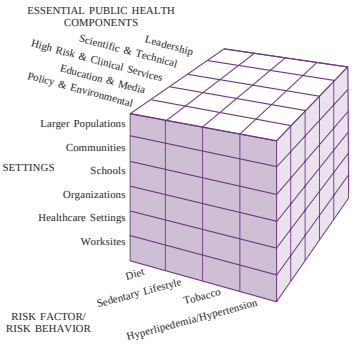
Figure 11.1. The ASSIST Cube and Subsequent Adaptations to Cardiovascular Disease

The ASSIST Conceptual Framework



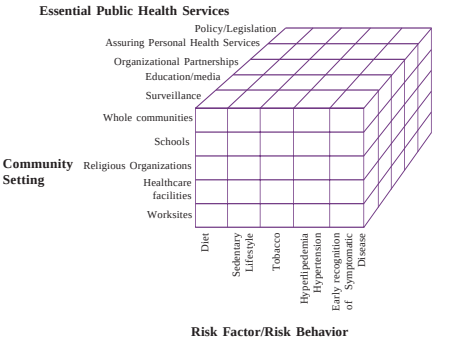
Source: ASSIST Coordinating Center. 1991. ASSIST program guidelines for tobacco-free communities. Internal document, ASSIST Coordinating Center, Rockville, MD.

A Conceptual Framework for Promoting Heart Health Cube from Singapore Declaration



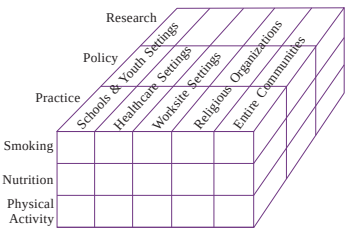
Source: The Singapore Declaration: Forging the will for heart health in the next millennium. Declaration of the Advisory Board of the Third International Heart Health Conference. Singapore: Third International Heart Health Conference, September 2, 1998.

Essential Public Health Services



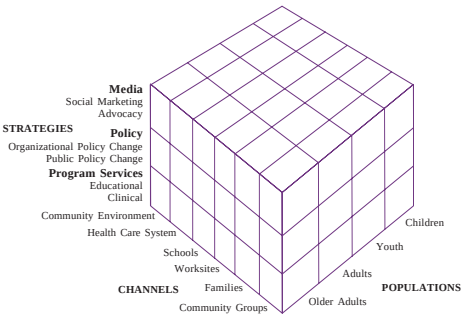
Source: Pearson, T. A., et al. 2003. American Heart Association guide for improving cardiovascular health at the community level. *Circulation* 107 (4): 647.

A Conceptual Framework for Evidence-Based Public Health Practice in CVD Prevention



Source: Stone, E. J., and T. A. Pearson. 1997. Community trials for cardiopulmonary health: Directions for public health practice, policy, and research. Executive summary. *Annals of Epidemiology* 7 (S7): S2.

NC Cardiovascular Health Strategies



Source: North Carolina Plan to Prevent Heart Disease & Stroke 1999–2003. *Start with your heart.* 1999. Raleigh: North Carolina Heart Disease and Stroke Prevention Task Force.

Excerpt from *Healthy People 2010*

"Over the years, it has become clear that individual health is closely linked to community health—the health of the community and environment in which individuals live, work, and play. Likewise, community health is profoundly affected by the collective behaviors, attitudes, and beliefs of everyone who lives in the community."

Source: U.S. Department of Health and Human Services. 2000. *Healthy People 2010.* Washington, DC: U.S. Department of Health and Human Services (p. 3).

The ASSIST project's focus on policy- and population-based approaches has contributed immensely to a paradigm shift in health promotion. Gone are the days of T-shirt and button interventions or exclusive focus on individual smoking cessation. Health promotion has matured to recognize that scientifically proven, comprehensive, population-based approaches have the greatest potential for community health improvement.

—Walter 'Snip' Young, former Colorado ASSIST Project Director and current Scientist at the Cooper Institute

services for individuals to a systems-level, community-based public health approach. It demonstrated on a large scale that the prevention of chronic diseases can be effected by mobilizing social, family, and community networks to advocate for the enactment of policies that will influence social norms and behaviors.

Before ASSIST, a policy and environmental approach to public health problems was used for preventing and controlling infectious diseases but not chronic diseases. Founded by an act that passed in 1798 during an era when infectious diseases such as yellow fever and influenza were often epidemic, the U.S. Public Health Service has a long history of population-wide approaches to preventing the spread of infectious diseases.[8,9,10] Policy interventions, such as requirements that children be immunized before attending school, inspection of water supplies, and quarantines to prevent the spread of infectious diseases, remain standard practice.

As chronic disease surpassed infectious disease as the leading cause of death, the public health field moved away from promoting and protecting the public's health by means of policy or population-based interventions toward an individual approach. Public health initiatives to prevent chronic diseases, such as heart disease and cancer, have traditionally reflected an individual approach. Individuals with high cholesterol levels were identified through screening and referred for counseling, and early tobacco prevention and control efforts focused on convincing individuals to stop smoking. While recognizing that changing health behavior is more complex than requiring immunizations, the ASSIST model called for an emphasis on policy interventions, thus contributing to a fundamental shift in the public health approach to preventing chronic diseases.

The move to incorporate policy- and environmental-level interventions in addition to working directly with individu-

als is now recognized as essential to preventing and reducing tobacco use. The following description of tobacco control initiatives existing in 1998 in a *Morbidity and Mortality Weekly Report* on state tobacco control laws illustrates this point:

> Developing and implementing public health policies are a central component of tobacco-control efforts. Tobacco-control policies cover a range of topics, including minors' access to tobacco, retail tobacco licensing, smoke-free indoor air, advertising and promotion, excise taxes, warning labels, and product ingredient disclosure. Some tobacco-related policies are instituted primarily at the federal level; however, most tobacco-related policies are established at the state and local level.[11(p22)]

This shift in emphasis from the individual to the community is embodied in the ASSIST model.

Media Advocacy

The use of media advocacy to bring about policy change within organizations, communities, and society epitomized the ASSIST approach. The concept of media advocacy, although not originated by ASSIST, is very closely associated with it. Prior to ASSIST, other public health programs, including NCI's Community Intervention Trial for Smoking Cessation (COMMIT) project, used a media advocacy approach. As is reflected in the quotation from Dr. Marc Manley, ASSIST advanced the use of media advocacy interventions for effective policy development. ASSIST brought high visibility to the effective use of media advocacy, thereby catalyzing the dissemination and increasing use of this intervention by public health programs.

> Media advocacy became a public health term.
>
> *—Marc W. Manley, former Chief, Tobacco Control Research Branch, NCI, and current Executive Director, Center for Tobacco Reduction and Health Improvement, Blue Cross and Blue Shield of Minnesota*

One vital area of expertise developed during ASSIST was the media advocacy skills that were crucial for framing prevention of tobacco use as a major public health problem and for countering messages promoted by the tobacco industry. ASSIST capitalized on a strategy the tobacco industry had used to its advantage for years—the use of the media to influence behavior and to change social norms. ASSIST's cadre of professionals were effective at countering many tobacco industry efforts to convince the public that the scientific evidence on the health consequences of tobacco use is unsound, but the challenge persists. Some tobacco companies and their allies continue to dispute whether secondhand smoke causes harm and the magnitude of risk associated with new tobacco products;[12(p1747)] yet, they appear to have known about these risks since at least 1982.[13–17] Tobacco prevention and control advocates continue to depend on media advocacy efforts to shed light on the tobacco industry's invalid claims against the relevant science base. To maintain credibility, these media advocacy efforts must be based on sound science.

The strategic use of media to affect social norms and of policies to change cultural, economic, and environmental factors that influence health behaviors has become a vital component of comprehensive programs to change health-related behaviors. The use of media interventions is increasingly included in program standards, requests for proposals, and best practices documents in various public health contexts.[2,18,19]

Policy

Intervening to change policies is typically a lengthy process that often begins with a gradual awakening to the awareness of a problem, progressing to analyzing and clarifying the problem, and then moving forward to community discussions of potential policy solutions that in time lead to building the social and political will needed for policy change. A hallmark of the ASSIST legacy was using policy as an intervention, ensuring that the policy was based on sound science.[19] ASSIST increased the use of policy in chronic disease prevention and demonstrated how to effect policy change.[20] (See Monograph 17 on the ASSIST evaluation.)

While ASSIST did not accomplish all of its policy goals, it did provide needed momentum on a number of policy fronts, as evidenced by (1) tobacco prevention and control policies enacted during the project period that endure today in their original form, (2) policy interventions that were in process and have come to fruition since the end of ASSIST, and (3) similar policies that are being promoted in other programmatic efforts. Three policy interventions are particularly noteworthy: (1) increasing the price of tobacco products through excise taxes, (2) blocking and reversing preemption laws supported and promoted by the tobacco industry,[21] and (3) promoting state and local clean indoor air laws.

Excise Taxes. ASSIST contributed to the increased recognition given to excise taxes as a primary tool for discouraging tobacco consumption through price increases and to an evolving process that led to a more favorable environment for these tax increases. In several ASSIST states, excise tax increases on cigarettes have been enacted since 1999—for example, in New York, Washington State, Maine, Rhode Island, Wisconsin,[22] and Virginia.[23] States continue to raise excise taxes in an effort to increase revenues as well as to provide a disincentive to use tobacco. Prior to the ASSIST implementation phase in 1993, the average state's cigarette excise tax was 29¢ per pack.[24] As of August 1, 2004, the average state's excise tax was 79.2¢ per pack and the average excise tax for the ASSIST states was 95.59¢ per pack.[25] Figure 11.2 presents a map with the 2004 cigarette excise tax indicated for each state.

Table 11.1, which contains a list of state excise taxes in 1998 and 2003, illustrates the change in excise taxes since ASSIST ended. Thirty-five states and the District of Columbia enacted state excise tax increases between 1998 and 2003, and 20 of those increases were in excess of 100%. It is noteworthy that several tobacco states—Kentucky, North Carolina, and South Carolina—have not increased their excise taxes in the last 5 years and that their existing taxes are single-digit.[26,27(p9)] The lack of a tax

Figure 11.2. Map of State Cigarette Tax Rates—2004

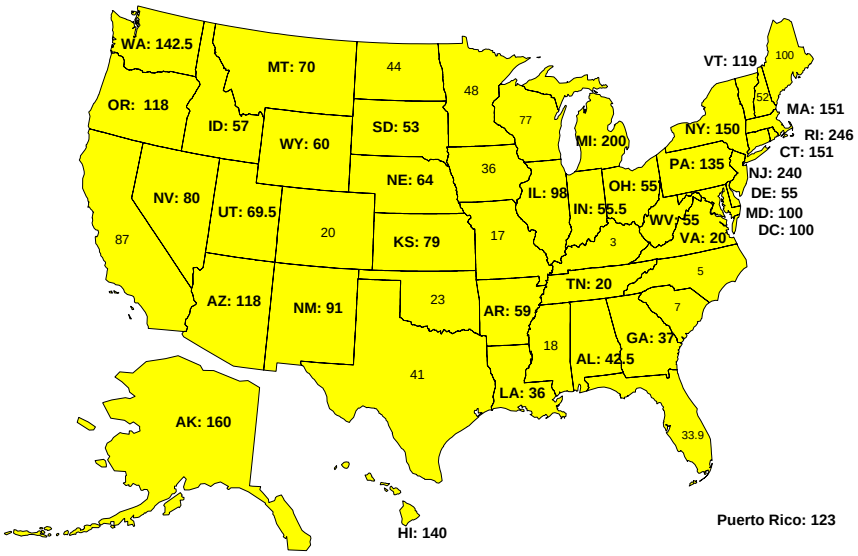
CAMPAIGN for TOBACCO-FREE Kids

MAP OF STATE CIGARETTE TAX RATES

Average State Cigarette Tax: 79.2 cents per Pack

Average Cigarette Tax in Major Tobacco States: 15.3 cents per Pack

Average Cigarette Tax in Non-Tobacco States: 87.7 cents per Pack



Map shows state cigarette tax rates in effect now or scheduled to be implemented soon. States with increases implemented or passed since 1/1/2002 marked in bold. Oregon raised its tax by 60¢ per pack in 2002, but a previous temporary 10¢ add-on to the tax rate expired on 1/1/04. The major tobacco states with extensive tobacco farming and, often, cigarette manufacturing are NC, KY, VA, SC, TN, & GA. State averages do not include Puerto Rico (which has a population larger than those in 20 different states) or U.S. territories (such as Guam, which raised its tax from 7¢ to $1.00 on 5/1/03). Including Puerto Rico raises the state average to 80.0 cents per pack and the non-tobacco state average to 88.5 cents. Federal cigarette tax is 39¢. Some local governments also tax cigarettes. For example, New York City increased its cigarette tax from 8¢ to $1.50 per pack in 2002, Cook County, IL, which includes Chicago, increased its tax from 18¢ to $1.00 per pack, effective 4/1/04, and more than 35 localities in VA have taxes ranging from two to 50 cents per pack. The U.S. Centers for Disease Control & Prevention estimates that smoking-caused health costs total $7.18 per pack sold.

National Center for Tobacco-Free Kids, August 1, 2004 / Katie McMahon

For more information on state cigarette taxes and the benefits from increasing them, see:

- http://tobaccofreekids.org/reports/prices
- http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=18

1400 I Street NW · Suite 1200 · Washington, DC 20005
Phone (202) 296-5469 · Fax (202) 296-5427 · www.tobaccofreekids.org

Source: National Center for Tobacco-Free Kids. 2004. *Map of state cigarette tax rates—2004* (August 1, 2004). Compiled by Katie McMahon. http://tobaccofreekids.org/research/factsheets/pdf/0222.pdf.

Table 11.1. State Cigarette Excise Taxes for 1998 and 2003 (Shading indicates ASSIST states.)

State	1998 Excise Tax Rate	2003 Excise Tax Rate	% Increase
Alabama	$0.165	$0.165	None
Alaska	$1.000	$1.000	None
Arizona	$0.580	$1.180	103
Arkansas	$0.315	$0.590	87
California	$0.370	$0.870	135
Colorado	$0.200	$0.200	None
Connecticut	$0.500	$1.510	202
Delaware	$0.240	$0.550	129
District of Columbia	$0.650	$1.000	54
Florida	$0.339	$0.339	None
Georgia	$0.120	$0.370	208
Hawaii	$1.000	$1.300	30
Idaho	$0.280	$0.570	103
Illinois	$0.580	$0.980	69
Iowa	$0.360	$0.360	None
Kansas	$0.240	$0.790	229
Kentucky	$0.030	$0.030	None
Louisiana	$0.200	$0.360	80
Maine	$0.740	$1.000	35
Maryland	$0.360	$1.000	177
Mississippi	$0.180	$0.180	None
Missouri	$0.170	$0.170	None
Montana	$0.180	$0.700	288
Nebraska	$0.340	$0.640	88
Nevada	$0.350	$0.800	128
New Hampshire	$0.370	$0.520	41
North Dakota	$0.440	$0.440	None
Ohio	$0.240	$0.550	129
Oklahoma	$0.230	$0.230	None
Oregon	$0.680	$1.280	88
Pennsylvania	$0.310	$1.000	223
Rhode Island	$0.710	$1.710	141
South Carolina	$0.070	$0.070	None
South Dakota	$0.330	$0.530	61
Tennessee	$0.130	$0.200	54
Texas	$0.410	$0.410	None
Utah	$0.515	$0.695	35
Vermont	$0.440	$1.190	170
Wyoming	$0.120	$0.600	400

Sources: The Tobacco Institute. *The Tax Burden on Tobacco. Historical Compilation 1998.* Washington, DC: The Tobacco Institute (p. 9); National Center for Tobacco-Free Kids. Map of State Cigarette Tax Rates—2003 (July 24, 2003) compiled by Eric Lindblom. www.tobaccofreekids.org/research/factsheets/pdf/0222.pdf.

increase in 14 states is a reminder of the formidable challenges that remain.

Preemption Laws. When the tobacco industry realized the power that ASSIST represented because of its local and state coalitions and infrastructures,[28] the industry successfully promoted the passage of laws in many states that restrict local jurisdictions from enacting local excise taxes and restrictions on tobacco use. ASSIST staff and volunteers brought attention to the threat posed by such preemption laws. In some states, local advocates were able to prevent passage of preemption laws or were able to repeal preexisting laws. (See chapter 6 for a more detailed discussion of preemption.)

At the end of 1998, the tobacco control laws in 30 states contained preemption provisions. The tobacco industry continues to use this tactic to constrain local tobacco prevention and control efforts. However, because of the successful transition of ASSIST to the National Tobacco Control Program and the expansion of effective state-based programs, efforts to prevent or reverse preemption laws continue. Recent actions in Maine,[11] Massachusetts,[29] Delaware,[30] North Carolina,[31] and West Virginia[32] successfully countered the tobacco industry's preemption strategy.[33]

Clean Indoor Air. The expectation of a smoke-free environment in public places has become a social norm. This norm was painstakingly achieved through a combination of public and private policy changes. The efforts of ASSIST and many other tobacco control initiatives and professionals drew attention to this intervention as an important tool for reducing tobacco use. Promoting clean indoor air was a central policy goal of ASSIST from the outset, and it became the subject of many activities at the state and local levels, as well as numerous training events and materials. By maintaining this focus on promoting clean indoor air and by training staff and volunteers on this topic, ASSIST was able to build momentum for these initiatives that far outlived the project itself.

California and Delaware led the nation in adopting comprehensive, statewide clean indoor air laws, and five other states continued this trend—Maine, New York, Massachusetts,[34] Connecticut, and Rhode Island.[35] Four of these were ASSIST states. ASSIST contributed to the supportive environment that facilitated the passage of clean indoor air laws and has led to action on this front in numerous other states and communities across the country.

Essential Components

ASSIST contributed to future public health interventions its insights about which program components are essential for success. During ASSIST, sufficient funding and a highly competent workforce emerged as two essential ingredients for a successful tobacco prevention and control program.

Sufficient Funding

With ASSIST came an increased awareness of the magnitude of resources needed to effectively implement a comprehensive approach to tobacco prevention and control. Considered inadequate by today's standards, the investment of federal funds in ASSIST was the largest

made in tobacco prevention and control programs at that time. That investment was accompanied by significant funding from ACS, NCI's designated private-sector partner in ASSIST. Today, the level of funding that a comprehensive tobacco prevention and control program receives is recognized as the single most important determinant of success.[36]

The IOM report *Taking Action to Reduce Tobacco Use* cites the evidence of a dose-response relationship between the level of funding and the effectiveness of tobacco prevention and control efforts. That evidence has been gleaned from experiences with ASSIST, state-supported programs, and CDC's Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT) and was used as a basis for IOM's recommendation to "apply the lessons of ASSIST nationwide."[3(p10)] California and Massachusetts, which had the highest levels of state funding during the 1990s, experienced the greatest reductions in tobacco consumption. During this time frame, per capita cigarette consumption fell by 57% in California and by 36% in Massachusetts—compared with 27% in the rest of the country.[37(pI-ii),38(pv)] A 2000 IOM report, *State Programs Can Reduce Tobacco Use*, concludes that the dose-response observation is "strong evidence that state programs have an impact, that more tobacco prevention and control correlates with less tobacco use and that the reduction coincides with the intensification of tobacco control efforts."[7(p4)]

Recognizing that adequate funding is essential to effective tobacco prevention and control, CDC provided guidance for state decision makers regarding funding levels necessary for each state to sustain an effective, comprehensive state-level program.[19] Approximate annual costs to implement all of the recommended program components were estimated to range from $7 to $20 per capita in states with smaller populations (< 3 million), from $6 to $17 per capita in states with medium populations (3–7 million), and from $5 to $16 per capita in states with larger populations (> 7 million). In addition, a base funding of $850,000–$1.2 million per year per state was recommended.[19]

The commitment to sustainable funding levels by CDC's Office on Smoking and Health (OSH) is even more critical today because state budget deficits have resulted in deep cuts in some state tobacco prevention and control programs. In 2002, California's program was cut by $61 million and Massachusetts's program was cut by $42 million and nearly eliminated.[39(p12)]

In a special report in the *New England Journal of Medicine*, "Tobacco Control in the Wake of the 1998 Master Settlement Agreement," Steven Schroeder reviews the small amount of funding that state tobacco prevention and control programs have received from the Master Settlement Agreement (MSA) and concludes with a quote from an interview with Joseph Califano Jr., the former Secretary of Health, Education and Welfare,

> The results: the money [from the MSA] is being spent to close budget deficits rather than to stop kids from smoking and help adults who are hooked.[1(p296)]

Competent Workforce

The issue of a competent workforce has been a growing concern within the

field of public health, as was brought to the forefront by the 1988 IOM report *The Future of Public Health*[40] and reiterated in the 2003 IOM report *Who Will Keep the Public Healthy?* According to the more recent report, one of public health's essential services

> is to assure a competent public health and personal care workforce. The state health department, in cooperation with local and federal public health agencies, has a major role to play in facilitating the competency of the public health workforce.[4(pp162–3)]

ASSIST leaders recognized the new set of competencies required for public health professionals and developed a model for providing training and technical assistance to support individuals and organizations in the field. ASSIST acknowledged that because new types of interventions were being promoted, staff needed new skills in community mobilization, media advocacy, and policy development to be able to carry out those new interventions. (See chapter 4.)

These types of skills are described in the recent IOM report on public health professionals, *Who Will Keep the Public Healthy?*:

> Public health communication requires skills to use mass media strategically in combination with community organizing to advance public health policies through media advocacy, targeting policymakers, organizations, and/or legislative bodies. Public health professionals should be able to frame public health problems as social inequities to derive policy solutions, as well as apply news values and advertising principles to design stories about these public health issues for media outlets.[4(p77)]

Examples of ASSIST Training Needs

- Media advocacy, social marketing, media relations
- Community organization (assessment, mobilization, creating ownership)
- Leadership development
- Policy analysis, implementation, and enforcement
- Conflict resolution
- Legislative analysis

ASSIST staff and volunteers advanced the understanding of the types and levels of skills needed by individuals who implement public health interventions and demonstrated how training and technical assistance can be delivered to support those individuals—both professional staff and volunteers.

NCI supported the development of the ASSIST Coordinating Center to provide training and technical assistance that responded to the needs of the staff and coalition members in the 17 states. (See chapter 4.) The states found the ASSIST training and technical assistance to be so worthwhile that they sought to retain this resource after ASSIST ended. They used their skills and worked through the Technical Assistance and Training Transition Team to advocate to CDC and key foundations for continued training and technical assistance. CDC sought to provide the necessary professional expertise and support for the implementation of its new National Tobacco Control Program. In addition, key partners recognized the need for extensive, highly skilled technical assistance, so they advocated for establishing the Tobacco Technical

Assistance Consortium (TTAC) to fill this critical need. (See chapter 10.)

This high level of technical assistance support is increasingly emphasized in public health initiatives and in the literature.[4] State health department leaders appreciate the importance of comprehensive tobacco prevention and control programs and of maintaining a highly skilled staff, and are working toward attaining this capacity. The pioneers trained during ASSIST constituted a new type of public health worker equipped to respond to challenges of the 21st century.

Effective Strategies for Implementation

Throughout this monograph, the design, core elements, strategies, and activities of ASSIST have been described, along with insights for their application and ASSIST's continued contributions to health behavior change. In addition to the infrastructure built, the methods and materials developed for effective interventions, and the training and technical assistance provided for professional skill development, two strategies—participatory decision making and inclusion—are especially noteworthy.

Participatory Decision Making

Early in ASSIST, the form of program management evolved from a hierarchical structure to a participatory management and decision-making structure. The state programs requested an integral role in decision making, and they became members of the ASSIST Coordinating Committee and its subcommittees. This participatory style of decision making was also reflected in the management of state programs, as they designated local ASSIST coalition members to serve in state-level leadership roles.

In addition to providing training and technical assistance to the 17 states, the ASSIST Coordinating Center provided administrative support and technical assistance to the ASSIST Coordinating Committee and its subcommittees. This high level of support made possible involvement of state staff in decision making, better feedback for program direction, greater retention of volunteers, and more efficient resource allocation by the coalitions. The Advance Teams and Transition Teams discussed in chapters 9 and 10 considered the ASSIST Coordinating Center and the ASSIST Coordinating Committee to be crucial components of the infrastructure for effective collaboration and coordination of a national tobacco prevention and control program. The principle has been carried forward into CDC's National Tobacco

> The ASSIST project located tobacco control at the state and community level, insisting on coalitions in order to include members of the community. Participants demanded that ASSIST become more diverse and inclusive. I think the ASSIST project helped define tobacco control as a national movement and helped the movement itself become more diverse and inclusive.
>
> *—Jerie Jordan, former National Manager, ASSIST Project, American Cancer Society, and current Program Consultant, Office on Smoking and Health, CDC*

The focused nature of ASSIST resulted in a clear strategy to reduce tobacco use. This evidence-based strategy educated health practitioners and community coalition members about best practices in tobacco prevention and control. These practices also translate into other public health arenas. I continue to use the strategic planning process in the public health programs I am involved in by first assessing the community environment through community interviews, scientific literature reviews, considering the five channels of delivery: community, community environment, health site, worksite, and school site.

—Rebecca Murphy-Hoefer, former ASSIST Western New York Field Director, former Utah IMPACT Coordinator, Utah Department of Health, and current Health Communication Specialist, Office on Smoking and Health, CDC

Control Program, although the size of the program has necessitated different mechanisms for participation. (See chapter 10.) It remains to be seen how extensively this promising ASSIST legacy of a national coordinating center and a coordinating committee will be realized.

Inclusion

Throughout the life of the project, ASSIST promoted the inclusion of and representation from diverse cultural groups. Progress was made in increasing the cultural diversity and competency of members of the tobacco control community and the staffs of state health departments, ACS, and NCI. They addressed difficult issues and made changes in certain committees to meet diverse needs.

The creation of the ASSIST Multicultural Subcommittee in 1994 helped ensure that all major population subgroups, and especially all ethnic population groups, would be involved or represented in all aspects of the project. (See chapter 3.) With the establishment of the Multicultural Subcommittee, state representatives of ASSIST directed efforts to educate and involve tobacco control priority populations at high risk for tobacco use. The ASSIST Multicultural Subcommittee set the following objectives:

increasing the awareness and skills of site staff to work more effectively with all multicultural and diverse groups in developing a long term commitment to tobacco control,

linking with other national multicultural and diverse groups to promote and expand their tobacco control efforts,

encouraging the dissemination of media materials appropriate to multicultural and diverse groups,

The coalitions included people who were pro-choice as well as pro-life. They included those who were in favor of the use of animals in research and those who had opposite views. They included the wealthy and the less wealthy and the middle class and the poor. The multicultural make-up of the coalition memberships did not constitute 'unlikely' partners but spoke forcefully to the determination of the coalitions to find and exploit their common ground.

—Helene G. Brown, former ASSIST Senior Advisor from ACS and current Associate Director, Community Applications of Research, UCLA Jonsson Comprehensive Cancer Center

The project focused not only on the inclusion of communities of color, but also gays and lesbians, women, and youths. This model continues to be the mainstay of the National Tobacco Control Program and the SmokeLess States National Tobacco Policy Initiative.

—Victor Medrano, former ASSIST New Mexico Field Director, former Program consultant, Office on Smoking and Health, CDC, and current Health Education Specialist, Youth Media Campaign, CDC Office of Communications

promoting and developing alternative funding options for minority groups particularly in intervention research and program delivery.[41(p2)]

Addressing multicultural issues was not restricted to the Multicultural Subcommittee. Two principles—ensuring that representation was diverse and that health disparities were addressed—were integrated into all facets of ASSIST. (See recommended benchmarks for multicultural activities in appendix 10.A.) ASSIST leaders sought effective means for reducing health disparities, and CDC built on those efforts. ASSIST staff and volunteers wanted to ensure that multicultural issues were represented in all aspects of the program. ASSIST's notion of inclusion extended beyond communities of color to other population subgroups such as gays and lesbians, women, and youths.

This principle has persisted in CDC's National Tobacco Control Program. CDC's 1999, as well as its most recent, request for applications for the National Tobacco Control Program[42,43] contained a specific goal related to health disparities and how that goal is to be integrated into the state programs. The Robert Wood Johnson Foundation's (RWJF's) SmokeLess States National Tobacco Policy Initiative and the American Legacy Foundation's Priority Populations Initiative also exemplify the same principle of inclusion.

Influencing Public Health Initiatives

As researchers increasingly reached consensus on the effectiveness of an ecological approach for addressing public health problems and on the strength of the evidence supporting policy interventions for preventing tobacco use, public health practitioners worked to apply this knowledge and innovative leaders responded. As a result of ASSIST and other important tobacco control programs, many new public health initiatives have proliferated. Many of these initiatives address health issues beyond tobacco control and include elements of the earlier successful programs.

Tobacco Control

ASSIST was an important early initiative that helped reshape tobacco prevention and control efforts. Frequent interactions among all the early leaders led to substantial cross-fertilization of ideas and information about promising approaches to preventing and reducing tobacco use.

Within this climate, states were also moving forward. Two innovative leaders, California and Massachusetts, were

California's Connection with ASSIST

"I can say from direct experience that the strategy that we developed in operationalizing the program was strongly influenced by the National Cancer Institute's 'Standards for Comprehensive Smoking Prevention and Control' in ASSIST RFP-56. Especially important was the statement: 'A smoking prevention and control initiative is based on successful worldwide examples that show that a widespread change in social acceptability of smoking is required to significantly reduce smoking prevalence' (p. 3). We often referred to the 'NCI Standards' for comprehensive tobacco control to justify and defend our social change approach. If you have looked at our *A Model for Change: The California Experience in Tobacco Control* (October 1998), you will see that California adopted the idea of reducing the 'social acceptability' of tobacco use as the key for reducing tobacco use among youth as well as adults.

"The 'categories of interventions for smoking prevention and control' in the ASSIST planning model helped us justify the heavy emphasis the California program placed on policy development and implementation. Especially helpful to us was the section of the 'NCI Standards' titled 'Smoking Prevention and Control Activities' (pp. 17–33), which provided us with invaluable ideas on how to change the social acceptability of tobacco use. We were particularly influenced by the suggestion that achieving and expanding clean indoor air policies could reduce disease and encourage smoking cessation (pp. 21, 22). We focused our program on many of the policies listed on page 24 of this chapter. We benefited also from the caution that 'public support for them [new policies] must be generated throughout the community' to achieve successful policy implementation (p. 25). Our mantra was that change happens at the community level.

"Overall, our program benefited tremendously from the ASSIST 'Standards for Comprehensive Smoking Prevention and Control.'"

—Jon Lloyd, Chief, Data Analysis and Evaluation Unit, California Department of Health Services, Tobacco Control Section

conceptualizing and building support for state-level funding. In short order, other government agencies, organizations, and foundations joined the effort. States that had not been selected to participate in ASSIST also insisted on federal support, leading to CDC's 1993 launch of IMPACT. (For more details, see chapter 9.) Working with coalitions in some states, RWJF provided funds for the American Medical Association to administer the SmokeLess States National Tobacco Policy Initiative. As additional agencies and organizations became more active, the tobacco control movement grew and there were mutual transfers of knowledge and information. NCI and CDC's collaboration with Massachusetts and California to air their effective public service announcements and paid media advertisements led to the establishment of CDC's Media Campaign Resource Center.

Rudiments of ASSIST's legacy are evident in the incorporation of core elements of the ASSIST model in a number of tobacco prevention and control initiatives that were launched during and following ASSIST. NCI was close to releasing its request for proposals when, in 1988, California passed a 25¢ tax increase on cigarettes known as Proposition 99. With 20% of the revenue from

the tax increase dedicated to its tobacco prevention and control program, the major design work of the California program began.[44] According to the chief of California's program at that time (who is an author of this chapter*), NCI's scientific underpinnings for ASSIST and the ASSIST model itself informed the design and strategic direction of California's program and also provided the credibility needed to gain support of California's decision makers. The outcomes from California's program were dramatic: Between December 1989 and December 1999, per capita cigarette consumption in California declined by 57%.[37(pI-iv)] These results demonstrated the effectiveness of a community-based approach to reducing tobacco use and provided the impetus for other states to adopt it.[45]

Massachusetts successfully competed for ASSIST funding while implementing its own tobacco control program with a massive infusion of state funding from its 25¢ tobacco excise tax increase. Using those tax funds, of which $116 million were used through June 1996[46]; ASSIST funding; and the intensive training programs and technical assistance received through ASSIST, Massachusetts built an exemplary tobacco prevention and control program that focused very successfully on strategic use of the media, one of ASSIST's core elements.

The severe budget reductions that the California and Massachusetts programs have experienced and the resulting loss of capacity in these two exemplary state programs and in other state programs have undermined years of steady progress in preventing tobacco use. Left unchecked, this erosion of funding and support for state-based tobacco prevention and control will reverse the important advances that have been made.

The SmokeLess States National Tobacco Policy Initiative, supported by RWJF and administered by the American Medical Association, was implemented in 1994. Its primary emphasis was on policy change—another core element of ASSIST. Support from SmokeLess States grants provided funding for activities that complemented work that ASSIST, with its limited funding and government restrictions, could not perform. Many key SmokeLess States national staff, including the codirector, had played important roles in ASSIST or had expanded their skills at ASSIST trainings, information exchanges, and national conferences. In addition, many state project directors and state coalition leaders had benefited from these same ASSIST trainings and had used ASSIST concepts and strategies in advancing their own policy goals in their respective states.

The national staff of the SmokeLess States Program provided considerable technical assistance and support to their grantees that was similar to that provided by ASSIST staff. Staff from the

*Note that the third author was chief, Tobacco Control Section, California Department of Health Services, from 1990 to 1992 and was with the department for 2 years before that. He was then director of the ASSIST Coordinating Center from 1992 to 1994 and chief of the Program Services Branch at OSH of CDC from 1994 to 2000 before becoming director of the Tobacco Technical Assistance Consortium.

SmokeLess States Program also participated in the annual National Conference on Tobacco or Health. SmokeLess States expanded its national staff to provide technical assistance targeted at specific resource gaps. For example, the SmokeLess States staff developed resource materials on clean indoor air, preemption, and taxation.[47] They enhanced their national meetings by focusing on training sessions and skill building rather than merely sharing coalition strategies. These efforts frequently complemented and strengthened activities of the ASSIST staff. (For more details on the SmokeLess States Program, see chapter 2 in *To Improve Health and Health Care,* vol. viii.)[48]

The ASSIST program increased recognition of the importance of high-quality technical assistance. SmokeLess States and other programs became resources that ASSIST coalitions and staff could use. The Campaign for Tobacco-Free Kids (CTFK) was a valuable resource during ASSIST and continues to play a critical role in the tobacco control movement. Its state advocacy team gives state and local tobacco prevention and control coalitions strategic and technical assistance on policy issues, helps them build stronger grassroots efforts,[49] and provides expert advice on media strategies. They also mobilize other CTFK resources, such as public opinion research; strategic communications, including media advocacy; and outreach to nontraditional partners.

Another organization that has taken on a key technical assistance role is the American Legacy Foundation, which was established in 1999 to provide "grants, technical training and assistance, youth activism, strategic partnerships, counter-marketing and grass roots marketing campaigns, public relations, and community outreach."[50]

Many national organizations acknowledge the importance of high-quality, timely technical assistance, the need for coordination, and the need for diffusion outlets capable of getting knowledge, skills, and abilities to the field in the shortest time possible. Beginning in 2001, ACS, the American Legacy Foundation, and RWJF pooled their resources to create the national Tobacco Technical Assistance Consortium. The consortium's mission is to build capacity at the state and local levels by providing technical assistance to strengthen the effectiveness of tobacco prevention and control programs.[51] The consortium has been critical in helping to prepare newly hired staff at all levels of government and has improved the effectiveness of tobacco prevention and control programs.

This comingling of ideas and information that occurred in tobacco control that stimulated the development and expansion of ASSIST-like concepts and incorporated the ASSIST core elements also spread to other public health arenas. Examples of such adaptations follow.

Beyond Tobacco Control

Although ASSIST's conceptual framework was not unique, its high visibility advanced the merits of the ASSIST cube that have been affirmed through its repeated application in other public health contexts. Figure 11.1 presents the ASSIST cube and adaptations

of the cube in four planning documents for heart health programs. The framework, along with core elements of the ASSIST program, can be seen in a number of non-tobacco-related public health initiatives, especially heart health, obesity, nutrition, and physical exercise.

Heart Health

With the success of ASSIST and state tobacco prevention and control efforts in California and Massachusetts, other public health programs looked to tobacco control for lessons learned and opportunities to achieve similar success. In the late 1990s, CDC launched its state-based cardiovascular health program. The CDC cardiovascular health program staff consulted with tobacco control staff for help in conceptualizing a framework for state-based programs that focus on an environmental and policy intervention model to change systemic factors within communities. The goals articulated for CDC's state-based cardiovascular health program mirror those of ASSIST:

> To increase state capacity by planning, implementing, tracking and sustaining population-based interventions that address heart disease, stroke, and related risk factors. . . . Strategies should include policy and environmental approaches or education and awareness supportive of the need for policy, environmental, and systems changes to support cardiovascular health.[52(p2)]

The core elements of the ASSIST model are also contained in the *American Heart Association Guide for Improving Cardiovascular Health at the Community Level:* "The Community Guide emphasizes the social and environmental origins of the CVD epidemic."[53(p646)] The Guide also reproduces an adaptation of the ASSIST cube and presents it as a "conceptual framework for public health practice in CVD prevention."[53(p647)] Because tobacco use is a major risk factor for CVD, it is especially encouraging to observe the diffusion of effective ASSIST-like interventions to other CVD risk factors and to the conceptualization of state-based cardiovascular health programs.

> In many ways, ASSIST was a leap of faith for tobacco control. Ten years after the state planning phase started, the evidence is clear that the leap was not too far off the mark. ASSIST states have shown that the model works for tobacco control, and other public health programs are now trying to emulate tobacco control's success.
>
> *—Pam Eidson, former Director of Health Promotion, Georgia Division of Public Health, and current Program Manager, Directors of Health Promotion & Education, an affiliate of the Association of State and Territorial Health Officials*

Nutrition, Physical Activity, and Obesity

There are obvious parallels between overweight individuals and smokers. They both grapple with behavioral health issues that are reinforced by social influences, environmental factors, and advertising. Therefore, efforts have been made to learn from the recent successful efforts in tobacco control for possible applicability to the obesity problem.[54] Just as passage and enforcement of clean indoor air laws affect tobacco use and the extent of health

Exploring Potential Adaptations for Heart Health

The success of the California and Massachusetts state tobacco control programs motivated planners of public health initiatives in cardiovascular health to consider expanding the reach of their public health initiatives to heart health:

> "Illustrating the possibility of a larger focus of action in California, the recent public health campaign to reduce cigarette smoking has doubled the rate of decline of smoking in the entire state (21). Massachusetts likewise has mounted a successful statewide campaign against smoking. These experiences suggest enlarging the concept of community for cardiopulmonary health purposes to the state, or even to the national or global level."

Source: Breslow, L. 1997. Social origins of cardiopulmonary disease: The need for population-focused prevention studies. *Annals of Epidemiology* S7:S4–S7 (p. S6).

consequences of secondhand smoke, laws or regulations pertaining to school lunch programs, vending machine placement in schools, and food labeling have important implications for weight control.[54] Pricing is another tool that can be useful for both applications. Raising cigarette excise taxes reduces the affordability of cigarettes and thereby decreases consumption. Similarly, lowering the prices of fruits, vegetables, and low-fat snacks may raise consumption of healthy foods.[54]

The relevance of lessons learned from tobacco control initiatives to the prevention of obesity has been noted by numerous researchers and public health experts. The goals of CDC's 12-state obesity control program reflect the core elements of ASSIST; its goals are to

> prevent and control obesity and related chronic diseases by supporting states in their development and implementation of nutrition and physical activity interventions, particularly through population-based strategies such as policy level change, environmental supports, and the social marketing planning process.[54(p1078S)]

Mercer and colleagues also point to the recent experience in comprehensive tobacco control in California and other states as evidence of the efficacy of policy-based initiatives and as suggestive of promising approaches for obesity.[54]

Eating and physical activity patterns are addressed in the scope of activities described for CDC's Nutrition and Physical Activity Program, which includes "policy and environmental change, communication and social marketing, and partnership development."[55(p1)] CDC's most recent request for proposals for its state nutrition and physical activity programs to prevent obesity and other chronic disease instructs prospective grantees to use the ecological model to guide their program planning:

> (f) Use the social-ecological theoretical model to guide State planning to address obesity and other chronic diseases in these populations; select and implement interventions from the list of proven strategies . . . so that multiple levels of influence in the social-ecological model are addressed. Consider using a social marketing approach in this intervention.[42(p15)]

A recent *Washington Post* article on obesity states that "policymakers nation-

wide are pursuing legislative solutions modeled after the anti-smoking campaigns of the 1990s to attack what many in the medical community say is one of the gravest threats to the nation's long-term health."[56] The article reports on state legislative efforts to require the posting of nutrition information in restaurants and restrictions on the sale of candy and soda in schools.[56] Public health approaches to promoting nutrition and physical activity and to controlling obesity that incorporate the insights gained from the tobacco control experience are proliferating.

Future Applications

As more data become available that substantiate the efficacy of the ecological model in programs that promote heart health, obesity control, physical activity, and nutrition, other fields are likely to adopt elements of the ASSIST model and intervention methods to implement environmental and policy changes. A recent IOM report puts forth a strategy to reduce and prevent underage drinking that embodies a number of elements of ASSIST: limits on youth access to alcohol, community-based coalitions, strategic use of the media, and increases in excise taxes. The report recommends restricting glamorous presentations of drinking in movies and music that appeal to teenagers, imposing penalties on those who sell alcohol to minors, and increasing taxes on beer.[57] A *Washington Post* article points out the link between these recommendations and recent antismoking interventions:

> The report marks an important shift in strategy that echoes recent antismoking efforts. If implemented, the recommendations would be the most dramatic crackdown in decades on alcohol makers, retailers and the entertainment media—and would put the campaign against underage drinking on the same footing as the war against teenage smoking.[58]

Given its enormous health toll, the potential benefits of funding a policy-based intervention aimed at underage drinking are substantial.

Advancing Evaluation Methodology

Efforts to evaluate the ASSIST project brought to the forefront the methodological challenges of evaluating a large-scale, community-based program that uses multiple interventions to effect systems-level change. The next NCI monograph in this series (Monograph 17) addresses in detail the evaluation efforts for the ASSIST program, from the development of the evaluation logic model and its basic assumptions and methodology, through implementation and results.[59] The evaluation model developed for the ASSIST project represents an important step, not only for gaining valuable data on tobacco control program effectiveness, but also for informing the implementation of evidence-based public health efforts in general. By developing and validating a logic conceptual model that reflects the complexity inherent in tobacco control and developing measures that correlate with tobacco control outcomes, this evaluation effort serves as a model for public health interventions whose components are diffused throughout an entire population, making ran-

> Because of their complexity, tobacco control programs are very difficult to evaluate. We have found how hard it is to measure our success in the real world.
>
> *—Marc W. Manley, former Chief, Tobacco Control Research Branch, NCI, and current Executive Director, Center for Tobacco Reduction and Health Improvement, Blue Cross and Blue Shield of Minnesota*

domized controlled trials infeasible or inappropriate.

The ASSIST evaluation defined and validated indirect measures of performance and correlated these measures with public health outcomes. The following are some of the evaluation methods and measures that evolved from this effort:

- The Strength of Tobacco Control (SoTC), an indirect measure of state-level tobacco control efforts based on three constructs: resources, capacity, and efforts.
- The Initial Outcomes Index (IOI), a measure of state tobacco control policy outcomes, which in turn could be correlated with subsequent population behavior and public health outcomes; and
- The ASSIST Print Media Database, a demonstration project to quantitatively index newspaper coverage of policy issues central to the ASSIST project.

With ASSIST, the field of evaluation advanced. The ASSIST evaluation represents an early step in developing techniques that researchers and policy makers need to determine which elements of community-based tobacco control programs are effective.

The complexity of the ASSIST project, the challenges posed in evaluating this type of project, as well as limited evaluation resources necessitated that the evaluation focus only on those components of the project that could be quantified as part of the evaluation logic conceptual framework. While it was not possible to fully evaluate all aspects of the ASSIST project, this evaluation was the first such effort to systematically measure the effectiveness of state-level tobacco control efforts across all states and to assess benefits associated with the investment in building infrastructure and focusing on policy change.

The IOM National Research Council report *Taking Action to Reduce Tobacco Use* points to the need for adequate funding and commitment and also highlights the importance of improved evaluation of tobacco prevention and control programs:

> The ASSIST program has shown that a more intense intervention produces results, but it does not clearly show which elements are most powerful. . . . An expanded commitment to tobacco control increases the importance of knowing which interventions matter most, requiring demonstrations at sufficient dose and duration to enable credible evaluation.[3(p11)]

In 1999, NCI released a request for applications for research in state and community tobacco control interventions:

> The scientific evidence supporting some of these policies is quite strong; for others it is more limited. Decision-makers

frequently must make decisions about the details of these policies in the absence of strong research.[60(p3)]

The ASSIST evaluation highlights the need for ongoing, systematic, and coordinated evaluation efforts to be continued. New surveillance and methodological strategies are still needed to identify the environmental factors, such as those identified in the ASSIST evaluation, that influence tobacco use. These new tobacco control evaluation strategies can provide much-needed information about programs at the national, state, and local levels.

Future Interventions and Research Initiatives

The ASSIST experience provided insights for planning research initiatives. Since the completion of ASSIST and the initiation of CDC's National Tobacco Control Program, NCI has sponsored initiatives to address research questions that will advance the ecological approach to tobacco prevention and control. NCI established the Tobacco Research Implementation Group, which brought together 24 leading scientists and experts to identify research priorities related to tobacco control. Some of those priorities are based on research needs gleaned from ASSIST. For example, the group identified the need to refine the media advocacy approach—to learn more about "how to tailor messages and materials appropriately for different populations."[61(p2)] They also are focusing on the need for more research on the impact of a range of public policies on tobacco use—for understanding "the full impact on tobacco use of clean indoor air policies, marketing restrictions, and youth access restrictions."[61(p5),62]

NCI is supporting targeted research studies that are encouraging partnerships between scientists, state tobacco control

> It is our hope and intention that the National Cancer Institute, in partnership with our many public and private partners, will help to achieve nothing less than the complete elimination of tobacco-related disease. Achieving this lofty goal will require that we make strategic decisions to support research that will serve as a solid foundation for policy development, will be effectively used by those in clinics and communities who are in the trenches and working to improve the world one person or community at a time, and will ensure that our understanding of tobacco use and its health outcomes is peerless. We recognize the global threat of tobacco and tobacco-related cancers, and working to provide a solid tobacco control evidence base will therefore benefit not just those in the United States but also children and families around the world—particularly in countries with few resources dedicated to research. We accept these goals as our challenge today, and we remain committed to a comprehensive tobacco control research program that will ensure public health benefits tomorrow and beyond.
>
> *—Scott J. Leischow, Senior Advisor for Tobacco Policy, Office of the Secretary, U.S. Department of Health and Human Services, and previously Chief, Tobacco Control Research Branch, and former Acting Associate Director, Behavioral Research Program, NCI*

programs, and tobacco control advocates.[60,63] Through a major initiative called the Tobacco Research Initiative for State and Community Interventions (TRISCI), NCI has funded 19 grants that will result in a total expenditure exceeding $75 million.[64,65] The purpose of the TRISCI initiative is to stimulate research on new or existing tobacco control interventions relevant to state and community tobacco prevention and control programs. This goal will be achieved through support of research on innovative tobacco prevention and control interventions at the community, state, or multistate level, particularly policy or media-based interventions, and by fostering collaboration among tobacco control researchers, state-based comprehensive tobacco control programs, and community-based coalitions. The results of this research will guide and inform existing and future tobacco prevention and control programs.

Onward from ASSIST

As the field of public health evolves, milestones are achieved through the application of a continuing accumulation of knowledge until a critical understanding is reached. ASSIST was such a milestone.

This monograph describes ASSIST's many contributions: the building of effective partnerships; the networks, communications, and other mechanisms used to establish community structures for participatory decision making and collaborative work; the effective application of ecological theory; the strategic use of media advocacy to frame policy development; an increased understanding of the importance of funding and of the critical components of effective programs; and insight into the advancing evaluation methodologies for community-based programs with multiple interventions.

This chapter highlights different ways in which ASSIST's impact can still be felt. Through the local infrastructures built during ASSIST, networks of public health specialists and community advocates with media and policy advocacy skills have taken what was learned during ASSIST and are now applying that knowledge to other public health initiatives. The tobacco industry viewed these local infrastructures as significant threats.

Policy initiatives that were the focus of ASSIST continue to play out at the state and local levels. Smoke-free environments in public places are now the norm though important progress is still required. Excise taxes are universally recognized as effective in reducing tobacco use, and states continue to raise taxes on tobacco products. Increased understanding of the power of preemption bills has given advocates the tools to prevent and in some cases reverse this particular tobacco industry tactic.

Key to these accomplishments and advances in understanding regarding what constitutes an effective tobacco prevention and control program was the cross-fertilization that occurred between ASSIST and other related efforts. Just as ASSIST raised awareness of the critical importance of a highly trained workforce, others took on this role and

informed subsequent ASSIST trainings. Similarly, ASSIST's media advocacy activities inspired others to use similar tactics and to develop resources that were then made available to ASSIST and others.

Researchers and practitioners now have a better understanding of the critical components and processes required to implement effective community-based tobacco prevention and control programs as well as other health behavior change initiatives. Seasoned staff in the field continue to apply the insights gained during ASSIST. Ultimately, ASSIST's legacy lies in its continuing impact on public health: healthier communities through reduced exposure to secondhand smoke; lower tobacco prevalence and consumption; reduced death and disease from tobacco use; stronger community coalitions; and continuing collaboration among researchers, state health department program staff, and tobacco control advocates.

Appendix 11.A. Tobacco Control Professionals Who Shared Their Insights regarding ASSIST

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