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

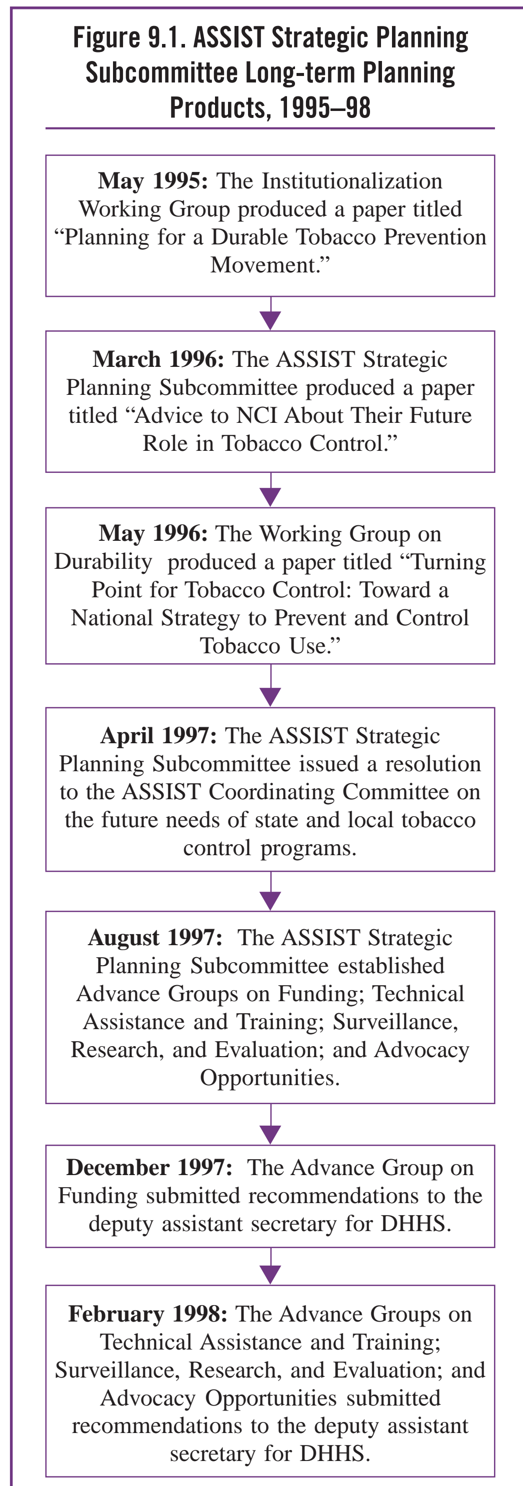
Concept Papers for a National Strategy and Program

"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



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:

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.

> 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

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.

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.

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.

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)]

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.

"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

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.

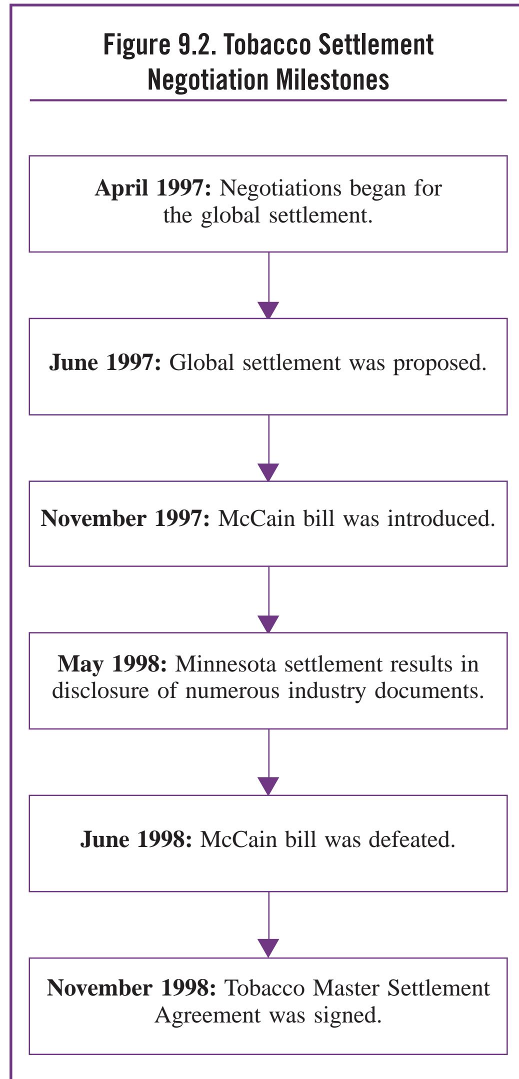
"NALBOH has been engaged in establishing a significant voice for local boards of health on matters of national public health policy."

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.



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
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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, NI-AID, 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-

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[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 <u>no reductions or gaps</u> 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

<u>Surveillance & Monitoring</u>

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

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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.

References

1. U.S. Department of Health, Education, and Welfare, Public Health Service. 1964. *Smoking and health: Report of the advisory committee to the surgeon general of the Public Health Service* (PHS publication no. 1103). Washington, DC: Public Health Service.
2. U.S. Department of Health and Human Services. 1992. *Smoking and health in the Americas: A report of the surgeon general* (CDC publication no. 92-8419). Atlanta: Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
3. Institute of Medicine of the National Academies. Home page. www.iom.edu/about.asp.
4. Lynch, B. S., and R. J. Bonnie, eds. 1994. *Growing up tobacco free.* Washington, DC: National Academies Press.
5. National Cancer Policy Board, Institute of Medicine and Commission on Life Sciences, National Research Council. 1998. *Taking action to reduce tobacco use.* Washington, DC: National Academies Press.
6. Institutionalization Working Group, Strategic Planning Subcommittee. 1995. Planning for a durable tobacco prevention movement. Discussion paper, ASSIST Coordinating Center, Rockville, MD.
7. Goodman, R. M., A. Steckler, and M. H. Alciati. 1997. A process evaluation of the National Cancer Insitute's Data-Based Intervention Research Program: A study of organizational capacity building. *Health Education Research* 12 (2): 181–97.
8. Haavelmo, T., and S. Hansen. 1991. On the strategy of trying to reduce economic inequality by expanding the scale of human activities (World Bank Environmental Work Paper 46). In *Environmentally sustainable development: Building on Brundtland,* ed. R. Goodland, R. Baly, and S. Serafy, 41–49. Washington, DC: World Bank.
9. Schooler, C., J. W. Farquhar, S. P. Fortumann, and J. A. Flora. 1997. Synthesis of findings and issues from community prevention trials. *Annals of Epidemiology* 7 Suppl. no. 7: S54–S68.
10. Bracht, N., B. Thompson, and C. Winner. 1996. *Planning for durability: Keeping the vision alive.* Training module, ASSIST Coordinating Center, Rockville, MD.
11. ASSIST Coordinating Committee. 1996. Advice to NCI about their future role in tobacco control. Discussion paper, ASSIST Coordinating Center, Rockville, MD.
12. 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.
13. ASSIST Coordinating Committee. 1996. Summary report of the ASSIST Coordinating Committee meeting of May 31, 1996. Internal document, ASSIST Coordinating Center, Rockville, MD.
14. Association of State and Territorial Health Officials and National Association of County and City Health Officials. 1996. *ASTHO/NACCHO policy statement: Tobacco use prevention and control.* Washington, DC: ASTHO/NACCHO.

15. Thurm, K. L. 1996. Presentation at ASSIST information exchange conference, October 22, 1996. Arlington, VA.
16. ASSIST Coordinating Committee. 1996. Summary report of the ASSIST Coordinating Committee meeting of October 25, 1996. Internal document, ASSIST Coordinating Center, Rockville, MD.
17. Brown, H. 1997. Testimony for National Cancer Policy Board re ASSIST, March 31, 1997.
18. Bartlett, D., and C. Dilorio. n.d. *A national evaluation of the America Stop Smoking Intervention Study for Cancer Prevention (ASSIST)'s impact on tobacco control. ASSIST II evaluation.* Atlanta: American Cancer Society.
19. ASSIST Coordinating Committee. 1997. Summary report of the ASSIST Coordinating Committee meeting of September 26, 1997. Internal document, ASSIST Coordinating Center, Rockville, MD.
20. ASSIST Advance Groups. 1997. Realizing America's vision for healthy people: Advancing a federal commitment to effective tobacco control, pt. 1. Internal report, ASSIST Coordinating Center, Rockville, MD.
21. ASSIST Advance Groups. 1997. Realizing America's vision for healthy people: Advancing a federal commitment to effective tobacco control, pt. 2. Internal report, ASSIST Coordinating Center, Rockville, MD.
22. Shalala, D. 1998. Letter to state tobacco control leaders, January 30, 1998.

Additional Resource

1. Pertschuk, M. 2001. *Smoke in their eyes: Lessons in movement leadership from the tobacco wars.* Nashville, TN: Vanderbilt Univ. Press.